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

Integrated Planning Workgroup Meeting
Thursday, March 30, 2023 – 2:00 PM
Meeting location: Broward Regional Health Planning Council

This meeting is recorded.

AGENDA

ORDER OF BUSINESS

1. **Welcome and Introductions**
2. **Integrated Planning Workgroup Governance**
   a. Integrated Planning Co-Chairs Nominations/Volunteers
   b. Vote on Integrated Planning Co-Chairs
3. **Structure of the Integrated Plan Goals, Objectives, and Strategies Section**
   a. Prevention EHE Workplan Items (from the Prevention EHE Plan)
   b. Part A EHE Workplan Items (from the Part A EHE Plan)
   c. Part B (FCPN) Workplan Items (Items finalized after Broward's plan was submitted)
   d. Community Workplan Items recommended from:
      i. Integrated Planning Workgroup Retreats
      ii. Part A Townhalls and Community Conversations
      iii. Part A Needs Assessment activities
4. **Development of Workplan Activities and Responsible Parties** (Community Workplan Items)
   a. Are/will activities be delegated to specific planning bodies or advisory groups?
   b. Some Community Workplan Items will have costs associated but are not associated with a funder. How should these types of items be addressed?
   c. Opportunities to "Integrate" planning across advisory bodies.
5. **Discuss how do we bring other data and information into the process?**
   a. Medicaid
   b. Opioid
   c. Ryan White Insurance Assistance data
6. **Discuss how updates be shared, how often, and in what format?**
   - Part A and Prevention EHE currently provide progress reports through online quarterly town halls
   - Part B (FCPN) provides progress reports during biannual meetings
   - Opportunities to "Integrate" reporting across Recipients and advisory bodies
   - Discuss stakeholder engagement in this process

6.

7. **Discussion Item: How often the Integrated Planning Group should meet?**
   a. Currently a quarterly meeting on the last Thursday of the Month at 2:00 pm
      i. March 30
      ii. June 29
      iii. September 28
      iv. December 28 (May change due to the holidays
8. Agenda Items for Next Meeting
9. Announcements
10. Adjournment

RYAN WHITE PART A
HIV HEALTH SERVICES PLANNING COMMITTEE

BY-LAWS - EXCERPT

ARTICLE VIII

SECTION 10: There shall be an Integrated Work Group

A. Membership.

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

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

B. Purpose.

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

C. Flow of Information.

1. The work group is expected to interact with numerous Prevention,

Part A, and Part B teams, work groups, and committees.

2. The workgroup's main point of contact and coordination will be the Executive Committees of the Council, BCHPPC, and SFAN.

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

Section 11: Joint Planning Body Meeting.

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

Broward Integrated HIV Plan Goals and Objectives

Integrated HIV Prevention and Care Plans

There are five (5) separate HIV plans that address Broward County. The state and local HIV Plans are organized by the goals, objectives, and strategies of the National HIV Plan. The state and local Ending the HIV Epidemic (Plans), while organized by the Four Pillars, also address all of the National HIV Plan Goals.

State of Florida HIV Plans	Broward County HIV Plans
• State of Florida Integrated HIV Plan • State of Florida EHE Plan	• Broward Integrated HIV Plan • Broward EHE Plan (Prevention) • Broward EHE Plan (Ryan White Part A)

HIV Prevention and Care Planning Bodies

Integrated HIV Planning efforts in Broward are more complex in Broward than in some other EMAs where there is a single Integrated HIV Prevention and Care Planning Council.

GOAL 1: PREVENT NEW HIV INFECTIONS

EDUCATIONAL CAMPAIGNS

1.1 Increase the percentage of people living in Broward County who are aware of their HIV status from the national baseline of 88.8% in 2019 to 95% by December 31, 2026.*

Strategy 1.1.1: Develop and implement campaigns, interventions, and resources to provide comprehensive sexual health education; HIV risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.

FDOH-Broward EHE Plan Activities

1. Develop and implement a social marketing campaign (e.g., www.hivtestnow.com).
2. Develop/ implement a community-driven campaign to decrease HIV testing stigma and fear.
3. 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.

Community Recommended Activities

1. Develop measures to quantify the impact of stigma on HIV prevention and care.
2. Tailor HIV education to subpopulations - Caribbean, Black, Hispanic/Latinx, etc.
3. Ensure that HIV /STI mobile test units are at festivals, beaches, concerts, etc.
4. Incorporate comprehensive and inclusive sex ed for adolescents and young adults discussing gender, sexuality, consent, and relationship wellness in various venues including schools.
5. Digitize educational materials on popular social media sites that youth utilize.

Strategy 1.1.2: Increase HIV knowledge among communities and health workforce.

