BROWARD COUNTY

INTEGRATED CITY-ONLY HIV PREVENTION AND CARE PLAN 2017-2021

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BROWARD HIV PREVENTION PROGRAM

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Leading Change: The Broward County Approach to addressing HIV/AIDS—From Separate to Parallel to Integrated

Introduction

Broward County is a subtropical urban center on the Atlantic coast of Florida and is accessible by land, air and sea. As Florida's second largest metropolitan area, with 1.87 million residents, it is a tourist destination for more than 10 million visitors annually. Broward County offers 23 miles of sun-kissed beaches, great dining, a vibrant night life, unlimited entertainment and attractions. According to the U.S. Census (2010), Broward County is projected to be the most diverse county in the United States by the year 2030. Shifts in the county's demographics are driven by immigration of foreign-born minorities and includes residents representing more than 200 different countries and speaking more than 130 languages. The 2014 American Community Survey reports that 40% of Broward residents spoke a language other than English at home, compared to 28% for Floridians generally. Broward County is also home to more than 60,000 Lesbian, Gay, Bisexual and Transgender (LGBT) residents. National tourist publications have dubbed Broward "the second most popular LGBT tourist destination in the United States."

Broward and Palm Beach counties are part of the Miami-Dade County metropolitan statistical area (MSA). The proximity of these mostly urban counties results in a fluid "work, worship and play environment." In all three counties HIV reported cases are primarily among men who have sex with men (MSM). Social and sexual activities among this population group are not restricted by distance or county boundaries. Sex is a primary mode of HIV acquisition, however, drug use and in particular injecting drug use (IDU) continues to contribute to the ongoing number of new HIV infections among Broward County residents. Other populations who are disproportionately affected in Broward include African American gay, bisexual, and other MSM; White gay men; Latino gay men; and African American women. In addition, large immigrant communities with limited English proficiency may encounter barriers accessing health services and information, leaving many at risk for undiagnosed HIV infection. With improved quality of life issues such as the warm climate, beaches, and nightlife, Broward County has become a center

for gay tourism as well as a relocation and retirement destination for HIV positive individuals. This may also lead to an increase in HIV transmission locally.

Broward County's Ryan White Part A Recipient's Office and the Florida Department of Health in Broward County (DOH-Broward) HIV Prevention Program have identified the unique characteristics of its residents and visitors, its distinctive approach to addressing the epidemic, and its ability to bring together groups of diverse stakeholders. It is due to these distinct differences and variances within the community that Broward County opted to submit a Comprehensive Integrated Prevention and Care Plan particular to its diverse strengths and needs. The stakeholders recognize there are several universal principles that align and guide this approach consistent with the Statewide Coordinated Statement of Need (SCSN) and this plan reflects that alignment. Collectively, it is acknowledged that the strengths and challenges that define Broward County should be addressed as a community and thus the submission of the Integrated City-Only Prevention and Care Plan to the Center for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) is warranted. This plan is also included as a chapter in the State of Florida's Integrated Plan.

History of Funding and Planning for the Epidemic in Broward County: HIV/AIDS has severely impacted Broward County. As a result, federal funding has been received for Prevention, Care and Treatment services for over two decades, reflecting the large and growing epidemic. Historically, Broward County has been an HIV under-resourced jurisdiction. The county consistently ranks among the top jurisdictions for newly diagnosed HIV cases in the entire United States. The per capita cases of new infections in Broward has not decreased in over a decade, prompting government health agencies to direct more funding to AIDS prevention campaigns in Broward.

The recommended funding allocation and the approved budget for Broward County continues to limit the Eligible Metropolitan Area's (EMA) ability to fully implement and attain the goals outlined under the President's National HIV/AIDS Strategy (NHAS), the CDC's PS12-1201 cooperative agreement, and Broward County's local Integrated Prevention and Care Plan. As an HIV/AIDS epicenter, an important area for program consideration is the adequate provision of capacity building and technical assistance to DOH-Broward, the Ryan White HIV/AIDS Program (RWHAP), and the community in

Broward County. With adequate resources, the EMA can be successful in creating systems of care for people at-risk and living with HIV/AIDS.

Broward is committed to the provision of effective prevention, care and treatment strategies utilizing clinical quality management, monitoring, evaluation, and other local resources to ensure the populations and geographic areas most affected by HIV achieve a maximum level of impact. These strategies can be achieved through: 1) development of active measurement tools; 2) ongoing evaluation practices; 3) reporting of NHAS progress achieved; 4) continuous stakeholder engagement; and 5) integrated planning. Integrated Planning provides a tremendous collaborative opportunity for effective planning and efficiency in responding to the local jurisdictional needs.

All programmatic activities, organized by DOH-Broward HIV Prevention Program, Ryan White Parts A-F, HOPWA, Broward County Public Schools, and other community stakeholders include comprehensive evaluation components in addition to the regular monitoring of outputs. Evaluation findings are critical for the identification of best practices and opportunities for improvement which then provide vital information for effective program planning and quality improvement of services.

Prevention Funding and Planning: In 1981, the first cases of acquired immune deficiency syndrome (AIDS) were reported in California, New York, and Florida. As a result of these first cases, the state of Florida in 1981 implemented surveillance of AIDS cases. Subsequently, in 1983 the CDC declared AIDS a reportable disease and the Florida State Health Officer declared AIDS to be a public health emergency requiring physicians to report diagnosed cases immediately. As active surveillance for AIDS began in Florida, anonymous HIV counseling and testing sites were established in county public health units in 1985 including Broward County. This was followed by implementation of a five-year health education risk reduction project funded in 1986. During the following year, Florida received funding to expand HIV Prevention education to minorities and community-based groups.

As Florida began to develop public health HIV/AIDS programming and infrastructure, Governor Lawton Chiles commissioned a Red Ribbon Panel in 1992 to address prevention and treatment issues. The recommendations of the Red Ribbon Panel group

prompted the state of Florida to create the Florida HIV/AIDS Community Planning Group in 1993 followed by the development of the first HIV Prevention Plan for Florida in 1994.

While a statewide prevention plan was developed, the Broward County Health Department also established and convened the first Broward County Community Planning Partnership in 1994 in response to the growing need to further involve the community in the planning process. This planning body was charged with the responsibility to address local HIV prevention priorities and needs. For over 10 years, this group guided HIV Prevention in Broward County and included community members, Health Department officials and individuals affected by HIV. In 2005, the State of Florida Department of Health Bureau of HIV/AIDS announced a funding shift based on prioritization of resources. The Bureau of HIV/AIDS could no longer provide funding for local community planning groups thus in 2006 the Broward County Community Planning Partnership embarked on a reorganization plan to ensure that community planning for prevention continued. This plan identified the need to provide leadership and ongoing coordination to support HIV prevention services in Broward County, resulting in the development of the 2007-2009 Comprehensive HIV Prevention Plan for Broward County. During this time, three advisory committees were formed, and several focus groups and provider forums were conducted to inform the planning process and assist in prioritizing activities to reduce incidence.

It was in 2009 that President Barack Obama called for the development of a national framework that would signal a new strategic shift in HIV/AIDS priorities. The first ever National HIV/AIDS Strategy was released on July 13, 2010. This came as no surprise to Broward County's HIV/AIDS community stakeholders as the White House Domestic Policy Council Office of National AIDS Policy held a series of community meetings across the nation, including a town hall meeting held at Dillard High School in Fort Lauderdale. Locally, the community was afforded the opportunity to voice concerns to help inform and shape the agenda. This prompted the public health community to adjust its methodology to address the epidemic.

The revised approach incorporated over 30 years of research, program development, and implementation and through a community collaborative process, a "Vision for Thoughtful Change" was developed. Using this document as the foundation for the 2012-

2016 Prevention Jurisdictional Plan, the DOH-Broward HIV Prevention Program took steps to increase its response and effectiveness in addressing the social, cultural, sexual, and structural factors that place specific groups at risk for HIV/AIDS. This plan was created to complement the state of Florida's plan and was future-oriented with a focus on scalability. It emphasized health department and community collaborations in order to reach the county's "priority populations" through new and innovative initiatives. Intended to serve as a roadmap to guide prevention efforts in Broward County, the Jurisdictional HIV Prevention Plan was developed specific to Broward County due to the unique needs of the population and to assure alignment of activities.

Care and Treatment Funding and Planning: In 1986, HRSA's AIDS Service Demonstration Grants and the Robert Wood Johnson Foundation's AIDS Health Services Program were launched to support community-based care networks in urban communities grappling with how best to respond to the new and growing epidemic. This was the precursor to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Eight different programs in nine sites were funded, with Broward County joining Miami-Dade. For over four years, Broward received $1.6 million in funding.

The CARE Act was enacted in 1990 and Fort Lauderdale was one of 16 cities who received the first Ryan White Part A Grant. This began the shift of accountability to local communities and included the creation of Planning Councils which were representative of the demographics of the community. Since its initial designation, Broward has continued to qualify as an EMA due to its consistently high HIV/AIDS prevalence.

The Fort Lauderdale/Broward EMA uses RWHAP Part A grant funds to support a comprehensive HIV Care Continuum of high-quality care and treatment for eligible HIV+ Broward residents. The EMA strives to sustain a seamless system of HIV care and treatment with high priority core medical and support services that ensure HIV+ residents obtain optimal clinical outcomes. Funds for these services support effective interventions for linking HIV+ individuals to care, retaining them in care, promoting adherence to antiretroviral therapy (ART), and achieving viral load (VL) suppression.

Part A grants to EMAs include formula and supplemental components as well as Minority AIDS Initiative (MAI) funds, which support services targeting minority populations. Formula grants are based on reported living HIV/AIDS cases as of

December 31 in the most recent calendar year for which data are available. Supplemental grants are awarded competitively on the basis of demonstrated need and other criteria. MAI funding is awarded using a formula that is based on the distribution of living HIV/AIDS cases among racial and ethnic minorities. Grants are awarded to the chief elected official (CEO) of the city or county that provides health care services to the greatest number of people living with AIDS in the EMA. In Broward County, the grant is awarded to the Broward County Board of County Commissioners and is administered by the Human Services Department.

Integration- A Collective Impact Framework: Broward County has worked collaboratively for over 2.5 years to create a unique plan and structure to foster a comprehensive approach to funding and services for HIV Prevention, Care and Treatment. The principals of the Integrated Planning effort chose to adopt and implement Collective Impact (CI) methodology as its framework for solving complex social problems. CI is "the commitment of a group of actors from different sectors to a common agenda for solving a complex problem." This framework is based on the premise that no one organization alone can tackle or solve complex multi-faceted problems that affect society. The five conditions for a successful collective impact initiative include: 1) common agenda; 2) shared measurement; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization. Broward County has been addressing the complex challenges associated with this disease by engaging diverse groups of community stakeholders, collecting and using data to inform decision-making, and developing mutually reinforcing activities to create and sustain meaningful change.

The success of the Integrated Planning process relies on the support of both Prevention and Care and Treatment planning bodies, each of which involve stakeholders throughout their own planning and development processes. Both insist on parity, inclusion and representation (PIR), ensuring that the planning bodies reflect the communities served and both embrace a fully transparent process that allows opportunities for regular feedback and input. The following Guiding Principles were adopted during the beginning stages of the planning process: 1) the focus must be on eradicating the epidemic; 2) prevention and care must cooperate in order to be successful; 3) continuous communication and inclusivity must be the norm; 4) common definitions for terms must

be utilized by both prevention and care; and 5) the HIV care continuum must be the framework for the integrated planning process.

In order for the Integrated HIV Prevention and Care Plan to be implemented successfully, it needed to be created locally, with input from the people most affected and with the most to gain or lose. The backbone for the collective impact framework was created with the support of Broward County's Human Services Department through the Ryan White Part A Program and the Florida Department of Health in Broward County's HIV Prevention Program. By using this framework an Integrated HIV Prevention and Care Plan was created that when executed fully, will serve to eradicate the HIV epidemic in Broward County, Florida and it will be recognized as a national model for replication.

