Broward County HIV Integrated Planning Workgroup Meeting
Tuesday, October 24, 2023
1:00 PM - 3:00 PM

Purpose: HIV planning groups are responsible for overseeing the planning and implementation of integrated HIV prevention and care activities within communities. *The Integrated Plan Workgroup will be composed of the Ryan White Part A HIV Health Services Planning Council, South Florida AIDS Network (SFAN), and the Broward County HIV Prevention Planning Council (BCHPPC) with three members and one alternate representing their respective planning or advisory body, as applicable. (HIVPC By-Laws Article VIII, Section 10)*

1) **Call to Order, Welcome, and Introductions – Joey Wynn**

2) **Review and Approve Minutes from 7/25/2023**

3) **Review and Approve Today's Agenda**

4) **Integrated Planning Workgroup Co-Chair Follow-up Discussion**
   i) Review of HIVPC By-Laws – Attachment 1
   ii) Next Steps

5) **Integrated Plan Monitoring, Reporting and Evaluation Plan**
   i) Part A Ending the Epidemic (EHE) Plan Quarterly Progress Report - Attachment 2
   ii) FDOH-Broward EHE Prevention Plan Quarterly Progress Report - Attachment 3
   iii) Florida Integrated HIV Plan (FCPN) Progress Report - Attachment 4
   iv) Broward Integrated HIV Plan Evaluation – National and EHE Indicators
      (1) National HIV/AIDS Strategy and EHE Indicator Data for Broward County - Attachment 5
      (2) Broward Integrated HIV Prevention and Care Plan: Tracking Our Progress - Attachment 6
         (a) Indicator Data for Broward County - AHEAD Dashboard - Attachment 6a
         (b) Local Data: Broward County, FL – AIDS Vu - Attachment 6b
         (c) BRHPC Scorecard System Review - Attachment 6 c

6) **Community Recommendations Workplan Activities**
   i) IP Workgroup will continue to address these items including developing timelines, responsible parties and measurable outcomes.

7) **Old Business**

8) **New Business**

   i) Discussion regarding joint recruitment effort opportunity – Attachment 7

9) **Agenda Items for Next Meeting**

10) **Next IP Workgroup Meeting Date**

11) **Adjournment**

Broward County HIV Prevention and Care Integrated Planning Workgroup

Tuesday, July 25, 2023, from 12:00 PM-3:00 PM

By In-person / Zoom Videoconference

Purpose: HIV planning groups are responsible for overseeing the planning and implementation of integrated HIV prevention and care activities within communities.

The Broward County workgroup is composed of the Ryan White Part A HIV Health Services Planning Council, South Florida AIDS Network (SFAN), and the Broward County HIV Prevention Planning Council (BCHPPC) with three members and one alternate representing their respective planning or advisory body, as applicable. (HIVPC By-Laws Article VIII, Section 10)

MINUTES

HIVPC Appointed Members Present: L. Robertson, R. Bhrangger, T. Pietrogallo V. Biggs,

BCHPPC Appointed Members Present: B. Barnes, T. Williams

SFAN Appointed Members Present: J. Wynn, J. Rodriguez

Ryan White Part A Recipient Staff Present: J. Roy, G. James, T. Thompson, W. Cius, Q. Cowan, B. Miller

FLDOH Staff (Part B and Prevention) Present: K. Kirkland-Mobley, S. Cook, A. Abdool,

Ryan White Part D: B. Fortune-Evans

Guest: M. Greene, P. Jenkins, S. Tinsley

BRHPC Staff Present: M. Rosiere, G. Berkeley-Martinez, M. Patel, N. Del Valle

1. **Call to Order, Welcome, and Introductions**

   J. Wynn, IP Workgroup Co-Chair, called the meeting to order at 12:38 p.m. The Co-Chair welcomed everyone to the meeting, opened the floor for attendees to make introductions, and a moment of silence was observed for those we have lost to HIV/AIDS, those currently receiving care, and the work towards prevention of HIV acquisition.

2. **Review and Approve Minutes from 3/30/2023**

   The approval for the minutes of the March 30, 2023, meeting was proposed by V. Biggs, seconded by L. Robertson, and passed unanimously.

3. **Review and Approve the Agenda 7/25/2023**

   The approval of the July 25, 2023, agenda was proposed by V. Biggs, seconded by S. Tinsley, and passed unanimously.

4. **Integrated Planning Workgroup Co-Chair Nominations**
   S. Tinsley self-nominated for the Co-Chair position and seconded by B. Fortune-Evans; T. Williams made a motion to serve as the interim Co-Chair pending Ms. Tinsley's appointment to the integrated

workgroup, seconded by B. Barnes and passed unanimously.

5. **Develop Integrated Plan Monitoring, Reporting, and Evaluation Plan**
M. Rosiere provided an overview of the handouts: the Ryan White Part A EHE Plan, the FLDOH EHE Plan, the State EHE Plan, Community Responses, and Questions requiring responses from HRSA/CDC feedback of the Integrated Plan, which was submitted in December 2022. The Ryan White Part A Office received joint HRSA/CDC feedback on the Integrated HIV Prevention & Care Plan 2022-2026. A meeting with HRSA is scheduled for Thursday, July 27th, which may provide further details on the next steps. Ms. Rosiere referenced Handout 5, with the two questions requiring a response to HRSA.

Question #1: *How the jurisdiction will collaborate and coordinate monitoring of the different plans within the state to avoid duplication of effort and potential gaps in service provision: Specific coordination activities and timelines for coordination*

IP Workgroup Response: Describe the formulation of the IP Workgroup, which is composed of different planning bodies, partner organizations, and community members, and that the workgroup has started monitoring/evaluation meetings. The IP Workgroup is pulling together the data components for each funded grantee, reviewing goals, objectives, activities, and community recommendations.

Question #2: *How will revisions to the Integrated Plan be coordinated: Who will be responsible for making revisions? How decisions will be made? The frequency of updates.*

IP Workgroup Response:

- The Workgroup has identified the stakeholders responsible for updating the Plan.
- Each grantee will report to the IP workgroup during meetings (K. Kirkland-Mobley for HIV Prevention, S. Cook for Part B, and Q. Cowan for Part A EHE.)
- The Workgroup will follow the state's template.
- Based on the IP Workgroup meetings, the jurisdiction will monitor the different plans to avoid duplication of effort and potential gaps. The Workgroup will review all the services, determine what is missing, where services are duplicated, and identify service gaps.
- The Workgroup will revise the Plan every two and a half years. Each grantee will provide their recommended revisions to the Plan.
    - Follow-up with the State Health Department in Tallahassee regarding their Plan to revise the State's EHE Plan. Contact Jimmy LLaque, Wayne Morrison, and Michelle Battles, as the state is responsible for updating the Plans and overseeing the 15 jurisdictions. The state laid out the structure and provided the data to the local jurisdictions.

Motion: L. Robertson made a motion that data reports be submitted to the Broward Regional Health Planning Council every quarter by each grantee, seconded by B. Barnes, and passed unanimously.

B. Barnes made a friendly amendment to the motion to ensure reports match with the State Work Plan format (Handout 3) and includes the National HIV/AIDS Strategy (NHAS) pillars, seconded by L. Robertson, and passed unanimously.

6. **Old Business/Review of Community Recommendations (Prevention)**
This agenda item was tabled for the October 2023 meeting as additional follow-up is required from grantee agencies: Follow-Up on Action Items from the 3/30 Meeting: Review of Community recommendations that pertain to prevention for duplication and/or integration into the FDOH EHE Plan – Completed by FDOH-Broward

7. **Agenda Items for Next Meeting**
    - Provide Integrated Workgroup with HIV Health Services Planning Council's By-Laws guidelines

for the integrated planning workgroup.

- Community Recommendations (Handout 4).
- FLDOH will provide feedback on the CDC-specific guidance regarding the needs assessment process.

8. Other Meeting Notes

Work Activities

- Staff will send IP Workgroup members the quarterly October, January, and May meeting dates.
- Consider shadowing how hospitals conduct needs assessments with a status-neutral approach.
- Each grantee will bring more information to assist with streamlining the EHE process.
- Complete a linear crosswalk with the community recommendations.
- Submit the requested data report to BRHPC for the October 17th IP meeting.
- Part A will report that they prioritize conversations about how EHE services will be coordinated should HRSA discontinue EHE funding.
- The IP Workgroup will determine how it will measure and evaluate data. Members will be responsible for reporting data results to their planning body, which will review, analyze, and develop recommendations for any changes.
- A BRHPC representative will attend SFAN meetings to ensure the collection of Part B data.

Meeting Summary

- The Workgroup identified a process for quarterly updates, which will be reported to each planning body.
- The Workgroup identified a reporting format that will mirror the state's format while keeping with the NHAS pillars.
- BRHPC will integrate the report into one document for universal tracking and access.

9. Next IP Workgroup Meeting Date: Tuesday, October 24, 2023 @12:30 PM

10. Adjournment

There being no further business, the meeting was adjourned at 1:56 PM.

Integrated Planning Workgroup Co-Chair Follow-up Discussion

i) Review of HIVPC By-Laws – Attachment 1

BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

BY-LAWS

Last amended: February 23, 2023

SECTION 10: There shall be an Integrated Work Group

A. Membership.

The workgroup will be composed of the Ryan White Part A HIV Health Services Planning Council, South Florida AIDS Network (SFAN), and the Broward County HIV Prevention Planning Council (BCHPPC) with three members and one alternate representing their respective planning or advisory body, as applicable.

1. Members from the Part A program may include Council members, committee members, or other appropriate community stakeholders, such as Housing Opportunities for People with AIDS (HOPWA) /housing; Federally Qualified Health Centers (FQHC)/Hospital districts; Broward County Public Schools; Funded community-based service providers; Behavioral health provider; Client engagement systems, including linkage and re-linkage to care and retention in care; Community leaders.
2. Part A members will be selected for recommendation by the Executive Committee but must be approved by the Council.
3. The desired membership of the workgroup should be reflective of the demographics of the epidemic in Broward County, and consideration shall be given to race, ethnicity, self-acknowledged HIV- positivity, and gender.

B. Purpose.

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

C. Flow of Information.

1. The work group is expected to interact with numerous Prevention, Part A, and Part B teams, work groups, and committees.
2. The workgroup's main point of contact and coordination will be the Executive Committees of the Council, BCHPPC, and SFAN.

D. Ratification.

The work of the workgroup is provided to the Council, the BCHPPC, and SFAN in the form of recommendations, and is subject to the approval of the respective planning body.

Section 11: Joint Planning Body Meeting.

A joint planning body meeting does not require a standing membership and may meet on a periodic but not regular schedule. The joint planning bodies are the Ryan White Part A HIV Health Services Planning Council, the South Florida AIDS Network, and the Broward County HIV Prevention Planning Council.

Integrated Plan Monitoring, Reporting and Evaluation

1) Part A Ending the Epidemic (EHE) Plan Quarterly Progress Report - Attachment 2

2) FDOH-Broward EHE Prevention Plan Quarterly Progress Report - Attachment 3

3) Florida Integrated HIV Plan (FCPN) Progress Report - Attachment 4

Subject: RE: EHE Service Utilization Jan.-Sept. 2023 | Integrated Plan
Date: Monday, October 23, 2023 at 4:36:30 PM Eastern Daylight Time
From: Cowan, Quasia
To: Maunika Patel
CC: Michele Rosiere
Attachments: image001.png

Hi,

I updated it to include additional activities. Please let me know if you have any questions.

Quasia Cowan, MPH
Program Project Coordinator, Senior
Broward County Community Partnerships Division
Email: QCowan@broward.org
Office: (954) 357- 7809

From: Cowan, Quasia
Sent: Monday, October 23, 2023 3:46 PM
To: mpatel@brhpc.org
Cc: Michele Rosiere <mrosiere@BRHPC.ORG>
Subject: EHE Service Utilization Jan.-Sept. 2023 I Integrated Plan

Good Afternoon,

Please see below for utilization of our EHE services from January 1st through September 30, 2023. Please note these are estimates.

	# of Clients Served	# of Services
Medical Case Management	262	2,192
Non-Medical Case Management	197	1,200
Food Bank	1,491	4,295
Food Voucher	761	2,044
Medical Transportation	273	1,208
DIS	704	1,829
Housing	11	N/A

Below are updates on additional activities included on our workplan:

- **Coordinate and facilitate an EHE Provider Network:** Ongoing, meetings are held quarterly
- **Coordinate and facilitate Broward County's EHE Advisory Board:** Ongoing meetings are held bimonthly
- **Provide training to HIV care and treatment service providers in order to improve service delivery and expand knowledge and skills:** Ongoing
- **Develop marketing materials to disseminate pertinent information about the**

FDOH-Broward EHE Progress Report-EHE Integrated Crosswalk- Updated on 10/23/2023

Activity		Status	Process indicator	Start	End	Target	Actual	Related IP Strategy	Related IP Activity	Community Recommended Activities
Strategy 1A: Expand routine HIV testing in targeted health care settings										
1A.1	Expand detailing regarding routine HIV testing (sexual history taking,	Progressing	# of PCPs reached	8/1/20	7/31/24	3	3	1.1.2: Increase HIV knowledge among communities and health workforce.		
		Progressing		8/1/20	8/1/24	3,600	3,922		Expand routine HIV testing in targeted healthcare settings	
1A.2	Partner with the FOCUS Project to recruit additional EDs to provide routine HIV testing	DONE!	Whether a partnership with Gilead Sciences (FOCUS project funders) is established	8/1/20	7/31/24	Yes	Yes	1.2.1: Test all people for HIV according to current USPSTF and CDC guidelines.		
		DONE!	# of funded FOCUS partners in Broward County targeted	8/1/20	7/31/24	3	2			
1A.3	Explore the provision of routine HIV testing in dental practices starting with a pilot at a university or college	Not Started	# of planning meetings	8/1/22	7/31/24	2	-	1.2.2: Develop new and expand implementation of effective, evidence-based, or evidence-informe+J8d models for HIV testing that improve convenience and access.	Explore provision of routine HIV testing in dental practices starting with a college pilot	
1A.4	Povide HIV testing in a mobile health care clinic	DONE!	# of funded agencies providing HIV testing via mobile clinic	3/2/21	7/31/24	2	2	1.2.2: Develop new and expand implementation of effective, evidence-based, or evidence-informed models for HIV testing that improve convenience and	Explore provision of HIV testing in a mobile healthcare clinic	Ensure that HIV /STI mobile test units are at festivals, beaches, concerts, etc.
		Progressing	# of individuals tested for HIV in a mobile health care clinic	3/2/21	7/31/24	3,200	6,270			
1A.6	Provide continuing education regarding routine HIV testing (opt-out law, sexual history taking, stigma, insurance reimbursement, to health care professionals and students	Progressing	# of planning meetings	10/1/22	7/31/24	2	-	Strategy 1.2.1: Test all people for HIV according to current USPSTF and CDC guidelines.	Explore provision of routine HIV testing in dental practices starting with a pilot	
1A.7	Partner with substance use treatment providers to provide routine HIV	Progressing	# of partnerships	10/1/22	7/31/24	3	1	Strategy 1.2.2: Develop new and expand implementation of effective, evidence-	Partner with SA providers to provide routine testing on admission	Collaborate with traditional and non-traditional partners to conduct testing
			# of HIV tests conducted	10/1/22	7/31/24	222	24			
Strategy 1B: Expand targeted HIV testing of priority populations in non-health care settings										
1B.1	Use the social network strategy (SNS) to identify and test persons at risk for HIV through peers and partners	DONE!	# of agencies funded to provide SNS	3/3/21	7/31/24	2	2	Strategy 1.2.2: Develop new and expand implementation of effective, evidence-based, or evidence-informed models for HIV testing that improve convenience and access.	Use social network strategy to identify and test persons at risk for HIV through peers and partners	
		Progressing	# of individuals recruited through a SNS strategy	3/3/21	7/31/24	629	556			
		Progressing	# of individuals tested through implementation of SNS	3/3/21	7/31/24	1,880	2,289			
1B.2	Expand access to HIV testing through the provision of in-home test kits at non-health care settings	Progressing	# of non-healthcare settings disseminating in-home test kits	8/1/21	7/31/24	6	6		Expand access to HIV testing through the provision of in-home test kits at community sites	
		Progressing	# of in-home test kits disseminated in non-healthcare settings	8/1/21	7/31/24	650	947		Expand targeted HIV testing of priority populations in non-healthcare settings	
1B.3	Expand the free in-home test kit program to high risk zip codes	Progressing	# of in-home HIV test kits distributed by DOH-Broward	8/1/20	7/31/24	1,500	1,932		Expand the free in-home test kit program to high-risk ZIP codes	
		Progressing	# of in-home test kits distributed in high prevalence zip codes	8/1/22	7/31/24	300	353			
1B.4	Provide technical assistance to support the implementation of	DONE!	# of TA services provided	10/1/22	7/31/23	2	1	Strategy 2.1.2 Increase number of schools providing on-site sexual health services	Partner with schools to expand the provision of HIV and STI testing for	
Strategy 1C: Develop and implement a social marketing campaign										
1C.1	Develop and implement a community-driven campaign to educate on the importance of knowing your status, where to obtain a test, and decreasing stigma and fear around HIV testing	Progressing	# of campaign materials disseminated	8/1/21	7/31/24	15,000	14,849	Strategy 1.1.1: Develop and implement campaigns, interventions, and resources to provide sexual health education; HIV risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.	Develop and implement a social marketing campaign (e.g., www.hivtestnow.com).	
		DONE!	# of impressions made	8/1/21	7/31/24	2 M	40.7 M		Develop/ implement a community-driven campaign to decrease HIV testing stigma and fear	

