Broward County HIV Integrated Planning Workgroup Meeting
Tuesday, January 23, 2024
1:00 PM-4:00 PM

Meeting Link: https://us02web.zoom.us/j/87402540058?pwd=OG5Xejc4ZmlKVWRXNEFkQk5KZXdaUT09

Co-Chairs: Joey Wynn and Tatianna Williams (Interim)

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), the Broward County HIV Prevention Planning Council (BCHPPC), and the EHE Advisory Group 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 Today's January 23, 2024, Agenda**
3) **Review and Approve Minutes from October 24, 2023** (HANDOUT A)
4) **Status of Integrated Planning Workgroup Representatives** (HANDOUT B)
    a. Broward County HIV Prevention Planning Council (BCHPPC) *(R. Mills)*
    b. Ryan White Part A Ending the Epidemic Advisory Body *(Q. Cowan)*
        - *Michael Green, Shawn Tinsley, and Kendra Hayes*

5) Integrated Plan Monitoring, Reporting, and Evaluation reports by funder:
    a. Part A Ending the Epidemic (EHE) Plan Quarterly Progress Report *(Q. Cowan)* (HANDOUT C)
    b. FDOH Part B Utilization, ADAP client data Quarterly Progress Report *(S. Cook)*
    c. FDOH-Broward EHE Prevention Plan Quarterly Progress Report *(K. Kirkland-Mobley)* (HANDOUT D)
    d. Florida Integrated HIV Plan (FCPN) Progress Report *(J. Wynn)*
        I. January 10, 2024, FCPN Meeting Update (HANDOUT E1)
        II. FCPN 2023 Coordination of Efforts Work Plan (HANDOUT E2)
        III. FCPN Red Robin Report December 2023 (HANDOUT E3)
    e. Part A CQM Annual Report (HANDOUT F)

6) Old Business
    a. Integrated Planning Co-Chair - Vote on Permanent Co-Chair
    b. **Review Community Recommended Workplan Activities & Determine Next Steps** (HANDOUT G)

7) Agenda Items for Next Meeting

8) Next IP Workgroup Meeting Date

Tuesday, April 23, 2024 (Time: 1:00 p.m.-4:00 p.m.), **LOCATION:** BRHPC, and via Zoom Videoconference.

9) Adjournment

HANDOUT A

FORT LAUDERDALE/BROWARD EMA
BROWARD HIV HEALTH SERVICES PLANNING COUNCIL
AN ADVISORY BOARD OF THE BROWARD COUNTY BOARD OF COUNTY COMMISSIONERS
200 OAKWOOD LANE, SUITE 100, HOLLYWOOD, FL 33020
(954) 561-9681 • FAX (954) 561-9685

Broward County HIV Prevention and Integrated Planning Workgroup

Tuesday, October 24, 2023 - 1:00 AM
Meeting at Broward Regional Health Planning Council and via WebEx

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)

DRAFT 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. Saboe-Rodriguez, S. Webb
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, R. Mills, K. Atrigenio-Conway
Ryan White Part D: None.
Guest(s): S. Tinsley-Jackson, J. Hidalgo, C. S. Keys
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 1:11 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 7/25/2023

Motion #1: The approval for the minutes of the July 25, 2023, meeting was proposed by T. Pietrogallo, seconded by L. Robertson, and passed unanimously.

3. Review and Approve 10/24/2023 Agenda

Motion #2: The approval of the October 24, 2023, agenda was approved by T. Pietrogallo seconded by L. Robertson and passed unanimously.

4. Integrated Planning Workgroup Co-Chair Follow-up Discussion

HIVPC By-Laws Overview
M. Rosiere reviewed the IP Workgroup Membership described in the HIVPC By-Laws (Attachment 1). Membership consists of three members from each planning body plus one alternate and only speaks to the selection of Part A members. The pending Co-Chair position is a member of the HIVPC; however, all four slots are filled. J. Wynn indicated that this matter is a technicality as current IP Workgroup members are all representatives of the three planning bodies. Members with concerns are free to consult with the County's legal Office. SFAN and HIVPC slots are filled with one vacancy and an alternate remaining for the Broward County HIV Prevention Planning Council (BCHPPC).

Next Steps

- Members discussed the next steps in filling the open seat for the Prevention Body. K. Kirkland-Mobley stated that the topic of the IP Workgroup vacancy will be added to the BCHPPC's November agenda to select a new representative(s).

5. Integrated Plan Monitoring, Reporting, and Evaluation Plan

i) Part A Ending the Epidemic (EHE) Plan Quarterly Progress Report

Q. Cowan presented the Part A (EHE) activities to highlight services and utilization and where Part A stands on specific EHE Workplan activities.
Workplan activities included coordinating and facilitating provider network and advisory board meetings, facilitating training, developing marketing materials for the community, and utilizing technology to enroll clients into medical care.

Q. Cowan clarified that all the EHE Clients are Ryan White Clients and that an individual does not have to be a Part A Ryan White Client to be eligible to access Broward County's EHE services, which includes non-residents. Q. Cowan clarified that RWHAP is the payor of last resort. The program eliminates duplication with other federal programs because RWHAP funds may not be used for services if another state or federal payor is available.

B. Barnes recommended that the EHE advisory group discuss the selection of members to join the IP Workgroup.

Motion #3: L. Roberston made a motion to accept the EHE advisory body to the IP Workgroup Body. The motion was seconded by B. Barnes and passed unanimously.

Introduction of Dr. Julia Hidalgo, Positive Outcomes, Inc. Dr. Hidalgo has worked with Broward County as a data consultant and was commended for her institutional knowledge. She will serve as a resource for the IP workgroup.

ii) FDOH-Broward EHE Prevention Plan Quarterly Progress Report

K**.** Kirkland-Mobley provided the progress report for the four EHE pillars for June, July, and August. The data was reported during the FLDOH statewide meeting and will be updated with the September data before the report is distributed to IP Workgroup members.

iii) Florida Integrated HIV Plan (FCPN) Progress Report

J. Wynn updated the workgroup by conveying HRSA's positive feedback on Broward County's HIV Prevention and Care Integrated Plan with minor technicalities to improve moving forward. He also presented the opportunity for the IP Workgroup to sync with the state of Florida in the statewide evaluation and integrated planning process. We can track the similarities and utilize the most appropriate performance indicators, metrics, and evaluation processes. J. Wynn noted that the state agreed to move forward with Broward County's proposed evaluation process.

iv) Broward Integrated HIV Plan Evaluation – National and EHE Indicators

M. Rosiere provided a summary of the National HIV/AIDS Strategy and EHE Indicator Data for Broward County, Broward Integrated HIV Prevention and Care Plan: Tracking our Progress, Indicator Data for Broward County – America's HIV Epidemic Analysis *Dashboard* (*AHEAD*) Dashboard, Local Data: Broward County, FL – AIDS Vu. AHEAD graphically visualizes data on the six indicators used to track progress toward ending the HIV epidemic and is a visualization tool designed to display data on the six indicators. The six indicators are knowledge of status, diagnoses, linkage to HIV medical care, viral suppression, and PrEP coverage. The purpose of this discussion is to build awareness of the data dashboards that are available to the IP Workgroup during the evaluation and monitoring process. Members were encouraged to consider the source and accuracy of the data. J. Rodriquez explained that data is as good as the information entered and is constantly changing and being cleaned for analysis. He further noted that the data-sharing agreements were modified and are currently being reviewed by attorneys.

BRHPC Scorecard System Review

N. Cohen Tindol, BRHPC Public Information Officer, provided an overview of BRHPC's Scorecard system, which tracks program performance measures and

goals. This system, if adopted, can be used as a resource for the IP Workgroup during its evaluation and monitoring activities.

6. Community Recommendations Workplan Activities

The IP workgroup will continue to address these items including developing timelines, responsible parties, and measurable outcomes.

7. Old Business: None

8. New Business:

- Discussion regarding joint recruitment effort opportunity. Planning bodies will review marketing plan materials to streamline recruitment efforts and will provide feedback to M. Patel.
- M. Rosiere discussed the new ADAP enrollment portal in preparation for open enrollment starting November 1, 2023.

9. Agenda Items for Next Meeting / Next IP Workgroup Meeting Date

- Each funder will provide a quarterly report. Representatives are not required to create new report templates.
- S. Cooke will provide a Part B utilization report.
- Funders will provide end-of-year reports to BRHPC.
- FLDOH will provide BRHPC with active ADAP client data.

The next IP meeting will be on Tuesday, January 23, 2023 (Time: 1:00 p.m.-4:00 p.m.), **LOCATION:** BRHPC, and via Zoom Videoconference.

10. Adjournment:
There being no further business, the meeting was adjourned at 4:07 p.m.

HANDOUT B

Broward County
Integrated Workgroup Members
As of January 23, 2024

HIVPC

Lorenzo Robertson

Ronald Bhrangger

Tom Pietrogallo

Von Biggs (Alternate)

BCHPPC

Tatiana Williams

Brad Barnes

(One Vacancy)

(Alternate)

SFAN

Joey Wynn

Greg Beltran

Ashley Mayfaire

Jay Saboe-Rodriguez (Alternate)

Part A EHE Advisory Body Representatives

Michael Greene

Shawn Tinsley

Kendra Hayes

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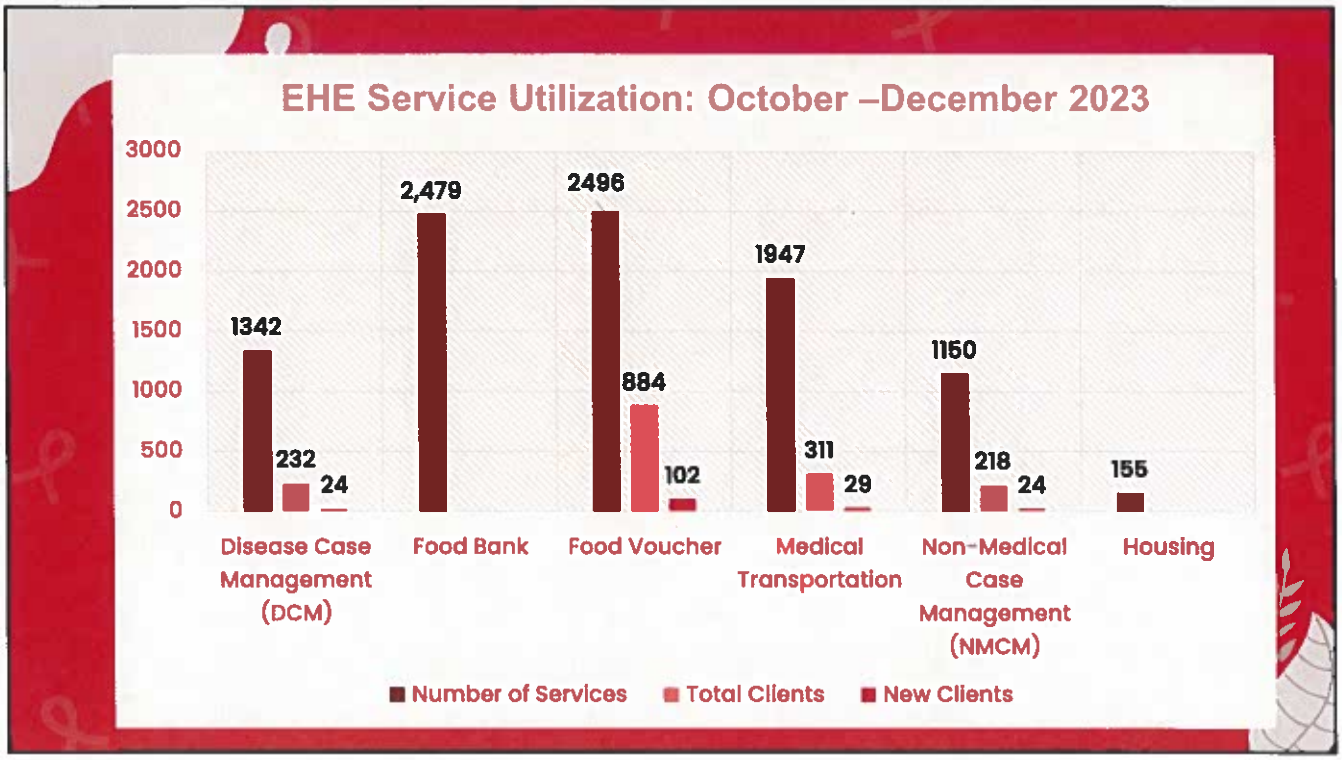
EHE Service Utilization: October –December 2023

Category	# of Services	Total Clients	New Clients	Male	Female	Trans	Black	White	Haitian	Hispanic	Totals
Disease Case Management	1,342	232	24	156	68	8	155	61	33	46	$164,794.04
Food Bank	2,479	--	--	--	--	--	--	--	--	--	$188,635
Food Voucher	2,496	884	102	603	271	10	491	379	58	221	$134,784.00
Medical Transportation	1,947	311	29	177	130	4	229	77	74	51	$30,900.36
Non-Medical Case Management	1,150	218	24	146	70	2	150	64	50	45	$84,708.75
Housing (Oct.-Nov.)	155	--	--	--	--	--	--	--	--	--	--

2



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Additional Activities

- **Coordinate and facilitate an EHE Provider Network**
  - Ongoing, no meetings held during the reporting period
- **Coordinate and facilitate Broward County's EHE Advisory Board**
  - Ongoing, 2 meetings held during the reporting period
- **Provide training to HIV care and treatment service providers to improve service delivery and expand knowledge and skills**
  - Ongoing, 2 meetings held during the reporting period
- **Develop marketing materials to promote funded services**
  - Ongoing
- **Utilize technology (PL Cares) to effectively and efficiently engage with hard-to-reach PWH from our population of focus:**
  - Ongoing
- **Coordinate and participate in community engagement activities to promote program services and increase HIV awareness**
  - Ongoing, 6 community engagement activities during the reporting period (hosted one faith-based event, participated in 5 community events)

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Broward EMA Ending the HIV Epidemic (EHE)
Work Plan: Year 4

EHE Pillar Two: *Treat people living with HIV (PLWH) rapidly and effectively to reach sustained viral suppression.*

Goal 1: *By end of Grant Year (GY) 5, increase the percent of persons newly diagnosed with HIV linked to care within 3 days* to ≥ 90%

Objective 1.1: By February 29, 2024, 80% of persons newly diagnosed with HIV will be linked to care within 3 days.

Strategy 1.1.A: Implementation of the EHE-Disease Intervention Specialist (DIS) model to rapidly identify, engage and link persons newly diagnosed with HIV to medical care and EHE services.

Key Activities/Action Steps	Start/End Date	Responsible Parties	Indicators
• Disease Intervention Specialist activities (contract renewals, program implementation, ongoing TA, evaluation, etc.)	3/1/2023-2/28/2025	Recipient Staff and Contracted Provider	Executed contracts, PE records

Goal 2: *By end of Grant Year 5, increase retention in care rates for PLWH enrolled in the EHE program to 90%*

Objective 2.1: By February 29, 2024*, increase retention in care rates for PLWH enrolled in the EHE program to 85%*

Strategy 2.1.A: Implementation of Intensive Care Teams (ICTs) through Disease Case Management (DCM) a) for intensive and individualized assistance to clients that experiencing challenges to stay in care and adherent to treatment, b) to rapidly identify and refer PWH lost to care or at risk of falling out of care to EHE-DIS for rapid re/engagement.

Key Activities/Action Steps	Start/End Date	Responsible Parties	Indicators
• Disease Case Management activities (contract renewals, program implementation, ongoing TA, evaluation, etc.)	3/1/2023-2/28/2025	Recipient Staff and Contracted Providers	Executed contracts, PE records

Strategy 2.1.B: Implementation of EHE Non-Medical Case Management (NMCM) and Peer Support Services (PSS) to help remove barriers affecting PLWH's abilities to access care and remain adherent to treatment and promote self-sufficiency so PWH actively engage in their care management leading to optimal health outcomes.

Key Activities/Action Steps	Start/End Date	Responsible Parties	Indicators
• Non-Medical Case Management and Peer activities (contract renewals, program implementation, ongoing TA, evaluation, etc.)	3/1/2023-2/28/2025	Recipient Staff and Contracted Providers	Executed contracts, PE records

Strategy 2.1.C: Implementation of Medical Transportation (MT) as a supportive service to help remove barriers preventing PLWH from reaching viral load suppression and promote self-sufficiency so clients actively engage in their care management leading to better health outcomes.

Key Activities/Action Steps	Start/End Date	Responsible Parties	Indicators
• Medical transportation via Uber and Lyft (contract renewals, program implementation, ongoing TA, evaluation, etc.)	3/1/2023-2/28/2025	Recipient Staff and Contracted Providers	Executed contracts, PE records

Strategy 2.1.D: Implementation of Food Services as a supportive service to help retain in care eligible PLWH whose needs assessments show unmet nutritional needs as a barrier to care, treatment adherence and better health outcomes

Key Activities/Action Steps	Start/End Date	Responsible Parties	Indicators
• Food vouchers and food bank activities (contract renewals, program	3/1/2023-2/28/2025	Recipient Staff and Contracted Providers	Executed contracts, PE records

Broward EMA Ending the HIV Epidemic (EHE)
Work Plan: Year 4

implementation, ongoing TA, evaluation, etc.)			

Strategy 2.1.E: Implementation of PositiveLinks (PL) Cares and Tele-Adherence Counseling (TAC) to keep clients fully engaged and providers easily accessible to clients via a phone-based app that provides clients and providers with the ability to rapidly connect with one another.

Key Activities/Action Steps	Start/End Date	Responsible Parties	Indicators
• PL Cares activities (contract renewals, program implementation, ongoing TA, etc.)	3/1/2023-2/28/2025	Recipient Staff and Contracted Providers	Executed contract, PL Cares system records

Strategy 2.1.F: Implementation of Care Support Services (CSS) to improve HIV care outcomes and life experience for EHE eligible PLWH whose needs assessments show unmet supportive needs as a barrier to accessing and adhering to care and treatment and achieving optimal health care outcomes and living a fulfilled life.

Key Activities/Action Steps	Start/End Date	Responsible Parties	Indicators
• Housing and CSS activities (contract finalizing, program implementation, ongoing TA, evaluation, etc.)	3/1/2023-2/28/2025	Recipient Staff and Contracted Providers	Executed contracts, PE records

EHE Pillar Four: *Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.*

(*Note: Pillar Four is led by CDC to rapidly detect HIV clusters and networks with support from the HRSA RWHAP to provide HIV care and treatment, as applicable.)*

Goal 1: Increase ability to rapidly respond to HIV clusters; Implement effective Community Engagement to increase linkage to and retention in care, and viral suppression.

Objective 1.1: Engage EHE partners, identify new or improved opportunities for meaningful support and collaboration, and coordinate EHE planning efforts with stakeholders through Broward County's existing planning bodies to improve access to and retention in care and improve viral load suppression.

Strategy 1.1.A: EHE staff will organize/preside over and attend multiple EHE Network Meetings, HIV Planning Meetings, and other stakeholder meetings to foster collaborative and cooperative relationships with key stakeholders and the Community at large.

Key Activities/Action Steps	Start/End Date	Responsible Parties	Indicators
1. Coordinate and facilitate an EHE Provider Network and EHE Advisory Board	5/31/2023-2/28/2025	Recipient Staff	Meeting agendas
2. Attend HIV planning meetings and community events to engage stakeholders and community members	3/1/2023-2/28/2025	Recipient Staff	Meeting agendas
3. Coordinate and conduct EHE Provider trainings to support and reinforce the implementation of the EHE Service Delivery Model	3/1/2023-2/28/2025	Recipient Staff and Contracted Provider	Documentation of event attendance logs, meeting agendas.
4. Develop EHE marketing materials to disseminate pertinent information about the program and funded services	3/1/2023-2/28/2025	Recipient Staff	Documentation of materials
5. Utilize technology to engage with hard- to-reach PWH from our population of focus	9/30/2023-2/28/2025	Recipient Staff	Documentation of social media posts

Broward County's Ending the HIV Epidemic Update

Florida Department of Health
September – December 2023

January 23, 2024

Treat

Treat People with HIV Rapidly and Effectively

Reaching Sustained Viral Suppression

Strategies

- Expand access to Test and Treat services.
- Eliminate barriers to HIV care and treatment.
- Expand access to safe/affordable housing opportunities for people with HIV.
- Increase retention in care and treatment and viral suppression.