Section I: Needs Assessment

A. Epidemiologic Overview

Introduction: This data uses the Florida Department of Health (FDOH), Bureau of Communicable Diseases, HIV and AIDS surveillance data on HIV infection to give key insights into the epidemiologic issues in Broward County. The overview presents epidemiologic data demonstrating significantly high HIV disease prevalence rates, high HIV unmet need, and the disproportionate impact of the HIV/AIDS epidemic on vulnerable populations. The information represents the most recent data available. The FDOH generated the HIV/AIDS epidemiologic data for Broward with reporting through Calendar Year (CY) 2014, December 31, 2014, as annual data trends. Living (prevalence) data are presented as of June 30, 2015, and include cases currently residing in the Fort Lauderdale EMA, regardless of where they were diagnosed. This data was utilized to inform decision-making and planning processes.

Geographic Region/Jurisdiction: Broward County is located along the southeastern

coastline of the state of Florida with Miami-Dade County to the south and Palm Beach County to the north. According the 2014 American Community Survey, Broward County had a total population estimate of 1.8 million, is the second most populous county in the state of Florida, accounting for 9.2% of the state's population and the seventeenth most populous county in the United States. The geographic region is made up of 1,323 square miles and is accessible by road, rail, air and sea. Broward County also hosts an estimated 10 million annual visitors including an estimated 250,000 winter seasonal residents. There are 3 interstate highways, Florida's Turnpike, an international airport and 2 north-south rail corridors that extend into Miami-Dade and Palm Beach Counties. Port Everglades Seaport, located on the southeastern border of the County, services more than 4,180 ships annually and is one of the top three cruise ports in the world.

Broward County includes 31 municipalities, five of which are home to more than 100,000 residents. A diverse county in which racial/ethnic minorities are the majority of the population, the racial/ethnic breakdown includes 40% White, 29% Black or African American, and 4% other races. Twenty-seven (27%) are Latino/Hispanic (including individuals of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish descent). These diverse populations represent more than 200 different countries and 130 different languages. One-third (31.8%) of Broward's residents are foreign-born, which is a higher rate than the Florida average. In addition, 44.3% of foreign-born residents are not U.S. citizens.

Geographic Areas Affected by HIV Infection: Designated as one of the first 11 established EMAs in the country, Broward County has continued to qualify as an EMA for the last two decades due to its consistently high HIV/AIDS prevalence. As of June 30, 2015 there were 19,391 persons living with HIV disease. The figure to the left (Figure 1) shows the number of PLWH by zip code. It was mapped to illustrate the geographical areas with the highest concentrations of HIV prevalence. Broward County has several zip codes (those with the darkest colors) where the rates of PLWH have higher prevalence compared to other zip codes within the county.

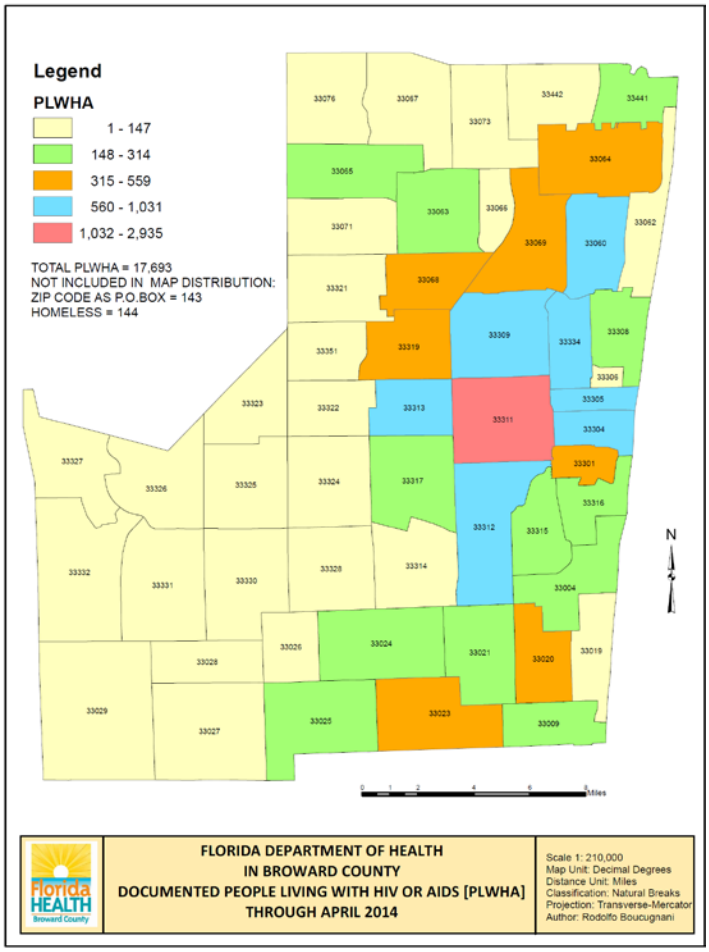
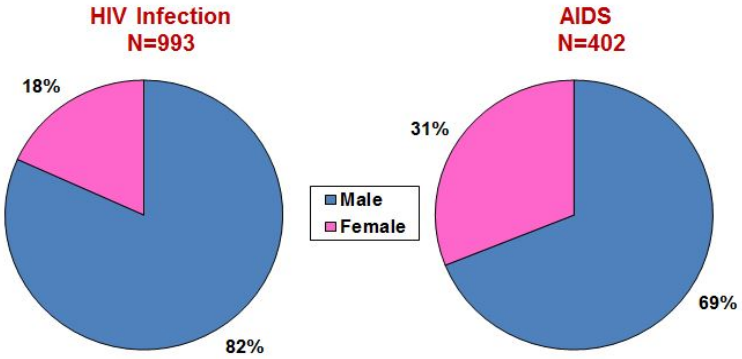


Figure 1. 2014 Prevalence Map

Socio-demographic characteristics: The following provides a brief overview of several socio-demographic characteristics of persons newly diagnosed, PLWH and persons at higher risk for HIV in the geographic area/jurisdiction. While there are some limitations associated with data sources and retrieval of data specific to the county, the information included is a description of the population disproportionately affected and provides a basis for planning purposes.

Figure 2. Percent of Adult HIV Infection and AIDS Cases by Sex, Diagnosed in 2014

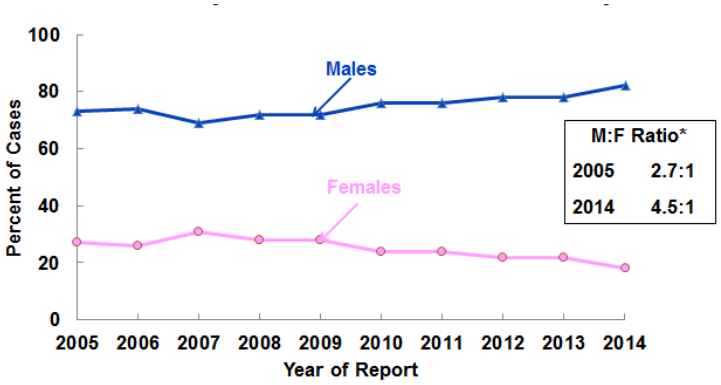


Source: Florida Department of Health HIV/AIDS Surveillance Program

Gender and HIV/AIDS: HIV disproportionately impacts Broward males. One in 62 Broward male residents are PLWH, compared to 1 in 180 female residents. In 2014, a total of 812 adult males and 181 adult females were diagnosed with HIV infection, representing 82% and 18% of cases, respectively (Figure 2). Also, in 2014 a total of 277 adult males and 125 adult females were diagnosed with AIDS representing 69% and 31% of cases, respectively.

In 2014, 82% of the adult HIV infection cases (N=993) were male, compared to 73% in 2005 (Figure 3). Over the past ten years, the proportion of HIV infections among men has increased while the proportion of women has decreased. The increased male to female ratio from 2005 (2.7:1) to 2014 (4.5:1) is due to this disproportionate infection rate between men and women, which may in turn be attributed to increases in HIV transmission among MSM.

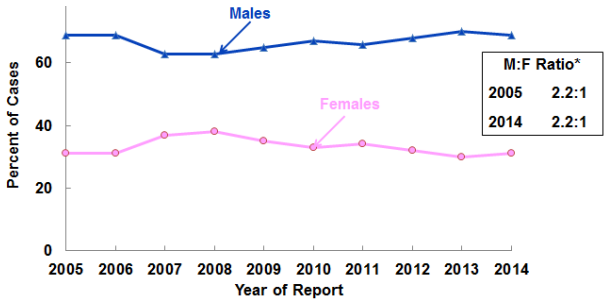
Figure 3. Percent of Adult HIV Infection Cases, by Sex and Year of Diagnosis, 2005-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

AIDS cases tend to represent HIV transmission that occurred many years ago. The number of adult AIDS cases for males and females from 2005 to 2014 remained relatively stable as seen in Figure 4. While it appears there was a slight increase in female AIDS cases between 2013 and 2014, the reason is not clear.

Figure 4. Percent of Adult AIDS Cases, by Sex and Year of Diagnosis, 2005-2014

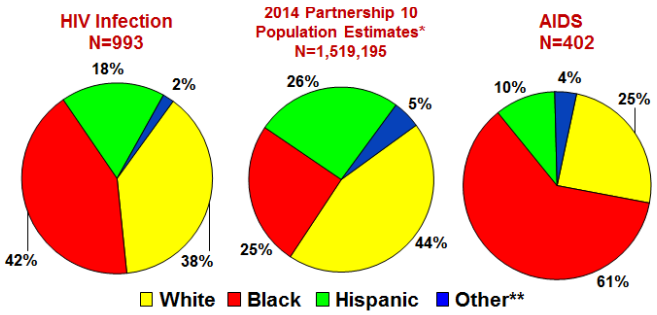


Source: Florida Department of Health HIV/AIDS Surveillance Program

Transgender: As FL-DOH does not collect data on the transgender population, this significantly impairs the EMA's ability to plan for the needs of PLWH transgender residents. Ryan White Part A does collect detailed data for transgender individuals through the client-level data system (PE), which indicated 52 transgender clients were served in 2014. Of the Part A transgender clients served in 2014, 98% were transgender male to female and 2% were transgender female to male.

Race and HIV: As previously stated, Broward County is a diverse geographic area, with shifts in demographics driven by immigration of foreign-born minorities, decreased White non-Hispanic birth rates, out-migration of White non-Hispanics, and increased White non-Hispanic death rates. The Hispanic population continues to grow more diverse, as new residents from Central and South America and the Caribbean immigrate to Broward. Less than one-half (48%) of adult Hispanic PLWH Broward residents were born in the United States (including 11% born in Puerto Rico). The remaining adult Hispanic PLWH residents were born in other countries. Haitians make up a growing portion of the Broward County population. The 2013 Census estimates that 63,343 Broward residents have Haitian ancestry and 53,000 speak Haitian Creole. Among the 7,455 Haitian-born PLWH Floridians reported through 2013, 23% resided in Broward. Residents born in Haiti and living in Broward represented 22% of Black non-Hispanic living AIDS cases and

Figure 5. Adult HIV Infection Cases, AIDS Cases and Population Data, by Race/ Ethnicity, Diagnosed in 2014

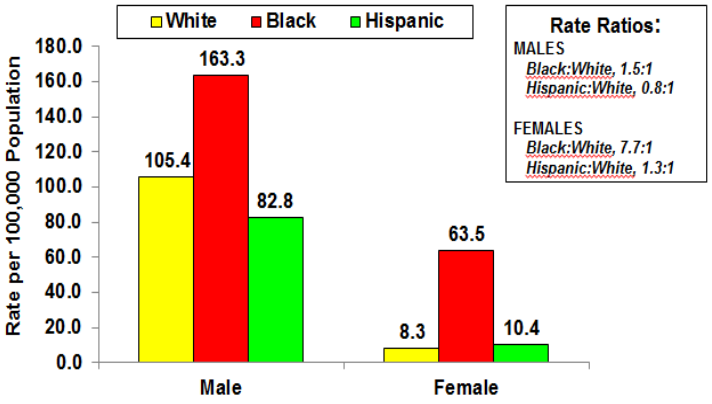


Source: Florida Department of Health HIV/AIDS Surveillance Program

17% of Black non-Hispanic living with HIV (not AIDS) cases through 2014. In this snapshot for 2014, Blacks are disproportionately impacted by HIV/AIDS to the extent that the percentage of cases exceeds the percentage of the population (see Figure 5). Blacks accounted for 42% of adult HIV cases and 61% of adult AIDS cases, respectively, but only 25% of the adult population. For the past ten years, blacks represented 42% or more of the cases each year.