Community Recommended Activities

1. Assess the feasibility of mobile training units for wider outreach capabilities.
2. Develop indicators to measure an increase in HIV knowledge among communities and the health workforce in areas disproportionally affected.
3. Collaborate with traditional and non-traditional partners to conduct testing in non-traditional settings (i.e., faith-based organizations, domestic violence/ human trafficking agencies)

Strategy 1.1.3: Integrate HIV messaging into existing campaigns and other activities about other parts of the syndemic, such as STIs, viral hepatitis, substance use, and mental health, and in primary care and general wellness, and as part of annual reproductive health visits and wellness visits.

TESTING

1.2 Increase Knowledge of HIV status

Strategy 1.2.1: Test all people for HIV according to current USPSTF and CDC guidelines.

FDOH-Broward EHE Plan Activities

1. Expand routine HIV testing in targeted healthcare settings

2. Expand testing detailing (opt-out law, sexual history taking, stigma, insurance PCP reimbursement)

3. Provide continuing education regarding routine HIV testing (opt-out law, sexual history taking, stigma, insurance reimbursement, to health professionals and students (explore mandatory continuing ed with license renewal). Partner w/ FOCUS Project to recruit additional EDs to provide routine testing.

RWHAP Part A EHE Plan Activities

1. Increase the number of high-risk individuals tested for HIV, including sex partners of PWH;
2. Increase the number of PWH aware of their HIV status but not in care and rapidly link to OAHS and initiate ARVs;

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.

FDOH-Broward EHE Plan Activities

1. Partner with big box stores, pharmacies, & urgent care to offer routine HIV and STI testing.
2. Explore provision of routine HIV testing in dental practices starting with a pilot at a college.
3. Explore provision of HIV testing in a mobile healthcare clinic.
4. Partner with BSO to provide routine HIV testing upon intake in clinics and correctional facilities.

5. Partner with substance use treatment providers to provide routine HIV testing on admission.
6. Partner with assisted living facilities and skilled nursing facilities to provide routine HIV testing.
7. Partner with academic institutions to provide routine HIV and STI testing in student health clinics.
8. Expand targeted HIV testing of priority populations in non-healthcare settings.
9. Use social network strategy to identify and test persons at risk for HIV through peers and partners.
10. Expand access to HIV testing through the provision of in-home test kits at community sites.
11. Expand the free in-home test kit program to high-risk ZIP codes.

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.

FDOH-Broward EHE Plan Activities

1. Create a seamless status-neutral HIV care continuum.
2. Collaborate with community partners to conduct SWOT analyses of HIV Continuum.
3. Create a seamless status-neutral HIV care continuum.
4. 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 1.2.4: Provide partner services to PWH or other STIs and sexual or syringe-sharing partners.

Strategy 1.2.5: Increase awareness and access to HIV testing.

Community Recommended Activities

1. Include activities related to self-testing.
2. Include activities related to targeted (prioritized) testing

PREVENTION INTERVENTIONS INCLUDING PrEP

1.3 Expand and improve implementation of safe, effective prevention interventions, including treatment as prevention (TasP), PrEP, PEP, and SSPs, and develop new options.

Strategy 1.3.1 Engage people at risk for HIV in traditional and nontraditional community settings.

Community Recommended Activities

1. Implement strategies to target PWH experiencing homelessness
2. Implement strategies that increase ability to make good decisions in the sexual setting

RWHAP Part A EHE Plan Activities

1. Provide intensive interventions that promote linkage and engagement in Outpatient Ambulatory educate about HIV and ways to avoid HIV transmission and support a rapid transition to OAHS.

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.

FDOH-Broward EHE Plan Activities

1. Provide education to community stakeholders, organizations, and elected officials about U=U and Treatment as Prevention to support HIV modernization activities that impact state laws.
2. Identify/develop interventions to improve outcomes among disproportionally affected groups.

Community Recommended Activities

1. Implement a social marketing campaign promoting the U=U strategy
2. Explore t implementation of pilot to provide incentives for attaining and maintaining VL suppression
3. Explore the expansion of our local resource and referral line to serve PWH
4. Provide HIPAA-compliant medical transportation

Strategy 1.3.3 Make prevention services, including condoms, PrEP, PEP, and SSPs, easier to access.

FDOH- Broward EHE Plan Activities

1. Expand access to PrEP throughout the system of care.
2. Expand hours for PrEP/nPEP provision at public providers to include evenings and weekends
3. Utilize telemedicine to provide PrEP/nPEP.
4. Explore the provision of PrEP/nPEP in a mobile healthcare clinic.
5. Raise community awareness of PrEP/nPEP through outreach and social marketing EHE.