Treat Pillar Highlights

- **895** primary care physicians educated on the Test and Treat Program.
- **312** clients referred to the Test and Treat Program.
- **289** clients enrolled in the Test and Treat Program.

Diagnose

Diagnose all People with HIV

As Early as Possible

Strategies

- Expand routine HIV testing in targeted health care settings.
- Expand targeted HIV testing of priority populations in non-health care settings.
- Develop and implement a social marketing campaign.
- Eliminate the barriers to HIV testing.
- Create a seamless status-neutral HIV care continuum.

Diagnose Pillar Highlights

- **81 in-home HIV test kits distributed in non-health care settings.**
- **54 in-home HIV test kits distributed via mail order.**
- **839 individuals tested for HIV in an EHE contracted mobile health care clinic.**
- **2,564 HIV tests conducted by our EHE providers.**

Prevent

Prevent New HIV Transmissions

Using Proven Interventions, Including Pre-Exposure Prophylaxis and Syringe Services Programs

Strategies

- Expand access to Pre-Exposure Prophylaxis (PrEP).
- Raise community awareness of PrEP through outreach and social marketing.
- Eliminate barriers to HIV prevention, such as PrEP.
- Create a seamless status-neutral HIV care continuum.

Prevent Pillar EHE Provider Highlights

- **2,328** PrEP screenings.
- **2,360** PrEP referrals.
- **718** PrEP medical visits.
- **125** events and **5,502** in-person contacts.

Broward Wellness Center PrEP Program Highlights

- **903** PrEP clinical visits.
- **723** enrolled in PrEP navigation.

Respond

Respond Quickly to Potential HIV Outbreaks

Get Vital Prevention and Treatment Services to People Who Need Them

Strategies

- Enhance the ability to conduct molecular cluster response by increasing the number of genotypes performed.
- Explore supporting HIV modernization activities that impact state laws.

Contact Information

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HIV Prevention Planner
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Phone: (954) 847-8069

Florida HEALTH

Thank You!

HANDOUT D

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			
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.	Expand routine HIV testing in targeted healthcare settings	
		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-informed 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 multi-county and 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	590	681			
3D.1	Collaborate with community partners to conduct strength, weakness, opportunity and threat (SWOT) analyses of the status-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 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			

Florida Comprehensive Planning Network (FCPN)
Coordination of Efforts Committee Conference Call Agenda January 10, 2024

Attendance:

Present:
Jhazmine Allen
Rebecca Arrington
Susan Barrows
LaCandria Churchill
Serena Cook
Gregory Davis
Meghan Daily
Cathy Frazier
Chris Gudis
Nicole Johnson
Jamie Marques, Co-Chair
Alaina McCorvey
Kim Molnar
Angela Mooss
Jonathan Morgan
Eric Martinez
Karissa Perry
Rob Renzi
Abril Sarmiento
Jessica Seidita
Gerald Sessions
Kira Villamizar
Joey Wynn, Co-Chair
Max Wilson
Robert Wilson
Scott Wilson

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
Nolan Finn
Warren Garrison
Dallen Michael Greene
Nicole Houston
Sylvia Hubbard
Ederick Johnson
Riley Johnson
Casey Messer
Alelia Munroe
Dan Merkan
Michelle Peaslee
Amy Pinter
Penny Pringle
Joshua Rodriguez
Jessica Roy
Jeff Satine
Geneve Simeus
Mary Sirmons
Sylvia Smith
Anthony Stowe
Kevin Williams

Review of in-person meeting at Fall FCPN

- Joey discussed how the committee elected a new co-chair, Jamie Marquis, and that the committee was assigned a new DOH liaison, Jhasmine Allen. Additionally, at the in-person committee meeting, the group developed a road map for the upcoming year.

Monitoring and Evaluation Plan Discussion

- **Assign roles and responsibilities:**
  - The monitoring and evaluation plan was shown to the membership, and the committee discussed where they were and responsibilities that needed to be assigned or volunteered.
  - Warren was identified as spearheading this assignment for the section and the committee was tasked with reviewing the plan prior to the next meeting.
- **Engaging with the plan / monitored activities**

- The committee opened the floor to discuss how local areas would engage with the plan. Some areas reported that they needed more time to report to their local areas the information that came out of the FCPN.
- Bobby Jordan and Warren Garrison are developing a spreadsheet to send out to the local areas to get plan expectation updates.
- Miami Dade has an evaluation workgroup looking at the different activities of the plan and has been identifying reporting entities as part of the end-of-year progress meeting.

VMSG Update

- Jhazmine Allen discussed that the section is finalizing the list of users who need access to the VMSG portal and is in the process of creating a communications email detailing the access and training process to the identified users. Timeline is dependent on approval process.
- A request was made by the co-chairs that at minimum two users be identified in each area to avoid any bottlenecks due to absence or turnover.

Committee Selection Form

- Scott shared a link to a committee selection survey that was brought up at FCPN. The purpose of this survey is to identify the primary Committee and preferred contact for all members. The link: https://survey.zohopublic.com/zs/DoE9hK

Review of Coordination of Efforts Workplan

- The 2023 workplan was shown to the membership & tasked with review of the workplan and to brainstorm edits that will need to be made.

Announcements: Jamie Marques announced that she has been selected as a presenter/panelist to the Academy of HIV Medicine workshop series.

Next Steps/Upcoming Agenda

- VMSG Update at next meeting to include template and license timeline
- Committee will develop revisions to the workplan
- TAI will re-send the Draft of the Monitoring and Evaluation Plan and the 2023 workplan to the membership with the call summary.
- Committee Members will review the plan and be prepared to fill in TBDs at next meeting
- Coordination of Effort co-chairs and TAI support staff will plan an additional co-chairs meeting.

Conclusion: With no further business to conduct, the meeting was concluded by the Co-Chairs at 1:26 PM (ET). The next formal virtual committee meeting is scheduled for **Wednesday, February 14, 2024, at 1:00 PM (ET).**

HANDOUT E2

2023 Coordination of Efforts Work Plan

Goal 1: Maintain a community engagement toolkit for local area use					
Key Action Steps	**Timeline**	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**	**Comments**
Review existing community engagement toolkit	July 2023	Toolkit reviewed	N/A	Committee members	
Update community engagement toolkit annually	October 2023	Toolkit updated	NA	Committee members	
Present work product for review and approval	As needed	Record of vote and approval	NA	The AIDS Institute/HIV/AIDS Section/COE Co-Chairs/	
Goal 2: Maintain a local planning guidance toolkit					
Key Action Steps	**Timeline**	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**	**Comments**
Routinely review the toolkit	Semi-annually (one month prior to face-to-face meeting)	Documented review of toolkit	NA	COE committee	
Update toolkit as appropriate	Ongoing	Updated toolkit	NA	The AIDS Institute/HIV/AIDS Section/COE Co-Chairs/	
Goal 3: Develop a comprehensive monitoring and evaluation process for the Statewide Integrated Plan (IP)					
Key Action Steps	**Timeline**	**Expected Outcome**	**Data Source and Evaluation Methodology**	**Person/Area Responsible**	**Comments**
Share most recent IP activities table with COE members	TBD	Email distributed with most recent IP activities table	NA	The AIDS Institute/HIV/AIDS Section/COE Co-Chairs/	
Review IP activity table by Goal in the context of the EHE Plan and in response to the programmatic grant requirements of the HIV/AIDS Section.	ongoing during quarterly conference calls	Updated Integrated Plan activities table	NA	COE members	

HANDOUT E3

Red Ribbon Report

A News Service of The AIDS Institute for the Florida HIV/AIDS Comprehensive Planning Network

The AIDS Institute

Program and Administrative Office

17 Davis Boulevard,

Suite 403

Tampa, FL 33606

813-258-5929

December | 2023

The **Florida HIV/AIDS Comprehensive Planning Network (FCPN)** held the bi-annual meeting at the Embassy Suites Tampa - USF, December 4-6, 2023.

The meeting followed a hybrid in-person/virtual format with more than 60 members, Department of Health staff, and community guests participating in person, and more than 100 additional virtual attendees.

The meeting covered many topics including statewide advisory group reports, updates from the HIV/AIDS Section, presentations on state and federal policy, data discussions with the Surveillance team, information on the VMSG (Vision, Mission, Services, Goals) Dashboard, and a robust discussion regarding feedback for the procurement and implementation of a statewide fiduciary agent for Ryan White Part B service delivery.

Day One: Community Co-Chairs, Ken Bargar, and Dan Wall welcomed the members, taking roll, and establishing a quorum before leading the group in a brief moment of silence with a special dedication to the late Advocate and State Epidemiologist, Spencer Leib.

Dr. Andrea Sciberras, Medical Director, Division of Disease Control and Health Protection, introduced herself virtually to the FCPN and gave a presentation with facilitated discussion on the state of telehealth in Florida as it specifically relates to ending the HIV epidemic.

Gary Hensley, Co-Chair, Community HIV/AIDS Advisory Group (CHAG), and Joey Wynn, Co-Chair,

Upcoming FCPN Standing Committee and Statewide Advisory Group meetings:

Florida Men's Health Workgroup (FMHW) provided updates on their respective advisory groups.

Community Co-Chair Dan Wall then opened up the floor to nominations for the second Community Co-Chair seat. One nomination was for the incumbent Co-Chair, Ken Bargar, and a second nomination was made for Jamie Marquis, Prevention Representative from Area 11A, setting the stage for a run-off election the next day.

Alaina McCorvey, HIV/AIDS Section Administrator for Partnerships, Jimmy LLaque, Program Director HIV Patient Care and Treatment Access Program, Daniel Grischy, Surveillance Manager, and Warren Garrison, Performance and Quality Manager, each gave brief administrative and programmatic updates for the HIV/AIDS Section.

Michelle Battles, Prevention Manager, provided a comprehensive overview of the Peer Certification program whose inaugural cohort is currently in the preceptorship stage of the training. There was also discussion of the FOCUS initiatives and potential expansion, as well as expanded PrEP programs.

The group also discussed funding restrictions and the availability of state-provided condoms and female condoms. The group also agreed that moving forward, a more inclusive description of female condoms would be internal, inserted, or receptive condoms. This discussion evolved into a lengthy Q&A session among FCPN members and Section staff on the many specifics and logistics surrounding HIV prevention in the state of Florida.

Next, LaCandria "Candy" Churchill, Implementation and 340B Compliance Manager, provided historical context for the transition to a Statewide Fiduciary Agent for Ryan White Part B service delivery, including the **most updated version of the Mercer report**. Candy gave a full rundown of the recommendations of the FCPN Ad-hoc committee which was created to discuss the model. Additionally, Candy gave a preview of the major points of discussion for Day 2.

Paul Mekeel, Benefits Manager, and Jeff King, Supervisor, HIV Patient Care and Treatment Access

FCPN Membership, Nominations & Bylaws Committee Meeting

Meets every other month on the second Tuesday at 10 AM (ET)

Next meeting is scheduled for Tuesday, January 9, 2024, at 10 AM (ET)

Register to attend

FCPN Coordination of Efforts

Committee Meeting

Meets every month on the second Wednesday at 1 PM (ET)

Next meeting is scheduled for Wednesday, January 10, 2024, at 1 PM (ET)

Register to attend

FCPN Medication Access

Committee Meeting

Meets every month on the second Thursday at 3 PM (ET)

Next meeting is scheduled for Thursday, January 11, 2024, at 3 PM (ET)

FCPN Executive Co-Chairs Committee Meeting

Meets every month on the fourth Tuesday at 11AM (ET)
Next meeting is scheduled for Tuesday, January 23, 2024, at 11 AM (ET)

Florida Men's Health Workgroup (FMHW)

Meets every month on the fourth Wednesday at 11 AM (ET)

Program joined Jimmy LLaque and LaCandria Churchill to give a presentation on the Patient Care & Treatment program including organizational changes, pharmacy metrics, formulary updates, insurance program updates, and fiscal & grant updates. The day concluded with an opportunity for public comments.

Participants who attended in-person or virtually are requested to fill out the **Day One Meeting Evaluation** if they have not already done so.

Next meeting is scheduled for Wednesday, January 24, 2024, at 11 AM (ET)

Community HIV Advisory Group (CHAG) Meets every month on the last Tuesday at 3PM (ET)

Next meeting is scheduled for Tuesday, January 30, 2024, at 3 PM (ET)

FCPN Needs Assessment Committee Meeting Meets every other month on the third Tuesday at 10 AM (ET)

Next meeting is scheduled for Tuesday, February 20, 2024, at 10 AM (ET)

Day Two

Following a welcome and roll call by the Co-Chairs, all FCPN members were reminded that as part of their roles and responsibilities, each member is required to select one primary standing committee on which to serve. A **virtual form** was shared for members to make their formal committee selections, and then all members were allowed to join their respective committees for face-to-face meetings.

Following these face-to-face committee break-out sessions, the Co-Chairs of each committee provided a summary of their discussions to the full body.

Nick Armstrong, Manager, Advocacy & Government Affairs, The AIDS Institute provided a comprehensive **update on current Federal Policy** relating to HIV, and Donna Sabatino, Director, State Policy and Advocacy, The AIDS Institute then provided an update on **State Policy and Legislative Affairs in Florida**.

Colby Cohen, Medical Health Care Program Analyst, and Angela Campbell, Biological Scientist IV, presented a detailed analysis of the epidemiological profile for HIV in Florida. Lorene Maddox, Surveillance Data Analysis Manager, also provided the FCPN with a presentation on in and out-migration of persons with HIV in Florida. The Surveillance team then facilitated a Q&A session with the membership to clarify all questions related to the data presentations. Colby Cohen wrapped up the surveillance update by informing the FCPN of the progress that has been made with the Data Sharing Agreement (DSA) to increase communication between state headquarters and Ryan White Part A providers.

Following the Surveillance presentations, Ken Bargar and Jamie Marquis, the two nominees for FCPN Co-Chair, gave short speeches to the membership, and a paper ballot vote was conducted. Following the results of the vote, Ken Bargar was elected to return and serve his second term as FCPN Community Co-Chair.

After the Co-Chair election, Warren Garrison, Performance and Quality Manager, facilitated a discussion of the Section's progress with VMSG integration, licensing, and training. And a high-level overview of the benefits that VMSG will bring to the state, and local areas, and the monitoring of the **Integrated Plan**. Warren also discussed limitations in Section capacity and the need for a participatory approach with the local areas and the FCPN Coordination of Efforts Committee.

The remainder of the day centered around a facilitated discussion of the Ryan White Part B Service Delivery Model. The facilitated discussion included a Mentimeter feedback activity led by Candy Churchill. The discussion revolved around five key topics: Network Development, Billing and Invoices, Reports Included, Data Informed Decisions, and Funding Allocations. The facilitated discussion then wrapped up with a lengthy Q&A session and discussion with the FCPN members present and attending virtually. The day ended with an opportunity for public comment.

Day Three: Following a welcome, roll call, and establishment of a quorum for the final day of the meeting, representatives from each area provided the membership with brief updates and highlights of their local areas, including some inspiring World AIDS Day activities that occurred the prior weekend.

Jimmy LLaque and Lacandria Churchill then led a final group discussion on the Ryan White HIV/AIDS Program Part B Care Model, while fielding any outstanding questions from the membership.

Upcoming National Conferences

USCHA Conference September 12 - 15, 2024 New Orleans, LA

Information and Registration

2024 National Ryan White Conference on HIV Care & Treatment August 20-23, 2024

Washington, DC Information and Registration

The meeting ended with a discussion of next steps, future meeting dates, and proposed topics. Suggested topics for the Spring meeting included a VMSG (Vision, Mission, Services, Goals) presentation, Housing Opportunities for Persons with AIDS (HOPWA), Medical Monitoring Project (MMP) and AIDS Drug Assistance Program (ADAP) updates, Integrated Plan progress check, and discussion of minimum standards of care. As the meeting adjourned, participants were reminded to please fill out the **Day Three Evaluation**.

Thank you all for this engaging, informative, and productive meeting of the Florida HIV/AIDS Comprehensive Planning Network, and we look forward to seeing everyone again in the Spring.

HANDOUT F

BRHPC

BROWARD RYAN WHITE PART A

CLINICAL QUALITY MANAGEMENT ANNUAL REPORT

FY2022-2023

A summary of Clinical Quality Management activities and performance measures designed to monitor the quality of care provided by Ryan White HIV/AIDS Program Part A-funded agencies as part of the Broward EMA's quality management plan.

GET CARE
BROWARD
TREAT HIV | BEAT HIV
RYAN WHITE | PART A

The creation of this document is 100% funded by a federal Ryan White HIV/AIDS Program Part A grant received by Broward County and sub-granted in part to a consultant agency.

OUR MISSION

"Broward Regional Health Planning Council is committed to delivering health and human service innovations at the national, state, and local level through planning, direct services, evaluation, and organizational capacity building."

FOR MORE INFORMATION

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This document was created by Clinical Quality Management (CQM) Support Staff, employed by Broward Regional Health Planning Council.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Broward County is Florida's (FL) second-largest metropolitan area, with 1.9 million residents. In 2021, the FL Department of Health reported that Broward County had 21,014 people with HIV, 75% male, and 25% female. The same year, Broward had the second-highest incidence rate of HIV cases in Florida, with 652 confirmed HIV diagnoses and 252 AIDS cases. The focus of the Ryan White Part A Program, as well as several public and private HIV and AIDS programs, is to improve the state of the epidemic by providing high-quality treatment to those already infected. Broward's position as one of the top-ranking counties for new infections and population-adjusted cases of HIV and AIDS means the work of the Part A Program and the Part A Clinical Quality Management (CQM) Program is increasingly important.

This Report details the activities of Broward's Part A CQM program, including Provider Networks and the HIV Planning Council's Quality Management Committee (QMC), and their focus on the application of the National HIV/AIDS Strategy (NHAS) HIV Care Continuum, HIV/AIDS Bureau (HAB) performance measures, quality benchmarks, and the collection and analysis of client, provider, and system-level data in 2022-2023.

The following Report provides an overview of the Ryan White Part A CQM Program and organizational structure, Network activities, HIV Care Continuum regarding the Broward EMA, performance measures, and Program accomplishments and challenges.

I

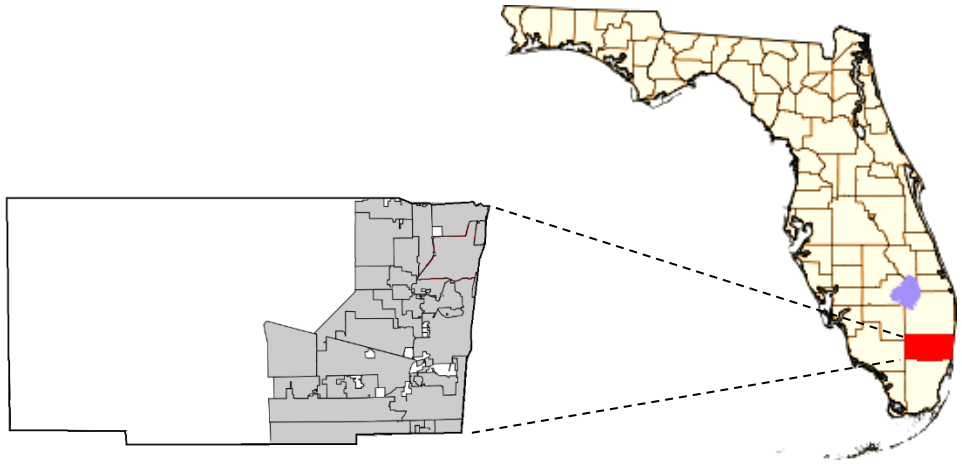
INTRODUCTION

Section 2604(h)(5)(A) of Title XXVI of the Public Health Services Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009, requires that Part A Grantees establish and implement a clinical quality management (CQM) program to (1) assess the extent to which HIV health services provided to clients under the grant are consistent with the Department of Health and Human Services (HHS) guidelines for the treatment of HIV/AIDS and related opportunistic infection, as applicable, and (2) develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services. The Health Resources & Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) requires that a Part A Grantee must have:

- Established and implemented a quality management plan with annual updates.
- Established processes for ensuring that services are provided in accordance with the Department of Health and Human Services (HHS) treatment guidelines and standards of care.
- Incorporated quality-related expectations into Requests for Proposals (RFPs) and EMA contracts, including the sub-recipient level.