Numerous disparities can affect the increases of HIV disease in a given population. Among black males, the HIV infection case rate is nearly 2 times higher than the rate among white males (Figure 6). Similarly, among black females, the HIV case rate is nearly 8 times higher than the rate among white females. Hispanic females have a HIV case rate that is slightly higher than the rate among white females. In contrast, Hispanic males have a slightly lower HIV case rate compared to the rate among white males.

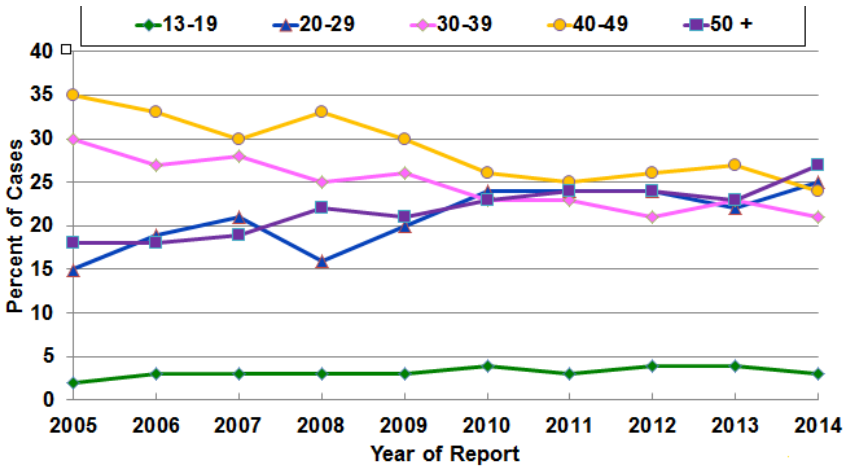
Figure 6. Adult HIV Infection Case Rates by Sex and Race/Ethnicity, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Age and HIV: Over the past ten years, the proportion of newly diagnosed adult HIV cases has shown an increase among the age group 20-29 by 10 percentage points. HIV infection trends show that adults 50 years or older are the fastest growing segment of the

Figure 7: Adult HIV Infection Cases, by Age Group at Diagnosis, and Year of Report, 2005-2014

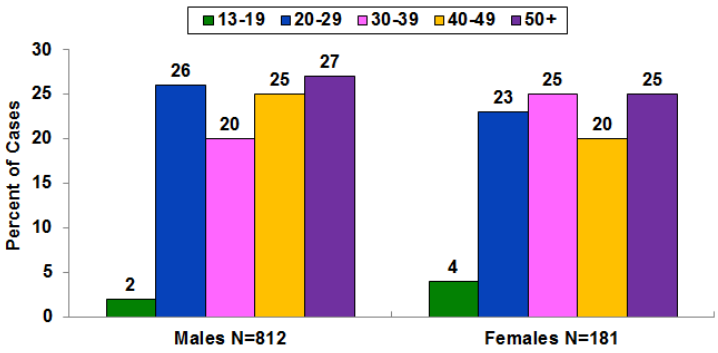


Source: Florida Department of Health HIV/AIDS Surveillance Program

Broward adult PLWH population. Aging of PLWH, in-migration of MSM, and Broward's popularity as a retirement community contribute to the rate of older PLWH as evidenced by a 9 percentage point increase from 2005 to 2014 among the '50 and over' age group. In contrast, the proportion of newly diagnosed adult HIV cases among those in the 30-39 and 40-49 age groups decreased by 9 and 11 percentage points respectively, over the same time period. The age group 13-19 remained relatively level during this time period with a 1 percentage point increase from 2005 to 2014 (Figure 7).

Sex and Age: With regard to the age groups and gender with the highest percent of HIV infection cases, recent estimates show that among males, 27% of HIV infection cases occur among those aged 50 or older, whereas among females, 25% of HIV infection cases occur among those aged 30-39 and 25% among those aged 50 or older (Figure 8).

Figure 8. Adult HIV Infection Cases, by Sex and Age Group at Diagnosis, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Socioeconomic Data: According to the U.S. Census Bureau, 2014 American Community Survey, the Broward County median household income was $51,608. The percent of families whose income was below the poverty level in the past 12 months was 11.3%. Almost one-fifth (18.8%) of Broward residents 18-24 years of age earned less than a High School diploma. Persons aged 25 and older that attained a High School diploma or higher was 88% and those who attained a Bachelor's degree or higher were 30.5%. Overall, 18% of Broward residents had no health insurance coverage in 2014; 10% of those were 18 years of age or younger and 24% of individuals were 18-64 years of age. The 2014 American Community Survey reports that 59.5% of Broward residents have private health insurance, 19.7% report having either Medicare or Medicaid, and 18% report being uninsured.

Table 1 provides Part A client-level PE data system information on the number of Part A clients who are: (1) enrolled in Medicaid, Medicare, Qualified Health Plans (QHP), or private insurance, (2) uninsured, and/or (3) at or below 138% and 400% of the FPL- the income tier of the population that would be addressed if Florida expanded Medicaid.

Table 1. Part A Clients Uninsured and Living in Poverty, 2014

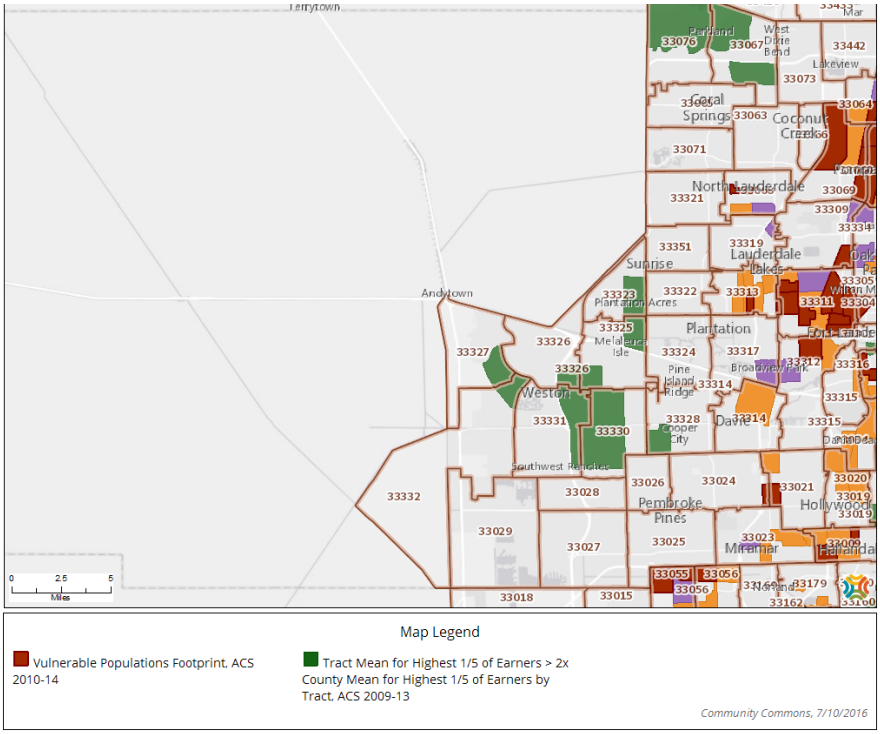
Medicaid		Medicare		QHP		Other Private Insurance		Uninsured		< 138% FPL		< 400% FPL	
#	%	#	%	#	%	#	%	#	%	#	%	#	%
999	12.5%	1,764	22.1%	771	9.7%	557	7.0%	3,879	48.7%	5,882	73.8%	7,945	99.7%

Homelessness: The number of individuals who are homeless in Broward County has grown significantly in Broward, contributed in part to insufficient affordable rental units, increased cost of living, and a sharp rise in the number of foreclosures. The Broward County Homeless Initiative Partnership surveyed residents in January 2015, and identified 2,624 individuals and families who were homeless, based on their residence in a place not meant for human habitation, emergency shelter, transitional housing, or temporary residence in an institution. An estimated 5% of the homeless were reported to be PLWH (137 respondents); 1% were in emergency housing; 3% were in a safe haven; 1% were unsheltered. Additionally, 16% were living in transitional housing.

The Part A client-level data system, PE, identified 1,675 PLWH Part A clients (23%) who were not permanently housed at some time in 2014. The 2014 consumer survey provided significant information on the Broward PLWH homeless population. Among respondents, 18% reported being homeless in the year. Black respondents reported the highest homeless rate (19%). Homeless respondents were significantly more likely than others were to be diagnosed within the past 10 years, to trade sex for something of value, and to be out of care at some point in the past six months. Only half of the respondents experiencing homelessness reported continuing to having a regular doctor, and 13% reported not receiving Outpatient Ambulatory Medical Care (OAMC) while homeless. They were less likely to be currently taking ART and less likely to be fully adherent if currently taking them.

There are two key social determinants of health-poverty and education-that have a significant impact on health outcomes. The map displayed in Figure 9 shows what is known as the "Vulnerable Footprint" of Broward County, based upon data from the United States Census Bureau, American Community Survey (2008-2012) and downloaded from www.communitycommons.org. This map identifies where high concentrations of population living in poverty and population living without a high school diploma overlap. These areas are also representative of the areas in which high concentrations of PLWH reside.

Figure 9. Broward County Vulnerable Footprint (the intersection of high poverty, lack of high school diploma, and low income)



Burden of HIV: According to the CDC 2014 HIV Surveillance Report, Florida ranked second among states in the number of HIV infection cases with 5,332 estimated cases reported. Broward County is part of the Miami-Fort Lauderdale-West Palm Beach, FL MSA which accounts for 47.5% of Florida's HIV infection cases. When examining the MSA by HIV infection case rate per 100,000 persons, Broward ranks second in the United States (44.7) just behind Miami (49.9), which ranks first. HIV prevention and service funds have not been equitably distributed to Broward. While the CDC, HIV/AIDS Bureau (HAB), and other federal agencies have targeted funds to address the Miami-Dade HIV epidemic, Broward's epidemic receives limited funding reflecting a lack of understanding of the impact of the HIV epidemic in Broward and the need for targeted funds to address prevention and care efforts. Broward's close proximity and juxtaposition between Miami and Palm Beach counties serves as a means for cross county social networking that can

increase this region's risk of HIV transmission. Broward's population of PLWH differs from the rest of the state, with a larger percentage of MSM living with HIV (56%) compared to the state of Florida (48%) (Table 2). This supports the need to have and evaluate targeted programs and interventions designed for the diverse gay and bisexual community of Broward County.