		Progressing	# of ads placed	8/1/21	7/31/24	196	460		Develop and implement a community-driven campaign to educate the community on the importance of knowing your HIV status and where to obtain an HIV test	
Strategy 1D: Incorporate health equity into HIV testing										
1D.1	Provide trainings to HIV Service Providers and community members	Progressing	# of training events	8/1/21	7/31/24	60	42	Strategy 1.4.1 Provide resources, incentives, training, and TA to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible testing, prevention, and support services.	Provide cultural competence training to all HIV testing counselors to better serve LGBTQ+	
		Progressing	# of participants attending trainings	8/1/21	7/31/24	550	681			
1D.2	Provide capacity building assistance to grassroots organizations serving priority populations	Progressing	# of grassroot organizations provided with capacity building assistance	8/1/20	7/31/24	10	23		Provide capacity-building assistance to grassroots organizations that serve priority populations.	
		Progressing	# of capacity building assistance services provided to grassroot organizations	8/1/20	7/31/24	60	67		Incorporate health equity into HIV testing	
1D.3	Provide mini grants to grassroots organizations that serve priority populations	Progressing	# of grassroot organizations funded to provide HIV services	3/3/21	7/31/24	2	2		Provide mini grants to grassroots organizations that serve priority populations.	
		Progressing	# reached during outreach	3/3/21	7/31/24	711	1,015			
		Progressing	# of individuals provided with HIV services	3/3/21	7/31/24	365	311			
Strategy 1E: Create a seamless status-neutral HIV care continuum										
1E.1	Train all HIV Counseling, Testing and Linkage Training participants on the status neutral approach	Progressing	# of Trainings	8/1/21	7/31/24	19	27	Strategy 1.2.3: Incorporate status-neutral approach to testing, offering linkage to prevention for people who test negative and immediate linkage to HIV care/treatment for those who test positive.	Create a seamless status-neutral HIV care continuum.	
		Progressing	# of participants in trainings	8/1/21	7/31/24	250	408		Collaborate with community partners to conduct CoC SWOT	
1E.2	Collaborate with community partners to conduct strength, weakness, opportunity and threat (SWOT) analyses of the status-neutral HIV care continuum	Not Started	# of registered testing site implementing the status neutral approach	8/1/22	7/31/24	48	-		Create a seamless status-neutral HIV care continuum.	
		Progressing	# of meetings	8/1/22	7/31/24	1	2		Collaborate with partners to conduct CoC SWOT analyses, # participants in trainings, PrEP prescribing data, # physicians detailed.	
Strategy 2A: Expand access to Test and Treat services in HIV primary care										
2A.1	Expand detailing regarding Test and Treat to primary care physicians (PCP)	Progressing	# of hired staff providing physician detailing	8/1/20	7/31/24	3	3			
			# of physicians reached	8/1/20	7/31/24	3600	3,922			
2A.2	Recruit and retain the network of T&T providers in the private sector	Progressing	# of private Providers in Test and Treat network	8/1/22	7/31/24	10	16			
Strategy 2B: Increase retention in care and treatment and viral suppression										
2B.1	Implement a social marketing campaign promoting U=U strategy	Progressing	# of campaign materials disseminated	8/1/21	7/31/24	6000	7,537	Strategy 1.3.2 Scale up treatment as prevention (i.e., U=U) by diagnosing all people with HIV, as early as possible and engaging them in care and treatment to achieve and maintain VL suppression.		Implement a social marketing campaign promoting the U=U strategy
		Progressing	# of ads placed (changed in April 2022)	8/1/22	7/31/24	N/A	70			
2B.2	Explore expansion of our local resource and referral line to serve	DONE!	# of sexual health related calls	7/1/21	7/31/23	N/A	486			Explore the expansion of our local resource and referral line to serve PWH
			# of sexual health referrals	7/1/21	7/31/23	N/A	801			
2B.3	Provide HIPAA-compliant medical transportation	Progressing	# of medical transportation services for PWH	7/1/22	7/31/24	N/A	9,920			Provide HIPAA-compliant medical transportation
Strategy 3A: Expand access to PrEP										

3A.1	Expand hours of operation for PrEP/nPEP provision at public PrEP/nPEP providers to include evenings and weekends	Progressing	% of DOH-Broward contracted EHE PrEP/nPEP Providers with non-traditional hours	3/2/21	7/31/24	1	1	Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.	Expand hours for PrEP/nPEP provision at public providers to include evenings and weekends	
3A.2	Use Telemedicine to provide PrEP/nPEP	DONE!	# of agencies funded to provide Telemedicine services	3/2/21	7/31/24	3	4		Utilize telemedicine to provide PrEP	
		Progressing	# of individuals receiving Telemedicine services	3/2/21	7/31/24	N/A	616		Expand access to PrEP throughout the system of care	
		Progressing	# of PrEP/nPEP prescriptions provided via Telehealth	8/1/21	7/31/24	N/A	522			
3A.3	Expand the provision of PrEP/nPEP in a mobile health care clinic	DONE!	# of agencies funded to provide PrEP/nPEP services via mobile unit	3/2/21	7/31/24	2	2	Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.	Explore the provision of PrEP/nPEP in a mobile healthcare clinic	
		Progressing	# receiving PrEP screenings via mobile unit	3/2/21	7/31/24	4140	4,891			
		Progressing	# receiving nPEP screenings via mobile unit	3/2/21	7/31/24	4140	4,638			
		Progressing	# attending a PrEP Medical Visit	3/2/21	7/31/24	1575	1,417			
		Progressing	# attending a nPEP Medical Visit	3/2/21	7/31/24	N/A	2			
		Progressing	# oPrEP/nPEP mobile prescriptions	3/2/21	7/31/24	N/A	1,264			
3A.4	Expand detailing to primary care physicians to recruit additional PrEP/nPEP prescribers	Progressing	# staff providing PrEP/nPEP physician detailing	8/1/20	7/31/24	3	3	Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.		Expand education to primary care physicians to recruit additional PrEP/nPEP prescribers.
		Progressing	# of physicians reached by Detailing staff	8/1/20	7/31/24	3600	3,922			
		Progressing	# of PrEP/nPEP medical locations on get prep broward PrEP Directory	8/1/21	7/31/24	N/A	171			
		Progressing	# of new Physician Practices That Agreed to be Listed as PrEP Providers	8/1/21	7/31/24	192	130			
3A.5	Address the financial barriers to PrEP/nPEP initiation and retention	Progressing	# of clients enrolled in PrEP Navigation	8/1/22	7/31/24	1200	2,157	Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.		Address the financial barriers to PrEP/nPEP initiation and retention.
		Progressing	# of payment assistance program enrollments	8/1/22	7/31/24	600	975			
3A.6	Work with partners to provide PrEP/nPEP in conjunction with an SEP, if implemented	DONE!	Whether a partnership with Gilead Sciences (FOCUS project funders) is established		7/31/24			Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.		Work with partners to provide PrEP/nPEP in conjunction with a SEP, if implemented.
3A.7	Explore the expansion of our local resource and referral line to serve	Progressing	# of sexual health related calls	7/1/21	7/31/24	N/A	486	Strategy 1.3.2 Scale up treatment as prevention (i.e., U=U) by diagnosing all		Explore the expansion of our local resource and referral line to serve PWH
		Progressing	# of sexual health referrals	7/1/21	7/31/24	N/A	801			
Strategy 3B: Raise community awareness of PrEP/nPEP through educational workshops, outreach, and social marketing										
3B.1	Expand street outreach regarding PrEP/nPEP	Progressing	# of outreach activities with PrEP/nPEP messaging	3/2/21	7/31/24	830	1,042	Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.	Expand Street outreach regarding PrEP/nPEP	
		Progressing	# of individuals reached with PrEP/nPEP messaging	3/2/21	7/31/24	9,010	46,583			
3B.2	Develop and implement a community-driven campaign to increase community awareness of PrEP/nPEP-update the staff reports	Progressing	# of campaign materials disseminated	8/1/21	7/31/24	60,000	83,240	Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.	Develop community-driven campaign to educate community on PrEP/nPEP and decrease stigma	
		Progressing	# of impressions made	8/1/21	7/31/24	5 M	15.9 M		Raise community awareness of PrEP/nPEP through outreach and social marketing EHE	
		Progressing	# of ads	8/1/22	7/31/24	96	7			
3B.3	Provide PrEP/nPEP education to HIV Prevention Service Providers,	Progressing	# of educational workshops provided	8/1/21	7/31/24	376	258	Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and	Expand education to primary care physicians to recruit additional	

	Broward Schools, Community stakeholders, and community	Progressing	# of participants in educational workshops	8/1/21	7/31/24	N/A	2,724	SSPs, easier to access.	PrEP/nPEP prescribers	
Strategy 3C: Incorporate health equity into HIV prevention										
3C.1	Provide capacity building and technical assistance to grassroots organizations that serve priority populations	Progressing	# of grassroot organizations provided capacity building assistance	8/1/20	7/31/24	10	23	Strategy 1.4.1 Provide resources, incentives, training, and TA to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible testing, prevention, and support services.	Provide capacity-building assistance to grassroots organizations that serve priority populations	
		Progressing	# of capacity building services provided to grassroot organizations	8/1/20	7/31/24	60	67		Provide capacity building and TA to grassroots organizations that serve priority populations	
3C.2	Provide mini grants to grassroots organizations that serve priority populations	Progressing	# of grassroot organizations funded to provide HIV services	3/3/21	7/31/24	2	2	Strategy 1.4.1 Provide resources, incentives, training, and TA to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible testing, prevention, and support services.	Provide mini grants to grassroots organizations that serve priority populations	
		Progressing	# of individuals reached during outreach	3/3/21	7/31/24	711	1,015			
		Progressing	# of individuals provided with HIV services	3/3/21	7/31/24	365	311		Include larger funding for grassroots organization capacity building	
3C.3	Provide trainings to HIV Service Providers and community members	Progressing	# of training events	8/1/21	7/31/24	60	42	Strategy 1.4.1 Provide resources, incentives, training, and TA to expand workforce and systems capacity to provide or link clients to culturally competent,	Provide cultural competence training to all HIV testing counselors to better serve LGBTQ+	
		Progressing	# of participants attending trainings	8/1/21	7/31/24	550	681			
3D.1	Collaborate with community partners to conduct strength, weakness, opportunity and threat (SWOT) analyses of the statues-neutral HIV care continuum-	Progressing	# of HIV CTL Providers implementing the status-neutral approach	8/1/20	7/31/24	48	-	Strategy 1.2.3: Incorporate status-neutral approach to testing, offering linkage to prevention for people who test negative and immediate linkage to HIV care/treatment for those who test positive.	Collaborate with community partners to conduct SWOT analyses of HIV Continuum	
		DONE!	# of status-neutral approach related meeting with HIV CTL sites	8/1/20	7/31/24	1	2		Collaborate with community partners to conduct SWOT analyses of care continuum data, number of participants in trainings, PrEP prescribing data, number of physicians detailed	
Strategy 4A: Enhance the ability to conduct molecular cluster response by increasing the number of genotypes										
4A.1	Conduct physician detailing to encourage genotype testing	Progressing	# of hired staff providing physician detailing	8/1/20	7/31/24	3	3		Enhance the ability to conduct molecular cluster response by increasing genotype testing	
		Progressing	# of T&T providers educated on the importance of genotype testing	11/1/22	7/31/24	26	-		Conduct physician detailing to encourage genotype testing	
Strategy 4B: Explore supporting HIV modernization activities that impact state laws (i.e., HIV decriminalization)										
4B.1	Provide education to community stakeholders, organizations, and elected officials about U=U and Treatment as Prevention (TasP) to support HIV modernization	DONE!	# of U=U and TasP educational activities provided by or in partnership with DOH-Broward	8/1/22	7/31/24	2	2		Explore supporting HIV modernization activities that impact state laws (ie, HIV decriminalization)	
		Progressing	# of individuals in attendance at educational activities	8/1/22	7/31/24	N/A	50			

Part B Progress Report

Florida Comprehensive Planning Network Coordination of Efforts Committee Call Summary Oct 11, 2023

Attendance:

Present:

Jhazmine Allen, Rebecca Arrington
Jeannette Begault
Susan Barrows, LaCandria Churchill
Gregory Davis, Meghan Daily
Cathy Frazier, Warren Garrison
Cecilia Gonzolez
Chris Gudis, Nataliya Johnson
Nicole Johnson, Bobby Jordan
Jamie Marques , Whitney Marshal
Kim Molnar, Rob Renzi
Joshua Rodriguez
Michele Rosiere
Abril Sarmiento
Jessica Seidita, Akia Smith
Kira Villamizar, Joey Wynn, Co-Chair
Scott Wilson, Maribel Zayas

Absent: John Acevedo

Mike Alonso, Stephen Aube
Anne Jean Baptiste
Ken Bargar, Brad Barnes
Michelle Battles, Gritell Berkeley Martinez
Johanne Belizaire-Francois, Vonn Biggs
Channel Bonner, Denise Brown
Julia Cooper, Timothy Dean, Co-Chair
Nolan Finn, Dallen Michael Greene
Nicole Houston, Sylvia Hubbard
Ederick Johnson, Riley Johnson
Casey Messer , Alelia Munroe
Dan Merkan, Eric Martinez
Michelle Peaslee
Amy Pinter, Penny Pringle
Jessica Roy, Jeff Satine
Geneve Simeus, Mary Sirmons
Sylvia Smith, Anthony Stowe
Kevin Williams

Agenda: Discussion Topics

- **Introduction of the HIV/AIDS Section Performance and Quality Management Team**
  - Warren Garrison, Performance and Quality Manager
  - Bobby Jordan, Clinical Quality Monitoring Liaison
  - Jhazmine Allen, Statewide Planning Coordinator
  - Jeannette Begault, Performance and Quality Liaison
  - Kiara Adenola, HAPC Coordinator
- **High level overview goals and strategies of the section**
  - Organization efforts focusing on goal achievement, internal stability, and environmental adaptation. Seven essential concepts for integrative services include goal focus, optimal power, communication, morale, autonomy, adaptation, and problem solving. Emphasis is on the importance of collaboration and the need for feedback and engagement on the plan and evaluation process.

- **Strategy Session Debrief – Joey Wynn**
    - Discussed how the diverse set of skills within the Section team and the Coordination of Efforts Committee (COE) will allow for the review of the Integrated Plan (IPC) efficiently and effectively. There are ongoing discussions to identify stakeholders, responsible parties, and reasonable timelines for monitoring and evaluating the (IPC)

- **Broward Regional Health Planning Counsil Metrics – Michele Rosiere**
    - A presentation was given to provide an overview of four Data Monitoring Dashboards: AHEAD, COMPASS, Charts, and AIDSVu. Michele also explained how to compare data points with national HIV indicators (NHAS and EHE). The full presentation slides are included as an attachment. There was a recommendation made that everyone participating in the monitoring and evaluation locally or statewide spend time exploring the Florida Health CHARTS website and dashboard at (https://www.flhealthcharts.gov/charts/default.aspx)

- **Monitoring and Evaluation Plan TBD determinations – Scott Wilson and Joey Wynn**
    - The Monitoring and Evaluation plan (attached) has three separate tables where items are marked as "TBD", and it will be the role of the Coordination of Efforts committee to inform those items. The first table covers roles and responsibilities. The second covers program benchmarks for plan activities. The third table covers data indicator sources. The roles and responsibilities section as it related to the Coordination of Efforts committee was populated using the COE charter.

Next Steps/Upcoming Agenda

- Review the data sources presented by Michele, and the Monitoring and Evaluation plan presented by the Section with your local areas to begin brainstorming how to fill in the TBDs
- TAI and Committee Chairs will review the committee membership to make sure all areas have active participation.

Announcements

A motion was made, seconded, and unanimously approved that the group will begin meeting monthly beginning January 2024 and until at least June 2024.

The meeting was concluded by the Co-Chairs at 1:54 PM (ET). The next formal virtual committee meeting is scheduled for **Wednesday, November 8, 2023, at 1:00 PM (ET).**

National HIV/AIDS Strategy and EHE Indicator Data for Broward County

Attachment 5

National HIV/AIDS Strategy (NHAS) and EHE Indicator Data for Broward County

EHE OVERARCHING GOAL

EHE aims to reduce new HIV infectionsby 75% in five years and by 90% in 10 years.

Incidence is the estimated number of new HIV infections in a given year.

		2017	2018	2019	2020	2021	2022	2025	2030
NHAS #2	Total Incidence	670	530	540	510	500		168	67

EHE MIDTERM GOAL

This indicator is used to show the historical movement towards achieving overall goals of EHE.

Knowledge of status is the estimated percentage of people with HIV who have received a diagnosis.

		2017	2018	2019	2020	2021	2022	2025	2030
NHAS #1	Knowledge of Status	88%	89%	89%	90%	90%		95%	95%
		18,936	19,334	19,650	19,811	20,137			

EHE LEADING INDICATORS

Leading indicators demonstrate movement towards meeting overarching goals of EHE.

Diagnoses

Diagnoses is the # of people diagnosed in a given year confirmed by laboratory or clinical evidence.

		2017	2018	2019	2020	2021	2022*	2025	2030
NHAS #3	Persons diagnosed	671	583	555	424	570	638	168	67

PrEP Coverage

PrEP coverage is the estimated percentage of individuals prescribed PrEP among those who need it.

		2017	2018	2019*	2020*	2021*	2022*	2025	2030
NHAS #4	Prescribed PrEP	10%	14%	19%	33%	41%	39%	50%	50%
		2,011	2,909	3,839	6,786	8,347	8,065		

Linkage to HIV Medical Care

Percentage diagnosed with HIV in a year who received medical care within one month of diagnosis.