Broward County, Florida, is the recipient of Part A federal funds (including Formula, Supplemental and Minority AIDS Initiative dollars) and manages the CQM Program for the Broward County/Fort Lauderdale Eligible Metropolitan Area (EMA).

Figure 1. *Florida/Broward County Jurisdiction Map*



THE CQM PROGRAM

Quality Statement

The mission of the CQM Program in the Fort Lauderdale/Broward County EMA is to ensure equitable access to a seamless system of high-quality, comprehensive HIV services that improve health outcomes and eliminate health disparities for people with HIV/AIDS in Broward County.

The purpose of the CQM program in the Fort Lauderdale/Broward County EMA is to systematically monitor, evaluate, and continuously improve the quality and appropriateness of HIV services provided to people with HIV/AIDS in Broward County. This will be accomplished by:

- Assessing the extent to which HIV services are consistent with the most recent HHS Clinical Guidelines for the Treatment of HIV/AIDS and related opportunistic infections;
- Developing strategies to ensure that such services are consistent with the guidelines for improvement in the access to, and quality of HIV services;
- Monitoring the quality of HIV services through the application of the HIV Care Continuum, HAB performance measures, HHS indicators, and Broward EMA local outcomes and indicators;
- Implementing continuous quality improvement strategies to ensure core and support services promote retention in care, adherence to medical treatment, and viral suppression;
- Applying client-level demographic, clinical, and utilization data to identify areas of improvement in clinical processes and outcomes; and
- Providing technical assistance to all providers throughout the course of creating, initiating, and evaluating quality management practices.

Organizational Structure

The Recipient is responsible for all quality-related activities that fulfill the legislative requirements for the CQM program in the Broward EMA. There are four interconnected bodies of the Broward EMA CQM program: Recipient CQM staff, CQM Support staff, HIV Planning Council (HIVPC) Quality Management Committee (QMC), and the Provider Networks.

Quality Management Committee

The Broward EMA has a robust quality management program supported by the CQM Support staff. The HIVPC's QMC is comprised of HIVPC members, RWHAP clients, RWHAP client service professionals, and HIV and non-HIV providers. The HIVPC Chair appoints the Chair and Vice-Chair of the Committee. They are responsible for convening the meetings and coordinating the work of the Committee in collaboration with the Part A Office. The HIVPC has approved performance measures, including outcomes along the

HIV Care Continuum, various HAB performance measures, and locally adopted outcomes and indicators to assess the quality of care provided across the Broward EMA. The QMC utilizes the HIV Care Continuum to inform the development of CQM program performance measures and CQM goals and objectives outlined in the CQM Plan. Therefore, the QMC reviews clinical performance issues related to service delivery to make data-informed recommendations on enhancing client health outcomes and experiences and makes proposals that guide the scope of systemwide quality improvement projects (QIPs) based on areas that need improvement.

Provider Networks

The Provider Networks are comprised of providers from locally funded Ryan White Part A service categories. Quarterly meetings provided an opportunity to discuss service delivery barriers and challenges within the EMA and identify strategies to resolve them. In addition, the CQM staff collaborates with the Networks to develop and implement quality management initiatives to strengthen system processes to develop improved health outcomes for Part A clients in Broward County.

Quality Network

The Quality Network is comprised of quality representatives from all locally funded Ryan White Part A service providers. Quality Network focuses on increasing quality representatives' capacity to develop and implement quality improvement projects and activities.

Roles & Responsibilities

Recipient CQM Staff

- Maintain oversight of EMA systemwide Part A QI initiatives and related activities.
- Facilitate integration and interaction among Part A QMC, Networks, and clients.
- Develop, review, and evaluate progress toward successful implementation of the CQM 3-Year Plan and annual work Plans.
- Ensure all provided services are consistent with the most recent HHS guidelines.
- Collaborate with CQM Support Staff to routinely extract Management Information System (MIS) data to assess the level of care, performance measures, and health outcomes.
- Collect, monitor, and analyze client- and system-level data and performance measures on a continual basis.
- Develop, guide, and monitor the adoption of Service Delivery Models (SDMs), standards of care, and performance indicators for each service category.
- Conduct annual on-site monitoring evaluation visits and monthly provider subrecipient calls.
- Provide and facilitate technical assistance (TA).

CQM Support Staff

- Research national guidelines and best practice models to ensure quality activities follow national standards.
- Facilitate the development, review, and updating of the CQM Plan, CQM Annual Work Plan, CQM Training Plan, and SDMs.
- Collaborate with Recipient CQM staff to routinely extract MIS data to assess the level of care, performance measures, and health outcomes.
- Collect, monitor, and analyze client- and system-level data and performance measures.
- Report data findings to the QMC and Quality Network to assess systemwide data and achievement of health outcomes.
- Assist with the planning and facilitation of the networks.
- Assist with the development, implementation, and tracking of QIPs to address identified deficiencies and successes.
- Plan and facilitate QI trainings to the QMC and Networks.

HIVPC QMC

- Develop Committee policies and procedures that are consistent with other HIVPC Committees.
- Review CQM data to evaluate progress in achieving CQM goals.
- Participate in the development and evaluation of Broward outcomes and indicators.
- Assist with the development and implementation of the CQM Plan, CQM Annual Workplan, and SDMs.
- Review and update SDMs to ensure services are provided in accordance with national guidelines and best practice models.
- Facilitate the implementation of QIPs.

Provider Networks

- Identify, design, and discuss standards of care and performance indicators for each service category.
- Review and provide input to the design of SDMs to ensure services are provided in accordance with national standards and best practice models.
- Address emerging barriers impeding access to and retention in services, and barriers to viral load suppression.
- Discuss new evidence-based practice ideas and emerging strategies to promote sustainable viral load suppression.

Quality Network

- Identify and discuss performance indicators.
- Identify and discuss areas for quality improvement.
- Develop and implement quality improvement projects at the provider level.

Data Collection

To streamline the collection of clients, agency, and system-level data, the Broward County Ryan White Part A Program, the AIDS Drug Assistance Program (ADAP), and Housing Opportunities for Persons with AIDS (HOPWA) program, use Provide Enterprise (PE) as their management information system database.

In 1999, the Broward County Health Care Services Division (BCHCS) Purchased the Provide® Care Management system under the direction of the HIV Planning Council. It was the software package selected to address the Plan of Information System (PCIS) project requirements. In 2009, the Broward County database was upgraded to the latest version of the software, PE.

The system accomplishes several goals:

- Provide a care management tool to funded agencies that enable them to collect all data and produce the Ryan White CARE Act Data Report and Client Level Data Extract.
- Enable agencies to bill BCHCS electronically.
- Improve the consistency and reliability of the data collected.
- Reduce duplication of services to clients.
- Facilitate improved community planning with more accurate and comprehensive information on the Clients served and the impact of the services being delivered.
- Coordinate care between provider agencies.

The CQM Program uses PE to extract client demographic data, conduct performance measurements, analyze client health outcomes, and monitor service utilization.

II

CQM ACTIVITIES

Provider Appreciation Week

CQM Support Staff facilitated a virtual Provider Appreciation Week. The event was held from February 6th -February 10th, 2023, for Broward County Ryan White Part A providers and community partners. The week consisted of short, mid-day webinar learning sessions with 66 individuals registered via the online registration form. The daily sessions ranged from 45 to 60 minutes.

The session topics were based on providers' requests acquired via survey and were developed in coordination with the Part A Recipient. The topics varied and were designed to appeal to all providers and agencies. Speakers for the event varied from a trauma-informed coach, a CDC ambassador, and a certified yoga instructor.

The topics were:

Monday, February 6, 2023 – Ryan White Parts Updates

Tuesday, February 7, 2023 – Quality Awards

Wednesday, February 8, 2023 – Implicit Bias and HIV-Related Stigma

Thursday, February 9, 2023 – Trauma Informed De-escalation

Friday, February 10, 2023 – Chair Yoga and Meditation

Accomplishments:

For the 2022 Provider Appreciation Week, the CQM Support Staff rearranged the sequence of the virtual events to help distribute the information in a way that did not overwhelm the participants. By creating this order, it allowed more participants to be engaged during each training session. In addition, surveying the providers about event topics before the Provider Appreciation Week proved successful. Based off the post survey feedback for the 2022 Provider Appreciation Week, the CQM Support Staff decided to create a part two to the Trauma Informed De-escalation session.

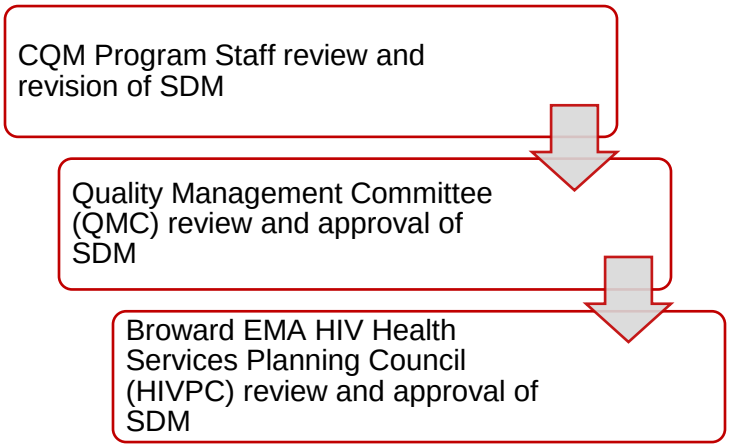
They successfully celebrated provider accomplishments via a virtual award ceremony. The CQM Support Staff also provided runner-up awards to help acknowledge agencies who made an impact on retention in care and viral suppression. They included new award categories such as Key Contributors to help acknowledge some qualitative attributes as well.

Updating Broward County Ryan White Part A Service Delivery Models

Service delivery models (SDMs) are a key component of providing high-quality HIV service delivery. Service delivery models align with the HIV/AIDS Bureau Policy Clarification Notice #16- 02 to meet the most current definition of service categories and allowable uses of funds under the Ryan White HIV/AIDS Program.

Figure 2. Service Delivery Model Review Process

SDM review and revision is a multi-step process involving the CQM Program Staff, Quality Management Committee (QMC), and Broward EMA HIV Health Services Planning Council. In FY21, 13 SDMs were updated through extensive research on current service standards, feedback from provider networks, and input from additional subject matter experts. The process is outlined in Figure 2.



Within the fiscal year, the Quality Management Committee and HIV Planning Council approved the following SDMs:

- Oral Health
- Legal Services
- Health Insurance Benefits Support Services
- Mental Health
- Food Services
- Substance Abuse
- Non-Medical Case Management
- AIDS Pharmaceutical Assistance (Local)
- Emergency Financial Assistance
- Integrated Primary Care and Behavioral Health
- Non-Medical Case Management
- Centralized Intake and Eligibility Determination
- Disease Case Management

Accomplishments:

Four SDMs were revised within the fiscal year to best meet the needs of Broward County's HIV community.

Increasing Capacity for Quality Improvement

Despite systemwide efforts to increase health workforce capacity for quality improvement (QI) through trainings and guidelines, there remained challenges in bridging the gap between quality improvement concepts, best clinical practices, and addressing client barriers to high-quality care. Therefore, the Broward EMA is empowering QI Mentors to move new initiatives through phases of planning, data-informed development, and implementation to address this gap.

Using the Quality Network, the CQM Support Staff implemented the QI Toolkit: *FY2022-2023 Resource Guide for Broward County Ryan White Part A Quality Network Providers*. The toolkit served as a guiding resource for Quality Network members during the QIP process. The toolkit was designed to provide network members with materials and a fiscal year plan to facilitate quality improvement activities' development, implementation, and resolution. The toolkit detailed the following steps of the QIP process:

1. Planning the Quality Improvement Project (March-May)
2. Aim Statements and Change Ideas (May-June)
3. PDSA Cycles (June-October)
4. QIP Evaluation and Presentation (November-February)

CQM Support Staff developed the QI Toolkit to provide a clear and timely framework of expectations during the QIP process, provide a comprehensive resource guide for network members tailored to the QIP process, allow all QIPs related resources/data/progress to be stored in a single location, and to enable the continuation of QIPs if unexpected events arise. Providers were able to submit components of their QIP by following checkpoints outlined in the toolkit. Providers received a reminder and an overview of each checkpoint at the Quality Network meetings and submitted their checkpoints via the survey links provided by CQM Support Staff.

Challenges:

Staff turnover at agencies was a significant challenge during the process. As Quality Network members are replaced with their successors, the transfer of knowledge and skills has been inefficacious. Some agencies are also short-staffed, which makes it more of a challenge for them to complete by the Checkpoint dates.

Accomplishments:

Through Quality Improvement skill-building, all RWHAP agencies conducted QIPs during FY22-23. Every agency submitted their final checkpoint and provided positive feedback on the checkpoints.

Agency Quality Improvement Projects (QIPs)

During FY22-23, the CQM team guided members of the Quality Network in conducting QIPs within their agencies, resulting in completed QIPs during the fiscal year as quality representatives became mentors and champions of change within their agencies. Technical assistance provided included assistance with checkpoint submissions, the development of aim statements, and guidance for PDSA cycles. As quality mentors

continue to activate Q.I. initiatives, this project's success will be measured by the health outcomes of clients receiving services from the 12 agencies.

Table 1: Subrecipient QIPs within FY2022-2023

Subrecipient	Funded Services	QIP Topic
AIDS Healthcare Foundation (AHF)	Integrated Primary Care and Behavioral Health, Disease Case Management, Case Management (non-medical), Oral Health Care (Routine), AIDS Pharmaceutical Assistance (local)	Improve the Rate of Retention in Care for Consumers by Increasing Access to Mental Health Services
Broward Community and Family Health Centers (BCOM)	Integrated Primary Care and Behavioral Health, Disease Case Management, Case Management (non-medical), Oral Health Care (Routine)	Increase Viral Suppression Rates through Medication Adherence Interventions for Ryan White Clients Aged 59 and Older
Broward Regional Health Planning Council (BRHPC)	Centralized Intake Eligibility Determination, Health Insurance Continuation Program	Monitor and Evaluate the Viral Suppression of New to Care Ryan White Clients
Broward House	Integrated Primary Care and Behavioral Health, Disease Case Management, Case Management (non-medical), Mental Health, Substance Abuse (Outpatient),	Improvement in Data Entry into Provide Enterprise to Increase Viral Suppression Reportability
Care Resource	Mental Health, Integrated Primary Care and Behavioral Health, Disease Case Management, Case Management (non-medical), Food Services (Food Voucher), Oral Health Care (Routine), HOPWA	Increase the Compliance Rate in Broward Ryan White Clients from the Disease Case Management Case Load
Community Rightful Center	Case Management (non-medical)	Expansion of Case Management Caseload and MAI services to the Haitian and Caribbean populations in Broward EMA
Latinos Salud	Case Management (non-medical)	Increase Retention in Care amongst the Hispanic/Latinx population
Legal Aid Services of Broward	Legal Services, HOPWA	Targeted Outreach to Increase Retention in Care for Clients who Utilize Legal Services
North Broward Hospital District (Broward Health)	Integrated Primary Care and Behavioral Health, Disease Case Management, Case Management (non-medical), Pharmacy (local)	Address the No-show Rate and the Impact on Viral Suppression

Nova Southeastern University	Oral Health Care (Routine and Specialty)	Increase Retention in Care Rates by Improving Overall Patient Experience
South Broward Hospital District (Memorial Healthcare System)	Integrated Primary Care and Behavioral Health, Disease Case Management, Case Management (non-medical)	To Focus on and Increase Retention Rates Among Black Women between the ages of 36 to 45 years
The Poverello Center	Food Services (Food Bank)	To Increase Retention in Care and Viral Suppression for Clients with High or Unknown Viral Suppression and/or those not Virally Suppressed

Network Meeting Attendance

Broward County RW Part A Agencies are contractually obligated to attend Network meetings. Agencies are responsible for sending a minimum of one representative to follow the agency network meeting obligations. Provider Networks meet every quarter, while the Quality Network meets more frequently (every six weeks). Agencies are allowed an absence if the reason for missing the meeting is communicated to the CQM Team prior to the meeting time. The following table displays the composition of the Network represented by agencies attending each meeting.

Table 2: FY 2022-2023 Agency Attendance

Network	Date of Meeting	Agency Attendance (%)
Support Services (n=11)	3/1/22	82%
	6/7/22	82%
	9/6/22	55%
	12/6/22	82%
FY 22-23 Network Avg		**75%**
Oral Health (n=4)	4/6/22	75%
	7/6/22	75%
	10/5/22	100%
	1/4/23	50%
FY 22-23 Network Avg		**75%**
Medical (n=6)	4/7/22	83%
	7/7/22	33%
	10/6/22	67%
	1/5/23	33%
FY 22-23 Network Avg		**54%**
DCM (n=6)	5/6/22	100%
	8/5/22	83%
	11/4/22	83%
	2/3/23	83%

FY 22-23 Network Avg		**87%**
Behavioral Health (n=6)	4/12/22	83%
	7/12/22	83%
	10/11/22	67%
	1/10/23	83%
FY 2022-2023 Network Avg		**79%**
Quality (n=12)	3/23/22	92%
	5/4/22	100%
	6/15/22	100%
	7/27/22	83%
	9/7/22	92%
	10/19/22	75%
	11/30/22	83%
	1/11/23	92%
	2/22/23	100%
FY 2022-2023 Network Avg		**91%**
FY 22-23 Overall Attendance		**77%**

**N-values represent the number of agencies within each Network.*

Limitations:
Agency staff turnover of representatives contributed to the absences throughout the fiscal year. Additionally, some of the agencies faced a staff shortage which limited the amount of time Network members could dedicate to the Network meetings, especially if they have other roles that take priority. The Medical Provider Network had the lowest average attendance from agency representatives.

EMA Systemwide Access to Care/Process Mapping Project
Clients and providers report challenges in navigating the system of care from eligibility to obtaining services. This is evident in some cases by low utilization of specific services (mental health, substance use, legal, disease case management) and the number of clients disengaged from care from the Florida DOH Test and Treat Program. Barriers to accessing healthcare services negatively affect the immediate health and long-term health outcomes of people with HIV (PWH). A better understanding of the processes involved in service access can help identify gaps in care and highlight needs and opportunities for quality improvement. The timeline for the process mapping project is still ongoing for the

PERFORMANCE MEASUREMENT

HIV CARE CONTINUUM

The Broward EMA utilizes the HIV Care Continuum to better identify gaps in HIV services. The HIV Care Continuum is a model that outlines the sequential steps or stages of HIV medical care that people with HIV go through, from the initial diagnosis to achieving the goal of viral suppression and shows the proportion of individuals with HIV who are engaged at each stage. Each quarter, the Broward EMA performs a system-wide and service-category-specific HIV Care Continuum analysis using PE. The PE report allows the Broward EMA to monitor the outcomes of individuals living with HIV receiving medical care and treatment and guides the development of QIPs.

HIV Care Continuum measures are based on the areas where gaps in client services occur and focus on increasing the proportion of individuals in each stage along the continuum. The Broward EMA Quarterly HIV Care Continuum Analytics highlights elements of HIV treatment and care provided to clients in the Part A system: People with HIV, Ever in Care, In Care, Retention in Care, On ARV, and Virally Suppressed. **Figures 3-8** show the HIV Care Continuum for all Broward County Part A Clients for the fiscal year 2022-2023 (ending on February 28, 2023) and broken down by gender, race, age, and risk factor. HIV Care Continuum measures are assessed bi-annually due to unnoticeable changes that tend to occur in one quarter.