Table 2. Persons Living with HIV Infection by Selected Demographics and Risk Factors in Florida and Broward County, 2014

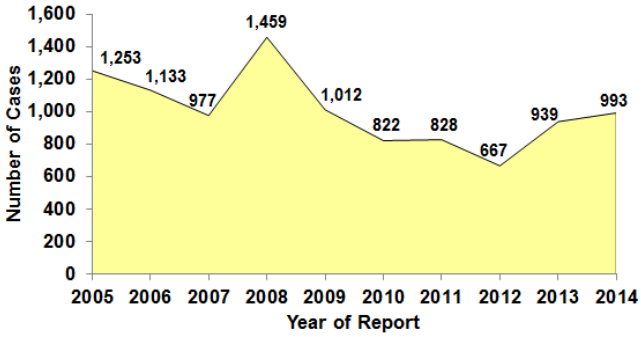
Subgroup	Florida (N=109,969)	Broward (N=19,391)
Male	72%	73%
Female	28%	27%
White	30%	35%
Black	47%	47%
Hispanic	21%	16%
Other	2%	2%
MSM	48%	56%
IDU	9%	9%
MSM/IDU	4%	3%
Heterosexual	37%	37%
Other	2%	1%
Age 0-24	4%	4%
Age 25-49	49%	48%
Age 50 and over	47%	49%

Source: Florida Department of Health HIV/AIDS Surveillance Program accessed: http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/partnership-slide-sets1.html

While Broward residents make up 9% of the Florida population, they represent 18% of Florida's PLWH. Due to Broward's uncontrolled HIV epidemic, at least one in every 97 Broward adults is a PLWH. The true magnitude of the epidemic may be even greater due to in-migration of PLWH individuals from other states and counties. These rates far exceed any other Florida EMA or Transitional Grant Area (TGA). According to the CDC, the Fort Lauderdale metropolitan division within the Miami-Fort Lauderdale-West Palm Beach MSA ranked third in the United States for population-adjusted AIDS cases in 2014 with a case rate of 19.0. Since 1995, the number of persons reported living with HIV/AIDS has increased over 460%. In 2014, the prevalence increased by 5% over the previous year with 17,828 adults living with HIV disease. Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in

newly reported cases of HIV infection in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of HIV infection in 2013. An additional 6% increase was observed in 201 4 compared to the previous year (Figure 10). This is higher than the 4% incline observed by the state during the same time period.

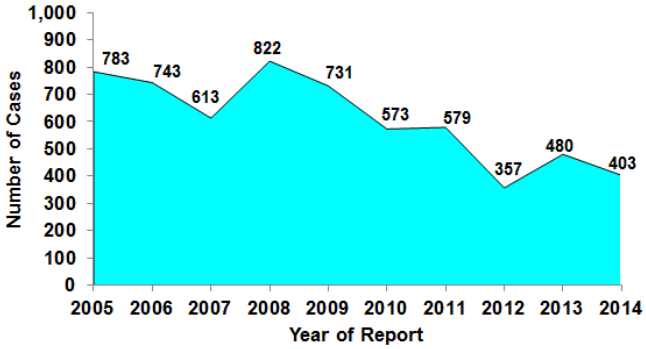
Figure 10. HIV Infection Cases and Rates, by Year of Diagnosis, 2005-2014



Year	Rate
05	71.8
06	64.9
07	56.1
08	83.9
09	58.2
10	47.0
11	47.2
12	38.0
13	52.6
14	55.3

Source: Florida Department of Health HIV/AIDS Surveillance Program

Figure 11. AIDS Infection Cases and Rates, by Year of Diagnosis, 2005-2014



Year	Rate
05	45.1
06	42.7
07	35.4
08	47.3
09	42.1
10	32.8
11	33.1
12	20.3
13	26.9
14	22.5

Source: Florida Department of Health HIV/AIDS Surveillance Program

As observed with HIV infection cases, ELR laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of AIDS in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of AIDS in 2013. AIDS cases in 2014 dropped by 16% from the previous year (Figure 11). This is lower than the 20% decline observed by the state during the same time period.

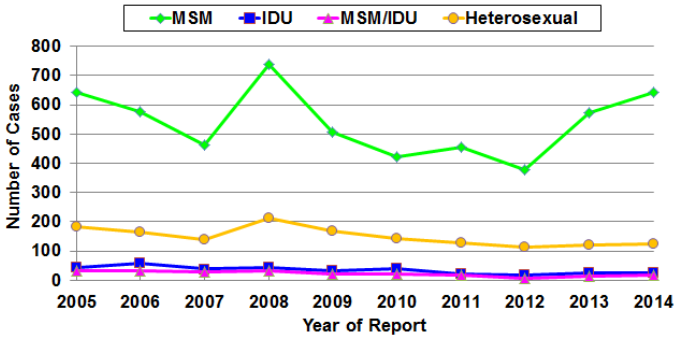
Indicators of Risk: FDOH provides DOH-Broward with annual surveillance slides for the county, which contains a list of priority populations specific to Broward. These populations are determined by a formula that takes into account rank of race/risk groups among all persons living with HIV disease in the enhanced HIV/AIDS Reporting System (eHARS) and race/risk groups among those newly reported with HIV in the county. The two ranks are weighted and combined resulting in the final list. Broward County's top 9 priority populations in 2014 for primary and secondary HIV prevention is listed below. This

list of priority populations guides the work that is designed and implemented through planning efforts.

1. White men who have sex with men (MSM)
2. Black heterosexual men and women
3. Black men who have sex with men
4. Hispanic men who have sex with men (MSM)
5. Black injection drug user (IDU)
6. Hispanic heterosexual men and women
7. White heterosexual men and women
8. White injection drug user (IDU)
9. Hispanic injection drug user (IDU)

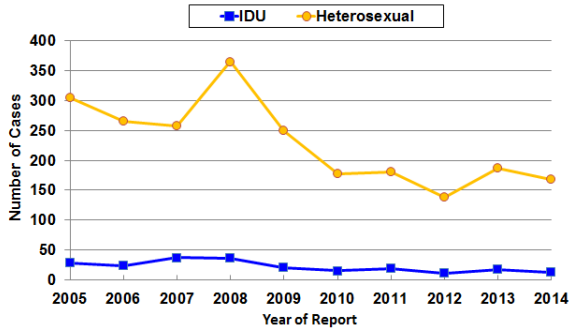
Over the past ten years, MSM remains the primary mode of exposure among male HIV infection cases. Over the years, the second highest mode of exposure for adult male HIV infection cases was heterosexual contact. From 2005 to 2014, IDU among adult male HIV infection declined by 47%. Similarly, the number of males infected by HIV by MSM/IDU decreased by 50% (Figure 12).

Figure 12: Adult Male HIV Infection Cases, by Mode of Exposure and Year of Report, 2005-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Figure 13: Adult Female HIV Infection Cases, by Exposure Category and Year of Report, 2005-2014

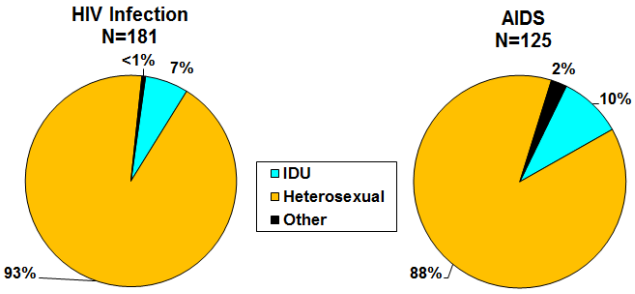


Source: Florida Department of Health HIV/AIDS Surveillance Program

Heterosexual contact has remained the primary mode of exposure among adult female HIV infection cases in Broward County over the past ten years. This trend is followed by injection drug use. The number of adult females infected with HIV by heterosexual contact decreased by 45% from 2005 to 2014. Similarly, the number of adult females infected with HIV by way of IDU decreased by 57% over the same time period (Figure 13).

Among the male HIV infection and AIDS cases reported for 2014, MSM was the most common risk factor (79% and 58%, respectively) followed by cases with a heterosexual risk (16% for HIV and 32% for AIDS) (Figure 14). MSM/IDU remains considerably lower than other modes of transmission for both HIV and AIDS cases. The recent increase among MSM is indicated by the higher MSM among HIV infection cases compared to AIDS cases, as HIV infection cases tend to represent a more recent picture of the epidemic. MSM represents the highest risk for all races. White adult males have the greatest proportion of MSM (90%) and the smallest proportion of heterosexual contact risk (3%). Black adult males have the highest proportion of heterosexual contact (44%). The second highest proportion of mode of exposure for black males was MSM (43%). MSM contact represents the highest proportion for Hispanic adult males (82%).

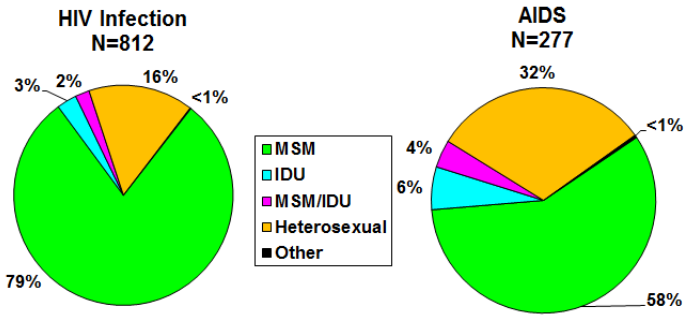
Figure 14. Adult Male HIV Infection and AIDS Cases by Mode of Exposure, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Among the adult female HIV infection and AIDS cases reported for 2014, heterosexual contact was the highest risk (93% and 88%, respectively) (Figure 15). This is compared to IDU, which was 7% and 10% of adult female HIV infection and AIDS cases, respectively. For adult females living with HIV by race/ethnicity in Broward County heterosexual contact is the majority risk for all races. Compared to other races, whites have the largest proportion of IDU risk (30%) for both males and females. Other modes of exposure are observed to be relatively lower than heterosexual contact.

Figure 15. Adult Female HIV Infection and AIDS Cases by Mode of Exposure, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Youth Risk Behavioral Surveillance System (YRBSS): The following displays a summary of indicators among 1,413 students in 29 public high schools surveyed in Broward County from 2009-2015 (Table 3). There was an overall decrease among all indicators with the exception of the percentage of students who experienced physical and sexual dating violence and those who used birth control to prevent pregnancy at last sexual encounter. Additional results from the 2015 Broward County High Schools Survey reveal that the among races/ethnicities, Blacks report the highest percentage of sexual contact with opposite sex only, sexual contact with same sex only, and sexual contact with both sexes. However, differences among Black males and Females exist: Black males have the highest percentage reporting ever having sexual contact (61.9%) while Black females have the highest percentage reporting never having sexual contact (51%). It appears that sexual initiation may occur earlier for young Black men compared to other youth, placing them at greater risk of acquiring HIV at earlier age.

Table 3. Youth Risk Behavioral Surveillance System (YRBSS) 2009-2015

Questions	2009	2011	2013	2015
Percentage of students who ever had sexual intercourse	52.2	48.8	41.4	39.9
Percentage of students who had sexual intercourse for the first time before age 13 years	9.2	8.3	5.9	5.3
Percentage of students who had sexual intercourse with four or more people during their life	19.8	16.8	12.4	10.6
Percentage of students who had sexual intercourse with one or more people during the past three months	38.4	33.6	28.2	27.6
Among the students who had sexual intercourse during the past three months, the percentage who drank alcohol or used drugs before last sexual intercourse	23.4	22.4	22.4	19.2
Among the students who had sexual intercourse during the past three months, the percentage who used a condom during the last sexual intercourse	70.6	71.2	70.0	61.5
Among students who had sexual intercourse during the past three months, the percentage who used birth control pills to prevent pregnancy before last sexual intercourse	9.9	7.9	13.3	13.8
Percentage of students who had ever been taught in school about AIDS or HIV infection	87.2	87.3	86.2	82.5
Percentage of students who have been physically forced to have sexual intercourse when they did not want to during the 12 months before the survey			5.4	6.1
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)			5.8	7.5
Percentage of students who experienced sexual dating violence (one or more times during the 12 months before the survey, including kissing, touching, or being physically forced to have sexual intercourse when they did not want to by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)			4.3	6.6

Source: Youth Risk Behavior Surveillance System accessed from http://www.cdc.gov/yrbss

Behavioral Risk Factor Surveillance System (BRFSS): The Florida Behavioral Risk Factor Surveillance System (BRFSS) has been collecting and reporting health behavior data since 1986. This statewide telephone survey is comprised of state-specific, population-based estimates of the prevalence of personal health and risk behaviors, selected medical conditions, and preventive health care practices among Florida adults. Table 4 displays estimates that 45.7 percent of adults have been tested for HIV in Broward County. Characteristics of persons reporting less frequent testing tend to be non-Hispanic White women, 65 years of age and older, those with less than a High School education, those with an annual income of $25,000 - $49,999, and persons who are married/coupled. The percent of adults who have ever been tested in Broward County will be monitored for increases due to Integrated Planning efforts.