		2017	2018	2019	2020	2021	2022*	2025	2030
NHAS #5	≥1 CD4/VL w/in 1 month	81%	84%	87%	87%	82%	82%	95%	95%
		541	527	517	402	467	523		

Viral Suppression

Viral suppression: percentage of people who have an amount of HIV < 200 copies per ml

		2017	2018	2019	2020	2021	2022	2025	2030
		67.5	68.2	69.7	68.7	68.7		95%	95%
NHAS #6	Persons diagnosed with HIV	12,499	12,867	13,416	13,410	13,586			
NHAS #6a	MSM	74	74.9	76.4	75.6	76.7			
NHAS #6b	Black MSM	58.5	60.9	64.4	63.4	63.3			
NHAS #6c	Latino MSM	75	75.3	76.3	75.5	77.2			
NHAS #6d	Black Females	60.3	60.5	62.9	62.4	59.1			
NHAS #6e	Transgender Women	(Not reported in the AHEAD Dashboard)							
NHAS #6f	People who Inject Drugs	60.1	60.8	62.5	54.1	54.9			
NHAS #6g	Youth	58.5	58.3	66.3	63.6	58.5			
NHAS #6h	People 50 and Over	71.7	72.1	72.8	72.2	72			

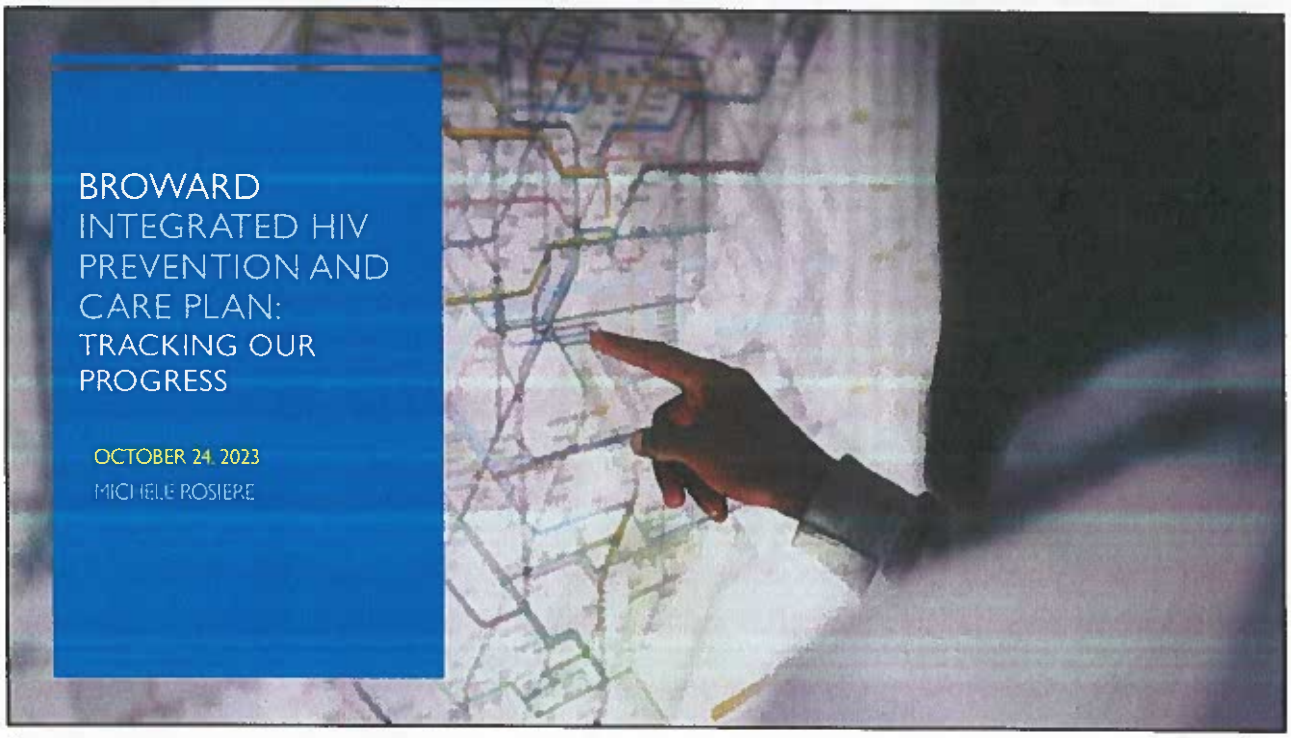
* indicates data is preliminary

Data Source: https://ahead.hiv.gov/locations/broward-county

Updated October 10, 2023

Broward Integrated HIV Prevention and Care Plan: Tracking Our Progress

Attachment 6



1

PRESENTATION OVERVIEW

- **NATIONAL/STATE DASHBOARDS**
  - AHEAD Dashboard (EHE)
  - Ryan White HIV/AIDS Program COMPASS
  - Florida Health Charts EHE Dashboard
  - AIDSVu
- **OVERVIEW OF NATIONAL HIV INDICATORS**
  - National HIV/AIDS Strategy (NHAS)
  - Ending the HIV Epidemic
  - NHAS and EHE Indicators Crosswalk
- **TRACKING BROWARD'S IMPACT**
  - Broward Indicator Data
  - Progress Implementing IP Components
    - Part B/State of Florida Plan
    - Part A HIVPC & CQM Workplans
    - Part A EHE Plan – Part A Recipient
    - Prevention EHE Plan – FDOH-Broward
  - **Brainstorming**
    - Integration of Community Recommendations

2

NATIONAL AND STATE DASHBOARDS

- Ending the HIV Epidemic AHEAD Dashboard
- Ryan White HIV/AIDS Program COMPASS
- AIDS Vu
- Florida Health Charts: Ending the Epidemic

3

National HIV/AIDS Strategy (NHAS) and EHE Indicator Data for Broward County

EHE OVERARCHING GOAL

NHAS #1	Total Incidence	670	530	540	510	500		168	67

EHE MIDTERM GOAL

NHAS #2	Knowledge of Status	88%	89%	89%	90%	90%		95%	95%
		19,936	19,334	19,630	19,811	20,137			

EHE LEADING INDICATORS

Diagnoses

NHAS #3	Persons diagnosed	671	583	593	624	570	630	168	67

PrEP Coverage

NHAS #4	Prescribed PrEP	19%	14%	19%	33%	41%	39%	50%	50%
		2,811	2,009	3,239	6,764	8,347	8,065		

Linkage to HIV Medical Care

NHAS #5	≥1 CD4 VL, w/in 1 month	81%	84%	87%	87%	82%	82%	95%	95%
		541	537	517	402	467	521		

Viral Suppression

		87.5	88.2	89.2	84.1	84.7			
NHAS #6	Persons diagnosed with HIV	12,499	12,867	13,418	13,410	13,586			
NHAS #6a	MSM	74	74.9	76.4	75.6	76.7			
NHAS #6b	Black MSM	58.5	60.8	64.4	61.4	63.3			
NHAS #6c	Latino MSM	75	75.1	76.3	73.5	77.2			
NHAS #6d	Black Females	60.3	60.3	62.9	61.4	59.1			
NHAS #6e	Transgender Women	(Not reported in the AHEAD Dashboard)							
NHAS #6f	People who Inject Drugs	60.1	60.8	62.5	54.1	54.9			
NHAS #6g	Youth	58.5	58.3	60.3	60.6	58.3			
NHAS #6h	People 50 and Over	71.9	72.1	72.8	72.2	72			

* indicates data is preliminary

Data Source: https://ahead.hiv.gov/locations/broward-county Updated October 10, 2023

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AHEAD DASHBOARD, JURISDICTION DATA, BROWARD

5

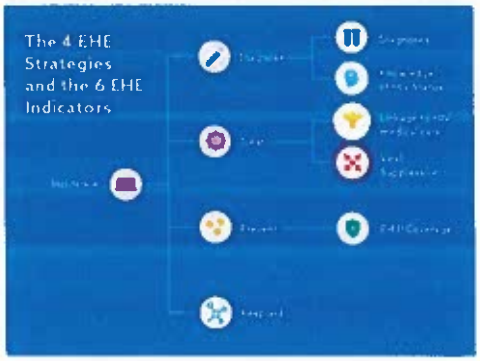
AMERICA'S HIV EPIDEMIC ANALYSIS (AHEAD) DASHBOARD

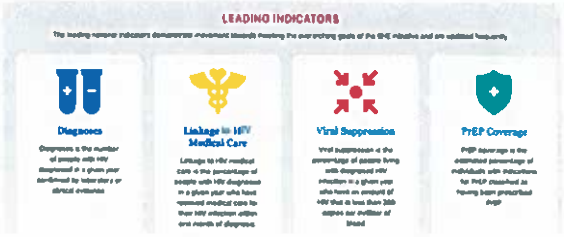
- Supports monitoring and tracking of the Ending the HIV Epidemic (EHE) initiative.
- AHEAD tracks the 6 EHE indicators
- Complements and serves as one of many important implementation elements of the EHE initiative and the National HIV/AIDS Strategy.
- Interactive dashboard used to inform planning and is a starting place to explore other HIV data sources.

6

Ending the HIV Epidemic

EHE LEADING INDICATORS





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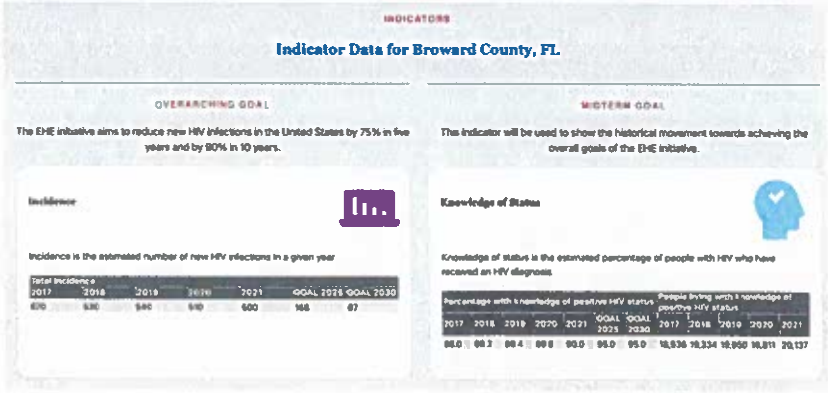

8

AHEAD

OVERARCHING GOAL

The EHE initiative aims to reduce new HIV infections in the United States by 75% in five years and by 90% in 10 years.

Incidence

National HIV/AIDS Strategy Indicator #2

Total incidence

	2017	2018	2019	2020	2021	GOAL 2025	GOAL 2030
Miami-Dade County, FL, Total	1,100	1,100	980	850	870	275	110
Broward County, FL, Total	670	530	540	510	500	168	67
Orange County (FL), FL, Total	420	410	450	440	460	105	42
Hillsborough County, FL, Total	280	270	240	290	180	70	28
Palm Beach County, FL, Total	270	260	240	300	230	68	27
Duval County, FL, Total	250	240	220	280	230	63	25
Pinellas County, FL, Total	140	140	150	160	no data*	35	14

Incidence is the estimated number of new HIV infections in a given year.

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AHEAD

KNOWLEDGE OF STATUS

Knowledge of Status

NHAS Indicator #1
EHE Mid-Term Goal

	Percentage with knowledge of positive HIV status							People living with knowledge of positive HIV status				
	2017	2018	2019	2020	2021	GOAL 2025	GOAL 2030	2017	2018	2019	2020	2021
Miami-Dade County, FL, Total	88.8	87.1	87.4	87.6	88.1	95.0	95.0	25,653	25,960	26,186	26,269	26,875
Broward County, FL, Total	88.0	89.2	89.4	89.6	90.0	95.0	95.0	18,936	19,334	19,650	19,811	20,137
Orange County (FL), FL, Total	85.4	83.0	83.3	83.5	83.7	95.0	95.0	8,231	8,555	8,759	8,892	9,252
Hillsborough County, FL, Total	85.2	84.2	84.8	85.2	86.7	95.0	95.0	6,561	6,775	6,989	7,176	7,379
Palm Beach County, FL, Total	87.7	86.8	86.8	86.3	86.8	95.0	95.0	7,706	7,779	7,864	7,925	8,034
Duval County, FL, Total	81.7	83.1	84.1	84.4	85.3	95.0	95.0	5,818	6,018	6,152	6,266	6,413
Pinellas County, FL, Total	87.8	86.5	87.6	88.3	88.9	95.0	95.0	4,410	4,524	4,731	4,836	4,895

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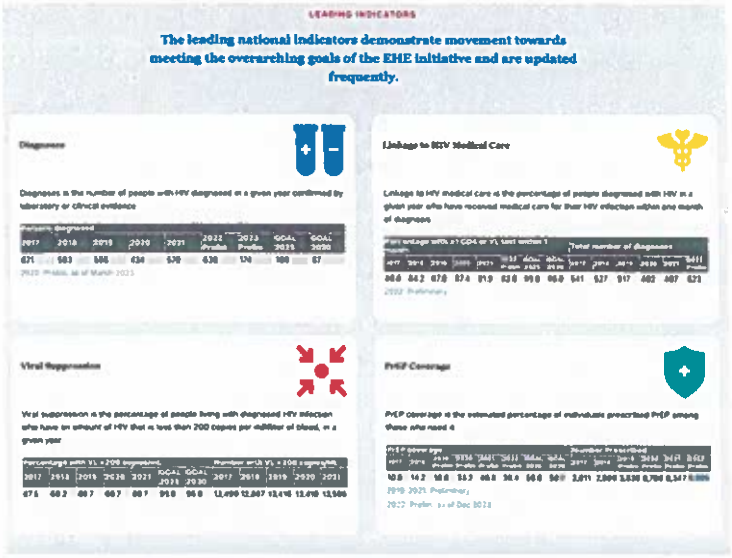

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Ending the HIV Epidemic AHEAD

HIV DIAGNOSES

NHAS Indicator #3
EHE Leading Indicator

Diagnoses

Diagnoses is the number of people with HIV diagnosed in a given year confirmed by laboratory or clinical evidence.

	Persons diagnosed								
	2017	2018	2019	2020	2021	2022 Prelim	2023 Prelim	GOAL 2025	GOAL 2030
Broward County, FL, Total	671	583	555	424	570	638	174	168	67
Duval County, FL, Total	300	267	279	231	280	310	69	75	30
Hillsborough County, FL, Total	300	284	256	237	294	335	90	75	30
Miami-Dade County, FL, Total	1,141	1,100	1,056	736	937	1,140	323	285	114
Orange County (FL), FL, Total	461	441	442	358	416	471	94	115	46
Palm Beach County, FL, Total	289	272	222	201	273	348	58	72	29
Pinellas County, FL, Total	164	174	179	149	122	134	43	41	16

2022: Prelim. as of March 2023

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LINKAGE TO HIV MEDICAL CARE

NHAS Indicator #5
EHE Leading Indicator

	Percentage with ≥1 CD4 or VL test within 1 month								Total number of diagnoses					
	2017	2018	2019	2020	2021	2022 Prelim	GOAL 2025	GOAL 2030	2017	2018	2019	2020	2021	2022 Prelim
Broward County, FL, Total	80.6	84.2	87.0	87.4	81.9	82.0	95.0	95.0	541	527	517	402	467	523
Duval County, FL, Total	70.3	74.5	76.9	80.3	79.3	74.2	95.0	95.0	211	204	210	184	222	230
Hillsborough County, FL, Total	76.3	82.4	85.7	84.6	79.6	83.9	95.0	95.0	229	248	228	209	234	281
Miami-Dade County, FL, Total	81.1	84.5	84.4	84.5	82.0	83.8	95.0	95.0	925	994	971	660	768	955
Orange County (FL), FL, Total	70.5	76.7	78.3	86.2	81.7	82.0	95.0	95.0	325	356	365	318	340	386
Palm Beach County, FL, Total	76.1	81.7	78.9	79.8	84.6	89.1	95.0	95.0	220	232	187	170	231	310
Pinellas County, FL, Total	75.6	86.3	85.3	84.2	81.1	86.6	95.0	95.0	124	151	157	128	99	116

2022: Preliminary

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VIRAL SUPPRESSION

NHAS Indicator #6
EHE Leading Indicator

	Percentage with VL <200 copies/mL							Number with VL <200 copies/ML				
	2017	2018	2019	2020	2021	GOAL 2025	GOAL 2030	2017	2018	2019	2020	2021
Broward County, FL, Total	67.5	68.2	69.7	68.7	68.7	95.0	95.0	12,499	12,867	13,416	13,410	13,586
Duval County, FL, Total	56.3	60.1	63.9	64.7	69.5	95.0	95.0	3,156	3,496	3,816	3,953	4,324
Hillsborough County, FL, Total	66.0	69.1	72.1	73.1	72.5	95.0	95.0	4,194	4,539	4,891	5,106	5,196
Miami-Dade County, FL, Total	60.0	61.8	59.6	59.2	61.6	95.0	95.0	14,919	15,543	15,194	15,256	16,142
Orange County (FL), FL, Total	64.2	66.4	69.0	71.0	72.0	95.0	95.0	5,065	5,418	5,815	6,118	6,433
Palm Beach County, FL, Total	59.1	61.6	62.4	64.3	64.7	95.0	95.0	4,459	4,704	4,854	5,034	5,100
Pinellas County, FL, Total	68.6	70.6	76.0	76.6	77.8	95.0	95.0	2,939	3,029	3,437	3,582	3,745

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Ending the HIV Epidemic AHEAD

PREP COVERAGE

NHAS Indicator #4
EHE Leading Indicator

	PrEP coverage								Number Prescribed					
	2017	2018	2019 Prelim	2020 Prelim	2021 Prelim	2022 Prelim	GOAL 2025	GOAL 2030	2017	2018	2019 Prelim	2020 Prelim	2021 Prelim	2022 Prelim
Miami-Dade County, FL, Total	9.1	17.5	29.7	46.9	52.4	51.7	50.0	50.0	2,018	3,805	6,470	10,202	11,411	11,256
Broward County, FL, Total	10.0	14.2	18.8	33.2	40.8	39.4	50.0	50.0	2,011	2,909	3,839	6,786	8,347	8,065
Orange County (FL), FL, Total	6.3	12.2	18.2	25.4	30.9	38.1	50.0	50.0	1,043	1,873	2,787	3,895	4,738	5,828
Hillsborough County, FL, Total	5.1	8.5	10.8	11.9	15.9	20.3	50.0	50.0	848	1,097	1,388	1,533	2,053	2,624
Palm Beach County, FL, Total	5.1	6.3	9.7	32.8	30.0	26.7	50.0	50.0	388	574	885	3,004	2,749	2,450
Duval County, FL, Total	2.8	4.1	5.5	8.0	9.8	18.8	50.0	50.0	256	365	494	717	878	1,507
Pinellas County, FL, Total	4.5	8.6	12.0	12.9	17.4	22.2	50.0	50.0	470	819	1,146	1,232	1,662	2,120

2019 - 2021: Preliminary
2022: Prelim. as of Dec 2022

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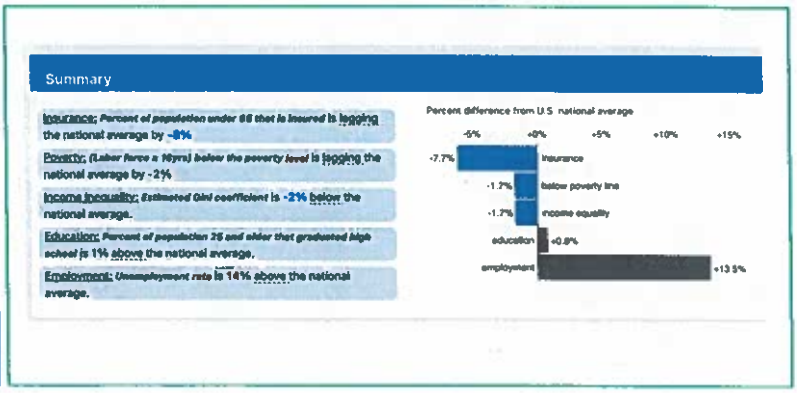
Ending the HIV Epidemic AHEAD

SOCIAL DETERMINANTS OF HEALTH



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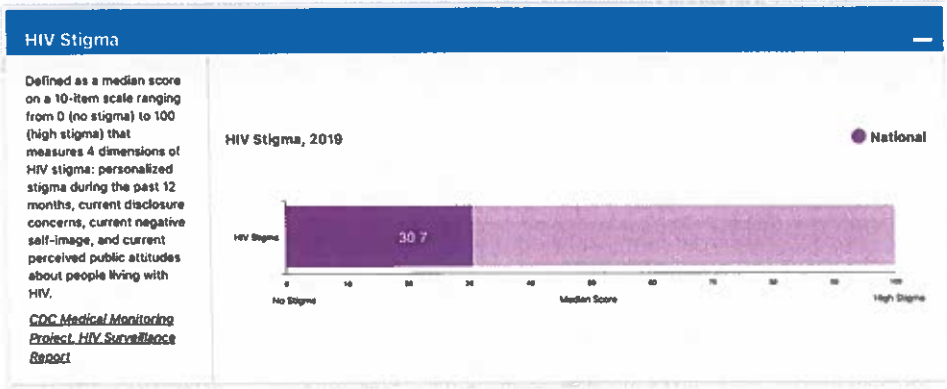
HOMELESSNESS AMONG PERSONS LIVING WITH HIV (NATIONAL)

17

STIGMA AMONG PERSONS LIVING WITH HIV (NATIONAL)



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RYAN WHITE HIV/AIDS PROGRAM
COMPASS

RYAN WHITE HIV/AIDS PROGRAM COMPASS

HIV INDICATOR DATA FOR PERSONS RECEIVING RYAN WHITE SERVICES

https://RyanWhite.HRSA.gov/data/dashboard

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COMPASS

VIRAL LOAD SUPPRESSION PERFORMANCE SUMMARY (BROWARD 2021)

Performance Summary for Ft. Lauderdale, FL, 2021

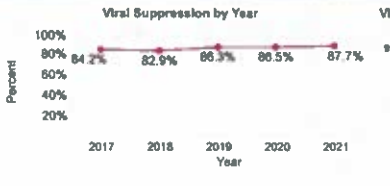
All Clients

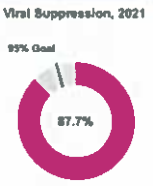
100% of clients (4,435/4,435)

About Standardized Performance
HRSA HAB's performance benchmarking methodology allows the calculation of expected outcome measure values based on a jurisdiction's client mix. This can then be compared to national averages, allowing a snapshot understanding of whether a jurisdiction is performing above or below expected results. Learn more by navigating to the Related Resources section at the bottom of this page and selecting Standardized Performance Fact Sheet.