6. Expand Street outreach regarding PrEP/nPEP.
7. Develop community-driven campaign to educate community on PrEP/nPEP and decrease stigma.

Community Recommended Activities

1. Work with partners to provide PrEP/nPEP in conjunction with a SEP, if implemented.
2. Partner with big box stores and retail pharmacies to offer PrEP/nPEP in on-site clinics
3. Expand education to primary care physicians to recruit additional PrEP/nPEP prescribers.
4. Address the financial barriers to PrEP/nPEP initiation and retention.

and linguistically appropriate models and other innovative approaches for delivering HIV prevention services.

Community Recommended Activity

1. Seek opportunities to increase the number of culturally competent providers (e.g., Haitian Creole).

Strategy 1.3.7 Ensure healthcare providers are complying with the updated PrEP guidance regarding insurance coverage of PrEP baseline and monitoring services.

Strategy 1.3.8: Expand awareness and use of the Collaborative Pharmacy Practice Agreement which gives pharmacists the authority to provide specific patient care services, including PrEP.

DIVERSITY AND EQUITY

1.4 Increase diversity and capacity of systems and workforce to prevent and diagnose HIV.

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.

FDOH- Broward County Ending the HIV Epidemic Activities

1. Incorporate health equity into HIV testing.
2. Provide Racial Equity Institute (REI) training to all registered HIV testing counselors.
3. Provide cultural competence training to all HIV testing counselors to better serve LGBTQ+
4. Provide capacity-building assistance to grassroots organizations that serve priority populations.
5. Provide mini grants to grassroots organizations that serve priority populations.
6. Include larger funding for grassroots organization capacity building.
7. Incorporate health equity into HIV prevention.
8. Provide REI training to FDOH-Broward contracted PrEP/nPEP providers.
9. Provide cultural competence training to FDOH-Broward contracted PrEP/nPEP providers
10. Provide capacity building and TA to grassroots organizations that serve priority populations.

Strategy 1.4.2 Increase diversity of HIV prevention, testing, and supportive services.

Strategy 1.4.3 Increase the inclusion of paraprofessionals on prevention teams by advancing training, certification, supervision, financing, and team-based care service delivery.

Strategy 1.4.4 Include comprehensive sexual health and substance use prevention and treatment information in medical and other health workforce education and training programs curricula.

GOAL 2: IMPROVE HIV-RELATED HEALTH OUTCOMES

LINKAGE TO CARE

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

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

FDOH- Broward County Ending the HIV Epidemic Activities

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

RWHAP Part A EHE Plan Activities

1. Increase the number of PWH aware of their HIV status but not in care and rapidly link them to outpatient/ambulatory health services (OAHS) and initiate ARVs.
2. Provide intensive interventions that promote linkage and engagement in OAHS, educate about HIV and ways to avoid HIV transmission, and support a rapid transition to OAHS.

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

Community Recommended Activities

1. 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
2. Create a coordinated universal eligibility and recertification system for Parts A and B with an annual recertification hybrid (in-person or electronic) process.
3. Utilize a quality approach to redesign a system of care that has its structure built on interagency communication, interservice networking, and meaningful collaborations.
4. Enhance the client health experience to outcomes by providing transparent and understandable information on the "steps" to access needed support and eligibility continuation services.
5. Develop a helpline to assist and empower consumers when they have access /eligibility concerns and/or challenges.
6. Develop a formal client orientation with a visual tour and access procedures explained by a Case Manager or Peer.
7. Create a countywide geo-mapping dashboard to identify service locations.
8. Create a resource inventory for HIV health services -including housing providers.
9. Streamline the process for patients entering care/already in care
10. Develop a system of handing off patients to case management after test and treat
11. Ensure patient information is up to date
12. Expand education to the community about services available to meet their needs to establish a clear presence within the community in need of care

RETENTION IN CARE, ADHERENCE, AND VIRAL SUPPRESSION

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

Strategy 2.2.1 Support the transition of health care systems, organizations, and patients/clients to become more health literate in the provision of HIV prevention, care, and treatment services.

Strategy 2.2.2 Develop and implement effective, evidence-based, or evidence-informed interventions and supportive services that improve retention in care.

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.

RWHAP Part A EHE Plan Activities

1. Deploy multidisciplinary Intensive Care Teams (ICTs) to engage and retain clients through rapid assessment, care planning, active referrals, follow-up, care coordination, and ongoing ICM.
2. Increase number of trained and credentialed peer workers and deployed as active ICT members.
3. Increase number of clients receiving thorough behavioral health assessments and actively link them to services.
4. Increase number of clients retained in high-quality OAHS through (a) efficient transportation that ensures clients keep tOAHS and other healthcare appointments and (b) telehealth, specialty consultation, and patient co-management with community physicians.
5. Increase percentage of clients residing in temporary or transitional housing via the BCHSD HIP.
6. Increase retention in care and stable housing rates by addressing social determinants such as illiteracy, unemployment, poverty, disability, inability to conduct activities of daily living (ADLs), and no insurance.