Broward County Part A Care Continuum Definitions

1. **Total HIV+ Clients:** Clients that are HIV+ and received at least one service from the selected service category(s) in the reporting period.
2. **Ever in Care:** HIV+ Clients that ever-had medical care service* documented.
3. **In Care:** HIV+ Clients that had medical care within the reporting period.
4. **Retention in Care:** HIV+ Clients that had two or more medical care services* at least three months apart in the reporting period.
5. **On ARV:** HIV+ Clients that have documented ARV Therapy at any time during the reporting period.
6. **Virally Suppressed:** HIV+ Clients with less than 200 copies/mL in their most recent viral load assessment, as of the end of the reporting period

**Medical Care Service = Medical Visit, Prescription Pickup, Viral Load, or CD4 lab*

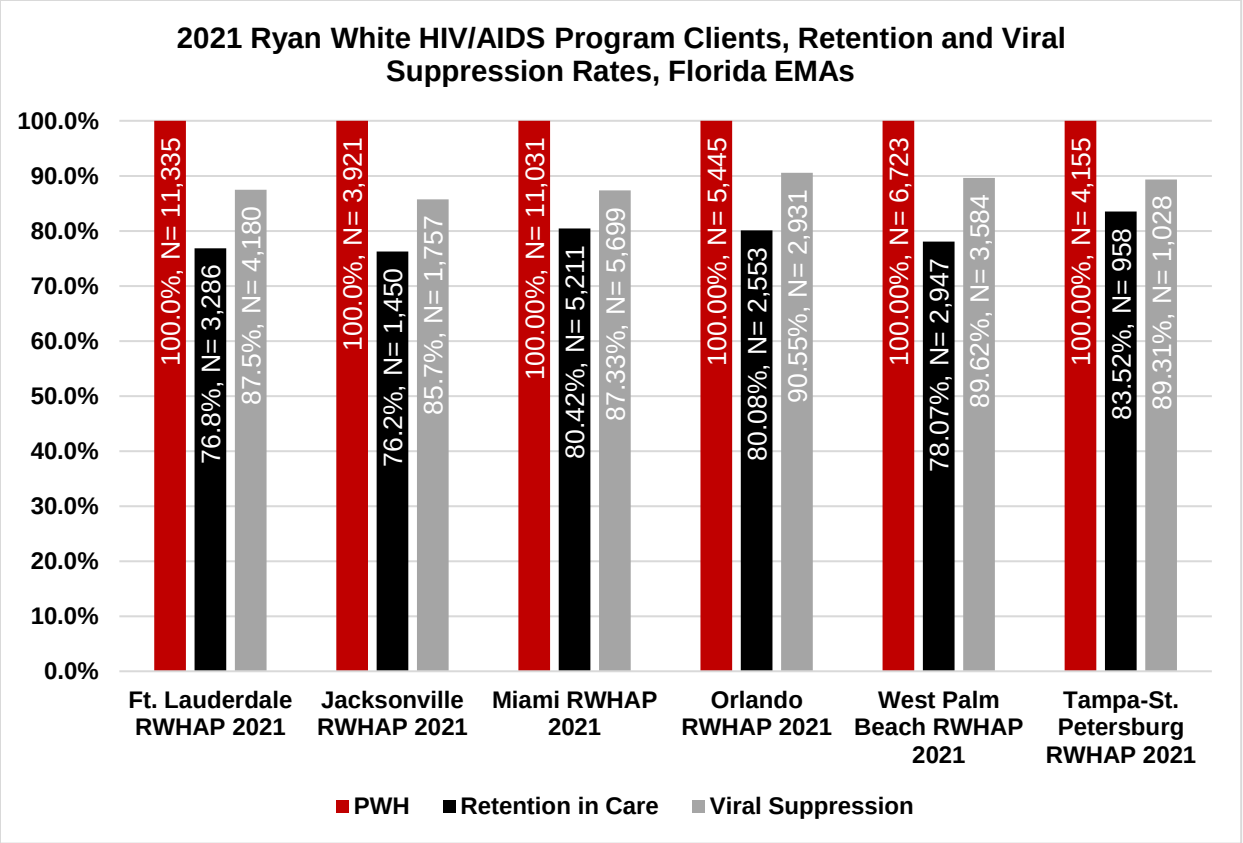
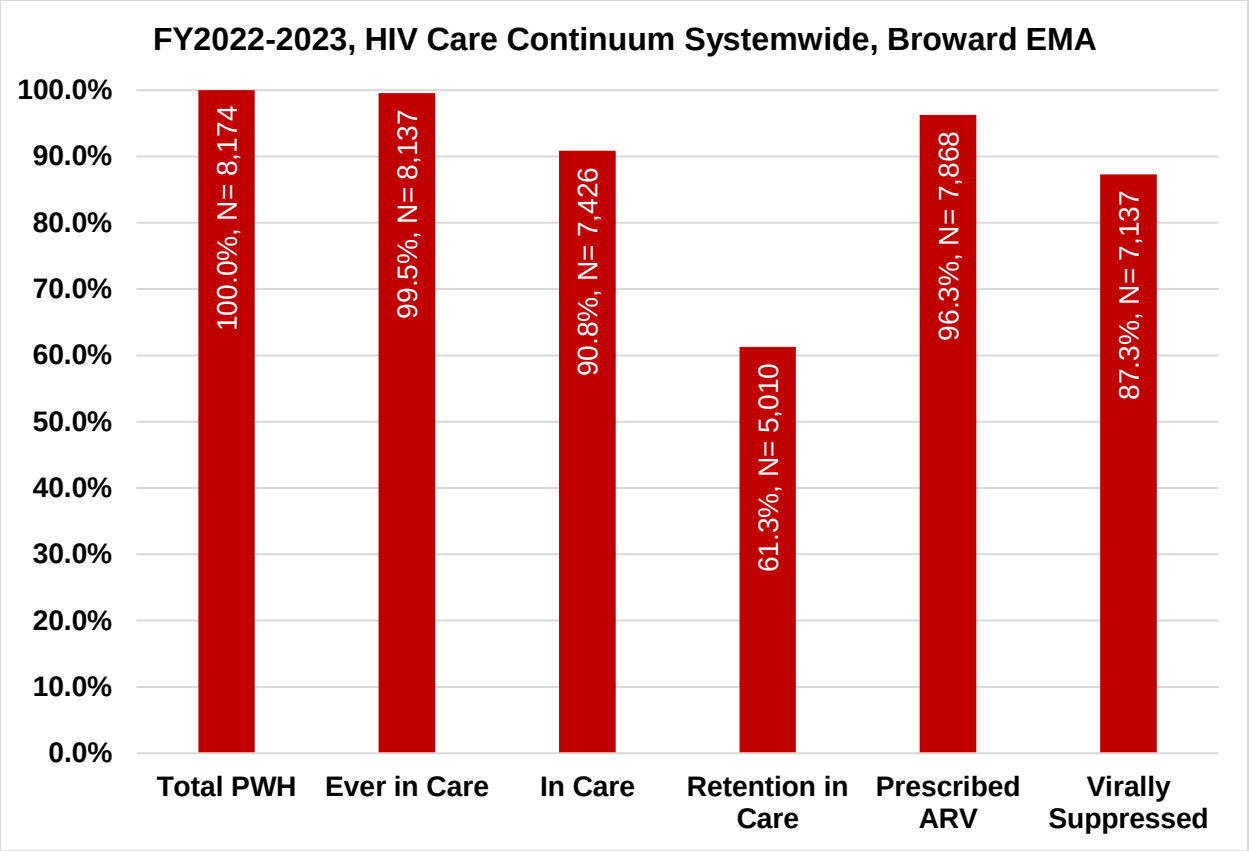


Figure 3. 2021 Florida EMAs Ryan White HIV/AIDS Program (RWHAP) Clients by Retention and Viral Suppression Rates

Figure 3 shows the 2021 RWHAP Annual Client-Level Data for the Florida EMAs published by the Division of Policy and Data, HIV/AIDS Bureau (HAB), Health Resources and Services Administration (HRSA), and U.S. Department of Health and Human Services[1]. Out of all the EMAs presented, the Ft. Lauderdale EMA has the most client data reported with the Miami EMA following second. Clients in the Ft. Lauderdale EMA were 1.27% to 6.72% less likely to be retained in care than clients in the Miami, Orlando, Tampa-St. Petersburg, and West Palm Beach EMAs. Clients in the Ft. Lauderdale EMA were 1.81% to 3.05% less likely to be virally suppressed than clients in the Orlando, Tampa-St. Petersburg, and West Palm Beach EMAs. As the retention rate continues to increase, the Ft. Lauderdale EMA strives to develop innovative ways to refine how client-level data is captured and reported to improve the effectiveness of the Ryan White program.

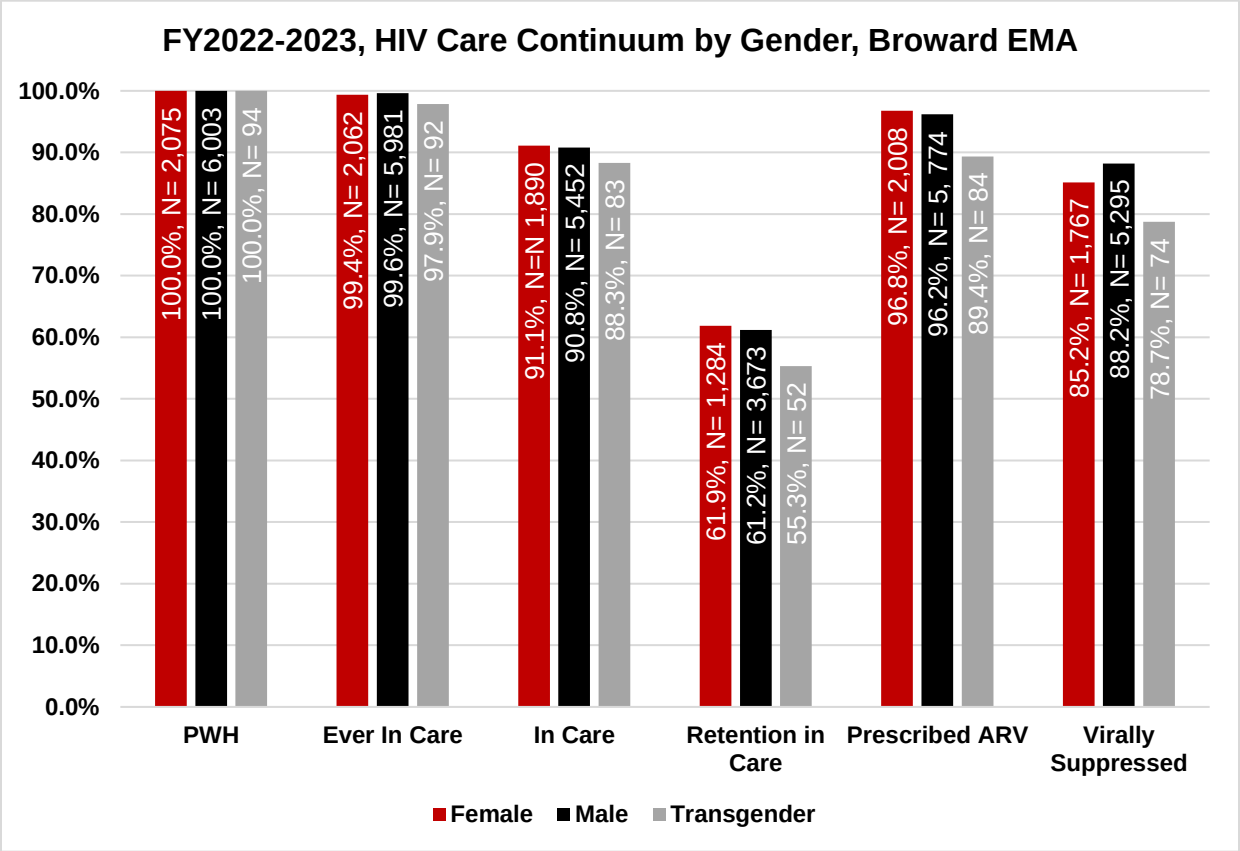
[1] Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2021. ryanwhite.hrsa.gov/data/reports. Published December 2022.



**Continuum of Care Report 3/1/2022-2/28/2023*

Figure 4. FY2022-2023, HIV Care Continuum Systemwide, Broward EMA

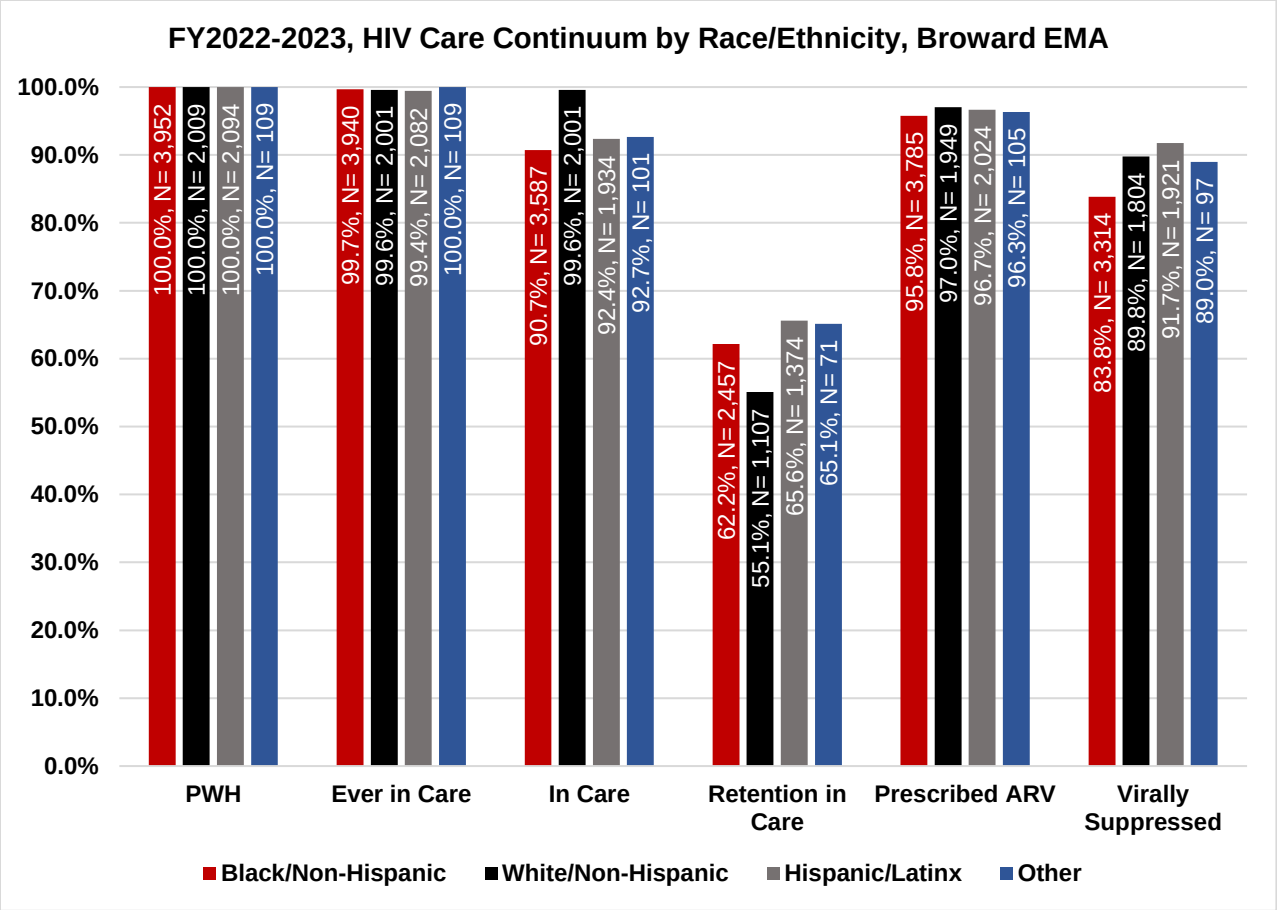
Figure 4 shows the system-wide HIV Care Continuum in the Broward County EMA for FY2022-2023. In total, 8,174 people were living with HIV. Of this total, 99.5% of those clients were ever in care, 90.8% were in care during the reporting period, 96.6% documented ARV therapy at any time during the reporting period, and 87.3% of clients were virally suppressed. Due to performance issues, the validity of the data was affected during the 2022-2023 fiscal year when using Provide Enterprise. In particular, the retention rate was affected by the data discrepancies and coding issues that distorted the retention rate from FY2022 Q1 to Q3. However, during the fourth quarter, the data issues were resolved, yielding a higher systemwide retention rate. Provide Enterprise will continue to be monitored to ensure any additional data discrepancies are resolved for future reporting.



**Continuum of Care Report 3/1/2022-2/28/2023*

Figure 5. FY2022-2023, HIV Care Continuum by Gender, Broward EMA,

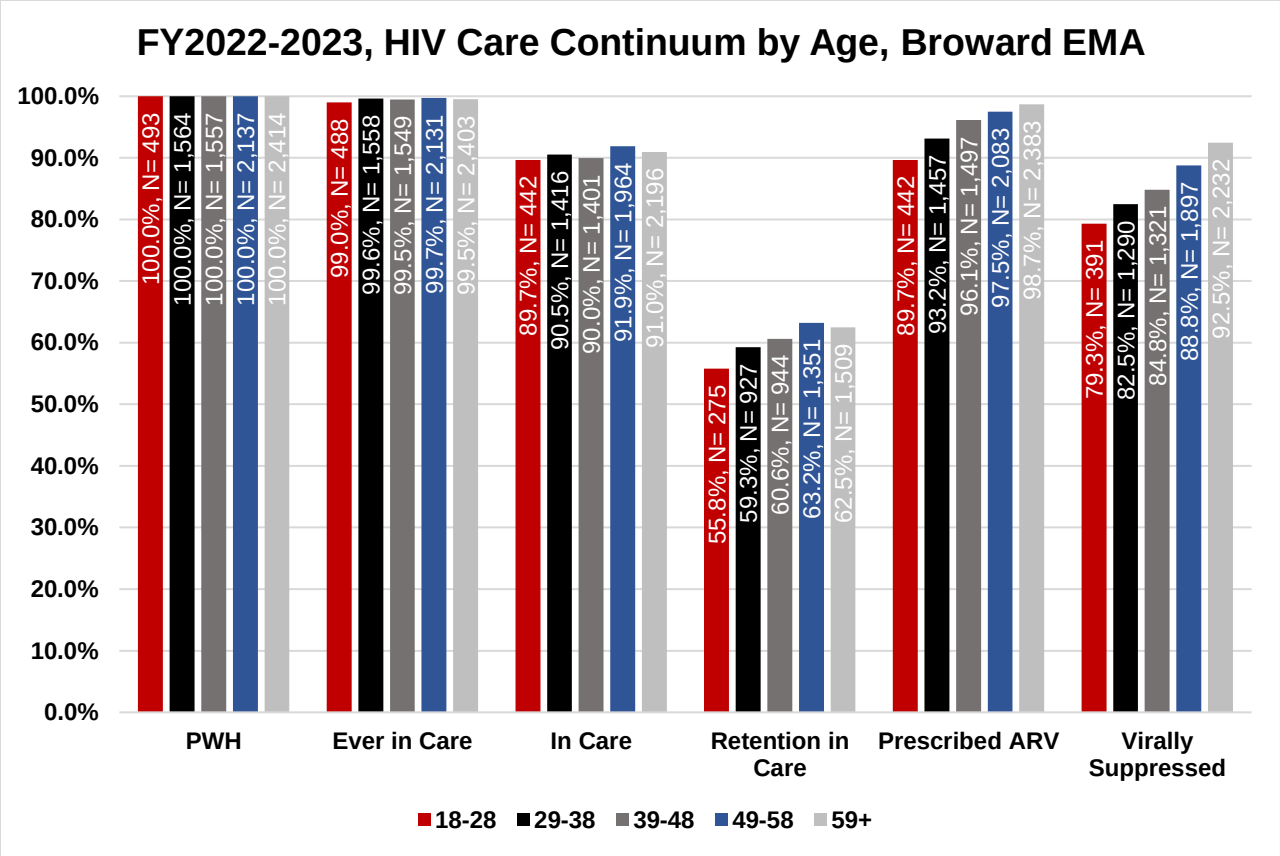
Figure 5 shows the HIV Care Continuum for all genders in the Broward County EMA during the 2022-2023 fiscal year. There were 2,075 female clients, 6,003 male clients, and 94 transgender clients living with HIV. For the Retained in Care service category, the percentages are as follows for all genders: female (61.9%), male (61.2%), and transgender (55.3%) clients. For the prescribed ARV service category, 96.8% of female clients documented being on ARV therapy, 96.2% of male clients documented being on ARV therapy, and 89.4% of transgender clients documented being on ARV therapy at any time during the reporting period. For the viral suppression service category, 85.2% of female clients were virally suppressed, 88.2% of male clients were virally suppressed, and 78.7% of transgender clients were virally suppressed.