Resources

Standardized performance is below average for the population served. Resources are available to help improve outcomes. Learn more by navigating to the Related Resources section at the bottom of this page and selecting Review Available Resources.



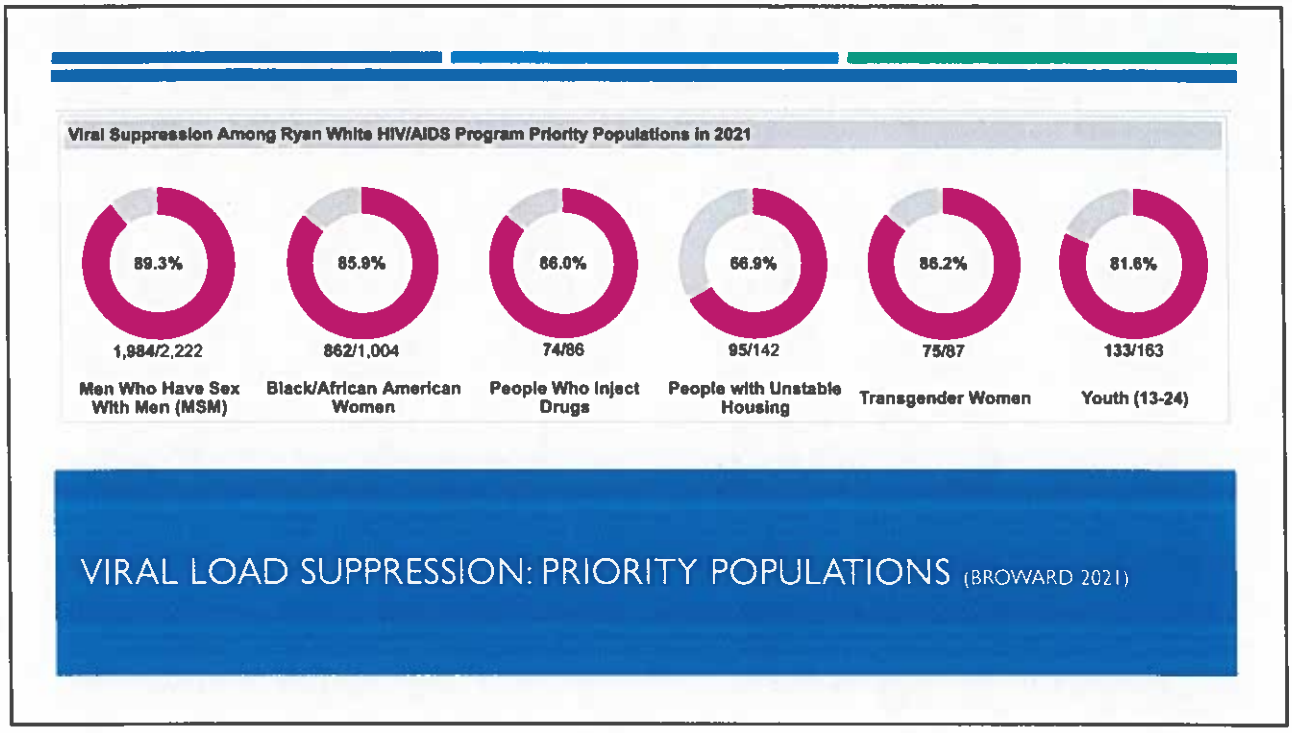


Standardized performance is below average. It is in the 2nd quintile compared to national

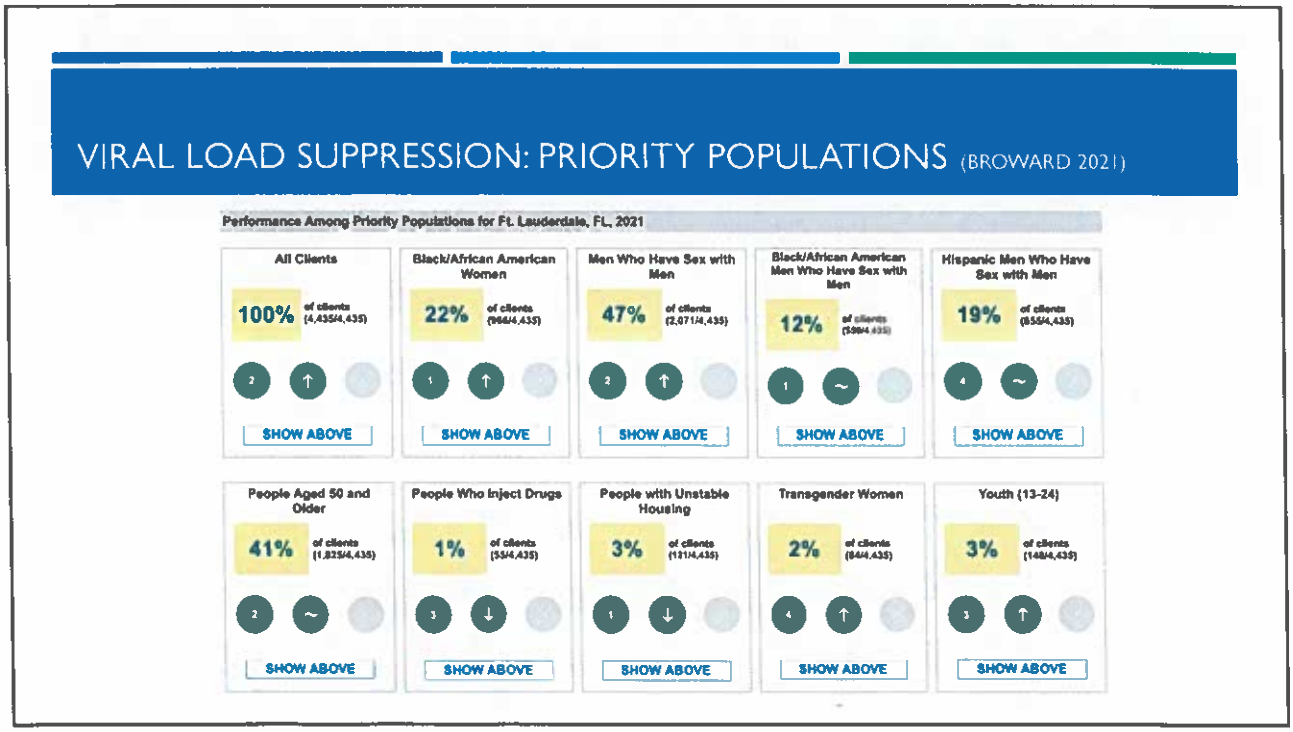
Viral Suppression has increased compared to the previous year.

Viral Suppression did not meet the national goal.

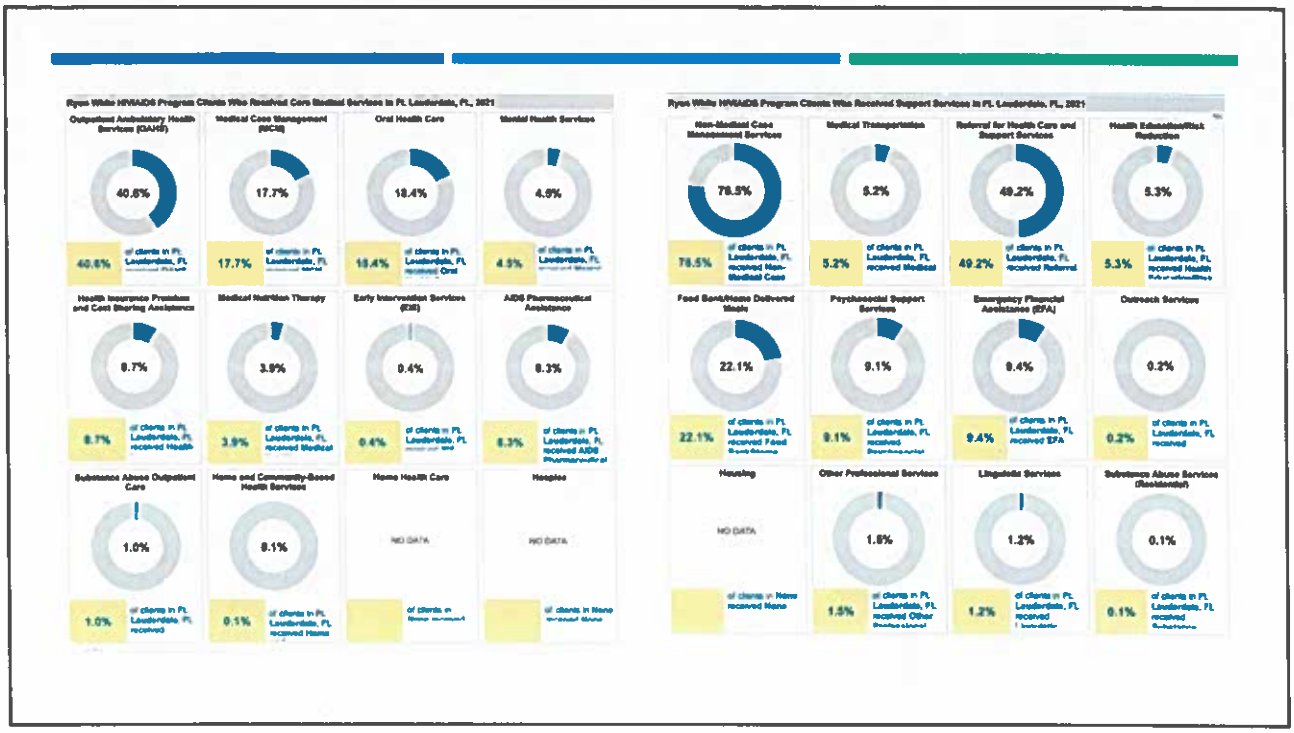
20


Viral Suppression Among Ryan White HIV/AIDS Program Priority Populations in 2021
89.3%
1,984/2,222
Men Who Have Sex With Men (MSM)
85.9%
862/1,004
Black/African American Women
86.0%
74/86
People Who Inject Drugs
66.9%
95/142
People with Unstable Housing
86.2%
75/87
Transgender Women
81.6%
133/163
Youth (13-24)
VIRAL LOAD SUPPRESSION: PRIORITY POPULATIONS (BROWARD 2021)

21


VIRAL LOAD SUPPRESSION: PRIORITY POPULATIONS (BROWARD 2021)
Performance Among Priority Populations for Ft. Lauderdale, FL, 2021
All Clients
100%
SHOW ABOVE
Black/African American Women
22%
SHOW ABOVE
Men Who Have Sex with Men
47%
SHOW ABOVE
Black/African American Men Who Have Sex with Men
12%
SHOW ABOVE
Hispanic Men Who Have Sex with Men
19%
SHOW ABOVE
People Aged 50 and Older
41%
SHOW ABOVE
People Who Inject Drugs
1%
SHOW ABOVE
People with Unstable Housing
3%
SHOW ABOVE
Transgender Women
2%
SHOW ABOVE
Youth (13-24)
3%
SHOW ABOVE

22



23

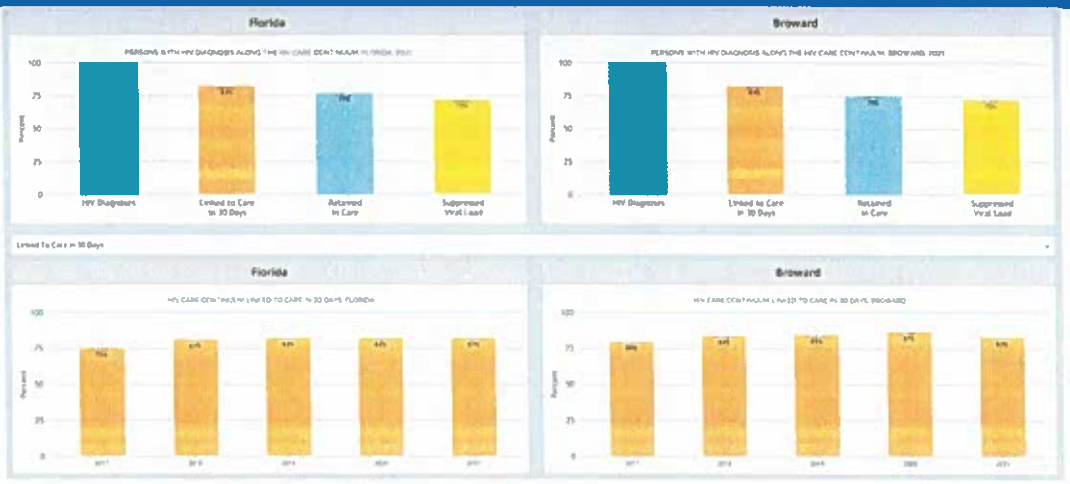
FLORIDA HEALTH CHARTS EHE DASHBOARD

INCLUDES INDICATOR DATA FOR ALL 67 COUNTIES

FLHealthCHARTS Ending the HIV Epidemic (EHE)

24

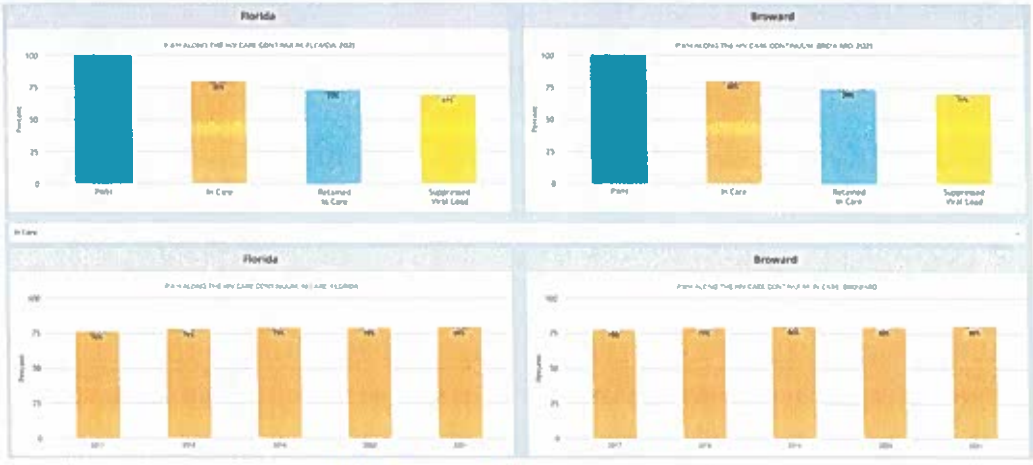
HIV DIAGNOSIS CONTINUUM (FL VS BROWARD)



FL Health CHARTS Ending the HIV Epidemic (EHE)

25

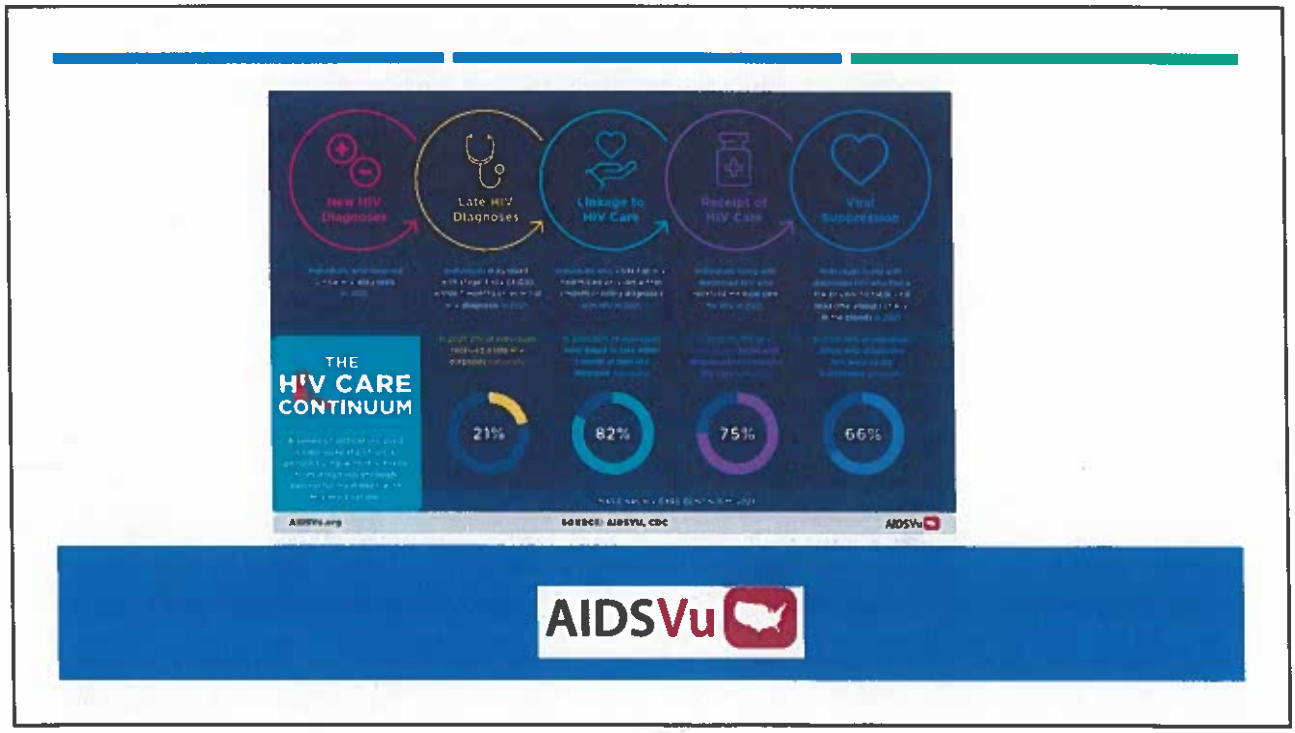
HIV CARE CONTINUUM (FL VS BROWARD)



FL Health CHARTS Ending the HIV Epidemic (EHE)

26

27


New HIV Diagnoses
Late HIV Diagnoses
Linkage to HIV Care
Receipt of HIV Care
Viral Suppression
THE HIV CARE CONTINUUM
21%
82%
75%
66%
AIDSVu

28

AIDSVu

NEW HIV DIAGNOSES, BROWARD 2020

Number of new HIV diagnoses, 2020
452

Rate of new HIV diagnoses per 100,000 population, 2020
31

Percent of people newly diagnosed with HIV, by Sex, 2020

Percent of people newly diagnosed with HIV, by Race/Ethnicity, 2020

Percent of people newly diagnosed with HIV, by Age, 2020

Number of New HIV Diagnoses, 2016-2020

29

AIDSVu

LINKAGE TO HIV CARE, BROWARD 2020

Linked to HIV Care

Linkage to care is defined as having a visit with an HIV health care provider within one month of being diagnosed with HIV.