Table 4. 2013 BRFSS Data for Broward County, Florida

2013 Florida BRFSS Data						Broward
HIV/AIDS Screening						
Percentage of adults who have ever been tested for HIV						
		2013 County		2013 State		
		Measure	95% CI	Measure	95% CI	
ALL	Overall	45.7	40.2 - 51.2	42.6	41.4 - 43.9	
SEX	Men	42.8	34.4 - 51.2	41.2	39.3 - 43.1	
	Women	48.4	41.2 - 55.6	43.9	42.2 - 45.6	
RACE/ETHNICITY	Non-Hisp. White	35.0	28.2 - 41.8	34.4	33.2 - 35.6	
	Non-Hisp. Black	69.1	56.6 - 81.6	65.8	62.1 - 69.5	
	Hispanic	41.6	29.0 - 54.2	48.7	44.9 - 52.5	
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	39.4	28.1 - 50.6	35.3	33.4 - 37.2	
	Non-Hisp. White Women	30.9	22.7 - 39.1	33.5	32.0 - 35.1	
	Non-Hisp. Black Men	64.0	42.6 - 85.5	62.0	55.9 - 68.0	
	Non-Hisp. Black Women	73.5	59.7 - 87.3	69.3	64.7 - 73.8	
	Hispanic Men	42.4	25.4 - 59.4	44.9	39.5 - 50.4	
	Hispanic Women	40.6	22.0 - 59.3	52.3	47.0 - 57.6	
AGE GROUP	18-44	58.0	48.2 - 67.9	56.9	54.7 - 59.2	
	45-64	44.9	36.2 - 53.7	42.7	40.6 - 44.8	
	65 & Older	19.5	12.5 - 26.4	15.9	14.3 - 17.6	
EDUCATION LEVEL	<High School	33.2	16.4 - 50.1	39.4	35.0 - 43.7	
	High School / GED	43.0	30.9 - 55.2	39.8	37.4 - 42.3	
	>High School	49.1	42.6 - 55.5	45.0	43.5 - 46.5	
ANNUAL INCOME	<$25,000	56.9	46.3 - 67.6	48.8	46.3 - 51.3	
	$25,000-$49,999	35.2	24.9 - 45.5	40.8	38.2 - 43.4	
	$50,000 or More	49.8	40.8 - 58.8	41.7	39.6 - 43.8	
MARITAL STATUS	Married/Couple	46.0	38.1 - 53.9	39.9	38.2 - 41.6	
	Not Married/Couple	46.2	38.3 - 54.0	46.1	44.1 - 48.1	

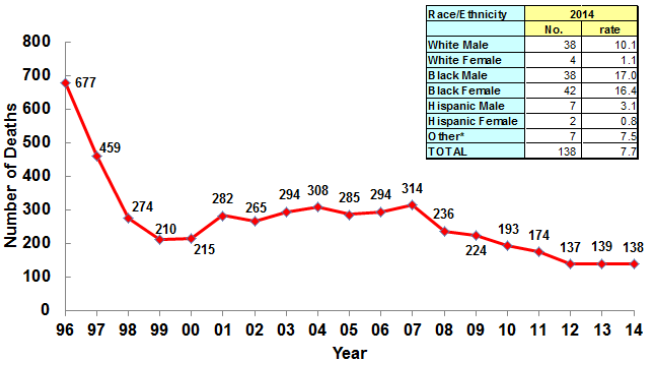
Source: http://www.floridahealth.gov/statistics-and-data/survey-data/behavioral-risk-factor-surveillance-system/reports/_documents/2013county/_documents/Broward.pdf

CI=Confidence Interval

Co-morbidity: In 2014, co-morbidity data captured in eHARS and Patient Reporting Investigating Surveillance System (PRISM) as of June 30th, 2015 shows that of the people living with HIV/AIDS in Broward County; zero (0) were diagnosed with Tuberculosis, 162 were diagnosed with Infectious Syphilis, 324 were diagnosed with Gonorrhea, 325 were diagnosed with Chlamydia, and 1,768 were living with HIV/AIDS and also with Hepatitis C (which includes history of acute and/or chronic viral Hepatitis C). Of the people living with HIV/AIDS in Broward County, data as of June 30th, 2015, 68 were identified as homeless, 2,532 have a history of substance abuse, and 1,003 have a history of chronic mental illness.

STD Surveillance Data: The reporting of communicable and sexually transmitted diseases (STDs) is important for the purpose of planning and evaluation of disease prevention and control programs, the assurance of appropriate medical therapy, and in the detection of common-source outbreaks. The rates of STDs have increased since 2001 in both Broward County and the state of Florida. Broward County's infectious syphilis and congenital syphilis rates are among the highest in the State. The average number of annual TB cases reported from Broward County is 65 (2004 – 2013), making Broward County the 2nd or 3rd highest incidence county in Florida from year to year.

Figure 16. Resident Deaths due to HIV Infection, by Year of Death, 1994-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

HIV-Related Deaths: The top five leading causes of death for residents of Broward County are heart disease, cancer, stroke, chronic lower respiratory disease, and unintentional injuries. According to the Florida Vital Statistics Annual Report 2014, HIV was the cause of death for 138 Broward County residents. Thirty (30) percent of the resident deaths due to HIV were among the age group 45-54, followed by 29% in the 55-64 age group. Due to increased use of ART and expanded virologic monitoring, the rate of Broward HIV/AIDS-related deaths has plateaued in recent years. HIV/AIDS accounted for approximately one percentage of all total deaths in 2014. Figure 16 shows an 80% decline in HIV resident deaths due to HIV disease from the peak

year of 1995. This is slightly higher than the 79% decline observed by the state. Since 2007, deaths have maintained a downward trend. Of the resident deaths due to HIV disease in 2014, black females accounted for 42 of those resident deaths. In 2014, the second highest racial/ethnic resident deaths due to HIV were among white males and black males both with 38, while the highest case rate of resident deaths due to HIV disease were among black males at 17.0.

HIV Counseling and Test Data: Table 5 provides an overview of Counseling and Testing data from registered testing sites in Broward County during 2014. Review of this data provides information on persons who access publicly funded testing services. The table shows the total number of tests conducted, the number of those testing negative (N) and those testing positive (P) and the positivity rate (P%). For sex, Transgender had the highest percent of positivity rates (7.5%) compared to males (1.13%) and females (0.36%). By race, the highest positivity rates were among American/Indian/Alaskan (2.23%) even though the largest majority of the tests were conducted among Blacks (54.6%). Sex with PLWH (5.91%) and MSM (2.42%) had the highest positivity percentage for reported risk factors. The age group with the highest positivity percentage were individuals 50 years and older. Of the 84,005 individuals that were tested for HIV in Broward County, 13,028 (16%) were first time HIV testers.

Table 5. 2014 Counseling & Testing Summary

Sex	N	P	Total	P%
Female	39247	140	39412	0.36
Male	43685	498	44265	1.13
Transgender	74	6	80	7.50
Missing Data	246	2	248	0.81
Grand Total	83252	646	84005	0.77

Race	N	P	Total	P%
Asian	788	7	797	0.88
Black	45461	344	45864	0.75
Hispanic	15136	138	15289	0.90
Amer Indian/Alaskan	219	5	224	2.23
Native Hawaiian/ Pac Isle	192	0	192	0.00
White	18844	135	19006	0.71
Mixed	697	7	705	0.99
Refused	504	0	505	0.00
Missing Data	1411	10	1423	0.70
Grand Total	83252	646	84005	0.77

Site Type	N	P	Total	P%
01-Anonymous	6	0	6	0.00
02-STD	0	0	0	0.00
03-Drug Treatment	481	1	483	0.21
04-Family Planning	2021	6	2027	0.30
05-Prenatal/OB	0	0	0	0.00
06-TB	194	1	195	0.51
07-Adult Health	982	7	990	0.71
08-Prison/Jails	4408	12	4430	0.27
09-College	0	0	0	0.00
10-Private/MD	24605	86	24710	0.35
11-Special Projects	5970	66	6050	1.09
12-CBO	41558	419	42034	1.00
13-CHD FieldVisit	3027	48	3080	1.56
Other-Missing	0	0	0	0.00
Grand Total	83252	646	84005	0.77

Risk	N	P	Total	P%
MSM/IDU	1588	22	1613	1.36
MSM	14174	353	14572	2.42
IDU	6256	11	6271	0.18
Sex with HIV	665	42	711	5.91
Sex with MSM	453	1	455	0.22
Sex with IDU	936	6	944	0.64
Sex with Other	268	3	271	1.11
Perinatal	8	0	8	0.00
STD Diagnosis	11849	56	11917	0.47
Sex for Drugs/Money	598	6	604	0.99
Sexual Assault	62	0	62	0.00
Heterosexual	43818	130	43978	0.30
Other Risk	1250	3	1256	0.24
No Identifiable Risk	642	2	644	0.31
Refused	227	1	229	0.44
Missing Data	458	10	470	2.13
Grand Total	83252	646	84005	0.77

Age Group	N	P	Total	P%
<2	4	0	4	0.00
2-4	6	0	6	0.00
5-12	20	0	20	0.00
13-19	7025	20	7053	0.28
20-29	33091	220	33346	0.66
30-39	19116	169	19308	0.88
40-49	12119	116	12257	0.95
50+	11705	120	11844	1.01
Missing Data	166	1	167	0.60
Grand Total	83252	646	84005	0.77

**Indeterminate and unconfirmed reactive rapid test results are not shown, but are included in the total tested.'

Source: Florida Department of Health Counseling and Testing Data Summary Report by Selected

Satisfaction Surveys: almost 400 surveys (in English and Spanish) were distributed and returned over a six month period in 2016. Of the surveys returned, over 60% were from individuals who were HIV+ and receiving Ryan White Part A services. An additional 12% identified as HIV+ but not receiving Ryan White Part A services. The youngest respondent was 18 years old and the oldest, 78. The average age of respondents was 50. Sixty-nine percent (69%) of respondents were born in the United States, and thirty-one percent (31%) were born in a country other than the United States. Of those born in a country other than the United States, the majority (34%) were born in Haiti, 41% were born in Central or South America, and 14% were born in Jamaica. Fifty-one percent (51%) of respondents identified as Black or African-American, 42% identified as White or Caucasian, 6% identified as Multi-Racial, and 1% identified as Asian. In terms of ethnicity, 81% identified as not Latino or Hispanic, while 19% identified as Latino or Hispanic. Most respondents (77%) indicated that English was the language they spoke most often, followed by Spanish (9%) and French Creole (9%).

In terms of residential status, of the 344 individuals who responded to this question, 50% (166) rent an apartment or home, 29% (98) own their apartment or home, 8% (26) are staying or living with family (on a permanent or temporary basis), 3% (10) are staying or living with friends (on a permanent or temporary basis), 2.4% (8) are living in transitional housing for homeless persons, and 2.1% (7) are living in a residential treatment center for substance abuse. Most respondents 91% (308) were not receiving Section 8 housing. Zip codes in which respondents lived corresponded to the prevalence map previously presented, with 23% of respondents residing in zip code 33311.

Regarding health insurance, 231 of the 342 individuals (68%) who answered this question indicated that they had health insurance, while 111 (32%) said they did not. Although only 231 individuals indicated they had health insurance, 258 replied to the question asking about type of health insurance. 109 (42%) said they had private insurance through their employer, 61 (24%) said they had Medicaid, 59 (23%) had Medicare, 26 (10%) had insurance through the Affordable Care Act Marketplace, 6 (2%) had private insurance through their partner or parent, and 7 (3%) did not know what type of insurance they had. 33 (13%) stated they had some “other” type of insurance.