**Continuum of Care Report 3/1/2022-2/28/2023; Other includes Alaskan Native, American Indian, Asian, Native Hawaiian, and Pacific Islander*

Figure 6. FY2022-2023, HIV Care Continuum by Race/Ethnicity, Broward EMA

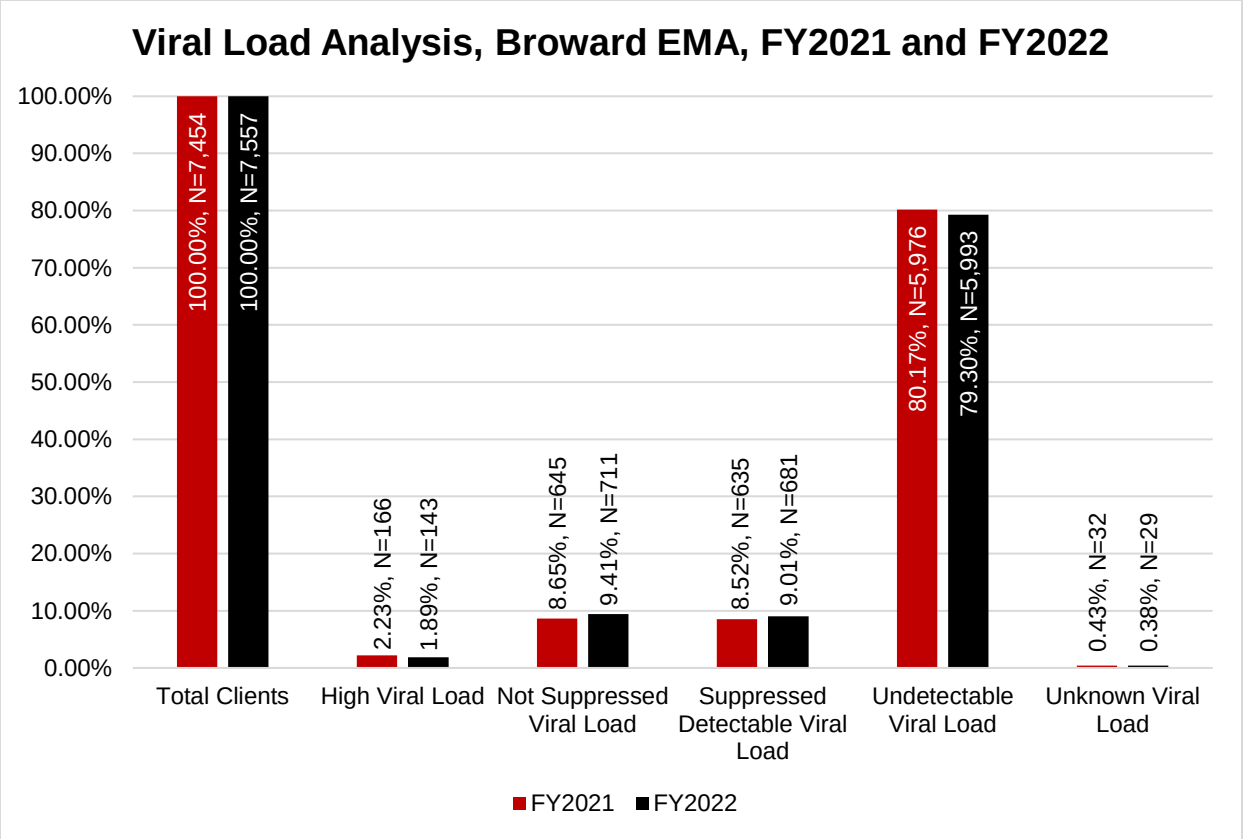
Figure 6 shows the HIV Care Continuum for all races and ethnicities in various service categories in the Broward County EMA for FY2022-2023. There were 3,952 Black (Non-Hispanic) clients, 2,009 White (Non-Hispanic) clients, 2,094 Hispanic/Latinx clients, and 109 clients who identified as Alaskan Native, American Indian, Asian, Native Hawaiian, or Pacific Islander who are living with HIV. For the Retained in Care service category, the percentages are as follows for all races and ethnicities: 62.2% Black (Non-Hispanic), 55.1% White (Non-Hispanic), 65.6% Hispanic/Latinx, 65.1% Other. For the prescribed ARV service category, the percentages are as follows for all races and ethnicities: 95.8% Black (Non-Hispanic), 97% White (Non-Hispanic), 96.7% Hispanic/Latinx, 96.3% Other. The percentages for the viral suppression service category are as follows for all races and ethnicities: 83.8% for Black (Non-Hispanic), 89.8% for White (Non-Hispanic), 91.7% for Hispanic/Latinx, 89% for Other.



**Continuum of Care Report 3/1/2022-2/28/2023*

Figure 7. FY2022-2023, HIV Care Continuum by Age, Broward EMA

Figure 7 shows the HIV Care Continuum for all age ranges in various service categories in the Broward County EMA for the FY2022-2023. In total, there were 493 18-28 aged clients, 1,564 29-38 aged clients, 1,557 39-48 aged clients, 2,137 49-58 aged clients, and 2,414 59+ aged clients. For the Retained in Care service category, the percentages are as follows for all age ranges: 55.8% for 18-28 aged clients, 59.3% for 29-38 aged clients, 60.6% for 39-48 aged clients, 63.2% for 49-58 aged clients, and 62.5% for 59+ aged clients. For the prescribed ARV service category, the percentages are as follows for all age ranges: 89.7% for 18-28 aged clients, 93.2% for 29-38 aged clients, 96.1% for 39-48 aged clients, 97.5% for 49-58 aged clients, and 98.7% for 59+ aged clients. For the viral suppression category, the percentages are as follows for all age ranges: 79.3% for 18-28 aged clients, 82.5% for 29-38 aged clients, 84.8% for 39-48 aged clients, 89.8% for 49-58 aged clients, and 92.5% for 59+ aged clients.

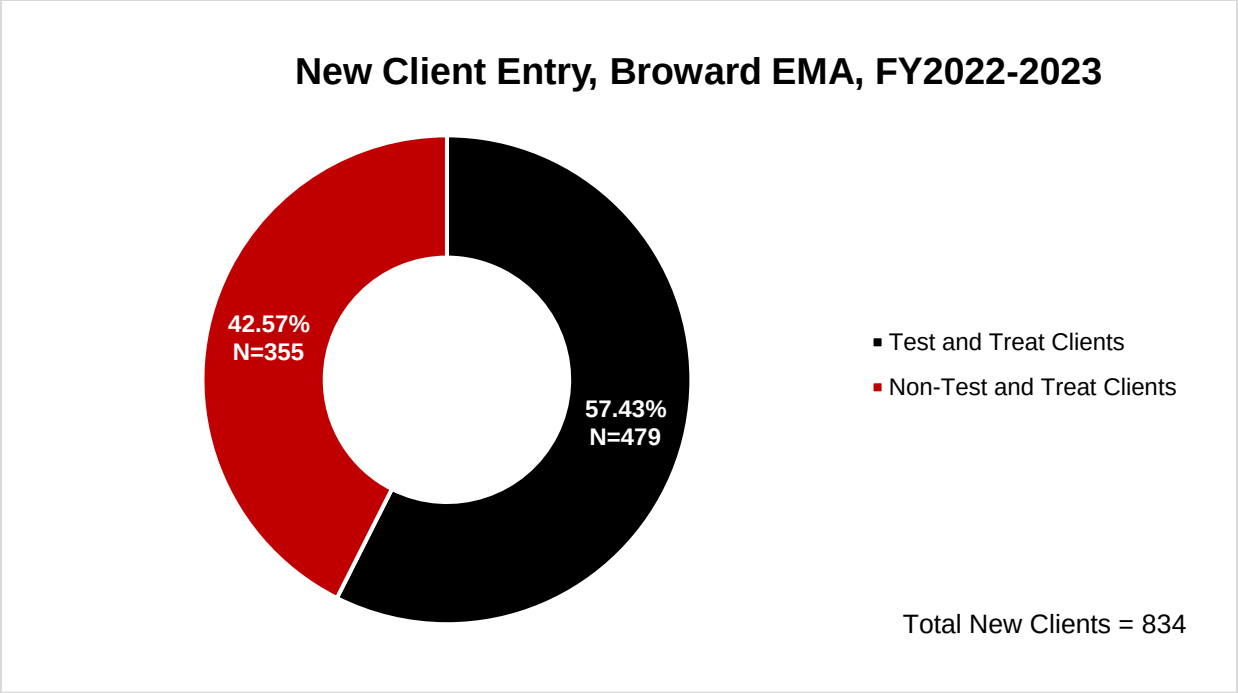


**Viral Load Analysis – Multi Program Report 03/1/2021 – 02/28/2022, 03/1/2022 – 02/28/2023*

Figure 8. Viral Load Analysis, Broward EMA, FY2021, and FY2022

Note. Undetectable clients are less than 50 copies per mL, suppressed clients are between 50–199 copies per mL, non–suppressed clients are between 200–99,999 copies per mL, and clients with a high viral load have greater than 100,000 copies per mL.

Figure 8 shows a viral load analysis comparison of FY2021 and FY2022, which does not reveal any notable changes between the two fiscal years. There were minor improvements, with a 0.34% decrease in clients with a high viral load for FY2022. Approximately, 88.3% of clients in the Broward EMA either have an undetectable viral load or suppressed detectable viral load for FY2022.



**Continuum of Care Report 03/1/2022 – 02/28/2023*

Figure 9. New Client Entry, Broward EMA, FY2022-2023

Note. See Figure 10 and Figure 11 for the process maps detailing modes of new client entry.

Figure 9 shows clients new to care within the Broward County Ryan White Part A system. These clients were noted to be new to any type of service provided by the Part A program. The total number of new clients for the 2022-2023 fiscal year was 834. Most new clients (57.43%) entered care through the Test & Treat Program, whereas 42.57% of new clients did not enter care through the Test & Treat Program.

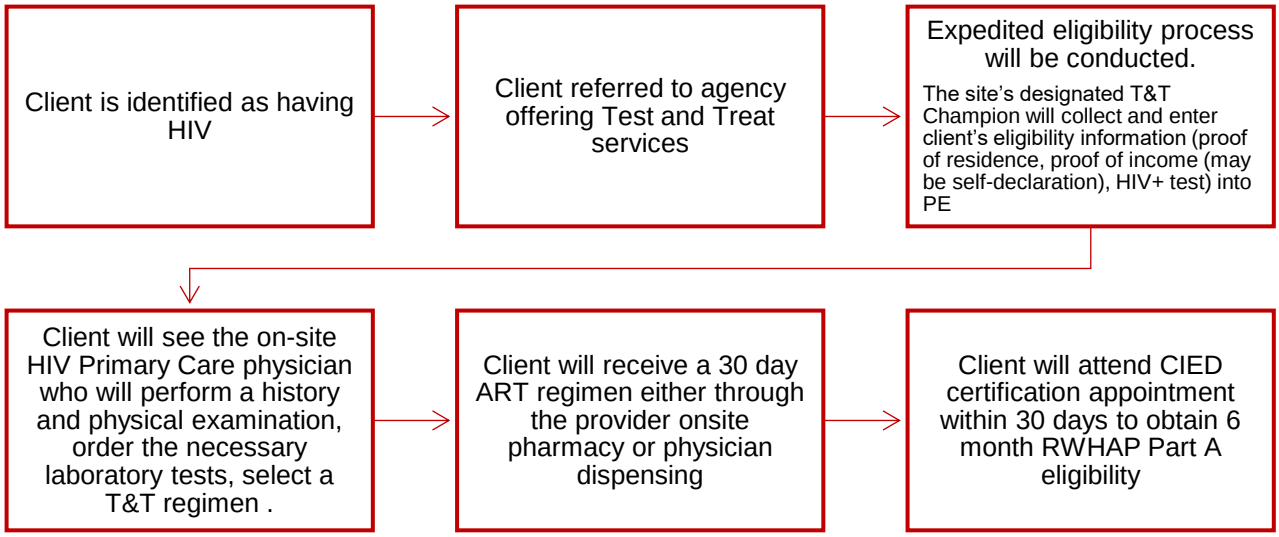


Figure 10. Broward Test & Treat Process Map

Note. Further detail on the Test and Treat program process can be found via https://getprepbroward.com/documents/BROWARD-COUNTY-TEST-AND-TREAT-PROGRAM-PROTOCOL.pdf.

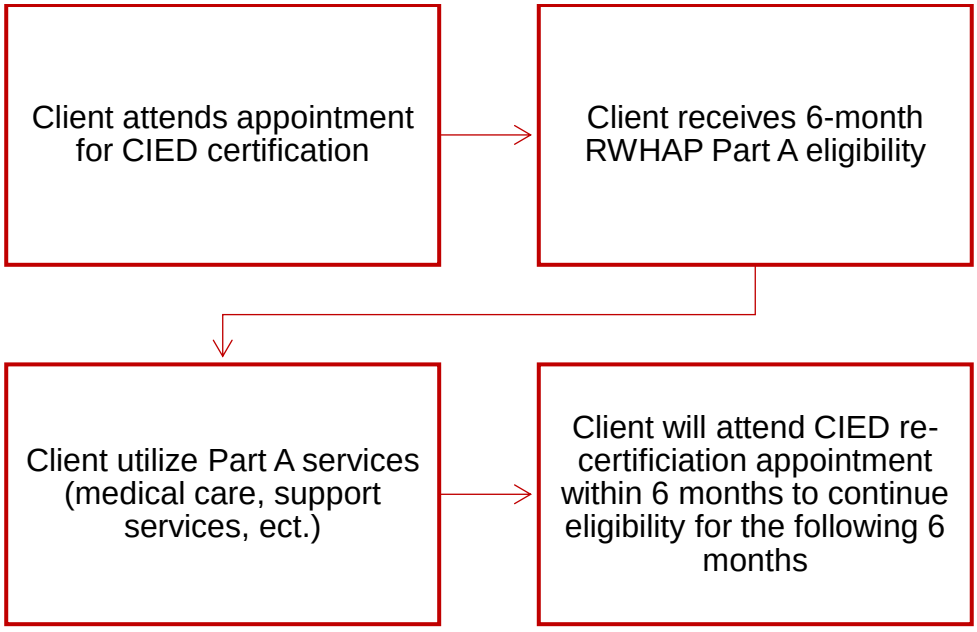


Figure 11. Broward CIED New Client Process Map

RYAN WHITE PART A SERVICE UTILIZATION

Service utilization refers to the client's use of clinical and support services offered by the Broward Ryan White Part A Program. Utilization is determined by the need for care, by whether clients know or feel that they need care or services, by whether they choose to obtain care or services, by the availability of Ryan White Part A funding for each service category, and by the accessibility of services to clients. In theory, service utilization should correlate highly with the need, however defined, for services. But some services are needed and not obtained.

Figures 12 and 13 show clinical and non-clinical service utilization. One notable takeaway from the clinical service utilization trend is that, between the previous fiscal year and now, utilization of AIDS Pharmaceutical Assistance decreased by roughly 64%. This could be contributed to increased eligibility in the Florida AIDS Drug Assistance Program (ADAP). Additionally, there were declines in several services (Centralized Intake Eligibility Determination and Disease Case Management) between FY2021-FY2022 and FY2022-2023. There were notable increases for some service categories: Oral Health, Mental Health, and Food services.

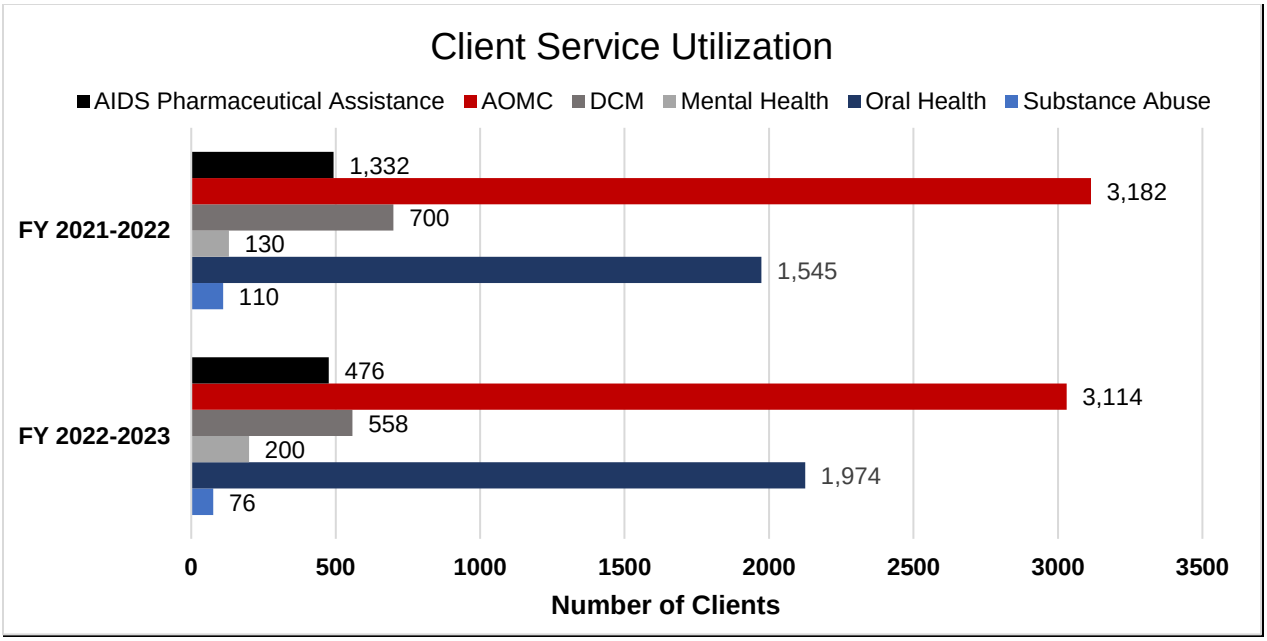


Figure 12. Clinical Service Utilization Trend (FY21-FY22 and FY22 – FY23)

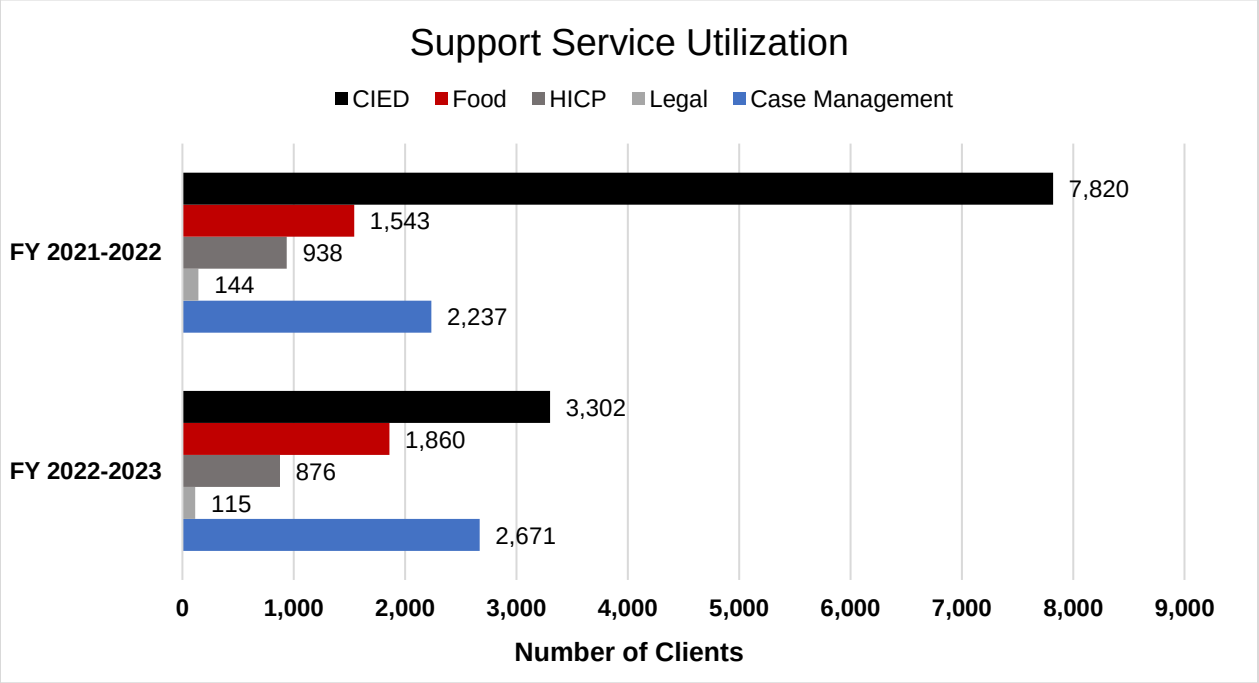


Figure 13. Support Service Utilization Trend (FY21-FY22 and FY22–FY23)

HAB MEASURES

The Health Resources and Services Administration's HIV/AIDS Bureau (HAB) is committed to improving the quality of HIV care and treatment services for people living with HIV. HAB developed a system of performance measures to help Ryan White recipients set goals and support clinical quality management, performance measurement, service delivery, and client monitoring at both the recipient and client levels.