Number of people diagnosed with HIV and linked to HIV care, 2020
393

Percent of people diagnosed with HIV and linked to HIV care, 2020
86.9%

Proportion of people linked to HIV care, by Sex, 2020
Male: 87.1%
Female: 86.4%

Proportion of people linked to HIV care, by Age, 2020
Aged 13-24: 87.1%
Aged 25-44: 89.1%
Aged 45-59: 82.9%
Aged 60+: 82.9%

Proportion of people linked to HIV care, by Race/Ethnicity, 2020
Black: 83.2%
Hispanic/Latinx: 93.3%
White: 85.6%

30

AIDSVu

LATE HIV DIAGNOSES

Late HIV Diagnoses

A late HIV diagnosis is defined as having an AIDS diagnosis within three months of an initial HIV diagnosis

Number of new HIV diagnoses that were diagnosed late, 2020
101

Percent of new HIV diagnoses that were diagnosed late, 2020
22.3%

Proportion of people with a late HIV diagnoses, by Sex, 2020
Male: 22.8%
Female: 20.5%

Proportion of people with a late HIV diagnoses, by Age, 2020
Aged 13-24: 8.6%
Aged 25-44: 20.0%
Aged 45-59: 32.5%
Aged 60+: 31.4%

Proportion of people with a late HIV diagnoses, by Race/Ethnicity, 2020
Black: 27.7%
Hispanic/Latinx: 16.0%
White: 19.6%

31

AIDSVu

VIRAL SUPPRESSION, BROWARD 2020

Viral Suppression

Viral suppression is defined as those living with diagnosed HIV who had suppressed HIV viral load (<200 copies/mL)

Number of people living with HIV who were virally suppressed, 2020
13,349

Percent of people living with HIV who were virally suppressed, 2020
68.1%

Proportion of people who were virally suppressed, by Sex, 2020
Male: 69.4%
Female: 64.2%

Proportion of people who were virally suppressed, by Age, 2020
Aged 13-24: 52.2%
Aged 25-44: 59.8%
Aged 45-59: 70.7%
Aged 60+: 73.5%

Proportion of people who were virally suppressed, by Race/Ethnicity, 2020
Black: 61.4%
Hispanic/Latinx: 69.0%
White: 77.0%

32

AIDSVu

HIV MORTALITY

HIV Mortality

Number of deaths of people living with HIV in Fort Lauderdale (Broward County), 2020

330

Number of deaths of people living with HIV in Florida, 2020

2,207

33

AIDSVu

SOCIAL DETERMINANTS OF HEALTH, BROWARD 2020

34

Indicator Data for Broward County - AHEAD Dashboard

Attachment 6a

⚠ Data for the year 2022 and 2023 are considered preliminary. Due to the impact of the COVID-19 pandemic, data for the year 2020 should be interpreted with caution.

Ending the HIV Epidemic

AHEAD
America's HIV Epidemic Analysis Dashboard

BROWARD COUNTY

Select a Location

VIEW DATA | DATA SET: INDICATOR DATA | SOCIAL DETERMINANTS OF HEALTH | VIEW DATA AS: CHARTS | TABLES

INDICATORS

Indicator Data for Broward County, FL

OVERARCHING GOAL

The EHE initiative aims to reduce new HIV infections in the United States by 75% in five years and by 90% in 10 years.

Incidence

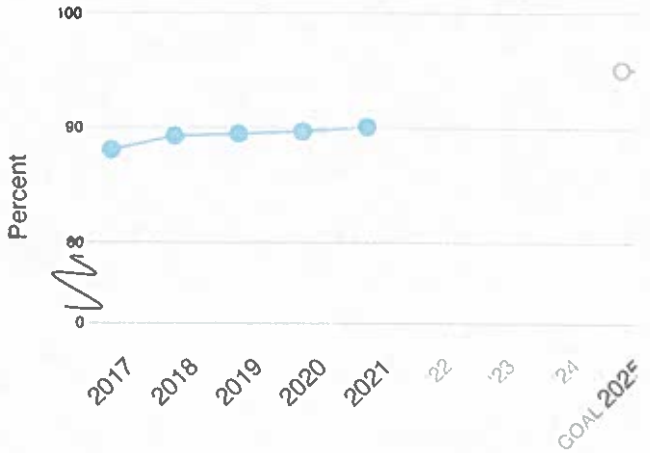
Incidence is the estimated number of new HIV infections in a given year.

MIDTERM GOAL

This indicator will be used to show the historical movement towards achieving the overall goals of the EHE initiative.

Knowledge of Status

Knowledge of status is the estimated percentage of people with HIV who have received an HIV diagnosis.



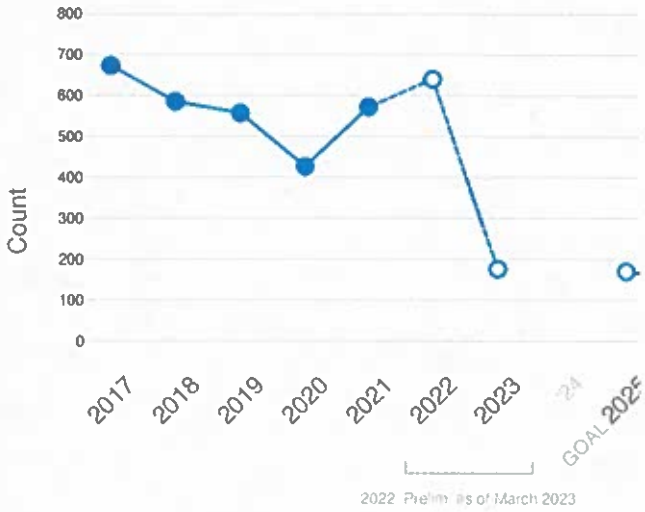
LEADING INDICATORS

The leading national indicators demonstrate movement towards meeting the overarching goals of the EHE initiative and are updated frequently.

2023
Broward County: **174 persons**

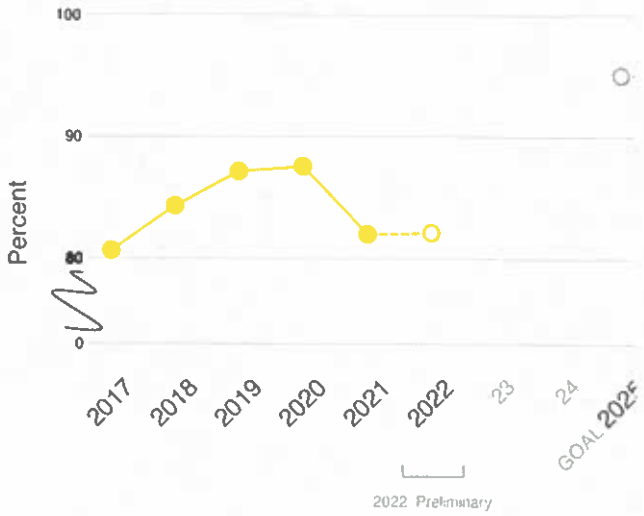
Diagnoses

Diagnoses is the number of people with HIV diagnosed in a given year confirmed by laboratory or clinical evidence.



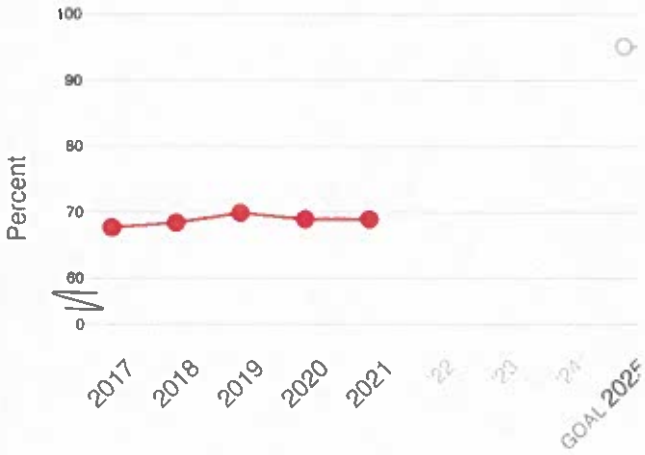
Linkage to HIV Medical Care

Linkage to HIV medical care is the percentage of people diagnosed with HIV in a given year who have received medical care for their HIV infection within one month of diagnosis.



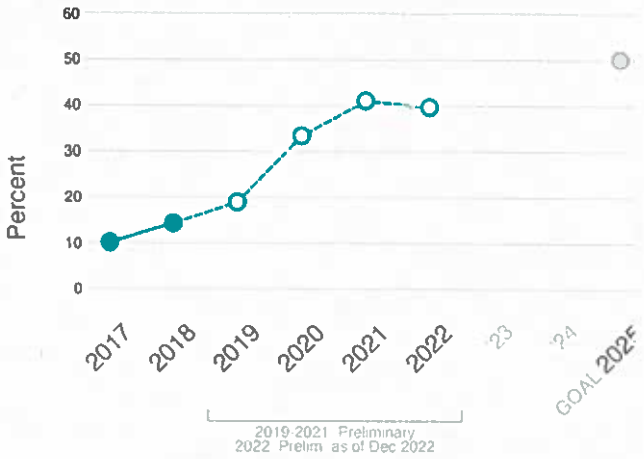
Viral Suppression

Viral suppression is the percentage of people living with diagnosed HIV infection who have an amount of HIV that is less than 200 copies per milliliter of blood, in a given year.



PrEP Coverage

PrEP coverage is the estimated percentage of individuals prescribed PrEP among those who need it.



BROWARD COUNTY

Select a Location | VIEW DATA | DATA SET: INDICATOR DATA | SOCIAL DETERMINANTS OF HEALTH | VIEW DATA AS: CHARTS | TABLES

Social Determinants of Health

Broward County, FL

What are Social Determinants of Health?

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH can be grouped into the following domains. Click on a SDOH domain to view its data.

- Poverty
- Health Insurance
- Gini Coefficient of Income Inequality
- Education/ Reading Levels
- Unemployment & Alternative Measures of Labor Underutilization

Summary

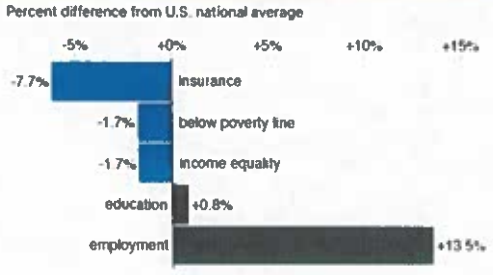
Insurance: *Percent of population under 65 that is insured* is lagging the national average by -8%

Poverty: *(Labor force ≥ 16yrs) below the poverty level* is lagging the national average by -2%

Income Inequality: *Estimated Gini coefficient* is -2% below the national average.

Education: *Percent of population 25 and older that graduated high school* is 1% above the national average.

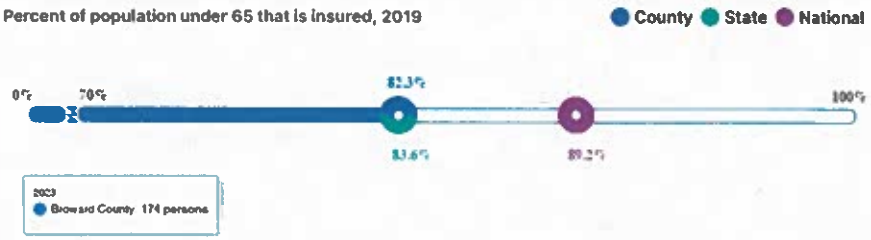
Employment: *Unemployment rate* is 14% above the national average.



Insurance

Counties with a higher percentage of people who are uninsured tend to have lower rates of PrEP uptake, lower rates of people living with HIV who learn their status, and lower levels of people linking to care and treatment.

U.S. Census Bureau, Small Area Health Insurance Estimates

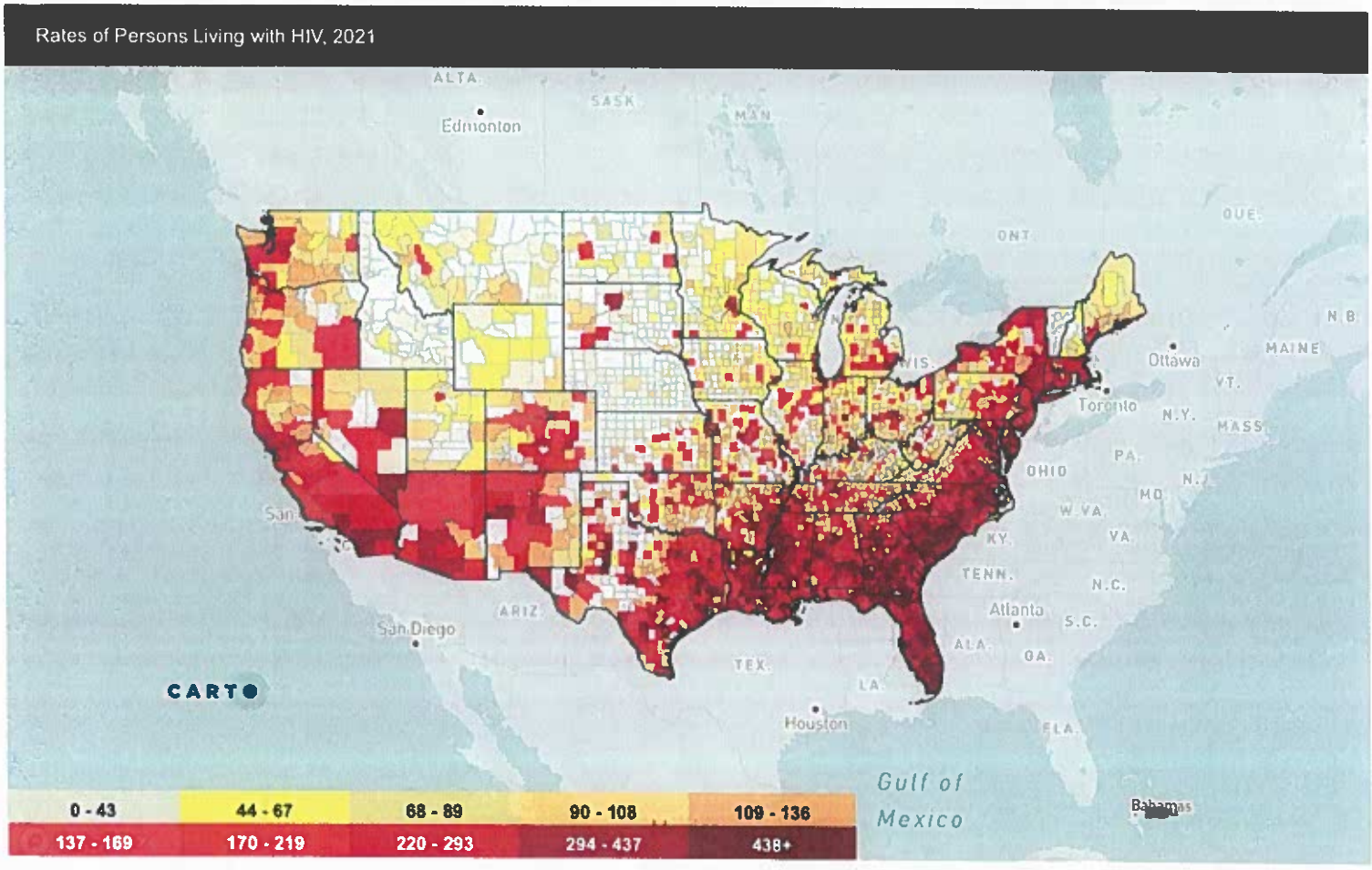


Local Data: Broward County, FL – AIDS Vu

Attachment 6b

Local Data: Broward County, FL

In 2021, there were 20,350 people living with HIV in Broward County.
In 2021, 35 people were newly diagnosed with HIV.



Want to view more? VIEW INTERACTIVE MAP →

Jump to: HIV Prevalence | New HIV Diagnoses | PrEP | HIV Care Continuum | Demographics | More

Local Data: Broward County, FL

In 2021, there were 20,350 people living with HIV in Broward County.
In 2021, 1,236 people were newly diagnosed with HIV.