Community Recommended Activities

1. Employ peer navigators at each agency.
2. Expand funding for peer navigator services.
3. Develop systems that serve the needs of PWH using technology

PEER TRAINING, CERTIFICATION, SUPERVISION, REIMBURSEMENT

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.

RWHAP Part A EHE Activities

1. Increase the number of trained and credentialed peer workers deployed as active ICT members.

Community Recommended Activities

1. Increase the number of Service Categories that integrate peer services.
2. Revise employment requirements for peers to allow for expansion to include lived/professional experiences outside of educational requirements.
3. Secure funding to continue the Broward HIV Peer Certification Training to equip individuals with the needed skills and capacity to serve on healthcare teams.
~~4. Replicate the Children Services Council's model of a $15 minimum wage for funded providers' staff.~~

AGING POPULATION AND LONG-TERM SURVIVORS

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

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

Community Recommended Activities

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.

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

Community Recommended Activities

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

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

Community Recommended Activities

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.

Strategy 2.4.4 Promote cross-agency collaborations, that address specific aging-related conditions in people with HIV, and other comorbidities and coinfections that can impact people with HIV of all ages.

Community Recommended Activities

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

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

GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES

CIVIL RIGHTS LAWS AND WORKFORCE

3.1 Reduce HIV-related stigma and discrimination.

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

Community Recommended Activities

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

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

FDOH- Broward County Ending the HIV Epidemic Activities

1. Incorporate health equity into HIV care and treatment
2. Provide REI training to all Ryan White Part A HIV primary care providers
3. Provide cultural competence training to all Ryan White Part A HIV primary care providers
4. Provide trauma-informed care training for all Ryan White Part A HIV primary care providers

Community Recommended Activities

1. Assess the ability to require organizations to adopt a DEI framework and are held accountable to the Diversity, Equity, and Inclusion (DEI) Framework.
2. Revise the language in the cultural competency curriculum for providers
3. Assess the possibility of expanding the HIV "helpline" functionality to include receiving calls regarding poor experiences with providers and addressing reported issues in provider cultural sensitivity training.
4. Expand provider network to meet the needs of HIV+ Haitian d 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, technical assistance, and learning collaborative.
8. Encourage and incentivize RWHAP providers to participate in the Escalate training. (RWAP Recipients)

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.

Community Recommended Activities

1. Provide financial resources for disproportionately affected communities i.e., wrap-around services
2. Define priority populations
3. Develop more appropriate and accessible mental health services
4. Improve collaboration across Continuum by enhancing the partnership among Part A, HOPWA \, BCHSD housing services, and FDOH to secure additional housing funds.
6. Ensure the County EHE program includes housing, skills building, self-empowerment programs, work development, and partnerships with correctional facilities

DISPARITIES IN NEW INFECTIONS

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

Community Recommended Activities

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

PWH EMPLOYMENT AND LEADERSHIP OPPORTUNITIES

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

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

Community Recommended Activities

1. Build the capacity of PWH to be meaningfully involved in the planning, delivering, and improving RWHAP services. (Incorporate programs from the organization, Meaningful Involvement of People with HIV/AIDS (MIPA) in Broward.
2. Partner with the National Minority AIDS Council's (NMAC) ELEVATE program to address workforce recruitment, development, and advancement needs for PWH in populations 50+, Young Black Men, T/GNC, Latinx, and the recovery community.
3. Build website: PWH Resources on Reducing Stigma, Leadership, Advocacy, Ed., and Opportunities.
4. Work with communities to reframe HIV services and messaging to not stigmatize people or behaviors.

SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH (SDOH)

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 3.4.1 Develop whole-person systems of care and wellness that address co-occurring conditions for people with or who experience risk for HIV.

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

Community Recommended Activities

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

Strategy 3.4.3 Improve screening and linkage to services for people with or who experience risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.

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

Community Recommended Activities

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

9. Increase financial security for people receiving SSDA or SSI by expanding knowledge of and access to existing work incentive programs to allow people to work and earn more income without losing disability.
10. Identify the appropriate stakeholders to develop interventions to address low health literacy.
11. Prioritize the quality of life in addition to viral suppression.

FDOH- Broward County Ending the HIV Epidemic Activities
1. Expand access to safe/affordable housing opportunities for PWH.
2. Increase communication and coordination across agencies that provide affordable housing.