Stigma Survey: Surveys were administered to 106 individuals in the community to gauge their condom use, knowledge of HIV prevention measures, and stigma related to HIV infection. The sample was evenly distributed between genders. The majority of respondents were 18-25 and born in the United States. Results showed that stigma continues to permeate the community.

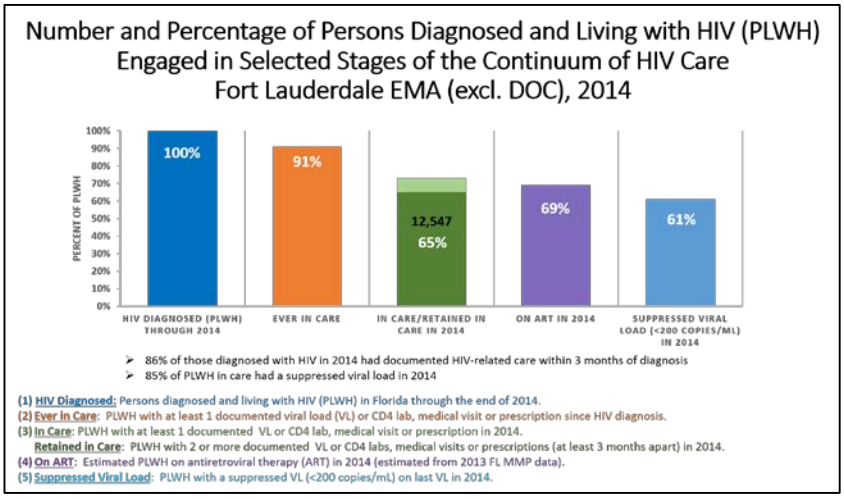
Considerations related to Epidemiology: Epidemiologic data for Broward County is provided by the State of Florida, and is not analyzed locally, therefore limiting the data presented in this section to that which is provided by the State Health Office. Information regarding HIV risk behaviors particular to Broward County is not included in this section as National HIV Behavioral Surveillance (NHBS) data is currently not collected specific to Broward County. Since 2008, Broward County was no longer an eligible NHBS site due to new funding criteria. Additional qualitative data is included in Section 1.D and limitations of data collection and analysis are further explained in Section I.E. The following are considerations when reviewing the above data:

- HIV Infection reporting represents newly Adult HIV Infection Cases, regardless of AIDS status at time of report, that were previously reported.
- AIDS cases and HIV infection cases by year of report are NOT mutually exclusive and CANNOT be added together.
- Frozen databases of year-end data are generated at the end of each calendar year. These are the same data used for Florida CHARTS and all grant-related data where annual data are included.
- HIV prevalence data are generated later in the year, usually in July, when most of the "expected" death data are complete.
- Adult cases represent ages 13 and older, pediatric cases are those under age 13. For data by year, the age is age of diagnosis. For living data, the age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.
- Unless otherwise noted, whites are non-Hispanic and blacks are non-Hispanic.
- Unless otherwise noted, area and county data exclude any Department of Corrections cases.

B. HIV Care Continuum

An examination of the HIV Care Continuum model is vitally important in the identification of issues and opportunities related to the improvement of service delivery to PLWH across the entire HIV Continuum of Care and the subsequent prioritization of program activities. Shared outcome measures are based upon the continuum of care that provide population percentages for individuals who are aware of their HIV positive status, linkage to care, retention in care, on ART and virally suppressed. The continuum of care is a shared set of measurements that fall under the responsibility of both Prevention and Care and Treatment. The targets for these indicators are set forth by NHAS 2020: 1) Increase the proportion of newly diagnosed patients linked to medical care to 85 percent; 2) Increase the proportion of PLWH who are in continuous care to 90 percent; and 3) Increase the proportion of virally suppressed to 80 percent. Broward County has developed a diagnosed-based approach to the HIV care continuum which depicts each step of the continuum as a percentage of the number of people living with diagnosed HIV as of the end of 2014. The diagnosed-based continuum informs steps that can be taken to help individuals with HIV access care and get them to viral suppression. This approach also gives more detailed information regarding persons who are diagnosed with HIV. The prevalence-based HIV Care Continuum shows each step of the continuum as a percentage of the total number of PLWH. Broward County is currently developing a prevalence–based continuum that includes the number of people who have been diagnosed with HIV *and* the estimated number of those who have not been diagnosed with HIV. The most difficult undertaking in the development of the prevalence-based continuum is the estimation of the size of the undiagnosed population. Broward will continue its efforts by conducting surveys of populations at high-risk and by obtaining data on HIV testing trends and percent positive by population subgroups over time. This approach will help determine whether people unaware of their HIV status are getting tested and to evaluate if the number of never tested individuals is decreasing.

Figure 17. Diagnosed-Based Continuum of HIV Care, Fort Lauderdale EMA, 2014



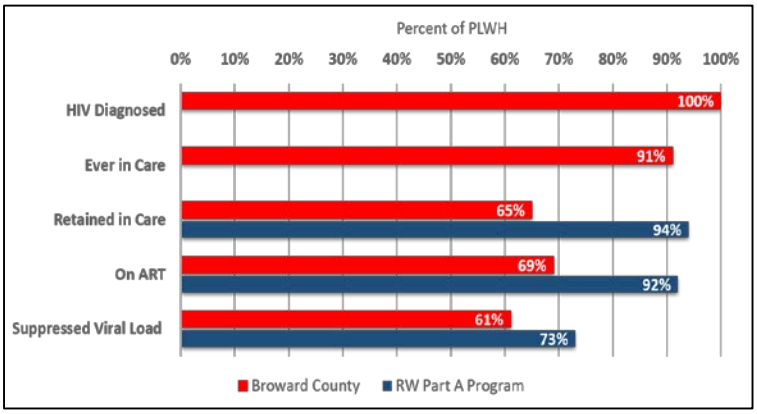
The diagnosed-based HIV care continuum shows each step of the continuum as a percentage of the number of people living with diagnosed HIV as of the end of 2014. Figure 17 depicts the Continuum and illustrates the rate of HIV+ Broward residents engaged at each Continuum stage: linked to OAMC, retained in care, prescribed ART, and virally suppressed. The data reflects CY 2014 for HIV+ individuals presumed alive and living in Broward. The sources include eHARS, CAREWare, AIDS Drugs Assistance Program (ADAP), and estimates based on 2013 data from the Florida Medical Monitoring Project (MMP). The analysis is impacted by: 1) completeness of eHARS lab reports; 2) maintaining timely death reporting; and 3) maintaining accurate current addresses to account for in and out-migration.

In a 2014 CDC Dear Colleague letter, all state and local health departments were encouraged to use HIV case surveillance data to improve the continuum of care in their communities, including the use of individual-level data to offer linkage and re-engagement to care services when appropriate. This data-to-care strategy was introduced as a resource to assist programs in moving forward with these activities. FDOH made significant strides to address data issues at the State and County levels. Efforts will be continued to improve the completeness of reporting. The diagnosed, linked to OAMC, retained in OAMC, and virally suppressed stages of the Continuum reflect eHARS data, including CAREWare and ADAP matching. Data for the prescribed ART stage was estimated from 2013 FL MMP data. FDOH could not generate County level data for the prescribed ART stage. Thus, FDOH applies the statewide estimated prescribed ART rate to Broward. In the coming years, FDOH will consider use of electronic health records (EHRs) to supplement eHARS for a more accurate estimate for the State and counties.

Locally, DOH-Broward collects and reports to FDOH the number of Broward HIV+ residents diagnosed and linked to OAMC. The results are then disseminated to the Broward Part A Recipient, who routinely monitors the accuracy of data collection efforts.

Part A-funded clients have higher rates in the Continuum stages than other Broward HIV+ residents (as shown in Figure 18). This data is included to provide a comparison of the health outcomes of Broward's Part A clients to all HIV+ Broward residents. The Part A data reflect the care status for RWHAP Part A clients served in FY 2014. PE collects data on the last three stages of the Continuum including the number of clients who are in care, prescribed ART, and virally suppressed. PE data completeness depends on accurate reporting from Part A sub-recipients who are contractually required to report client-level PE data. As part of the integration, proposed plans are being developed to further enhance the use of data by implementing data-to-care activities that utilize eHARS in addition to improving data sharing within the PE database to identify and track clients as they move along the Continuum. Figure 18 illustrates how Part A data were superimposed over the last three indicators in Figure 17 to provide a comparison of the health outcomes of Broward's Part A clients to all HIV+ Broward residents. Note, however, these populations are limited to those HIV+ individuals with information collected in PE, the Ryan White Part A database. The PE data system and usage is further explained in Section I.E. The comparison of continuum measures provides evidence for the effectiveness of the Ryan White program in improving outcomes for those living with HIV. The targets set forth will also assist in measuring success of the combinations of activities selected to be implemented in Broward County within the Integrated Plan in Section II.

Figure 18. Diagnosed-based HIV Continuum of Care, Fort Lauderdale EMA, 2014



Definitions of the numerators and denominators used to compute each Continuum stage are explained below:

- Diagnosed: Stage 1 of the Continuum shows the rate of Broward HIV+ residents diagnosed and living with HIV disease through 2014, regardless of AIDS status or where diagnosed. A total of 19,391 HIV+ individuals were known to be diagnosed and living in Broward through 2014, regardless of where they were diagnosed. FDOH provided these data, which are current as of June 30, 2015.
- Ever in Care: Stage 2 of the Continuum shows the rate of Broward residents through 2014 (n=17,731) with at least 1 documented VL or CD4 lab, medical visit or prescription since HIV diagnosis.
- Retained in Care/In Care: The Stage 3 numerator (Retained in Care) (n=12,547) is the number of HIV+ persons with two or more OAMC visits, or VL or CD4 tests at least three months apart in 2014. The denominator is the number of Broward HIV+ cases diagnosed through 2014 (n=19,391). The rate of Ryan White Part A clients in care (shown in Figure 18) was calculated by dividing the number of clients with at least one documented OAMC visit, VL, or CD4 test (7,523) by the total number of clients served in FY2014 (n=8,018).
- Prescribed ART: The Stage 4 numerator (Prescribed ART) (n=13,304) is based on MMP data that estimates the number of HIV+ Florida residents diagnosed in 2014 and prescribed ART. The denominator is the number of Broward HIV+ cases diagnosed through 2014 (n=19,391). The rate of Part A clients prescribed ART (shown in Figure 18) was calculated by dividing the number of clients with a documented OAMC visit and on ART (n=5,848), by the total clients with a documented OAMC visit in FY 2014 (n=6,355).
- Virally Suppressed: The Stage 5 numerator (Virally Suppressed) (n=11,872) is the number of HIV+ individuals whose most recent VL test in 2014 is < 200 copies/mL. The denominator is the number of HIV+ Broward cases diagnosed through 2014 (n=19,391). The rate of Part A clients who are virally suppressed (shown in Figure 18) was calculated by dividing the number of clients with a documented OAMC visit and a suppressed VL < 200 copies/mL (n=4,661) by the total clients with a documented OAMC visit in FY2014 (n=6,355).

Data Limitations

- An estimate of 4,000 out-of-state cases who were in care in Florida through 2012 were not yet entered into eHARS at the time of these analyses, therefore the data were adjusted accordingly to account for the un-reported cases.
- Laboratory data may not be complete; therefore the percent in care this year were adjusted to accommodate the estimated number of missing data.
- MMP data were used to estimate those on ART and those with a suppressed viral load. Estimates were not available below the state level, therefore the statewide estimates were applied to each of the local areas. Eventually, a process may be in place to link the patient care databases with eHARS to get a more accurate estimate by area.