The HAB performance measures comprise the following categories: 1) core, 2) all ages, 3) adolescent/adult, 4) medical case management, and 5) oral health.

In Table 3, the zero percentages reported for Tobacco Cessation Counseling, Dental Medical History, and Dental Treatment Plan are likely due to providers documenting this information in their electronic medical record systems (EMRs) rather than in PE.

Table 4 shows the two-year trend for HAB performance measures by quarter for fiscal years 2021-2022 and 2022-2023. Depression screening showed an overall decrease of 13% from quarter one to quarter four in fiscal year 2021-2022, while there was an 18% increase from quarter one to quarter four for fiscal year 2022-2023. For Oral Health Education, there was a notable increase of 49% between the quarter fours of fiscal year 2021-2022 and 2022-2023. Influenza Immunization from October to March decreased by 23% between fiscal years 2021-2022 to 2022-2023.

Table 3: FY 2022-2023 HAB Measures

Measure	Numerator/Denominator	Percentage
Core Measures		
HIV Viral Load Suppression	2,851/3,478	82%
Prescription of HIV Antiretroviral	3,383/3,478	97%
HIV Medical Visit Frequency	1,175/2,981	39%
Gap in HIV Medical Visits	830/2,849	29%
PCP Prophylaxis NQF #405	1/77	1%
Annual Retention in Care	2,257/3,478	65%
All Ages		
HIV Resistance Testing before Therapy	4/3,383	0%
Influenza Immunization	952/2,890	33%
Lipid Screening	2,556/3,383	76%
Tuberculosis Screening	1,970/2,256	87%
Adolescent/Adult		
Cervical Cancer Screening	258/788	33%
Chlamydia Screening	563/737	76%
Gonorrhea Screening	22/737	3%
Hepatitis B Screening	2,328/2,410	97%
Hepatitis B Vaccination	1,202/2,773	43%

Hepatitis C Screening	3,248/3,478	93%
HIV Risk Counseling	201/3,478	6%
Oral Exam	625/3,478	18%
Pneumococcal Vaccination	1,803/3,221	56%
Depression Screening	2,170/3,481	62%
Tobacco Cessation Counseling	0/9,934	0%
Substance Abuse Screening	376/705	53%
Syphilis Screening	3,050/3,475	88%
Oral Health		
Dental and Medical History	0/531	0%
Dental Treatment Plan	0/531	0%
Oral Health Education	307/531	58%
Periodontal Screening	391/531	74%
Phase 1 Treatment Plan	45/62	73%

*HAB Measures for Medical Case Management have been omitted due to the measures not populating in the Provide Enterprise-generated report. The Broward County Ryan White Part A program does not offer Medical Case Management as a service category.

Table 4: HAB Measures – FY 2021-2022, 2-Year Trend

Measures								
ADOLESCENT/ADULT	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**FY21 Q4**	**FY22 Q1**	**FY22 Q2**	**FY22 Q3**	**FY22 Q4**
Cervical Cancer Screening	43%	41%	40%	40%	38%	36%	34%	33%
Chlamydia Screening	76%	77%	75%	76%	74%	76%	78%	75%
Gonorrhea Screening	12%	9%	7%	6%	4%	4%	3%	3%
Hep B Screening	97%	97%	96%	96%	96%	96%	96%	96%
Hep B Vaccination	48%	48%	46%	47%	46%	45%	44%	43%
Hep C Screening	94%	93%	92%	92%	92%	92%	92%	93%
HIV Risk Counseling	15%	14%	12%	8%	6%	6%	6%	6%
Oral Exam	16%	17%	17%	18%	17%	18%	18%	18%
Pneumococcal Vaccination	62%	61%	60%	60%	58%	57%	56%	56%
Depression Screening	54%	55%	44%	41%	45%	55%	59%	63%
Tobacco Cessation Counseling	0%	0%	0%	0%	0%	0%	0%	0%
Substance Abuse Screening	36%	45%	50%	52%	53%	55%	53%	53%
Syphilis Screening	85%	87%	87%	88%	89%	88%	88%	88%
ORAL HEALTH	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**FY21 Q4**	**FY22 Q1**	**FY22 Q2**	**FY22 Q3**	**FY22 Q4**
Dental and Medical History	0%	0%	0%	0%	0%	0%	0%	0%
Dental Treatment Plan	0%	0%	0%	0%	0%	0%	0%	0%
Oral Health Education	10%	7%	7%	9%	16%	32%	45%	58%
Periodontal Screening	77%	73%	74%	72%	77%	73%	73%	74%
Phase 1 Treatment Plan Completion	52%	45%	55%	71%	76%	88%	78%	71%
CORE	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**FY21 Q4**	**FY22 Q1**	**FY22 Q2**	**FY22 Q3**	**FY22 Q4**
HIV Viral Load Suppression	82%	82%	82%	84%	81%	81%	80%	82%
Prescription of ART	98%	98%	98%	98%	98%	97%	97%	97%
HIV Medical Visit Frequency	43%	42%	42%	42%	43%	42%	41%	39%
Gaps in HIV Medical Visits	26%	25%	30%	31%	29%	27%	28%	29%
PCP Prophylaxis NQF #405	1%	1%	3%	3%	5%	5%	2%	1%
Annual Retention in Care	87%	88%	64%	64%	65%	63%	64%	65%
ALL AGES	**FY21 Q1**	**FY21 Q2**	**FY21 Q3**	**FY21 Q4**	**FY22 Q1**	**FY22 Q2**	**FY22 Q3**	**FY22 Q4**
HIV Resistance Therapy Before Therapy	0%	0%	0%	0%	0%	0%	0%	0%
Influenza Immunization October-March	55%	55%	46%	44%	43%	43%	39%	32%
Lipid Screening	82%	79%	76%	76%	75%	75%	75%	75%
Tuberculosis Screening	85%	85%	86%	86%	86%	86%	87%	87%

BROWARD CLIENT-LEVEL OUTCOMES & INDICATORS

The Broward EMA has established outcomes and indicators to assess the performance of each funded service category. In 2012, the HIV Health Services Planning Council (HIVPC) approved revisions to the Broward outcomes and indicators for the following service categories: Mental Health, Substance Abuse (Outpatient), Legal Services, AIDS Pharmaceutical Assistance (Local), Medical Case Management, Food Services, and Centralized Intake and Eligibility Determination. Table 5 shows the performance of each service category for FY 2021-2022 and FY 2022-2023.

Data displayed in **green** shows that performance is equal to or above the indicator. Data displayed in **yellow** shows that performance is within 5% of the indicator. Data displayed in **red** shows that performance is below the indicator.

For fiscal year 2022-2023, AIDS Pharmaceutical Assistance, Legal, and Oral Health performance met and/or exceeded the indicator. Disease Case Management's performance did not meet the goal for both indicators 1.1 and 1.2. Although Disease Case Management Indicator 1.1 had a notable decrease of 11.01%, it did increase from last fiscal year by 5.11%. The Health Insurance Continuation Program had a notable decrease of 22.67% during the reporting period. Substance Abuse-Outpatient did not meet their goals for both Indicator 1.1 (75.28%) and Indicator 2.1 (73.96%). Although the Mental Health service did not meet the goal for Indicator 1.1 by 8.8%, there was an increase of 11.48% between the reporting periods. The service categories that did not meet the performance indicator could be affected by data discrepancies that surround retention in care.

Table 5: Broward Outcomes and Indicators, FY2021-2022 and FY2022-2023

Broward Outcomes and Indicators	FY 2021 - 2022		FY 2022 - 2023	
AIDS Pharmaceutical Assistance	**Num/Den**	**%**	**Num/Den**	**%**
Outcome 1: Improve access to medication. **Indicator 1.1:** Attempts will be made to contact 95% of clients who do not pick up medications within 7 to 14 days of filling the prescription.	**14/14**	**100%**	**10/10**	**100%**
Outcome 2: Clients provided an opportunity to improve medication adherence. **Indicator 2.1:** 95% of those clients who were not successfully contacted and/or did not pick up medications will be referred to appropriate provider (i.e., medical case management, Clinical pharmacist, prescribing physicians, Treatment Adherence).	**2/2**	**100%**	**1/1**	**100%**
CIED				

Outcome 1: Increase access, retention, and adherence to primary medical care. **Indicator 1.1:** 95% of Part A clients who have not had a primary medical care visit within the last six (6) months at the time of recertification have a primary medical care or disease case management appointment scheduled within one (1) business day. **Indicator 1.2:** 80% of clients will not experience a lapse in Ryan White Part A eligibility.*	**87/93** **12,656/18,562**	**93.55%** **68.18%**	**117/144** **13,649/13,687**	**81.25%** **99.72%**
Disease Case Management				
Outcome 1: Increased access, retention, and adherence to primary medical care. **Indicator 1.1:** 85% of clients achieve one (1) or more action plan goals by the target resolution date. **Indicator 1.2:** 90% of clients are retained in primary medical care.	**321/466** **525/609**	**68.88%** **86.21%**	**347/469** **467/573**	**73.99%** **81.50%**
Food Services				
Outcome 1: Increased access, retention, and adherence to Primary Medical Care. **Indicator 1.1**: 85% of clients are retained in primary medical care. **Outcome 2:** Increased viral suppression. **Indicator 2.1:** 80% of clients on ART for more than six months will have a viral load less than 200 copies/mL.	**1,737/2,078** **1,948/2,201**	**83.59%** **88.51%**	**1,463/2,064** **1,919/2,229**	**70.88%** **86.09%**
Health Insurance Continuation Program				
Outcome 1: N/A **Indicator 1.1:** 85% of clients are retained in primary medical care.	**122/142**	**85.92%**	**74/117**	**63.25%**
Integrated Primary Care & Behavioral Health				
Outcome 1: N/A **Indicator 1.1:** 85% of clients are retained in Integrated Primary Care and Behavioral Health services. **Indicator 1.2:** 90% of clients on ART for more than six (6) months will have a viral load less than 200 copies/mL	**2,360/3,078** **2,936/3,314**	**76.67%** **88.59%**	**2,107/2,916** **2,788/3,126**	**72.26%** **89.19%**
Legal Services				
Outcome 1: Increased access to benefits for which the client is eligible. **Indicator 1.1:** 60% of clients whose cases are accepted for representation at the Social Security Appeals Council will win approval of cash benefits and/or medical benefits or will have their case remanded for a hearing before an Administrative Law Judge. **Indicator 1.2:** 80% of clients whose cases are accepted for representation at a Social Security Administrative Law Judge hearing will win approval of case benefits and/or medical benefits thus improving their financial stability.	**0/0** **35/35**	**-** **100%**	**0/0** **12/12**	**-** **100%**
Mental Health				

Outcome 1: Improvement in client's symptoms and/or behaviors associated with primary mental health diagnosis. **Indicator 1.1:** 85% of clients achieve treatment plan goals by designated target date. **Outcome 2:** Increased access, retention, and adherence to primary medical care. **Indicator 2.1:** 85% of clients are retained in primary medical care	**44/68** **285/328**	**64.71%** **86.89%**	**80/105** **315/368**	**76.19%** **85.60%**
Non-Medical Case Management				
Outcome 1: Continuity of oral health care. **Indicator 1.1:** 85% of clients achieve one (1) or more action plan goals by the target resolution date. **Indicator 1.2:** 85% of clients are retained in primary medical care.	**1,527/1,728** **1,523/1,762**	**85.45%** **86.44%**	**1,498/1,706** **1,547/1,907**	**87.81%** **81.12%**
Oral Health				
Outcome 1: Continuity of oral health care. **Indicator 1.1:** 75% of clients have a dental visit at least 2 times within the past 12 months. **Outcome 2:** Screening of periodontal health is provided. **Indicator 2.1:** 75% of clients with a history of periodontitis who received an oral prophylaxis, scaling/root planning, or periodontal maintenance visit at least 2 times within the past 12 months.	**2,042/2,142** **1,404/1,404**	**95.33%** **100%**	**2,040/2,145** **1,397/1,400**	**95.10%** **99.79%**
Substance Abuse - Outpatient				
Outcome 1: Improvement in client's symptoms and/or behaviors associated with primary substance abuse diagnosis. **Indicator 1.1:** 85% of clients achieve treatment plan goals by designated target date. **Outcome 2**: Increased access, retention, and adherence to primary medical care. **Indicator 2.1**: 85% of clients are retained in Primary Medical Care.	**67/85** **66/78**	**78.82%** **84.62%**	**67/89** **71/96**	**75.28%** **73.96%**

**Data not available currently due to reporting issue in Provide Enterprise.*

CLIENT DEMOGRAPHICS

Analyzing client demographic data can help improve the quality of care for all clients. Through this analysis, the Broward Ryan White Part A program can identify and address differences in care for specific populations, distinguish which populations do not achieve desired health outcomes, and advise the development of additional patient-centered services. All client demographic data is entered into the Provide Enterprise data platform when provided during the client intake and eligibility determination process or during temporary eligibility through rapid engagement in care.

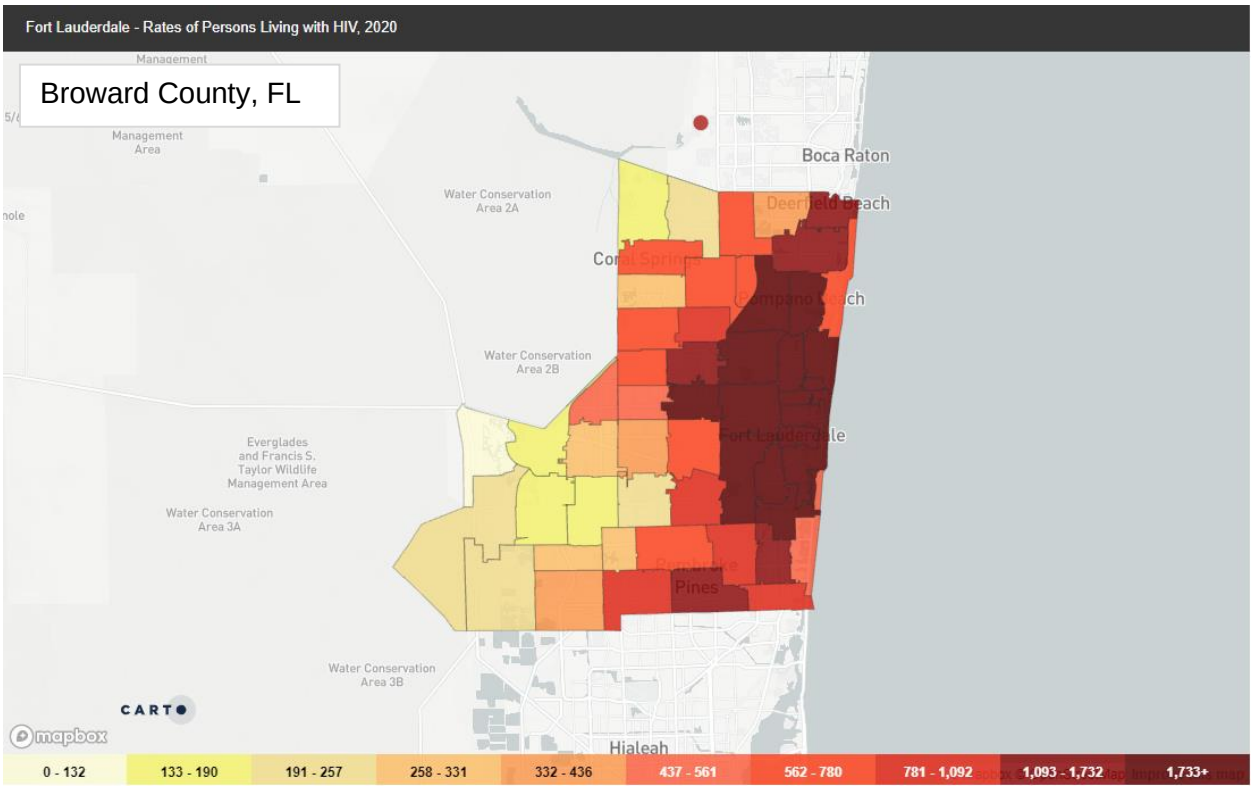


Figure 14. AIDSVu Geospatial Distribution of HIV/AIDS Epidemic - Broward County 2020

Figure 14 shows 19,592 people living with HIV in Fort Lauderdale (Broward County) in 2020. In 2020, the rate of people living with HIV was 1,329 per 100,000 population. Additionally, there were 452 people newly diagnosed with HIV. The rate of new HIV diagnoses was 31 per 100,000 population.