Strategy 3.4.5 Increase financial security for people with HIV receiving SSDA or SSI by expanding knowledge of and access to existing work incentive programs to allow people to work and earn more income w/out losing disability benefits.

Community Recommended Activities
1. Identify the appropriate stakeholders to develop interventions to address low health literacy
2. Prioritize the quality of life in addition to viral suppression

Strategy 3.4.7 Develop new and scale-up effective, evidence-based, or evidence-informed interventions that address intersecting factors of HIV, homelessness or housing instability, mental health and violence, substance use, and gender especially among cis- and transgender women and gay and bisexual men.

Community Recommended Activities
1. When collaborating with the community to end the epidemic, conversations should include transgender community
2. Be more creative in dismantling systems and creating a safe space for the transgender community to access services without judgment and oppression from providers.

Strategy 3.4.8 Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including healthcare workers, researchers, and community partners, particularly from underrepresented populations.

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

Community Recommended Activities
1. Develop and test strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.
2. Increase diversity and cultural competence in health communication research, training, and policy.
3. Expand community engagement in health communication initiatives and research.
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 THAT ADDRESS THE HIV EPIDEMIC AMONG ALL PARTNERS AND INTERESTED PARTIES

INTEGRATED AND COORDINATE EFFORTS

4.1 Integrate programs to address the syndemic of HIV, STIs, viral hepatitis, substance use, and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence.

Strategy 4.1.1. Coordinate and align strategic planning efforts on HIV, STIs, and viral hepatitis across programs and jurisdictions, specifically between Palm Beach , Broward, and Miami-Dade.

Strategy 4.1.2 Increase coordination among and sharing of best practices from HIV programs across all levels of government and with public and private health care payers, faith-based and community-based organizations, the private sector, academic partners, and the community.

Strategy 4.1.3 Focus resources including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV.

Strategy 4.1.4 Enhance collaboration among local, state, tribal, territorial, national, and federal partners, and the community to address policy and structural barriers that contribute to persistent HIV- related disparities and implement policies that foster improved health outcomes.

Strategy 4.1.5 Coordinate across partners to quickly detect and respond to HIV outbreaks.

FDOH-Broward EHE Plan Activities

1 Enhance the ability to conduct molecular cluster response by increasing genotype testing.
2. Conduct physician detailing to encourage genotype testing.

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

Community Recommended Activities

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

Data Quality and Data Sharing

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

Community Recommended Activities

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

Strategy 4.2.1 Foster private-public-community partnerships to identify/scale up best practices and accelerate HIV advances.

Community Recommended Activities

1. Adopt approaches that incentivize the scale-up of effective interventions among academic centers, health departments, community-based organizations, allied health professionals, people with HIV and their advocates, the private sector, and other partners.
2. Expand opportunities and mechanisms for information sharing and peer technical assistance within and across jurisdictions to move effective interventions into practice more swiftly.
3.Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing persons of all ages living with HIV.

Monitor, Evaluate, and Report Progress

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

Community Recommended Activities

1. Ensure all planning bodies and committee/workgroup chairs identify activities to advance NHAS strategies including participating in a half-day "think tank"/IP training session.
2. Committee/workgroup chairs should include activities in their committee/work plans and report on the progress at a bi-annual Joint Executive meeting.
3. Streamline and harmonize reporting and data systems to reduce the burden and improve the timeliness, availability, and usefulness of data.
4. Monitor, review, evaluate, and regularly communicate progress on the NHAS.
5. Implement bi-annual Joint Executive (Committee Chairs of Part A, B, Prevention & CSB) IP meeting
6. Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners.
7. 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.

Community Recommended Activities

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

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

1. 2022-2026 Integrated Planning Implementation Approach

The purpose of this section is to describe the infrastructure, procedures, systems, and tools that will be used to support the key phases of integrated planning. This section includes detail on how best to ensure the success of Integrated Plan goals and objectives through the following 5 key phases: Implementation, Monitoring, Evaluation, Improvement, and Reporting and Dissemination.

a. Implementation

Broward County initiated the Implementation, Monitoring, Evaluation, Improvement, and Reporting/Dissemination with the establishment of the Integrated Workgroup in April 2022, which involves representatives from each planning body, the health department, Ryan White Part A, B, C, and D, HOPWA, affected community members, and stakeholders.