HIV Prevalence

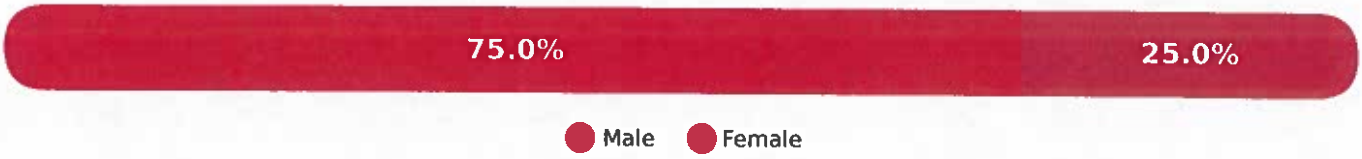
Number of people living with HIV, 2021

20,350

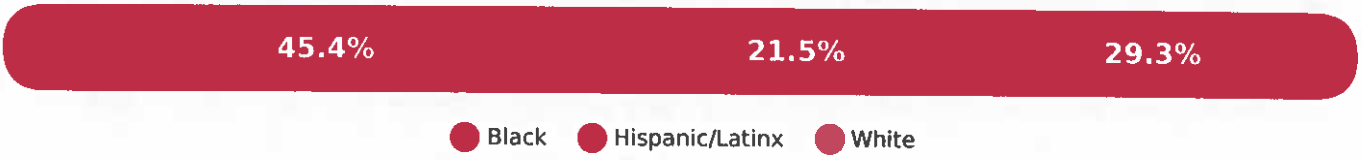
Rate of people living with HIV per 100,000 population, 2021

1,236

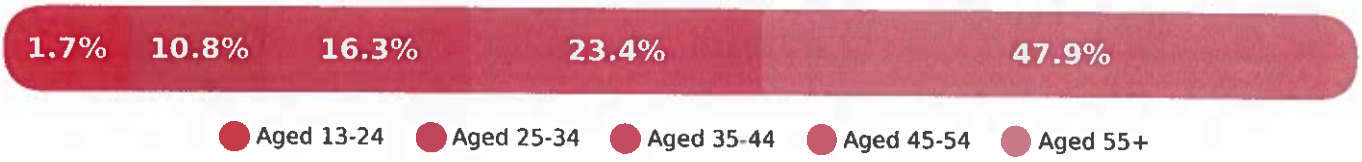
Percent of people living with HIV, by Sex, 2021



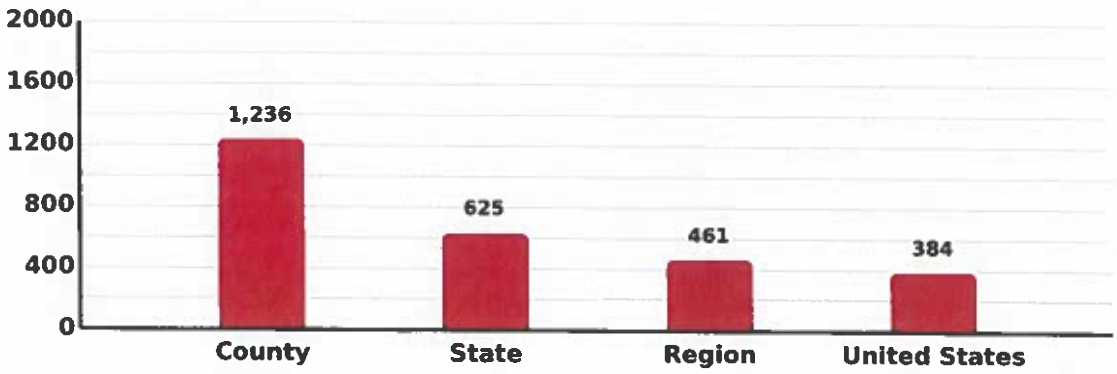
Percent of people living with HIV, by Race/Ethnicity, 2021



Percent of people living with HIV, by Age, 2021



Rate of people living with HIV per 100,000 population, by Geography, 2021



New HIV Diagnoses

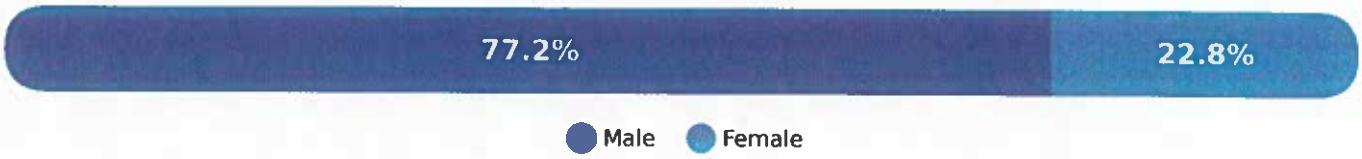
Number of new HIV diagnoses, 2021

570

Rate of new HIV diagnoses per 100,000 population, 2021

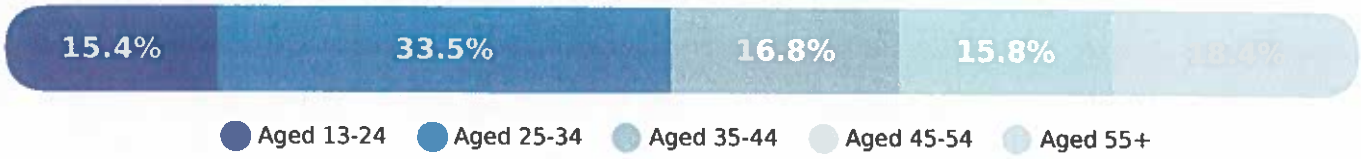
35

Percent of people newly diagnosed with HIV, by Sex, 2021

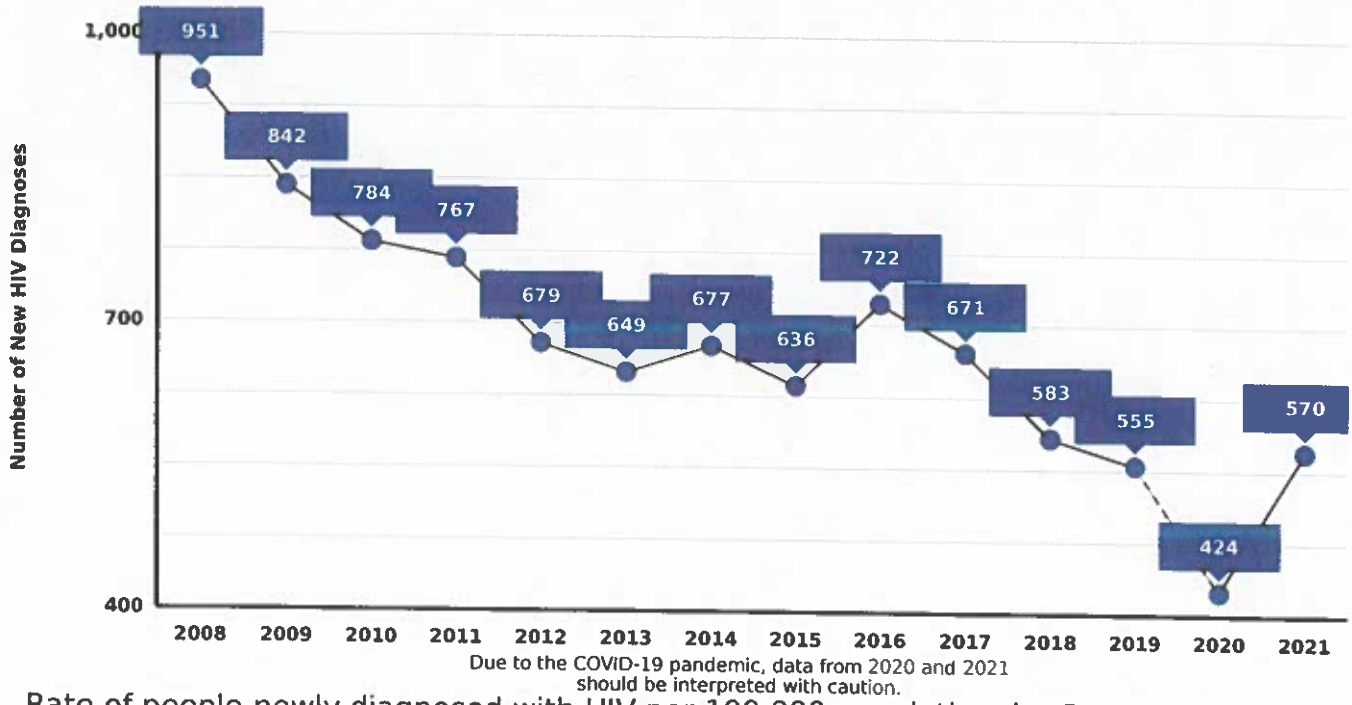


Percent of people newly diagnosed with HIV, by Race/Ethnicity, 2021

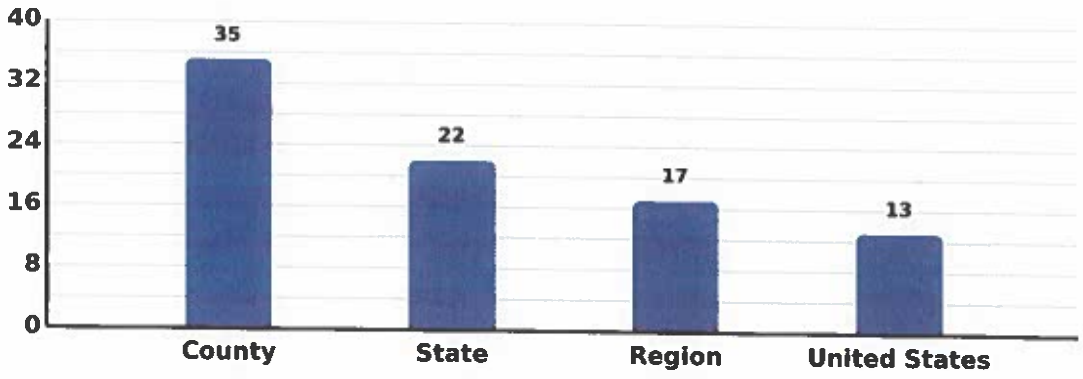
Percent of people newly diagnosed with HIV, by Age, 2021



Number of New HIV Diagnoses, 2008-2021



Rate of people newly diagnosed with HIV per 100,000 population, by Geography, 2021



PrEP (Pre-Exposure Prophylaxis)

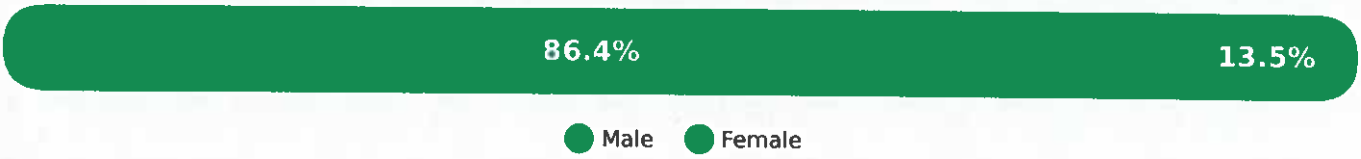
Number of PrEP users, 2022

8,059

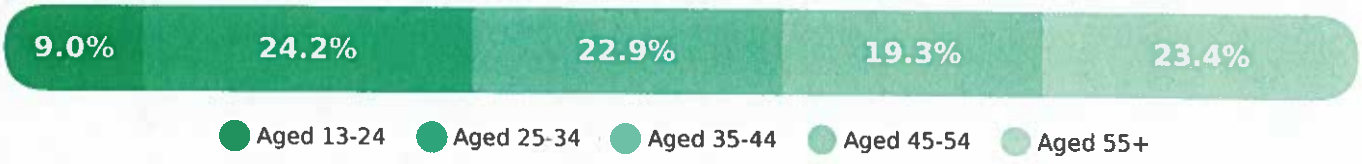
Rate of PrEP users per 100,000 population, 2022

525

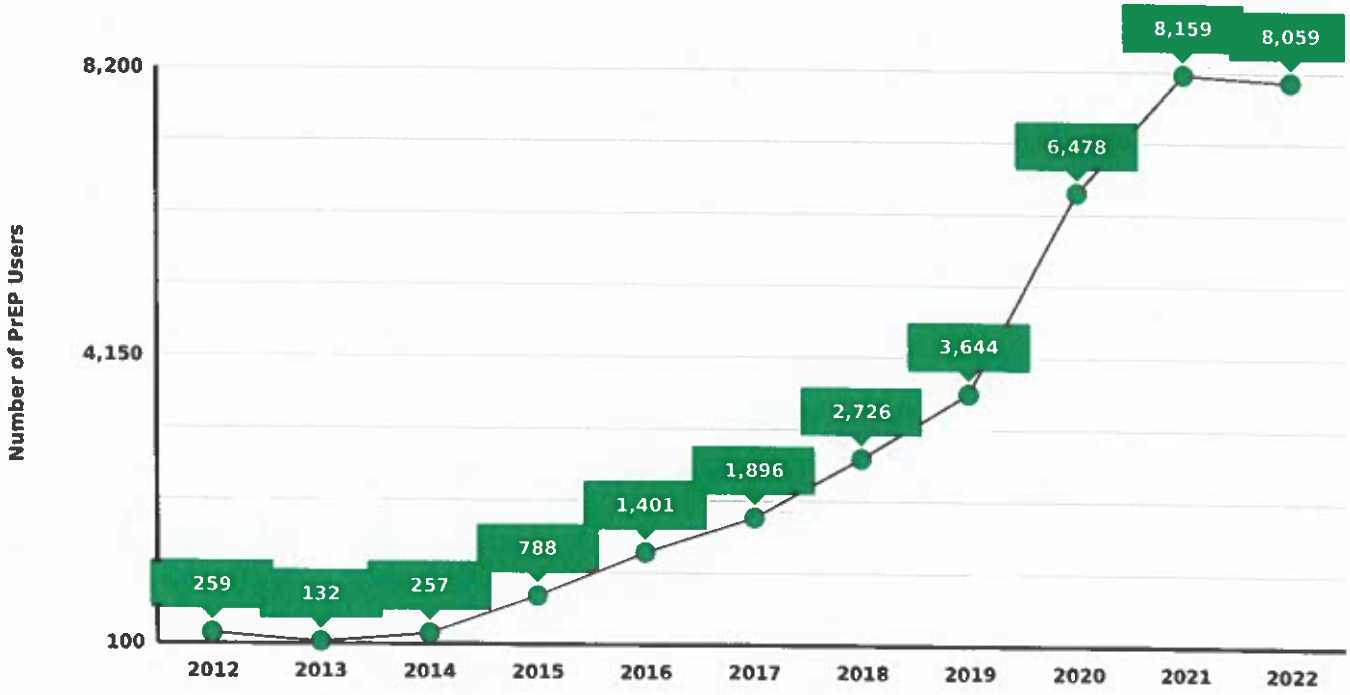
Percent of PrEP users, by Sex, 2022



Percent of PrEP users, by Age, 2022



Number of PrEP Users, 2012-2022



PrEP-to-Need Ratio (PNR)

The 2022 PrEP-to-Need Ratio (PNR) is the ratio of the number of PrEP users in 2022 to the number of people newly diagnosed with HIV in 2021. PNR serves as a measurement for whether PrEP use appropriately reflects the need for HIV prevention. A lower PNR indicates more unmet need.

PNR, 2022

14.14

PNR, by Sex, 2022

Male: 15.83

Female: 8.38

PNR, by Age, 2022

Aged 13-24: 8.28

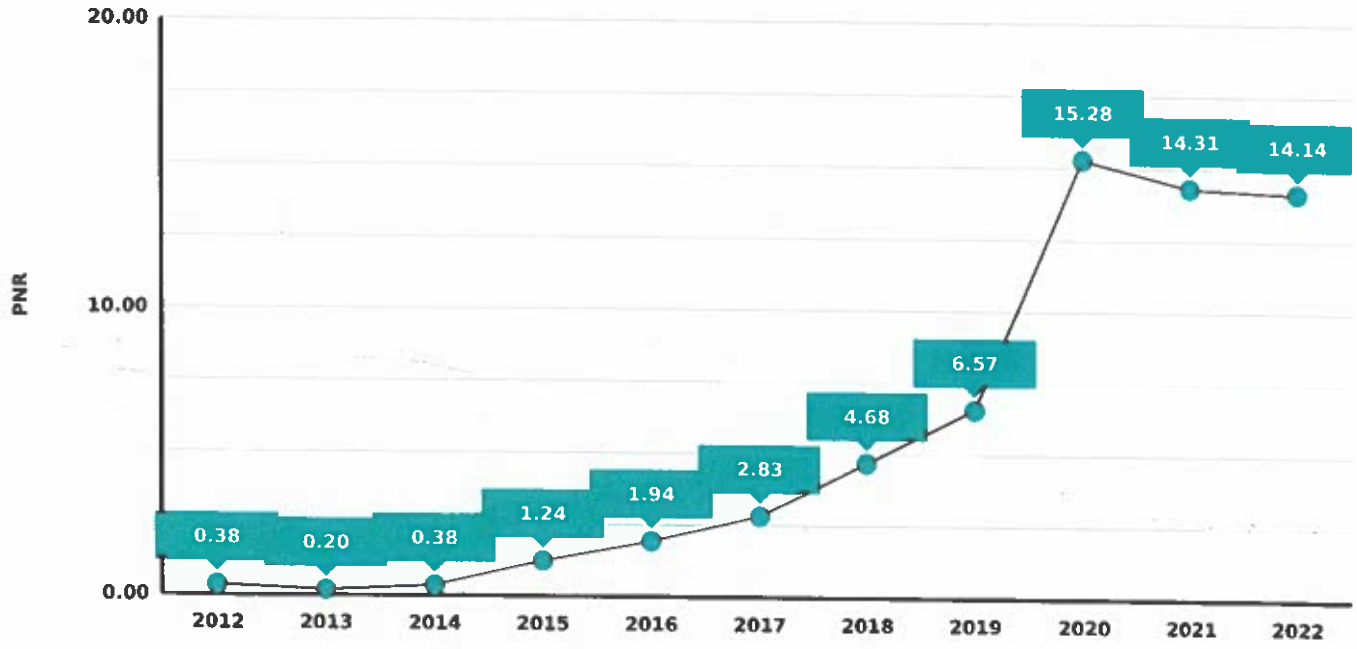
Aged 25-34: 10.23

Aged 35-44: 19.20

Aged 45-54: 17.24

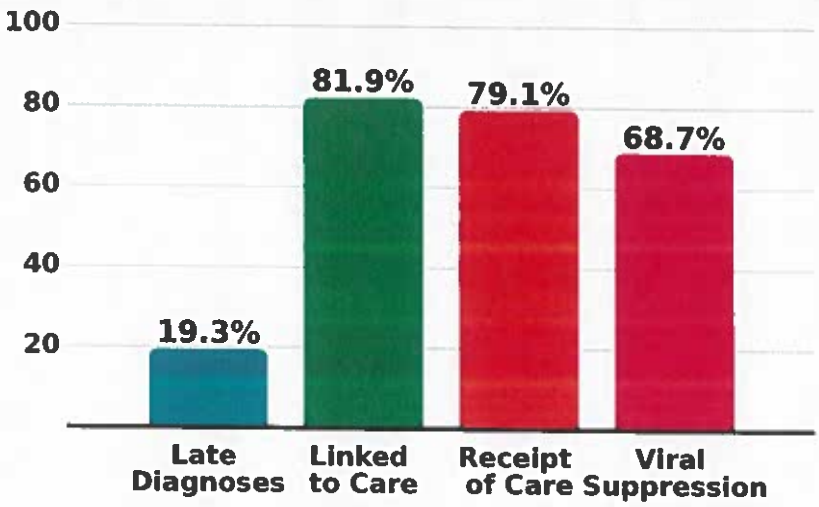
Aged 55+: 17.96

PNR, 2012-2022



HIV Continuum of Care, 2021

Late Diagnoses and Linked to Care are among people newly diagnosed with HIV and Receipt of Care and Viral Suppression are among all people living with HIV.