Disparities in Engagement among Key Populations: While significant success was achieved in integrating the Continuum into the Part A planning and implementation process, Broward has experienced one of the most intractable HIV epidemics in the US. Broward's long standing ranking in HIV incidence and prevalence among MSAs underscores the major challenges encountered. Due to clients' changing needs, the Continuum was expanded to the extent to which Federal, State, local, and third party insurance funds are available. *Systems remain in Broward to facilitate linkage and engagement of newly infected, underserved, hard-to-reach, and emerging populations. While services target disproportionately impacted racial/ethnic minorities, these systems are highly stressed due to sharply increased demand for services and decreased funds.*

Broward addresses disparities in access to HIV screening and linkage services among target and other groups by promoting expanded HIV screening and adoption of rapid HIV testing in communities where targeted and other groups reside. Timely epidemiologic data will continue to be used by DOH-Broward and other HIV screening programs to identify those groups. The Integrated Plan will ensure that culturally and linguistically appropriate HIV screening is available to diverse populations based on race/ethnicity, gender, sexual orientation, age, HIV behavioral risk factors, and immigration status. The cultural norms and concerns about HIV stigma and disclosure will be considered, for

example, in the placement of HIV mobile testing units in neighborhoods hardest hit by the HIV epidemic. HIV screening programs will routinely meet to share their experiences in optimizing the location of mobile testing units or incorporating HIV screening in community health screening events to address concerns about HIV disclosure.

The DOH-Broward Prevention Program will continue to lead efforts in identifying HIV+ unaware individuals by promoting HIV screening in community and healthcare settings. This responsibility will continue to be shared by Broward Health, Broward's only Part C Recipient, which will use available Part C Early Intervention Services (EIS) funds for HIV screening in their system and to supplement FDOH HIV screening funds. CDC funds will continue to be used by DOH-Broward to conduct the Broward>AIDS Initiative, a comprehensive community education, prevention, and media campaign targeting high-risk populations. The campaign will maintain its focus on health promotion and wellness, with messaging centered on Broward>AIDS and other evidence-based population-focused campaigns designed to change community norms. In Fiscal Year (FY) 2015, the DOH-Broward collaborated with Part A to expand the media campaign to address linkage and retention in care. Part A launched the "Get Care Broward. Treat HIV. Beat HIV." media campaign to promote increased linkage to care for HIV+ individuals. DOH-Broward has identified 10 diverse physician ambassadors to implement this campaign in private healthcare settings. DOH-Broward will continue to deploy its mobile HIV, Sexually Transmitted Infections (STI), and Hepatitis C Virus (HCV) testing unit to non-traditional sites to the extent that funds are available. Community-Based Organizations (CBO) mobile testing units will continue to be deployed throughout Broward. FDOH will maintain funding for HIV awareness, outreach, screening, linkage, and prevention interventions in Federally Qualified Health Centers (FQHCs), Emergency Departments (EDs), and CBOs. FDOH will also continue to fund agencies based on their expertise in HIV screening and linkage with the priority populations addressed by the Integrated Plan. Agencies must demonstrate the ability to implement services in a timely manner, test large numbers of individuals, identify individuals unaware of their HIV+ status, link HIV+ persons to OAMC, and participate in data collection, Quality Management (QM), and evaluation.

Key stakeholders in Broward have determined that it is critical to increase viral suppression among all HIV+ residents, particularly among groups with the greatest

burden of disease including young adults, Black non-Hispanic men and women, MSM, homeless, and transgender individuals. Efforts to decrease community VL depends on coordinated efforts across funders to maximize available resources and access to services. Data sharing among funders presents a challenge to ensuring clients' needs are addressed consistently across the Continuum. With many clients receiving services from various funders, data sharing is critical in providing clients' complete and efficient services. Limited data sharing by FDOH, for example, compromises Broward's ability to be fully informed. DOH-Broward is required to collect and report data to FDOH. These data are analyzed and redistributed by FDOH at a later time, impairing availability of meaningful data for efficient and timely decision-making. Broward is addressing this challenge via Data Use Agreements with Housing Opportunities for People with AIDS (HOPWA), integrating PE with the DOH-Broward prevention programs, and ongoing data sharing with all other RWHAP recipients.

The Broward Continuum is consistent with increasing access to services and decreasing HIV health disparities among disproportionately impacted sub-populations and historically under-served communities.

HIV Care Continuum Used in Planning, Prioritizing, and Targeting Resources: The Continuum framework helps to plan, prioritize, target, and monitor available resources in response to the needs of HIV+ Broward residents and improving engagement at each Continuum stage. The Continuum framework allows Broward to measure progress and to direct HIV resources most effectively. Broward has successfully supported PLWH as they move across the Continuum stages. It has become increasingly important for Care and Treatment and CDC-funded prevention providers to align effectively their prevention and care activities to maximize their impact. Integration of prevention and care offers new potential to increase significantly the number of Broward HIV+ residents linked, engaged, or re-engaged in OAMC. The recent introduction of the Continuum model and the increasing intersection of HIV primary and secondary prevention, care, and treatment have prompted Broward stakeholders to consider new HIV service strategies in recent years.

HIV+ Broward residents access the Continuum through many entry points. Most Broward HIV screening activities are funded by the CDC, Part C EIS, and health insurers.

To address this need, Broward uses CDC-funded and Part C EIS to support anonymous and confidential testing at DOH-Broward's Counseling and Testing Sites (CTS). Broward's EIS activities support the Continuum's diagnosis and linkage stages for newly identified HIV+ residents. Part A funded Client Intake and Eligibility Determination (CIED) coordinates with EIS funders in Broward to ensure timely linkage to OAMC within 48 hours via Memoranda of Understanding (MOUs) and co-location of service sites, Part A-funded CIED and prevention providers have collaborated to close the gap between diagnosis and linkage to OAMC. Part A has established protocols and implemented strategies through CIED to assist clients to be retained in OAMC. CIED conducts eligibility certification and recertification every six months using PE to ensure clients are engaged in OAMC. A PE scheduling system alerts CIED staff when clients are out of care, and facilitates rapid re-engagement in OAMC through appointment making. Part A requires that all sub-recipients use PE to monitor retention in OAMC. This approach allows sub-recipients to query PE and receive alerts on their clients' kept or missed OAMC visits. PE also alerts sub-recipients when a client has not had an OAMC appointment in the last six months. Currently, numerous databases are used to collect data on HIV positive individuals. These databases are fragmented and lack integration, preventing a comprehensive and complete surveillance system. HIV CTS data is collected locally and then sent to FDOH for aggregate data analysis. This process prolongs the time to produce local data reports and utilize the local client-level data. Integrated data systems are critical in promoting effective linkage of newly identified HIV+ individuals to ensure linkage to OAMC. The Part A and DOH-Broward CTS staff plan to integrate HIV CTS data in PE. Accurate data needed to calculate the rates of Continuum stages cannot be achieved until integration of these databases are complete.

A significant drop-off in transition occurs between linkage and retention in OAMC. This drop-off between Continuum stages points to the need to improve the rate of HIV+ Broward residents retained in OAMC. In 2014, there were 993 reported HIV infection cases with 86% linked to care. Even with high linkage rates, only 65% of the estimated 19,391 individuals living with HIV are currently retained in care and 61% are virally suppressed. There is a need to increase outcomes along the Continuum of Care for Individuals living with HIV in Broward County. To further this effort, DOH-Broward has

developed PROACT (Participate, Observe, Adhere, Communicate and Teamwork), a linkage, retention, re-engagement, and adherence program. PROACT is a public health initiative designed to support the community-based provision of HIV primary care services in Broward County through the delivery of high-intensity interventions (which include linkage to care at 1st visit), as well as to promote retention in care and adherence to ART for all Broward County residents living with HIV. Newly and previously diagnosed HIV positive individuals referred to PROACT have a 95% and 96% (respectively) linkage rate within 90 days, which is higher than the overall county rate of 86%. In order to accomplish this a PROACT Database has been created in addition to the regular monitoring of monthly program performance through DOH-Broward's Internal Review System, Active Strategy Enterprise. HIV DIS also have access to the PE database and are able to get reports of PLWH in the Part A system that are not in care. This allows for accurate data on information for retention in care reporting. PROACT referrals come from DOH-Broward contracted providers, FQHCs, CBOs, HIV care providers and the local Ryan White Part A program. PROACT staff aim to contact clients referred within 2 days of referral and keep a database on client dispositions. As of July 2016, PROACT HIV Disease Intervention Specialist (DIS) staff have successfully contacted 1,355 referred clients and facilitated their linkage to care.

Part A CIED conducts Part A eligibility screening, insurance eligibility screening, enrollment assistance, linkage services, and referral to OAMC and other services. As part of the Integration of Prevention, Care and Treatment in Broward County, proposed plans are being developed to enhance the program by implementing data-to-care activities that utilize eHARS in addition to the existing database and expanding the use of the PE system to identify clients in need of being re-engaged in care and monitoring viral suppression. For several years, PROACT staff have been essential in facilitating HIV screening and transitioning PLWH to Part A CIED for rapid RWHAP eligibility and linkage to OAMC. PROACT staff will also assist PLWH to schedule their CIED and OAMC appointments and accompany them if requested.

To reinforce collaborative efforts, PROACT also intersects with DOH-Broward's Perinatal Program, where pregnant women who are HIV positive are identified, tracked and provided Intensive Case Management. This service consists of the following: 1)

comprehensive HIV education; 2) linkage to care, retention and monitoring and 3.) ART adherence counseling and support. In 2014, 68% of the female HIV cases were women were of childbearing age (13-49). New HIV cases among Black women were more than 14 times higher than among non-Hispanic White women in Broward. In 2015, there were 22,205 births among women aged 13–49 and 128 known HIV positive pregnant women. Of these pregnant women, 104 (81%) were Black, 14 (11%) were White and 10 (8%) were Hispanic. Since the Perinatal Program's inception in July 2013, the perinatal program has been able to keep perinatal transmission to as close to zero as possible as shown in Table 6.

Table 6. Number of Perinatal Transmission Cases in Broward County by Year

Year	Number of Perinatal Transmission cases
2013	0
2014	0
2015	1
2016	0 as of 9/1/2016

Another drop-off exists between the Continuum ART coverage and viral suppression stages. This drop-off is addressed by emphasizing the importance of adherence and viral suppression. Broward County Ryan White Part A funded services are designed to fill service gaps and ensure accessibility along the stages of the Continuum. The HIVPC examines the rate of PLWH engaged at each Continuum stage to identify barriers in linking them to sustained, high quality care and to implement improvements to support individuals transitioning through the Continuum. The HIVPC understands and seeks to address through the Priority Setting and Resource Allocation (PSRA) process, factors contributing to drop-off between Continuum stages, including disparities associated with subpopulations. The Recipient and HIVPC consider the services supported by other funders to avoid duplicated services and ensure seamless transition along the Continuum. Part A covers services that engage individuals along the Continuum from linkage onward, including core medical and support services. Part A monitors available resources in response to the needs of HIV+ Broward residents to improve engagement at each Continuum stage.

Services such as Oral Health Care (OHC), substance abuse and mental health

treatment, and home health services are supported by these funders. Several funders support mental health and substance abuse treatment that promotes OAMC retention. The Florida Department of Children and Families (FL-DCF) funds a mental health and substance abuse system serving all eligible indigent Broward residents. Due to inadequate funding, Part A funds are used only for HIV+ Broward residents with severe mental illness and addictions for which rapid entry in care is critical. For example, Part A substance abuse and mental health services complement FL-DCF funded services to ensure that HIV+ Broward residents receive mental health and substance abuse treatment and adhere to medical regimens. Part B and the Medicaid Project AIDS Care (PAC) Waiver Program support home health. Hospice services at three licensed facilities provide nursing, physician, social work, and pastoral services to terminally ill patients. Hospices also provide nutritional and bereavement counseling for terminally ill patients and their families. In addition to core services, many other social support services are offered in Broward to support the goals of the NHAS including linkage to and retention in OAMC, access to ART, and viral suppression. Parts A and B fund support services including emergency food bank, home-delivered meals, legal, medical transportation, and non-medical case management (non-MCM). These services are designed to promote engagement and retention in OAMC. Federal, State, and local funds support these and other services to enhance Broward's high quality Continuum. Part A medical case management (MCM) and non-MCM assist clients to engage in OAMC, adhere to ART, and address barriers that impede adherence to OAMC appointments. MCM and non-MCMs advocate on behalf of their clients, counsel patients on effective ways to navigate the healthcare and entitlements systems, and link clients to other services to achieve viral suppression. MCMs and CIED intake specialists follow-up on client referrals and eligibility recertification, which helps to engage and retain clients in OAMC.