Broward County supports the National HIV/AIDS Strategy for the United States (NHAS) related to preventing new HIV infections; improving HIV-related health outcomes for PWH; reducing HIV-related disparities and health inequities and achieving a more coordinated national response to the HIV epidemic. To achieve these goals, the jurisdiction is committed to increased monitoring and accountability through the following:

- Development of Integrated HIV Prevention, Care, and Treatment indicators
- Ongoing evaluation practices
- Reporting of progress achieved
- Continuous stakeholder engagement

The goal of integration in Broward County is to streamline HIV prevention and care planning in a manner that will enhance prevention efforts for the highest-risk populations and improve the metrics along the Continuum of Care for those infected with HIV to create a coordinated response to the HIV epidemic and a seamless provision of HIV services. Broward County has identified a set of shared metrics that include the percentage of persons diagnosed and living with HIV, the percentage linked to care, the percentage retained in care, and the percentage with suppressed viral load.

The Integrated Workgroup will track the Plan's progress to identify areas where the Plan is performing optimally and where progress is falling behind. Findings and recommendations will be reported to the noted participants through quarterly meetings.

As described in a previous section, each of the three HIV planning bodies selected three (3) members to represent their respective areas in developing the Integrated HIV Prevention and Care Plan through membership in the Integrated Plan Workgroup, the oversight body for

Integrated Planning in the jurisdiction. Members are responsible for identifying the scope and timeline for integrated plan monitoring, evaluation, improvement, and reporting.

The HIVPC, SFAN, and BCHPPC will continue to function as separate bodies to implement the assigned activities required in this plan as well as in their individual work plans and to work collaboratively to address mutually reinforcing activities.

The Integrated Workgroup will complete its implementation activities within CY 2023 and will be the forum for monitoring, evaluating, and improving the conduct of the various processes and activities that make up the Plan going forward. Therefore, within CY 2023, the Integrated Workgroup will be tasked with identifying:

- Weaknesses in implementation, measurement, and processes.
- How well the RWHAP and FDOH-BOC and their responsible entities are doing to advance the Plan.
- What parts of the Plan are working well or are falling behind; and
- Where technical assistance should be provided.

b. Monitoring

While the Integrated Plan Workgroup assumes overall responsibility for monitoring progress to implement the goals, objectives, and activities of the Plan, each of the three HIV planning bodies and their respective Recipients will be responsible for collecting, tracking, and reporting data specific to the requirements by their grant award. As mentioned previously, the Integrated Plan is a living document that will be updated on at least a quarterly basis.

At the first Integrated Plan Workgroup meeting following the submission of this Plan, each of the HIV planning bodies will be asked to provide additional input on the monitoring and evaluating the Plan through input of the respective bodies.

Prevention/Ending the HIV Epidemic Activities

Prevention and EHE specific activities will be monitored by the FDOH, and results will be reported at quarterly prevention planning meetings. As appropriate, committees will be tasked with coordinating the implementation and monitoring of activities, tracking the progress of specific activities, providing regular status updates, including challenges and proposed solutions, and suggesting revisions to better achieve the goals.

Part B and ADAP Specific Activities

Part B and ADAP specific activities will be monitored by FDOH, and results will be reported at bi-annual Florida Comprehensive Planning Network (FCPN) meetings. The FDOH-Broward Recipient's office will report results to the local HIV planning bodies, the Funder's Collaborative, and the Integrated Workgroup.

Part A Specific Activities

The Integrated HIV Plan functions as the foundation for each HIVPC committee's work plan. As appropriate, committees will be tasked with coordinating the implementation and monitoring

of activities, tracking the progress of specific activities, providing regular status updates, including challenges and proposed solutions, and suggesting revisions to better achieve the goals. While the process of implementing, reviewing, and reporting on the Integrated Plan goals will be revised to ensure participation and accountability from all committees, many monitoring activities are already included in the work of committees as shown below.

The RWHAP PART A/HIVPC approach:

Each HIVPC committee will develop an annual work plan that includes monitoring and evaluation of Part A specific Plan goals. Review of the Plan goals will be a standing agenda item for all committees.

The annual work plans will be modified as needed to reflect: 1) Identified successes and challenges achieving plan goals, 2) Changes in resources and priorities, 3) Changes in the implementation process of each goal and activity, and 4) Roles and responsibilities.

Each committee will report progress achieving Plan goals as well as identified challenges, barriers, and next steps to the HIVPC on a monthly/bi-monthly/quarterly basis. An annual review of the Plan goals will identify system-wide accomplishments, challenges, barriers, and next steps to be reported to the HIVPC.

Client-level data and clinical outcomes will be used to assess the Part A's success.

c. Evaluation

Describe the performance measures and methodology the jurisdiction will use to evaluate progress on goals and objectives. Include information about how often the jurisdiction conducts analysis of the performance measures and presents data to the planning group.