Diagnoses-based HIV Continuum Care, 2021

Late HIV Diagnoses

A late HIV diagnosis is defined as having an AIDS diagnosis within three months of initial HIV diagnosis.

Number of new HIV diagnoses that were diagnosed late, 2021

110

Percent of new HIV diagnoses that were diagnosed late, 2021

19.3%

Linked to HIV Care

Linkage to care is defined as having a visit with an HIV health care provider within one month of being diagnosed with HIV.

Number of people diagnosed with HIV and linked to HIV care, 2021

467

Proportion of people linked to HIV care, by Sex, 2021

Male: 81.6%

Female: 83.1%

Proportion of people linked to HIV care, by Race/Ethnicity, 2021

Black: 79.9%

Hispanic/Latinx: 85.5%

White: 81.1%

Percent of people diagnosed with HIV and linked to HIV care, 2021

81.9%

Proportion of people linked to HIV care, by Age, 2021

Aged 13-24: 87.5%

Aged 25-34: 83.8%

Aged 35-44: 77.1%

Aged 45-54: 80.0%

Aged 55+: 80.0%

Receipt of HIV Care

Receipt of HIV care is defined as those living with diagnosed HIV who received medical care for HIV and had at least one CD4 count or HIV viral load test in that year.

Number of people living with HIV who received HIV care, 2021

15,644

Proportion of people who received HIV care, by Sex, 2021

Male: 80.1%

Female: 75.9%

Proportion of people who received HIV care, by Race/Ethnicity, 2021

Black: 74.2%

Hispanic/Latinx: 80.2%

White: 84.9%

Percent of people living with HIV who received HIV care, 2021

79.1%

Proportion of people who received HIV care, by Age, 2021

Aged 13-24: 77.3%

Aged 25-34: 79.4%

Aged 35-44: 76.5%

Aged 45-54: 79.3%

Aged 55+: 79.9%

Viral Suppression

Viral suppression is defined as those living with diagnosed HIV who had suppressed HIV viral load (<200 copies/mL).

Number of people living with HIV who were virally suppressed, 2021

13,586

Proportion of people who were virally suppressed, by Sex, 2021

Male: 71.4%

Female: 60.3%

Proportion of people who were virally suppressed, by Race/Ethnicity, 2021

Black: 58.7%

Hispanic/Latinx: 73.0%

White: 79.8%

Percent of people living with HIV who were virally suppressed, 2021

68.7%

Proportion of people who were virally suppressed, by Age, 2021

Aged 13-24: 58.5%

Aged 25-34: 63.3%

Aged 35-44: 63.3%

Aged 45-54: 69.3%

Aged 55+: 72.0%

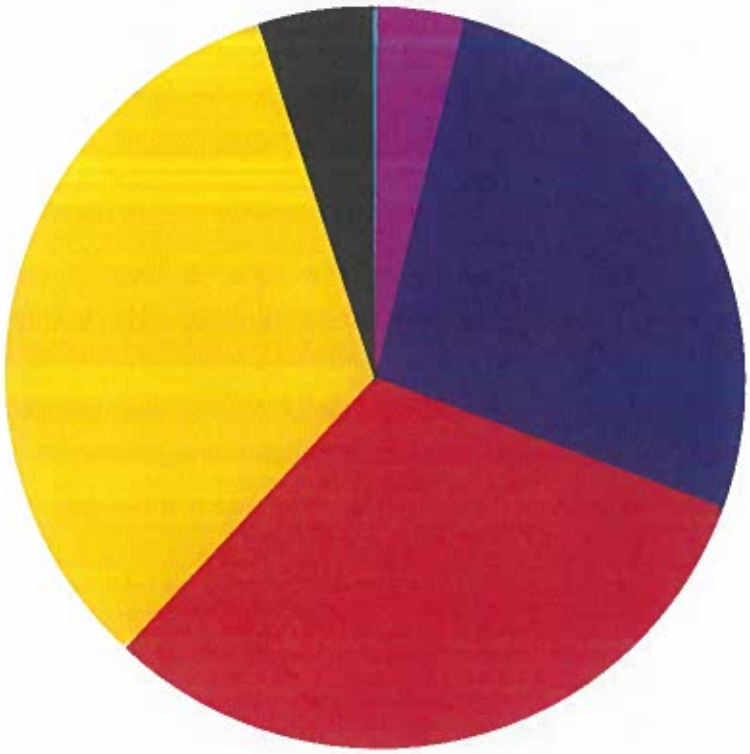
Demographics, 2020

Total Population

1,944,375

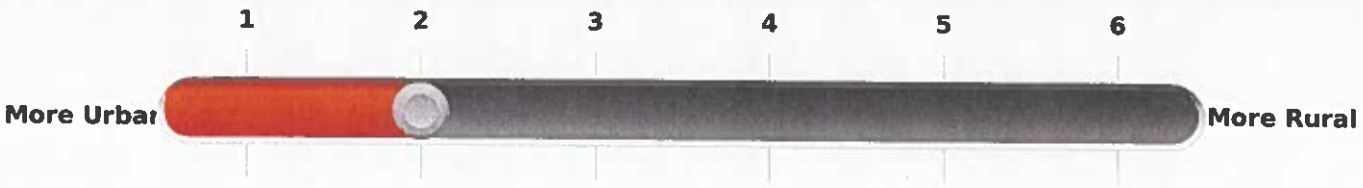
County Population by Race/Ethnicity

- **American Indian / Alaska Native (0.2%)**
- **Asian (3.8%)**
- **Black (26.6%)**
- **Hispanic / Latinx (31.3%)**
- **White (33.1%)**
- **Other* (5.0%)**



*Includes other races/ethnicities or missing/suppressed data

Urbanicity, 2013

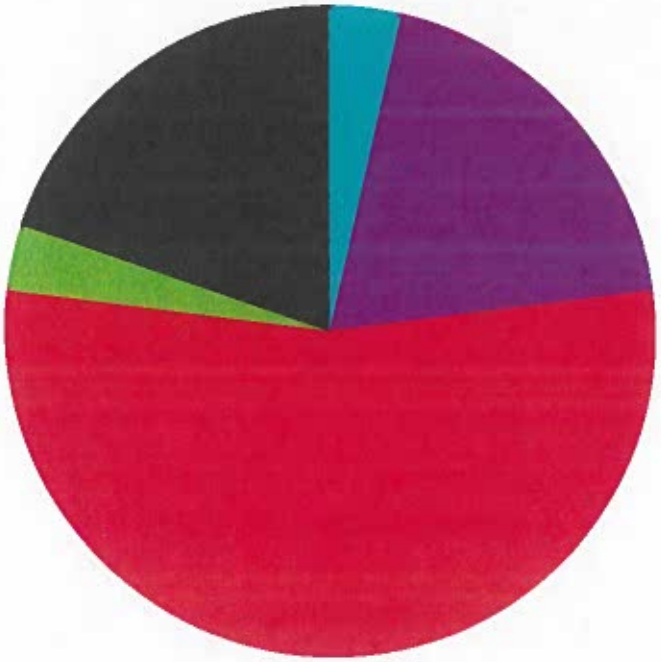


*Full CDC urbanicity definitions can be found here.

People Living with HIV, by Transmission Category, 2021

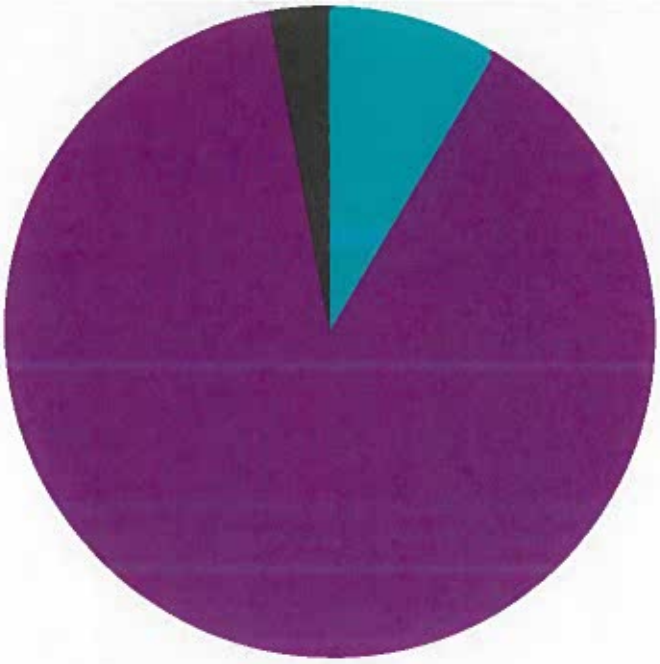
Percent of People Living with HIV, by Transmission Category, 2021

Male Transmission Categories



- Injection Drug Use (3.6%)
- Heterosexual Contact (19.3%)
- Male-to-Male Sexual Contact (54.0%)
- Male-to-Male Sexual Contact & Injection Drug Use (3.3%)
- Other* (19.8%)

Female Transmission Categories



- **Injection Drug Use (8.5%)**
- **Heterosexual Contact (88.6%)**
- **Other* (2.9%)**

*Includes risk factor not reported or identified, along with hemophilia, blood transfusion, perinatal exposure, or missing/suppressed data.

HIV Testing, 2016-2017

Percent ever tested for HIV, 2016-2017

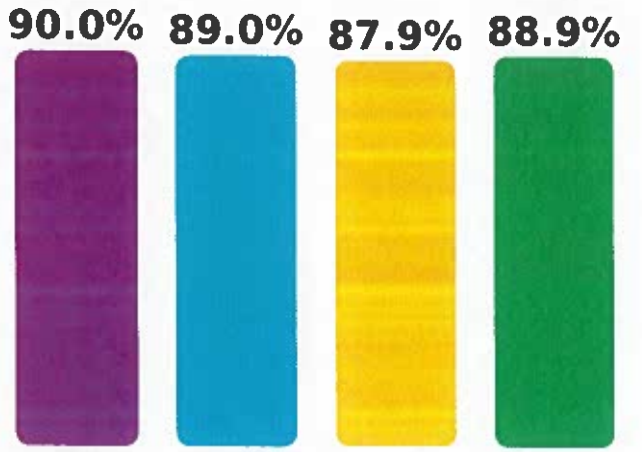
54%

Percent tested in the past year for HIV, 2016-2017

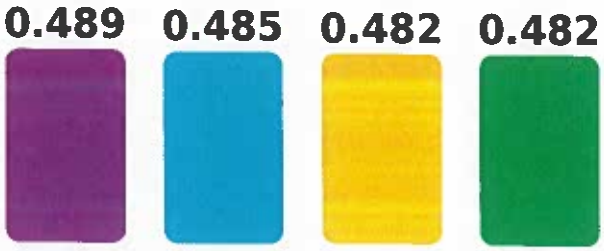
19%

Social Determinants of Health, 2021

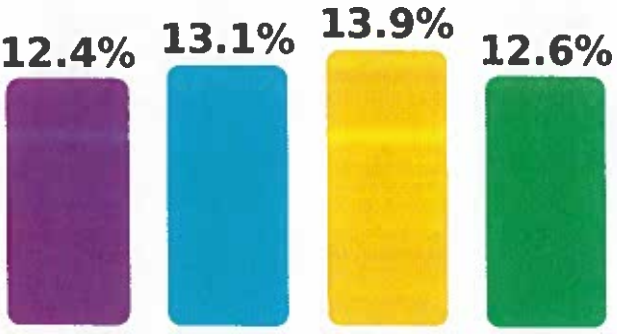
County State Region United States



Percent of Population with a High School Education, 2021

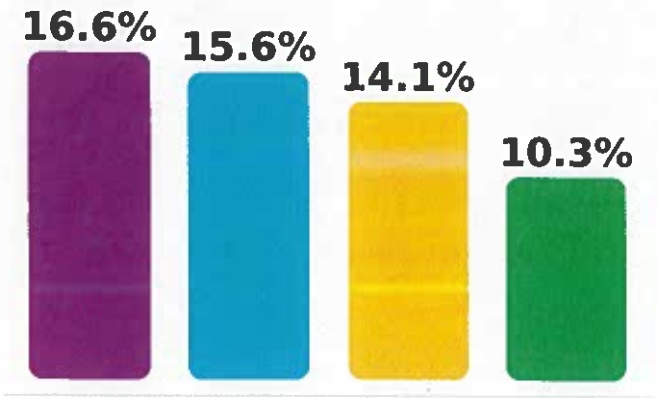


Income Inequality (Gini Coefficient), 2021

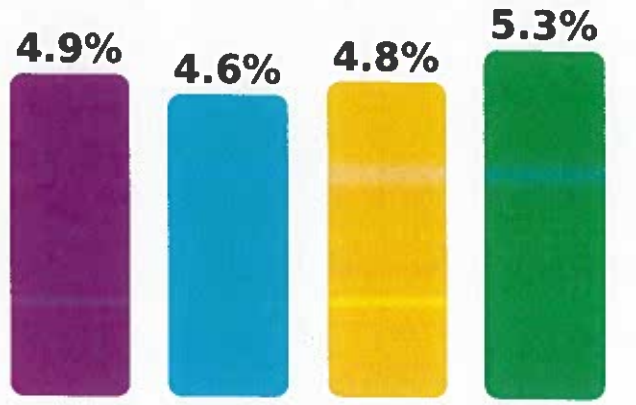


Percent of Population Living in Poverty, 2021

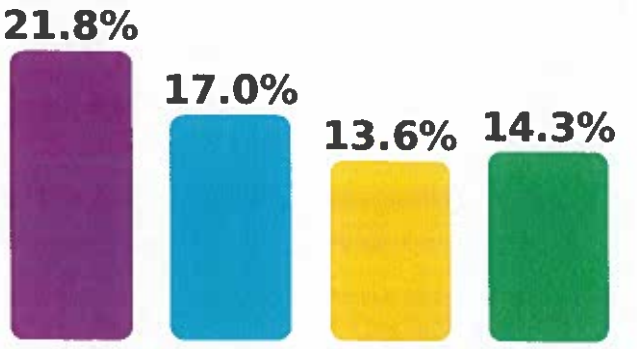
Median Household Income, 2021



Percent of Population (<65) Lacking Health Insurance, 2021

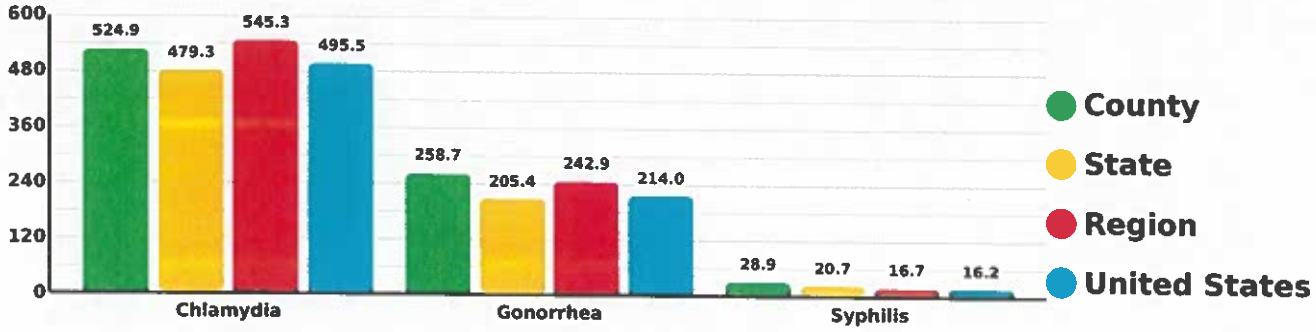


Percent of Population Unemployed, 2021



Percent of Population Living in Unstable Housing, 2021

Sexually Transmitted Diseases, 2021

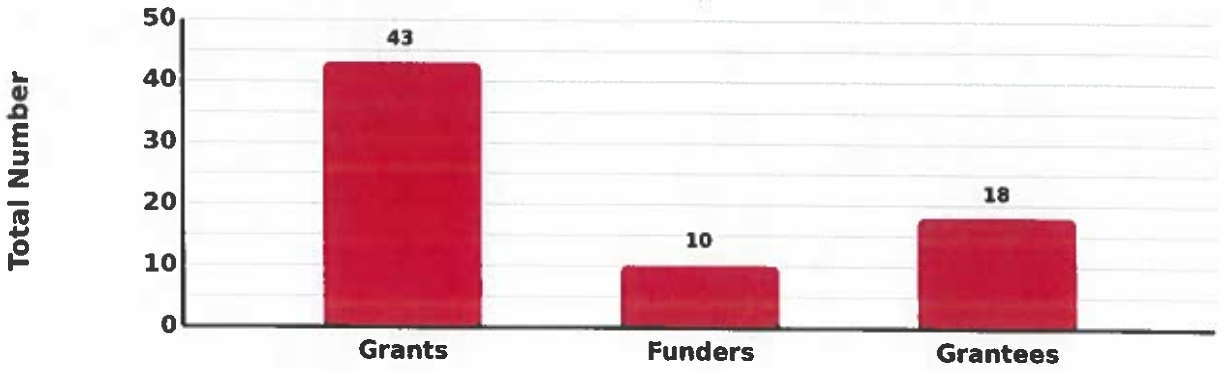


Rates of Sexually Transmitted Diseases per 100,000 Population, 2021

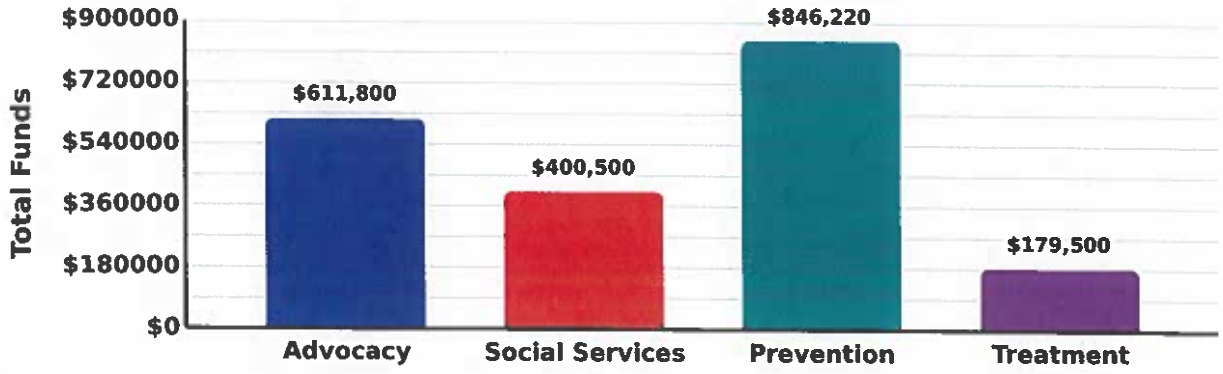
2020 HIV-Related Philanthropic Funding to Jurisdiction

Funding Distribution

$1,744,020



Intended Use and Strategy



PrEP

* Pre-exposure Prophylaxis

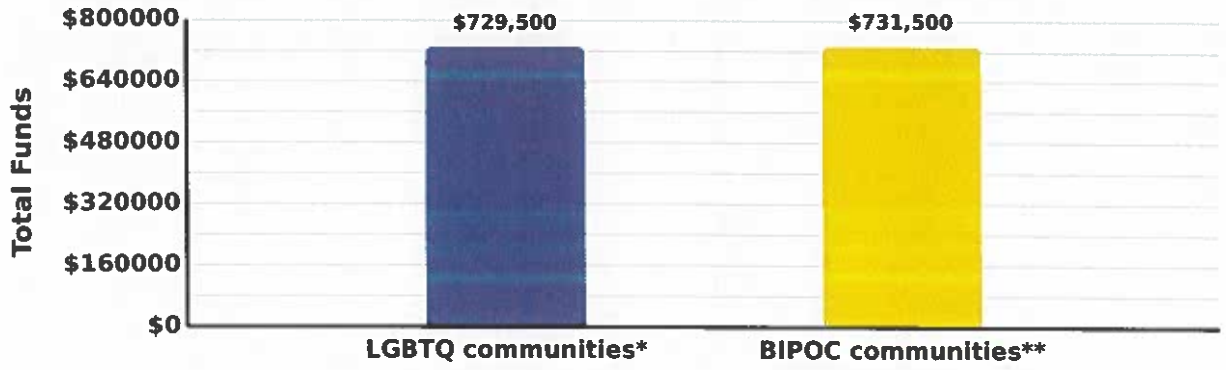
Total funding for any PrEP-related work, including: medical training, staffing for PrEP provision or related services, advocacy and awareness campaigns, or PrEP-related research.