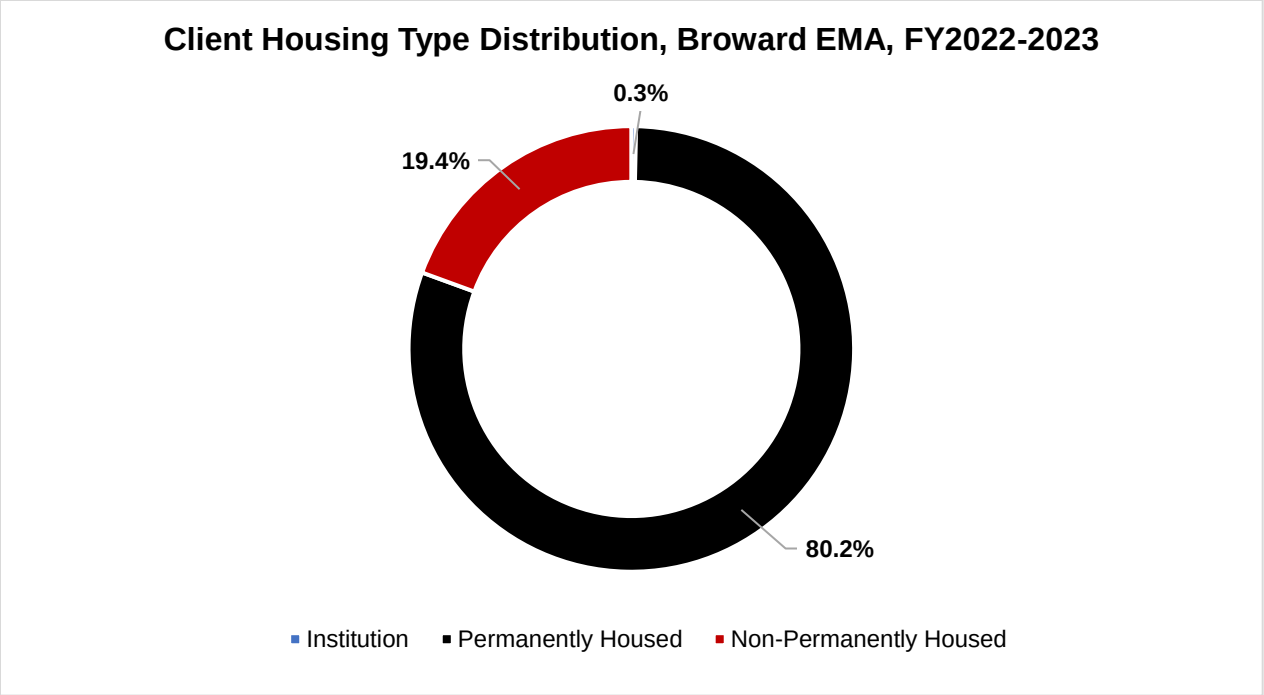
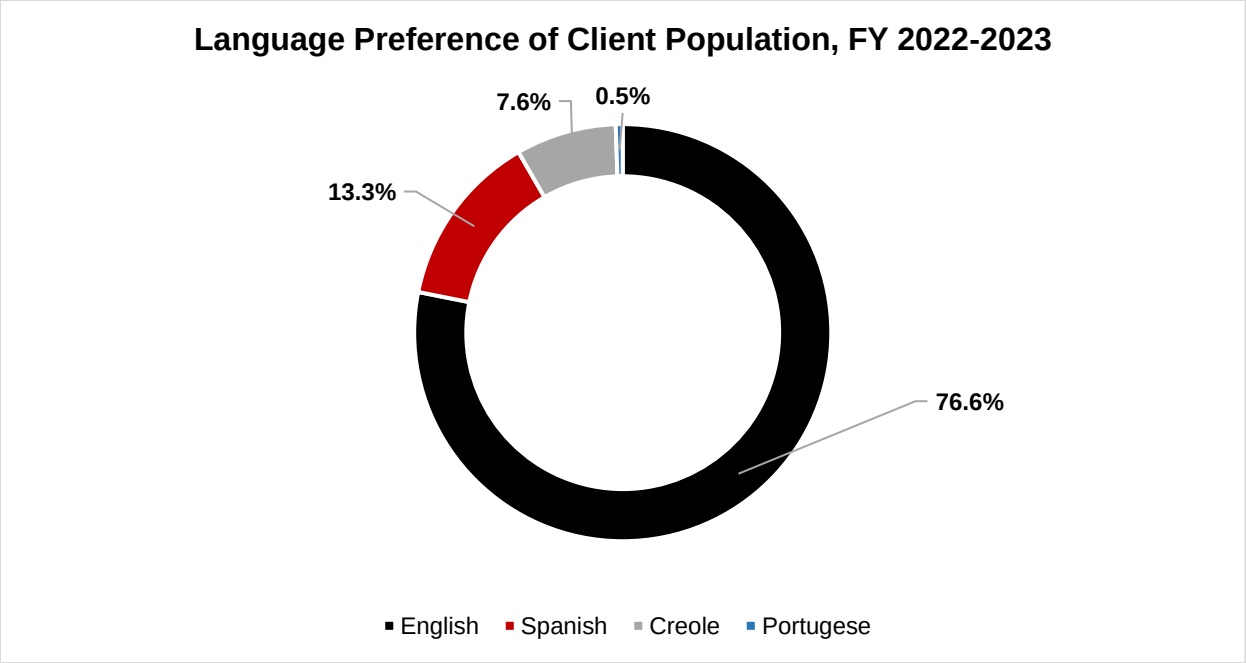


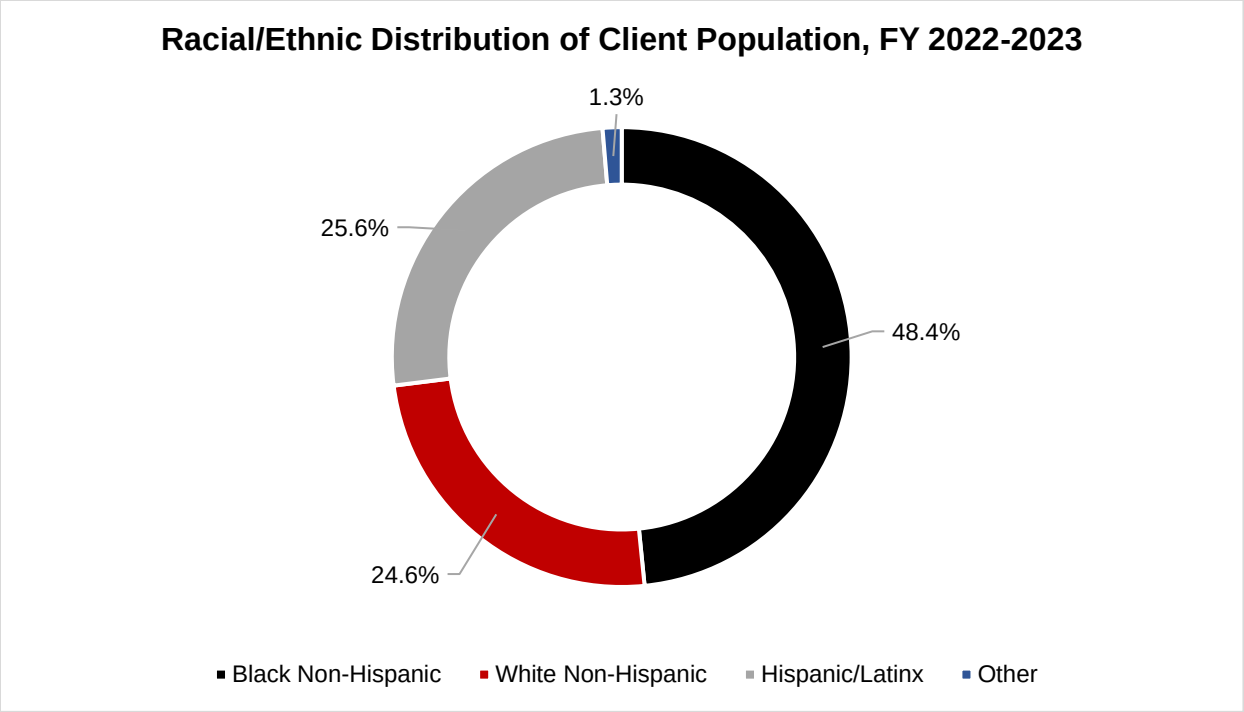
Figure 15. Client Housing Type Distribution, Broward EMA, FY2022-2023

Figure 15 shows the distribution of housing types within the client population during FY2022-2023. A majority (80.2%) of Broward RWHAP clients are permanently housed. Nearly one-fifth (19.4%) of clients are non-permanently housed whereas less than one percent of clients (0.3%) reside in an institution.



Figures 16. Language Preference of Client Population, FY 2022-2023

Figure 16 displays the Language Preference of the Client Population in FY2022-2023. English is the preferred language of 76.6% of clients while 13.3% and 7.6% of clients prefer Spanish and Creole, respectively. Less than one percent of clients (0.5%) preferred Portuguese.



Figures 17. Racial/Ethnic Distribution of Client Population, FY2022-2023

Figure 17 displays the Racial/Ethnic Distribution of the Client Population in FY2022-2023. Most clients (48.4%) were Non-Hispanic Black/African Americans. White Non-Hispanic (24.6%) and Hispanic/Latinx (25.6%) clients each represented a quarter of the total client population. Other races (Asian, Native American, and Pacific Islanders) each represented less than two percent of the total client population (1.3%).

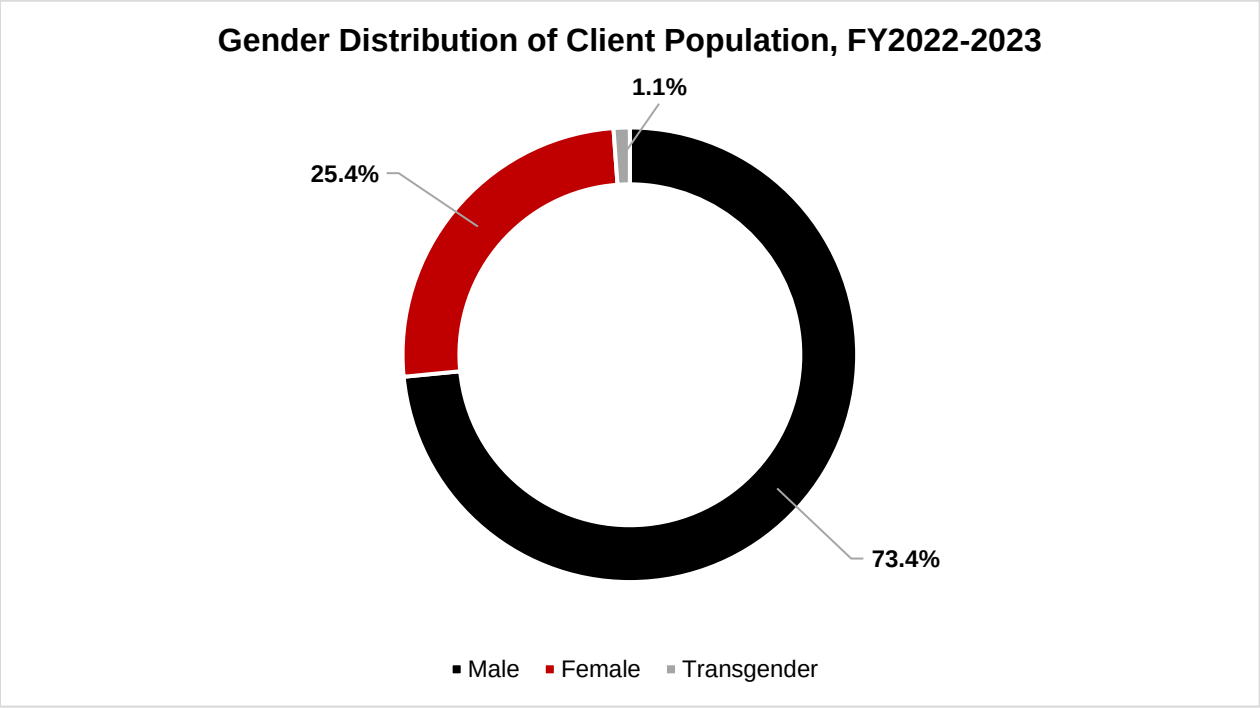


Figure 18. Gender Distribution of Client Population, FY2022-2023

Figure 18 shows the Gender Distribution of the Client Population for FY2022-2023. Most clients in the care continuum are Male (73.4%), while the Female population made up about one-quarter (25.4%), and the Transgender male to female made up less than two percent (1.1%).

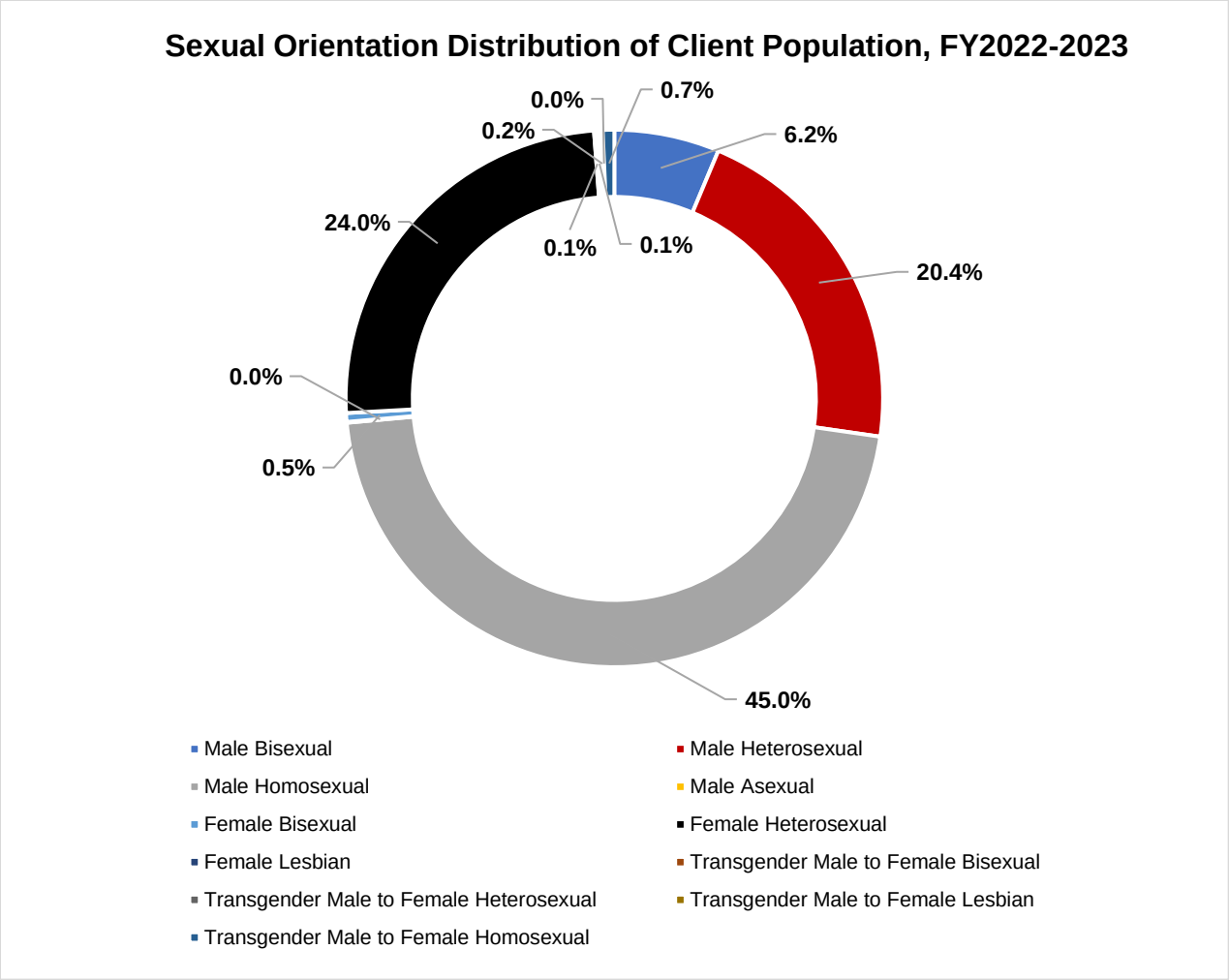


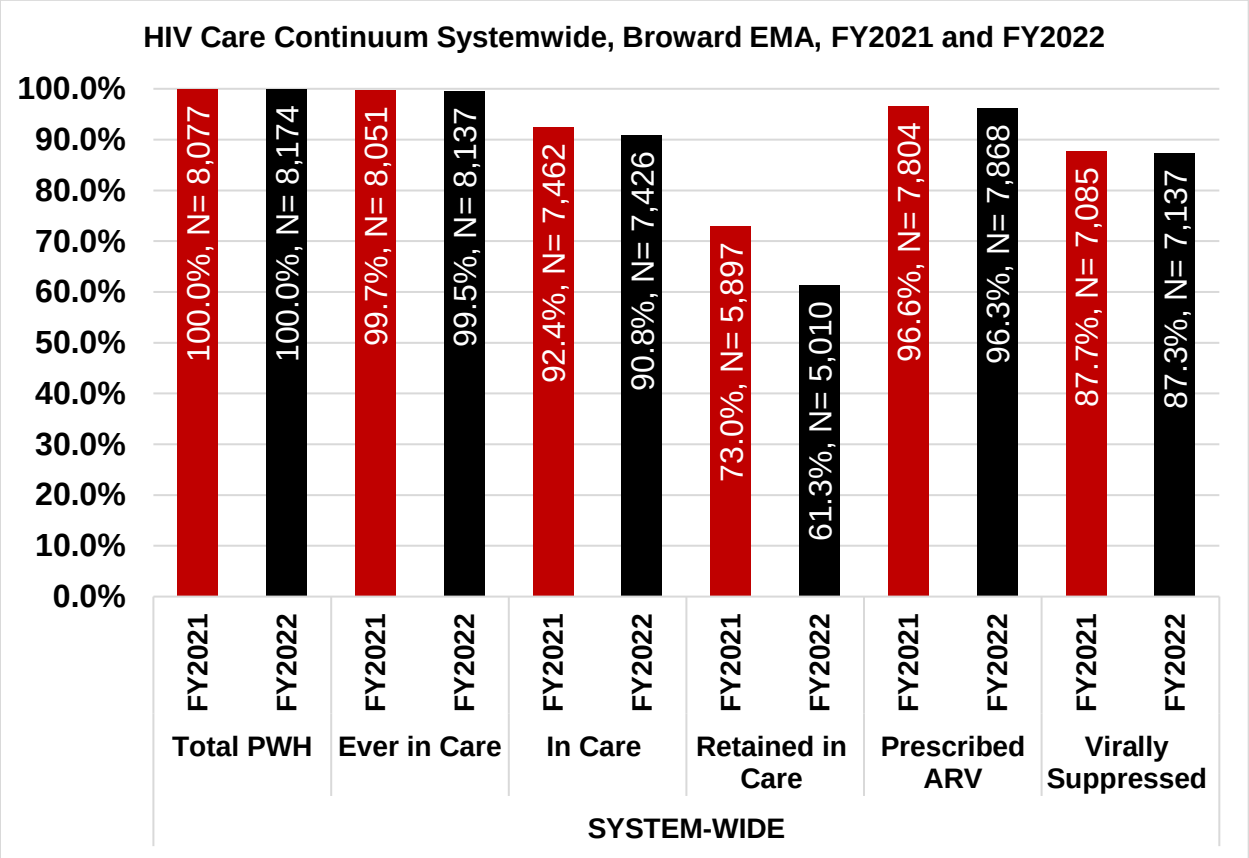
Figure 19. Sexual Orientation Distribution of Client Population, FY2022-2023

Figure 19 shows the Sexual Orientation Distribution of the Client Population for FY2022-2023. Most clients (45.0%) identified as male who are homosexual. Approximately one-quarter (24.0%) of clients identified as female who are heterosexual whereas approximately one-fifth (20.4%) of clients identified as male who are heterosexual. Approximately five percent of clients (6.2%) identified as male who are bisexual. The following subpopulations each represented less than one percent of the client population in fiscal year 2022-2023: Transgender Male to Female Homosexual (0.7%), Female Bisexual (0.5%), Female Lesbian (0.1%), Transgender Male to Female Heterosexual (0.2%), Transgender Male to Female Bisexual (0.1%), and Transgender Male to Female Lesbian (0.0%).

Special Population Measures

Continuum of Care Analysis

The Broward EMA utilizes the HIV Continuum of Care to address drop-offs along the HIV care continuum and increase the proportion of individuals in each stage. **Figures 21-24** compare the HIV Care Continuum for all Broward County Part A Clients for the FY 2021-2022 and FY 2022-2023.