Evaluation findings are critical for the identification of best practices and opportunities for advancement which then provides vital information for effective program planning and quality improvement of services. Over the next five years, hired external consultants will review the data yearly to measure the impact of the Integrated Plan on the local HIV epidemic. The results of this evaluation will be submitted for academic publishing and then larger dissemination. The external evaluator will also be responsible for presenting to the three planning bodies the outcomes of their evaluation.

The local jurisdiction will evaluate progress on the Integrated Plan goals and objectives by based on achieving the HIV National Strategic Plan (NHAS) indicator and the Ending the Epidemic indicators targets. Data will be collected from the AHEAD Dashboard, an online data visualization tool that reports data on six different measures (known as "indicators") that track progress toward meeting EHE goals. The section below provides an overview of the performance measures and performance targets. Progress on these measures will be reported on a bi-annual basis to the local HIV planning bodies and the Integrated Planning Workgroup.

HIV National Strategic Plan and Ending the Epidemic Indicators (Broward Targets)

1. Increase **knowledge of status** to 95% from a 2017 baseline of 88%. **(**EHE Midterm Goal)
2. Reduce **new HIV infections** by 75% from the 2017 baseline of 670. **(***EHE Overarching Goal)
3. Reduce new **HIV diagnoses** by 75% from a 2017 baseline of 671. **(**EHE Diagnoses Indicator)
4. Increase **PrEP coverage** to 50% from a 2017 baseline of 10%. **(**EHE PrEP Coverage Indicator)
5. Increase **linkage to care** w/in 1 month of diagnosis to 95% from 2017 baseline of 80.6%. **(**EHE LTC)
6. Increase **viral suppression** to 95% from 86.5% for RWHAP clients. (FDOH reporting on all PWH)

(6 and 6a-6h below include 2020 baseline data for RWHAP clients from HRSA COMPASS Dashboard)

   a. Increase MSM VL suppression to 95% from 87.7%.
   b. Increase Black MSM VL suppression to 95% from 81.4%.
   c. Increase Latino MSM VL suppression to 95% from 92.6%.
   d. Increase AI/AN MSM VL suppression to 95% from 93.5%.
   e. Increase Black female VL suppression to 95% from 84.9%.
   f. Increase Transgender female VL suppression to 95% from 80.8%.
   g. Increase PWID VL suppression to 95% from 90.2%.
   h. Increase Youth VL suppression to 95% from 79.9%.

7. Decrease stigma among PWH by 50% from a 2018 baseline median score of 31.2 (National Baseline)
8. Reduce homelessness among PWH by 50% from the 2017 baseline of 5.1%. (RWHAP)
9. Increase the median percentage of secondary schools that implement at least 4 out of 7 LGBTQ-supportive policies and practices to 65% from a 2018 national baseline of 59.8%.
10. Improve the quality of life for PWH (*Will be identified by CDC/HRSA and progress monitored thereafter)

Data Notes

- NHAS Indicators 1 through 6 are identical to EHE's 6 indicators which are included in the AHEAD Dashboard. AHEAD is a data visualization tool designed to display EHE data on the six indicators for each of the Phase I jurisdictions.
- NHAS Indicators 6 & 6a - 6h are also included in the HRSA COMPASS Dashboard (RWHAP Clients Only).
- NHAS Indicator 1 and 2 = FCPN Objective 1.2

*The overarching EHE goal refers to the main goal of the Ending the HIV Epidemic initiative: to end the HIV epidemic in the U.S. by reducing the number of HIV infections by 75% by 2025 and 90% by 2030. That is why the overarching goal is tied to the incidence indicator. The midterm goal refers to the indicator that will give us the best idea of overall progress which is knowledge of HIV status. The knowledge of the HIV status indicator is tied to the midterm goal because an increase in knowledge of status gives us a good indication of progress.