$505,720

Population Spotlight

* Includes LQBTQ - general, MSM, Transgender.

** Includes African American, Latinx, Asian American, Indigenous.



These data only capture a portion of the populations and strategies that FCAA tracks, please see a complete analysis of 2020 HIV Philanthropy in our most recent report:

https://www.fcaaids.org/inform/philanthropic-support-to-address-hiv-aids/

Understanding HIV in Fort Lauderdale (Broward County)

AIDSVu is an interactive online mapping tool that visualizes the impact of the HIV epidemic on communities across the United States.

There are approximately 19,592 people living with diagnosed HIV in Fort Lauderdale (Broward County).

View Local Data for Fort Lauderdale (Broward County) →

Find Services in Fort Lauderdale (Broward County) →

View Fort Lauderdale (Broward County) Map →

View National Map →

AIDSVu News & Updates

Stay up to date with new data releases, maps, educational resources, infographics, and Q&As to help you better understand the HIV epidemic.

READ MORE NEWS →

OCTOBER 16, 2023

NLAAD 2023 Webinar: PrEP Use among the Hispanic/Latinx Community

READ MORE

OCTOBER 11, 2023

Luis Mares on Community Outreach and Celebrating the 20th Anniversary of NLAAD

READ MORE

GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES

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

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

Community Recommended Activities

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

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

Community Recommended Activities (Recommended Next Steps for Review @ 7/23 Meeting)

1. Create a coordinated universal eligibility and recertification system for Parts A and B with an annual recertification hybrid (in-person or electronic) process. (Implemented on November 1, 2022)
2. Utilize a quality approach to redesign a system of care that has its structure built on interagency communication, interservice networking, and meaningful collaborations. (Part A CQM Staff & Consultant)
3. Develop a system of handing off patients to case management after test and treat. (HIVPC SOC)
4. Ensure patient information is up to date. (Part A CQM Staff and QI Networks)
5. Develop a helpline to assist and empower consumers when they have access /eligibility concerns and/or challenges. (Discuss feasibility and potential funding sources @ July 2023 IP Workgroup)
6. Develop Tools to Assist Consumers with Accessing the System of Care
   (Discuss action steps and potential funding sources @ July 2023 IP Workgroup)
   a. Increase awareness of available programs by developing a high-end visual guide depicting all available programs across all communities including a flow-chart to educate clients to maneuver the system. Streamline the process for patients entering care/already in care.
   b. Enhance the client health experience to outcomes by providing transparent and understandable information on the "steps" to access needed support and eligibility continuation services.
   c. Develop a formal client orientation with a visual tour and access procedures led by Case Manager or Peer.
   d. Create a countywide geo-mapping dashboard to identify service locations.
   e. Create a resource inventory for HIV health services -including housing providers.
   f. Expand education to the community about services available to meet their needs to establish a clear presence within the community in need of care.
7. Develop systems that serve the needs of PWH using technology.

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

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

Community Recommended Activities

1. Employ peer navigators at each agency. (Develop action steps @ July 2023 Meeting)

- Discussion/presentation by RWAP/Prevention funders on current contractual requirements and opportunities to employ peer navigators at each funded agency. Recommendations/Next Steps:

2. Expand funding for peer navigator services. (Develop action steps @ July 2023 Meeting)

Agenda Item- Discussion/presentation by RWAP/Prevention funders regarding opportunities to expand funding for peer navigator services. Develop Recommendations/Next Steps:

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

Community Recommended Activities

Recommended Next Steps for Review by Integrated Planning Workgroup @ July 2023 Meeting

1. Increase the number of Service Categories that integrate peer services. (RW & Prevention Recipients)
2. Secure funding to continue the Broward HIV Peer Certification Training to equip individuals with the needed skills and capacity to serve on healthcare teams. (Discuss potential funding sources @ July 2023 IP Workgroup)
3. Develop a minimum pay rate for all peers employed by RW & Prevention funded agencies. (Discuss feasibility)
4. Revise employment requirements for peers to allow for expansion to include lived/professional experiences outside of educational requirements. (Discuss feasibility and next steps @ July 2023 IP Workgroup)

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

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

Community Recommended Activities (Discuss and Recommended Next Steps @ 10/23 IP Workgroup Meeting)

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

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

Community Recommended Activities (Discuss and Recommended Next Steps @ 10/23 IP Workgroup Meeting)

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

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

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

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

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

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES

3.1 Reduce HIV-related stigma and discrimination.

Strategy 3.1.1 Strengthen enforcement of civil rights laws (including language access services and disability rights), promote reform of state HIV criminalization laws, and assist states in protecting PLWH from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, substance use, and sexism.

Community Recommended Activities

1. Explore supporting HIV modernization activities that impact state laws (i.e., HIV decriminalization)
2. Partner with the Florida HIV/AIDS Advocacy Network (FHAAN) in its public policy and legislative advocacy activities.

Strategy 3.1.2 Ensure that healthcare professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or who experience risk for HIV, including LGBTQI+ people, immigrants, people who use drugs, and people involved in sex work.

Community Recommended Activities

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

Strategy 3.1.3 Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.

Community Recommended Activities

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

Strategy 3.1.5 Create funding opportunities that specifically address social and structural drivers of health (SDOH) as they relate to Black, Latino, American Indian/Alaska Native, and other people of color.

Community Recommended Activities

1. Provide financial resources for disproportionately affected communities i.e., wrap-around services
2. Define priority populations

3. Develop more appropriate and accessible mental health services
4. Improve collaboration across Continuum by enhancing the partnership among Part A, HOPWA , BCHSD housing services, and FDOH to secure additional housing funds.
6. Ensure the County EHE program includes housing, skills building, self-empowerment programs, work development, and partnerships with correctional facilities

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

Community Recommended Activities

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

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

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

Community Recommended Activities

1. Build the capacity of PWH to be meaningfully involved in the planning, delivering, and improving RWHAP services. (Incorporate programs from the organization, Meaningful Involvement of People with HIV/AIDS (MIPA) in Broward.
   a. Consider partnering with the National Minority AIDS Council's (NMAC) ELEVATE program to address workforce recruitment, development, and advancement needs for PWA 50+, Young Black Men, T/GNC, Latinx, recovery community.
   b. Consider developing website: PWH Resources on Reducing Stigma, Leadership, Advocacy, Ed., and Opportunities.

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

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

Community Recommended Activities

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

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

Community Recommended Activities

1. Implement a plan to educate all eligible consumers about benefits of enrolling in ACA and Medicare.
2. Implement a Housing workgroup in partnership with HOPWA to conduct a comprehensive assessment of the housing need and develop a plan to integrate services and share data on housing opportunities
3. Allocate more funding to Housing services.
4. Identify and provide additional affordable housing opportunities in Broward County
5. Challenge requirements for housing programs
6. County needs to expand transportation to include ride-share services to access HIV services
7. Assess food insecurity needs and gaps resulting in a county-specific food resource directory.

8. Develop model employment services initiatives and increase awareness of various programs to increase capacity of case managers to understand and help clients navigate the intricacies of programs.
9. Increase financial security for people receiving SSDA or SSI by expanding knowledge of and access to existing work incentive programs to allow people to work and earn more income without losing disability.
10. Identify the appropriate stakeholders to develop interventions to address low health literacy.
11. Prioritize the quality of life in addition to viral suppression.

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

Community Recommended Activities

1. Develop and test strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.
2. Increase diversity and cultural competence in health communication research, training, and policy.
4.Include critical analysis and health communication skills in HIV programs to provide participants with the tools to seek and identify accurate health information and to advocate for themselves and their communities.
5. Expand effective communication strategies between providers and consumers to build trust, optimize collaborative decision-making, and promote success of evidence-based prevention and treatment.

GOAL 4: ACHIEVE INTEGRATED, COORDINATED EFFORTS

Strategy 4.1.6 Support collaborations between community-based organizations (CBOs), public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.

Community Recommended Activities

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

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

Community Recommended Activities

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

Monitor, Evaluate, and Report Progress

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

3.3 Community Recommended Activities

1. Ensure all HIV Planning Body Committee/Workgroup Chairs participate in "think tank"/IP training sessions.
2. Ensure all HIV Planning Body Committee/Workgroup Chairs integrate strategies in committee work plans.
3. Implement bi-annual Joint Executive (Committee Chairs of Part A, B, Prevention & CSB) IP meeting
4. Ensure HIV Planning Body Committee/Workgroup Chairs include report on the progress of their Integrated Plan committee/work plan activities at a bi-annual Joint HIV Planning Council Executive meeting.
5. Streamline and harmonize reporting and data systems to reduce the burden and improve the timeliness, availability, and usefulness of data.
6. Monitor, review, evaluate, and regularly communicate progress on the NHAS.
7. Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners.
8. Identify and address barriers and challenges that hinder achievement of goals by funded partners and other parties.

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

4.3.1 Community Recommended Activities

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

Ryan White Orientation Videos: Get Care Broward You Tube Channel @getcarebroward148

Broward Ryan White & You: "The Simple Facts" Series

When You Learn You're Living with HIV https://youtu.be/T5sAYb7nDRc
What do you do when you learn you're living with HIV? Residents of Broward County can turn to Broward Ryan White Part A to access HIV medical and support services. In this segment, an HIV advocate, maps out 5 basic steps to getting the care you need to live your best and healthiest life.

How Can Broward Ryan White Help You? https://youtu.be/wPF3WpMMupM
Learn how the Ryan White Part A Program helps Broward County residents who are living with HIV. In this segment, an HIV advocate, gives you the Simple Facts: who Broward Ryan White serves and how they provide HIV medical and support services.

Applying for HIV Services: Ryan White "CIED" https://youtu.be/fVyBdcWMIV4
A guide for applying for Broward Ryan White HIV services for residents of Broward County. In this segment, an HIV advocate, explains the Simple Facts about the Centralized Intake and Eligibility Determination ("CIED") process. Details include who is eligible, how to apply and benefits that are available to help people "live longer and healthier with HIV."

Getting the Most From Your HIV Doctor https://youtu.be/a50L9N9Mbtc
Having an optimal relationship with your doctor is key in getting the most from your HIV care. In this segment, an HIV advocate, visits Dr. Vanessa Rojas, who explains the importance of doctor-patient communication and trust as key elements of building a strong relationship in order to achieve and maintain undetectable status.

5 Reasons to Stay Connected to HIV Care https://youtu.be/Q7OX5EqUO7c
The Broward Ryan White Part A Program is committed to 'treat and beat' HIV. If you're living with HIV, staying in care is of the utmost importance for your personal health and for the health of the greater community. In this segment an HIV advocate, outlines 5 key reasons to stay connected to HIV care.

Peer Leadership Opportunities

ELEVATE will address needs in workforce recruitment, development, and advancement for PWH in populations 50+, Young Black Men, transgender/gender non-conforming (T/GNC), Latinx, and the recovery community.

Eligibility Requirements

Each ELEVATE training will consist of 75% people with HIV and 25% RWHAP. Individuals participating in the ELEVATE training must be persons with HIV aligned with a RWHAP Recipient/Subrecipient.

ELEVATE Training Application

https://www.surveymonkey.com/r/IndELEVATE

Remaining Virtual Training Dates August 7th – 11th, 2023 Black Women

ESCALATE Training facilitates transformative and relational change in RWHAP by increasing participants' knowledge and skills to recognize and address HIV-related stigma within their organizations and communities they serve. This happens through a deepening awareness of and practices for cultural humility amongst people with HIV. Trainers create an equitable and transformational environment for RWHAP providers to learn with and from their people with HIV partners.

ESCALATE Training Application

https://singuser8c3ecfcb.iad1.qualtrics.com/jfe/form/SV_ahPVSAj65Dp6ad8

Remaining ESCALATE Training Schedule

Aug. 13 - 18, 2023 Detroit, MI

HANDOUT E

WHAT YOU NEED TO KNOW ABOUT THE BROWARD COUNTY RYAN WHITE PART A PROGRAM.

SERVICES COVERED

- Medical/Non-Medical Case Management Services
- Outpatient Medical Services
- Mental Health Services
- Outpatient Substance Abuse
- Services
- Dental Care Services
- Medical Nutrition Services
- Pharmaceutical/ Medication Assistance Services
- Healthcare Co-payment Assistance Services
- Emergency Financial Assistance Services
- Legal Aid Services
- Centralized Intake & Eligibility Determination Services (CIED)
- Food Bank/ Food Vouchers Services

Service Providers are located across Broward County

QUESTIONS?

Contact us:

954.561.9681 ext 1343

hivpc@brhpc.org

: BrowardHIVPC

: BrowardHIVPC

: Broward HIV Planning Council

Opportunity To Serve...

HIVPC

Broward County HIV Health Services Planning Council

Join the Broward County HIV Health Services Planning Council and help people with HIV/AIDS (PWH) get the Healthcare resources and services they need.

Council members must commit to the following:

1. Attend one meeting of the full Planning Council monthly.
2. Attend and actively participate in at least one Sub-Committee meeting per month.
3. Be inspired to make a difference in the lives of PWH and affected communitites in Broward.

Applications are being accepted; after submission, you will be notified with further information.

For questions, contact Planning Council Support Staff at hivpc@brhpc.org or call 954.561.9681 ext 1292

For more information

log on to https://brhpc.org/hiv-planning-council/

Broward HIV Planning Council BrowardHIVPC BrowardHIVPC

APPLY TODAY!

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BrowardHIVPC

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Broward HIV Planning Council

BrowardHIVPC

BrowardHIVPC

APPLY TODAY!

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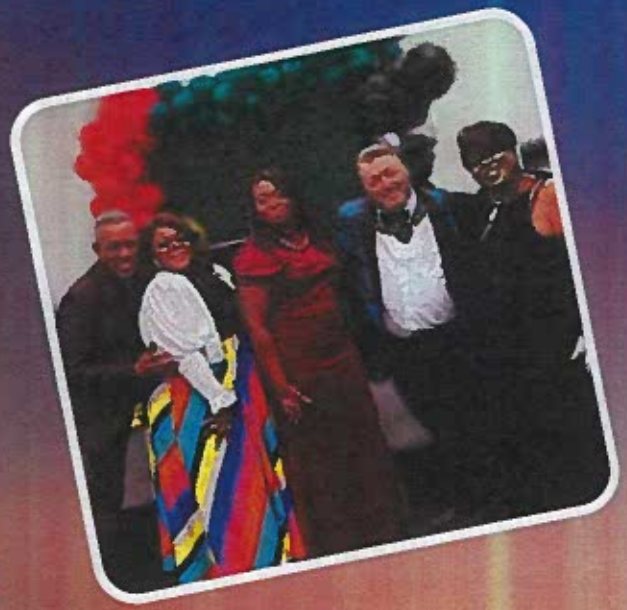

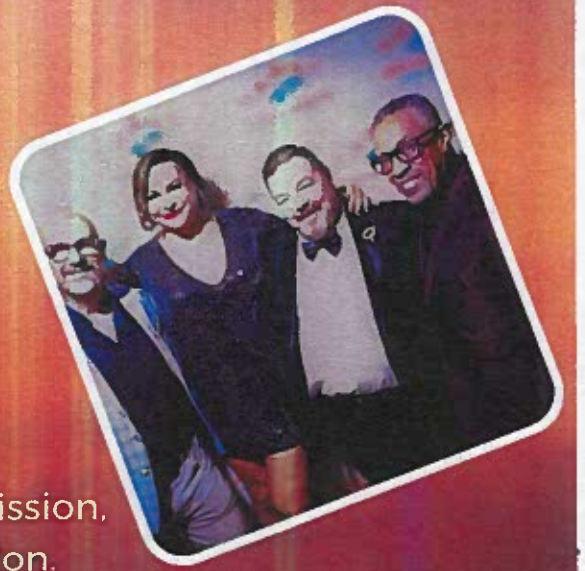

Applications are being accepted; after submission, you will be notified with further information.

APPLY TODAY!

Applications are being accepted; after submission, you will be notified with further information.

CONTACT INFORMATION

(Please Print Clearly)

First Name: _____

Last Name: _____

Email Address: _____

Contact Number: _____

What is the best time to contact you?

(Please Circle One)

Morning Afternoon Evening

HIVPC

Broward County HIV Health Services Planning Council

Get Involved!!

I'D LIKE TO GET INVOLVED BY:

- ☐ Doing outreach, community education, and collecting feedback.
- ☐ Recruiting and training members
- ☐ Determining priorities and funding for HIV services
- ☐ Reviewing health data and HIV services standards.
- ☐ Improving the system of HIV care and treatment

WE NEED YOUR VOICE

gay and bisexual men accounted for 70% of the total new HIV infections in the United States.

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https://brhpc.org/hiv-planning-council/

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the black community accounted for 40% of the total new HIV infections in the United States.

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34,800 new HIV infections in the United States.

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31% new HIV infections in the United States were ages 13-29

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