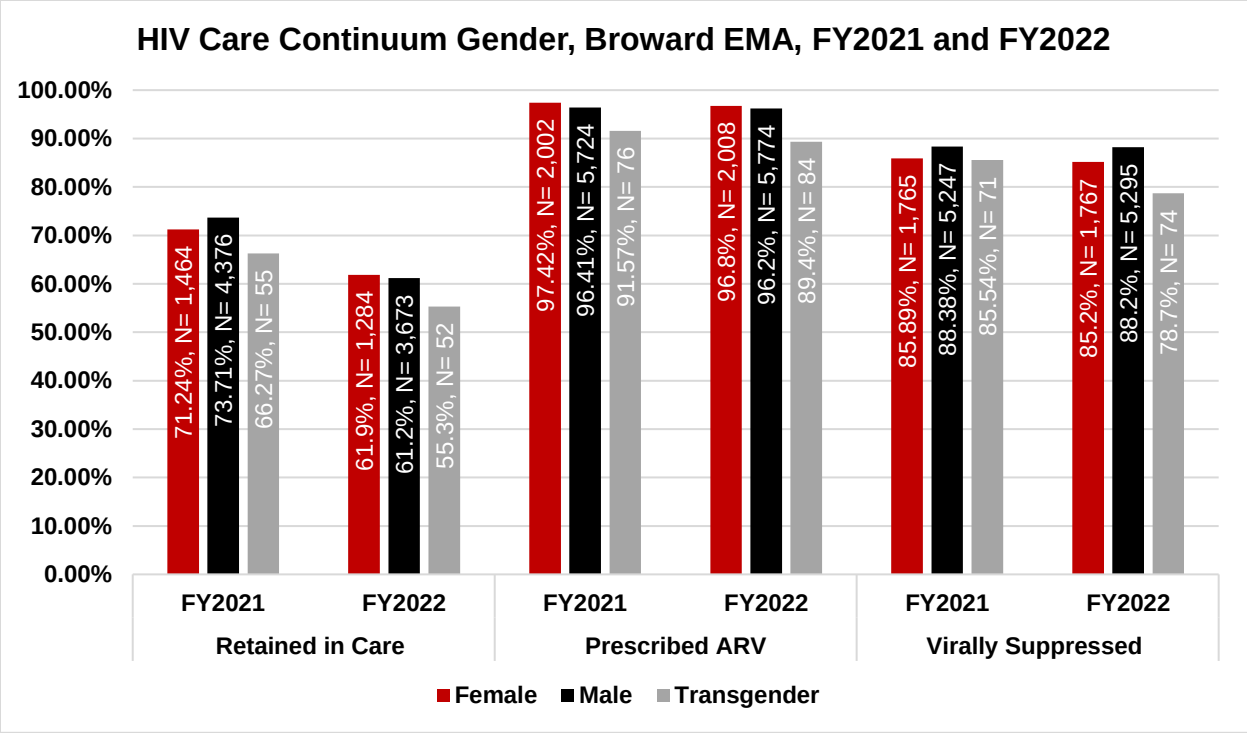


**Continuum of Care Report 03/1/2021 – 02/28/2022, 03/1/2022 - 02/28/2023*

Figure 21. FY2021 and FY2022, HIV Care Continuum Systemwide, Broward EMA

Figure 21 compares the systemwide HIV Care Continuum of FY2021 and FY2022. As the Broward EMA continues to recover from the impact of COVID-19, there were notable improvements systemwide as the Ryan White Part A program made strives to improve the system. This change is noted by the 8.4% retention rate increase between FY2020 and FY2021. However, with the data discrepancy issues that took place within the 2022-2023 fiscal year, this negatively impacted how data was captured in Provide Enterprise. In turn, this severely affected the systemwide retention rate for the Broward EMA. During the fourth quarter (Q4) of FY2022, the Recipient staff worked with Provide

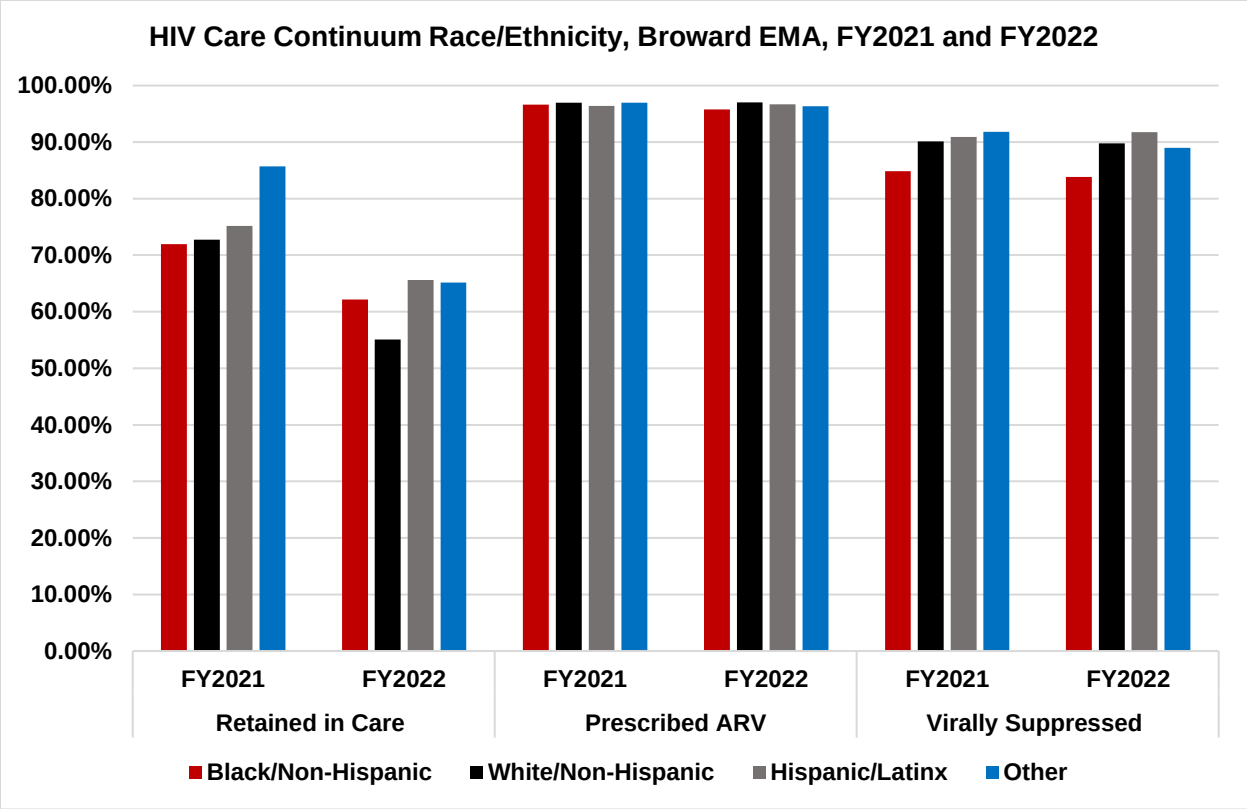
Enterprise to address the coding issues that distorted the retention rate. For FY2022 Q4, the retention rate was 79.5% (N= 6,494). There is more work that needs to be done to resolve the issues for the annual FY2022 data reporting and beyond. Provide Enterprise will continue to be monitored to resolve any discrepancies in future reporting.



**Continuum of Care Report 03/1/2021 – 02/28/2022, 03/1/2022 - 02/28/2023*

Figure 22. FY2021 and FY2022, HIV Care Continuum by Gender, Broward EMA

Figures 22 compares the three genders represented in the HIV Care Continuum for FY2021 and FY2022. Due to the data discrepancy issues for FY2022, there is a notable decrease between FY2021 and FY2022 for the retained in care service category. There were no remarkable changes for the prescribed ARV and Viral Suppression service categories.



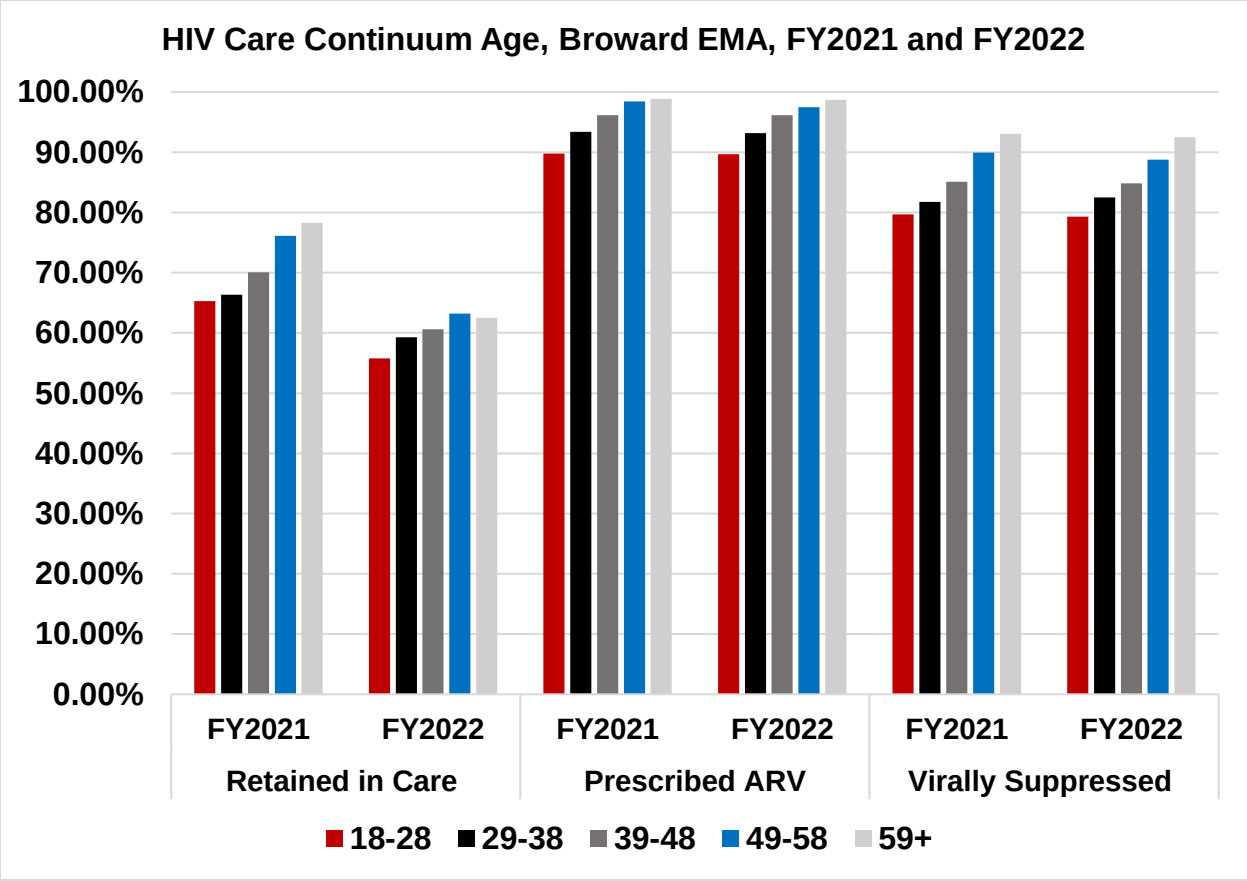
**Continuum of Care Report 03/1/2021 – 02/28/2022, 03/1/2022 – 02/28/2023; Other includes Alaskan Native, American Indian, Asian, Native Hawaiian, and Pacific Islander*

Figure 23. FY2021 and FY2022, HIV Care Continuum by Race/Ethnicity, Broward EMA

Figures 23 compares all races and ethnicities represented in the HIV Care Continuum for FY2021 and FY2022. Due to the data discrepancy issues for FY2022, there is a notable decrease between FY2021 and FY2022 for the retained in care service category. There were no remarkable changes for the prescribed ARV and Viral Suppression service categories.

Table 6: HIV Care Continuum by Race/Ethnicity, Broward EMA, FY2021 and FY2022

Race/Ethnicity	FY2021 People Living With HIV	FY2021 Ever in Care	FY2021 In Care	FY2021 Retained in Care	FY2021 Prescribed ARV	FY2021 Virally Suppressed
Black (Non-Hispanic) (N)	3,940	3,929	3,606	2,834	3,807	3,344
Black (Non-Hispanic) %	100%	99.7%	91.5%	71.9%	96.6%	84.9%
White (Non-Hispanic) (N)	2,117	2,107	1,948	1,540	2,053	1,908
White (Non-Hispanic) %	100%	99.5%	92%	72.7%	97%	90.1%
Hispanic/Latinx (N)	1,907	1,904	1,804	1,434	1,838	1,734
Hispanic/Latinx %	100%	99.8%	94.6%	75.2%	96.4%	90.9%
Other (N)	98	98	97	84	95	90
Other %	100%	100%	99%	85.7%	96.9%	91.8%
Race/Ethnicity	**FY2022 People Living With HIV**	**FY2022 Ever in Care**	**FY2022 In Care**	**FY2022 Retained in Care**	**FY2022 Prescribed ARV**	**FY2022 Virally Suppressed**
Black (Non-Hispanic) (N)	3,953	3,940	3,587	2,457	3,785	3,314
Black (Non-Hispanic) %	100%	99.7%	90.7%	62.2%	95.8%	83.8%
White (Non-Hispanic) (N)	2,009	2,001	2,001	1,107	1,949	1,804
White (Non-Hispanic) %	100%	99.6%	99.6%	55.1%	97%	89.8%
Hispanic/Latinx (N)	2,094	2,082	1,934	1,374	2,024	1,921
Hispanic/Latinx %	100%	99.4%	92.4%	65.6%	96.7%	91.7%
Other (N)	109	109	101	71	105	97
Other %	100%	100%	92.7%	65.1%	96.3%	89%



**Continuum of Care Report 03/1/2021 – 02/28/2022, 03/1/2022 – 02/28/2023*

Figure 24. FY2021 and FY2022, HIV Care Continuum by Age, Broward EMA

Figures 24 compares all ages represented in the HIV Care Continuum for FY2021 and FY2022. Due to the data discrepancy issues for FY2022, there is a notable decrease between FY2021 and FY2022 for the retained in care service category. There were no remarkable changes for the prescribed ARV and Viral Suppression service categories.

Table 7: HIV Care Continuum by Age, Broward EMA, FY2021 and FY2022

Age Group	FY2021 People Living With HIV	FY2021 Ever in Care	FY2021 In Care	FY2021 Retained in Care	FY2021 Prescribed ARV	FY2021 Virally Suppressed
18-28 (N)	527	526	469	344	473	420
18-28 %	100%	99.8%	89%	65.3%	89.8%	79.7%
29-38 (N)	1,457	1,453	1,341	967	1,361	1,191
29-38 %	100%	99.7%	92%	66.4%	93.4%	81.7%
39-48 (N)	1,570	1,565	1,443	1,100	1,510	1,336
39-48 %	100%	99.7%	91.9%	70%	96.2%	85.1%
49-58 (N)	2,277	2,268	2,119	1,733	2,242	2,048
49-58 %	100%	99.6%	93.1%	76.1%	98.5%	89.9%
59+ (N)	2,238	2,232	2,083	1,752	2,212	2,083
59+ %	100%	99.7%	93.1%	78.3%	98.8%	93.1%
Age Group	**FY2022 People Living With HIV**	**FY2022 Ever in Care**	**FY2022 In Care**	**FY2022 Retained in Care**	**FY2022 Prescribed ARV**	**FY2022 Virally Suppressed**
18-28 (N)	488	493	442	275	442	391
18-28 %	100%	99%	89.7%	55.8%	89.7%	79.3%
29-38 (N)	1,564	1,558	1,416	927	1,457	1,290
29-38 %	100%	99.6%	90.5%	59.3%	93.2%	82.5%
39-48 (N)	1,557	1,549	1,401	944	1,497	1,321
39-48 %	100%	99.5%	90%	60.6%	96.1%	84.8%
49-58 (N)	2,137	2,131	1,964	1,351	2,083	2,383
49-58 %	100%	99.7%	91.9%	63.2%	97.5%	88.8%
59+ (N)	2,414	2,403	2,196	1,509	2,383	2,232
59+ %	100%	99.5%	91%	62.5%	98.7%	92.5%

Recommendations

Continuum of Care

The Black (Non-Hispanic) subpopulation in the HIV Care Continuum of concern. As of FY2021-2022, the Black (Non-Hispanic) subpopulation is 1.7%-8.9% less likely to be in care. CQM Support staff further drilled down this age group. Of the 3,953 Black (Non-Hispanic) clients:

- 41.3% identified as female,
- 57.4% identified as male,
- 71.08% identified as heterosexual,
- 26.6% identified as either homosexual, asexual, bisexual, or lesbian
- 70.6% reported education level between 8th and 12th grade,
- 77.1% reported permanent housing,
- 33.6% reported an FPL between 0%-50%,
- and 64.8% status was HIV Positive, Not AIDS.

Black (Non-Hispanic) clients make up approximately 48% of the HIV Care Continuum. However, the FY2021-2022 Q4 data showed a decrease in their numbers across three service categories: In Care, Retained in Care, and Viral Suppression. Although this subpopulation makes up almost half of the HIV Care Continuum, its retention rate is 71.9% at the end of FY 2022-2023. Further probes into the logistical barriers and health disparities that Black (Non-Hispanic) Ryan White Part A clients experience are necessary to address the lower retention and viral suppression rates among this subpopulation.

HAB Measures

Further probes into the barriers and social determinants of health may account for the 23% decrease in Influenza Immunization from October to March. This can also be related to the low perceived risk of influenza and vaccine hesitancy due to safety concerns.

Broward Outcomes and Indicators

The notable decreases in Indicator 1.1 for Health Insurance Continuation Program (22.67%) and Indicator 1.1 for Disease Case Management (11.01%) between the reporting periods are likely related to processing issues in Provide Enterprise and data discrepancies that surround retention in care. Nonetheless, both changes are related to clients meeting their action plan goals and should be further probed as they have continued from previous quarters.

Additional Recommendations

In the Ryan White Part A grant application for FY2022-2025, three subpopulations of focus were identified. Those subpopulations – Black non-Hispanic/Latinx cisgender adolescent/adult males and females who acquired HIV infection due to heterosexual contact, Hispanic/Latinx adolescent/adults engaged in male-to-male sexual contact (MMSC), and White non-Hispanic adolescent/adult MMSC – were selected based on FY2020 epidemiologic data received from the Florida Department of Health as well as PE

data analyses. Further analysis of these subpopulations should occur among the Quality Management Committee and the Quality Network.

Appendix A

Analysis of Black (Non-Hispanic) subpopulation, HIV Care Continuum, Broward EMA, FY2022-2023 Drill Down

Gender	N	%	Education	N	%
Male	2,271	57.4%	8th or less	298	7.53%
Female	1,633	41.3%	8th -12th	2,794	70.6%
Transgender	49	1.23%	College	850	21.5%
Total	3,953	100.0%	Total	3,953	100.0%
Exclusions (unknown)	0		Exclusions (unknown)	11	0.27%

Housing	N	%
Permanent	3,051	77.1%
Non-Permanent	889	22.4%
Institution	13	0.32%
Total	3,953	100.0%
Exclusions (unknown)	0	

HIV Stage	N	%
HIV Positive Not AIDS	2,564	64.8%
HIV Positive AIDS Status Unknown	384	9.71%
AIDS	1,005	25.4%
Total	3,953	100.0%

Sexual Identification	N	%	FPL	N	%
			>500%	15	0.37%
Bisexual	270	6.83%	0%-50%	1,330	33.6%
			50%-100%	884	22.3%
Heterosexual	2,810	71.08%	100%-150%	516	13.0%
Homosexual	772	19.5%	150%-200%	369	9.33%
Lesbian	10	0.25%	200%-250%	322	8.14%
Asexual	2	0.05%			
			250%-300%	201	5.0%
Declined	9	0.22%	300%-350%	138	3.49%
Did Not Ask	1	0.02%	350%-400%	91	2.3%
			400%-450%	17	0.43%
			450%-500%	6	0.15%
Total	3,953	100.0%	Total	3,953	100.0%
Exclusions (unknown)	79	1.99%	Exclusions (unknown)	64	1.6%

HANDOUT G

Broward Integrated HIV Plan Goals and Objectives

Integrated Plan Work Group: Community Recommendation

GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES

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

1. Create a coordinated universal eligibility and recertification system for Parts A and B with an annual recertification hybrid process. (Implemented 11/22)
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 D. C-S.)
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 funding sources)
6. Develop Tools to Assist Consumers with Accessing the System of Car (Discuss action steps and potential funding)
   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.

1. Employ peer navigators at each agency. (Discuss with RWAP/Prevention funders)
2. Expand funding for peer navigator services. (Discuss with RWAP/Prevention funders)

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.

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)
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)

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

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.

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

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.

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. Implement training for providers and case managers on clients turning 65 and what to expect for 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 aging services, housing for older adults, substance use treatment, and disability and other medical services.

1. Include HIV awareness, capability, and collaboration of Long-Term Care/assisted living facility providers to support older people with HIV to increase cultural competence and decrease stigma
2. Develop a promotional PSA and associated social media messaging on healthy aging
3. Engage with partner agencies and programs to address the multitude of aging and chronic conditions

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.

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.

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.

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 3.1.4 Ensure resources are focused on communities and populations where the need is greatest, especially Black, Latino, American Indian/Alaska Native, and other people of color, particularly those who are also gay and bisexual men, transgender people, people who use substances, sex workers, and immigrants.

Strategy 3.1.5 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.

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.

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.

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
   b. Consider 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.

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.

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.

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 and supportive services.
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 (HIV prevention, care continuum, & SDOH)
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 NHAS goals.
1. Ensure all HIV Planning Body Committee/Workgroup Chairs participate in half-day "think tank"/IP training sessions.
2. Ensure all HIV Planning Body Committee/Workgroup Chairs Integrated Plan 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.
1. Review data relevant to PSRA process including recommendations from the QM, SOC, and CEC 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.