Figure 14 Indicators to Measure Progress with 2025 Targets

Fort Lauderdale/Broward EMA HIV Integrated Plan Indicators								Goals NHAS 2025	Goals EHE 2025
NHAS Indicator #1		Knowledge of HIV Status	2017	2018	2019	2020	2021		
	Midterm EHE Goal	Living diagnosed or undiagnosed	21,500	21,800	22,100				
		Living diagnosed	19,209	19,542	19,863				
			89.3%	89.6%	89.9%			95%	95%
NHAS Indicator #2		New HIV Infections	2017	2018	2019	2020	2021		
	Overall EHE Goal	Estimated incidence	2,028	1,680	1,703			507	420
NHAS Indicator #3		New HIV Diagnoses	2017	2018	2019	2020	2021		
	EHE Indicator	New diagnoses	671	616	594	460	510	168	168
NHAS Indicator #4		PrEP Coverage	2017	2018	2019	2020	2021		
	EHE Indicator	Number prescribed PrEP	2,011	2,861	3,767	6,711	5,684	10235	
		Number w/ PrEP indications	20,030	20,470	20,470	20,470	20,470	20,470	
		PrEP coverage	10.0%	14.0%	18.4%	32.8%	27.8%	50%	
NHAS Indicator #5		Linkage to Care	2017	2018	2019	2020	2021		
	EHE Indicator	At least one CD4 or VL test	622	611	604	488	382		
		Total diagnoses	671	626	594	460	339		
	Residents	Linkage Percent All Residents	80.6%	84.2%	87.0%	87.2%	87.0%	95%	95%
	RWAP	Linkage RWAP Clients							
NHAS Indicator #6		Viral Suppression	2017	2018	2019	2020	2021		
	EHE Indicator	Total persons alive	18,513	18,862	19,237				
		VL below 200	12,567	12,935	13,486				
	Residents	Viral suppression	67.9%	68.6%	70.1%				
RWAP Clients		Viral suppression: RWHAP Clients	84.2%	82.9%	86.3%	86.5%			
N=4,418	54%	MSM	86.7%	83.3%	87.8%	87.6%		95%	
N=1,841	22%	Black MSM	79.5%	74.5%	80.6%	81.4%		95%	
N=1,435	17%	Latino MSM	90.8%	87.6%	93.3%	92.6%		95%	
N=1461	18%	Black Female	78.2%	82.0%	82.3%	84.9%		95%	
N=156	2%	Transgender Women	76.8%	75%%	83.8%	80.8%		95%	
N=112	1%	People who Inject Drugs (PWID)	84.8%	90.3%	82.5%	90.2%		95%	
N=455	6%	Youth	72.2%	68.0%	80.3%	80.2%		95%	
		People Aged 50 and Over	90%	89%	90%	91%		95%	
NHAS Indicator #7		Stigma Among PWH	2017	2018	2019	2020	2021		
To implement, a measurement tool and administration protocol is needed									
NHAS Indicator #8		Homelessness Among PWH	2017	2018	2019	2020	2021		
		RWHAP w/ Unstable Housing	73	94	246	332			
NHAS Indicator #7		Schools w/ LGBTQ policies		2018	2019	2020	2021		
Secondary schools w/ 4/7 LGBTQ supportive policies								59.8%	
NHAS Indicator #10		Improve Quality of Life	2017	2018	2019	2020	2021		
*(*Data sources, measures, and targets will be identified by CDC/HRSA and progress monitored thereafter.)*									
Resident Data Source: EHE AHEAD Dashboard									
Note: 2020 & 2021 Data are Preliminary									
RWAP Data Source: RWHAP Compass Dashboard: Jusristictional Benchmarking Report									

d. Improvement

The purpose of this section is to describe the methods and/or means by which progress in achieving goals and meeting challenges will be monitored. Monitoring and evaluation will ensure that the activities implemented to achieve the goals are prioritized, analyzed, and adapted as needed to align with shifts in resources and priorities. This section of the Plan describes how to progress in achieving goals, meeting challenges and barriers, and adapting over time will be monitored. It also provides a detailed description of the well-established Quality Management (QM) process already in place designed to promote quality services and improved health outcomes.

e. Reporting and Dissemination

Progress in the implementation and execution of this Plan will be shared at the quarterly or bi-annual Integrated Workgroup meetings reported to each planning body as part of regular committee reporting. Groups who participated in community engagement activities, the system of care, quality management, and other community stakeholders will also be advised of updates and will be encouraged to contribute to ongoing planning and execution of the Plan goals. Special presentations may be made to any community stakeholders, as appropriate or by request. Reports will be posted on a dedicated page on www.brhpc.org. Printed copies will be distributed at in-person meetings and are always available by request. Findings will also be incorporated into the Annual Report provided to the Ryan White Part Office.

f. Updates to Other Strategic Plans Used to Meet Requirements

Throughout the reporting period, those attending the Broward County HIV Prevention Planning Council's full council and advisory workgroup meetings received routine updates on pertinent information related to EHE. Attendees of these meetings included community leaders, people with HIV (PWH) affected by HIV, and representatives from community-based organizations (CBOs), healthcare facilities, grassroots organizations, and non-profits.

In July 2021, the Florida Department of Health in Broward County (FDOH-Broward) hosted an EHE townhall in partnership with Broward's Ryan White Part A Program and two local federally qualified health centers (FQHCs) that received Health Resources and Services Administration Primary Care HIV Prevention funding. During the townhall, community members received updates on each organization's Year 1 EHE activities and learned about new activities planned for Year 2.