Broward County also collaborates with key funders and other stakeholders to identify HIV+ residents, link them to OAMC, initiate and sustain ART, and retain them in OAMC. Broward also considers the Continuum in the Part A PSRA process. Part A and DOH-Broward collaborate to implement the Continuum and improve engagement at each stage and have taken considerable efforts to plan and integrate Broward's HIV prevention and care services.

Improving Engagement and Outcomes along the Continuum: Despite the challenges, Broward has successfully supported PLWH as they move across the Continuum stages. Broward understands the importance of supporting effective interventions for each stage of the Continuum and of assessing related data to improve quality of care and health outcomes. Broward is committed to working with consumer, clinical, public health, and community partners to improve performance, ensure data quality, and monitor outcomes across the Continuum so that HIV+ residents are linked, engaged in OAMC, and initiate ART as early as possible. Services along the Continuum expanded based on the availability of federal, state, local, and health insurance resources to meet evolving needs. Highly developed, integrated systems operate in Broward to promote linkage and engagement of newly infected, underserved, hard-to-reach, and emerging populations including disproportionately impacted racial/ethnic minorities. Despite expansion, the Continuum is overburdened due to increased demand and decreased per capita funding.

The Part A Recipient has led Florida's Part A recipients in creating a renewed focus on insurance reimbursement and eliminating duplicated funding. All Florida Part A recipients work with Florida ADAP to avoid duplicative funding. Access to health insurance assistance promotes linkage and retention in OAMC, and ensures access to ART. Parts A and B fund the Health Insurance Continuation Program (HICP) to purchase insurance premiums, co-payments, and deductibles for clients enrolled in Qualified Health Plans (QHP) through the Affordable Care Act (ACA) Marketplace. Both Parts A and B assist clients to enroll in insurance plans that cover ARTs. Part A clients not enrolled in QHPs predominantly receive access to ART through ADAP. Clients ineligible for ADAP receive access to ART and other medications through Local AIDS Pharmaceutical Assistance Program (LPAP). The Part A LPAP and Part B ADAP offer adherence counseling that encourages collaboration between patients and their clinicians. Nationally, the CDC estimates that 37% of HIV+ Americans who received OAMC in 2011 were prescribed ART. In contrast, 69% of Broward HIV+ residents receiving OAMC were prescribed ART in CY 2015, compared to 92% of Part A clients receiving OAMC, reflecting the benefit of having health insurance.

Broward has identified several gaps, barriers, and unique challenges while developing

and applying the Continuum model. Part A addresses these issues through collaborations with community stakeholders and the implementation of a high quality Continuum. Most HIV screening activities undertaken in Broward are through CDC funding, Part C EIS, and health insurance payments. Through MOUs and co-location of service sites, Part A-funded CIED and prevention collaborate to address the gap between diagnosis and linkage. The prevention recipient facilitates HIV testing and CIED assists with rapid linkage to care. An important component of addressing this gap is the integration of data systems to track newly tested HIV+ individuals to ensure their engagement in OAMC. The Part A Recipient and DOH-Broward CTS staff are working towards the integration of HIV CTS data into PE. Until the data systems are integrated, this presents a unique challenge to accurate data collection about the Continuum.

Examining outcomes across the continuum is necessary to be able to evaluate program effectiveness and monitor program utilization. Moving forward with evaluation, Broward will began to utilize a prevention care continuum, similar to the care and treatment continuum but building on HIV testing as the foundation of linking “high-risk” negative individuals to prevention, retention, and adherence to services, helping with the prevention of HIV acquisition and transmission. This is necessary in framing a comprehensive responsive to HIV in Broward and in measuring the performance of HIV prevention program services. Next steps regarding improvements along the care continuum will be to create several additional continuums that reveal more specific information such as 1) HIV Incidence continuum which would exclude retention in care measures; 2) HIV Prevalence continuum which would exclude linkage to care measures; 3) HIV Prevention continuum for ‘high risk’ negative individuals; and 4) Ryan White funded services only continuum. Common definitions for each continuum measure will also be developed between both Prevention, Care and Treatment and a local monitoring and evaluation report will be produced outlining Prevention, Care and treatment progress towards the goals of the NHAS.

C. Financial and Human Resources Inventory

Broward County Florida has an extensive inventory of financial and human resources dedicated to supporting HIV/AIDS services. The financial resources include comprehensive funding for the Ryan White Part A, B, C, D and F Programs in addition to funding provided by the CDC under FOA PS12-1201 High Impact Prevention and FOA PS13-1308 awarded to Broward County Public Schools for promoting adolescent health through School based HIV/STD Prevention and School based Surveillance. Funding for HIV/AIDS services is also provided through the Substance Abuse and Mental Health Services Administration (SAMHSA), HOPWA, the Veterans Health Administration (VA) and the Florida Medicaid Program.

In this section each funding component is described for the jurisdiction. It is important to note that while the funding sources may appear distinct and separate from each other, all funding sources enhance and complement one another to ensure integration of prevention and care and treatment services.

HRSA funds Ryan White Part A, B, C, D and F services. The Broward County Board of County Commissioners receives funds for Ryan White Part A Services. These services provide core medical and support services for eligible PLWH which includes Outpatient and Ambulatory Medical Care (OAMC), Local AIDS Pharmaceutical Assistance Program (LPAP), Oral Health Services, Health Insurance Premium and Cost Sharing Assistance, Mental Health Services, Outpatient Substance Abuse Treatment Services, Medical Case Management–Disease Management, Case Management (Non-Medical), Centralized Intake and Eligibility Determination (CIED), Emergency Financial Assistance (EFA), Food Services, Legal Services and Outreach Services. For a list of commonly used acronyms, please see Attachment 1 and for a definition of these services please refer to the Integrated Lexicon of Terms in Attachment 2.

Care and treatment services are provided by DOH-Broward through the Ryan White Part A and Part B funded programs. These services include HIV/AIDS medications through ADAP, health insurance premium cost sharing assistance, home and community based-health services (home health services and durable medical equipment), outpatient substance abuse services, food bank and home delivered meals, medical transportation (bus passes) and treatment adherence counseling.

Part C provides funding to local community-based organizations to promote outpatient ambulatory health service and support services through EIS. The Part C EIS funds comprehensive primary health care in outpatient settings for people living with HIV. Part C providers are organizations seeking to enhance their response to the HIV epidemic in their area through the provision of comprehensive primary HIV medical care and support services. Broward Health, a local hospital district, receives funding for Part C services.

Part D providers render outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children, and youth living with HIV. Part D providers are local, CBOs seeking to enhance their response to the HIV epidemic in their area through the provision of family-centered primary medical care and support services to women, infants, children, and youth living with HIV when payments for such services are unavailable from other sources. The Children's Diagnostic & Treatment Center (CDTC) receives funding for Part D Services in Broward County.

Part F funds the Community-Based Dental Partnership Program to increase access to oral health care services for people living with HIV while providing education and clinical training for dental care providers, especially those practicing in community-based settings. Nova Southeastern University provides Part F services in Broward County.

The CDC funds FOA PS12-1201 High Impact Prevention (HIP) which is an approach to reducing HIV infections in the United States. DOH-Broward County receives funds through the State of Florida for HIP activities. The five components of HIP are: 1) effectiveness and cost; 2) feasibility of full-scale implementation; 3) coverage in the target populations; 4) interaction; and 5) targeting and prioritization. HIP activities include HIV testing, condom distribution, prevention for positives, policy initiatives, social marketing media and mobilization and evidence-based interventions for high risk negatives.

The CDC FOA PS13-1308 was awarded to Broward County Public Schools for promoting adolescent health through school-based HIV/STD Prevention and school-based surveillance. The purpose of this funding is to build the capacity of school districts and individual schools to effectively contribute to the reduction of HIV infection and other STDs among adolescents, reduce disparities in HIV infection and other STDs experienced by specific adolescent sub-populations and conducting school-based surveillance through the YRBS and School Health Profiles implementation.

SAMHSA funds the Men Educating and Gaining Awareness (MEGA) grant implemented by Broward House. This five year grant is a substance abuse intervention program focused on high-risk minority MSMs ages 18-29.

The HOPWA is funded by the Department of Housing and Urban Development (HUD). HOPWA meets the emergency housing needs of people infected with the disease. Services include short-term rent, mortgages, utilities, permanent housing placement, housing case management, project-based rent, facility-based housing and tenant-based rental vouchers. The City of Ft. Lauderdale provides HOPWA services in Broward County.

Attachment 3 summarizes the availability of public funds for HIV services in FY 2016. The table includes funding amount, funded service provider agencies, services delivered and HIV Care Continuum Steps Impacted. The table specifies RWHAP funding (e.g., Parts B, C, D, and F), federal, State, and local public funding, and HIV/AIDS-related service funds available in FY 2016. Attachment 4 provides information specific to the providers and the services they render in Broward County.

HIV Workforce Capacity: The HIV workforce in Broward County is skilled and culturally diverse. The HIV workforce provides services for Prevention, Care and Treatment. The HIV Workforce is composed of professionals and paraprofessionals of health and social service backgrounds, including licensed Medical Doctors, Registered Nurses, Licensed Practical Nurses, Licensed Clinical Social Workers, Medical Case Managers, Non-medical case managers, Community Health Workers, Public Health Professionals and other allied health care workers.

The jurisdiction employs over 550 full-time employees and over 40 part-time employees dedicated to providing HIV-related services. All organizations require employees to maintain licensure and certification in keeping with their identified professions. In addition, providers offer continuous education and training to the workforce in a variety of areas. Providers indicated that for the most part, they had staffing resources to meet the current need, however identified the need for additional case managers and financial counselors.

In Broward County there is a need for additional training of the workforce on the science and treatment of HIV/AIDS and biomedical interventions. In 2013, the Black AIDS Institute, in partnership with the CDC, National Alliance of State and Territorial AIDS

Directors (NASTAD), Johns Hopkins University and the National Latino Commission on AIDS, conducted the first national Knowledge, Attitudes, and beliefs survey of the HIV/AIDS workforce. The purpose of the survey was to assess the workforce knowledge on the science and treatment of HIV/AIDS and biomedical interventions. Nationally, a total of 3,663 individuals participated in the study. In the state of Florida, 210 participated and in the Miami/Ft. Lauderdale area 80 individuals participated. The overall grade for the nation, state, and the local area was a "D." Most individuals had completed some or all post graduate studies (50%), while 19% had earned their Bachelor's degrees and 31% had earned an Associate's degree or less.

Collaborations between Funding Sources: Prevention and Care and Treatment coordinates with other public HIV funders to: 1) link newly diagnosed individuals to care; 2) retain individuals in care; 3) achieve viral suppression; 4) ensure that Ryan White funds are the payer of last resort; 5) maximize the number and accessibility of services available; and (6) reduce duplication of services. Prevention and Care and Treatment work collaboratively to ensure a seamless and continuous system of care by linking newly diagnosed HIV positive clients to care and treatment services including medical and support services and access to life saving medications through ADAP. Additional collaboration includes linkage and re-engagement to care for those PLWH who have fallen out of care.

In an effort to engage stakeholders, the Integrated Development Collaborative was created. This Integrated Development Collaborative was the first step toward bringing all key funders in Broward County with established work plans together to plan for and expand funding for HIV services in the County. Broward County intends to expand the Integrated Development Collaborative by including other key funding stakeholders to plan for the provision of integrated service delivery such as the Florida Medicaid Program and the Veterans Health Administration. To that end, Broward County has undertaken additional efforts to engage funders providing specific resources including:

Medicaid**:** Covered benefits, budget, and reform activities are major considerations in planning a comprehensive Continuum and PSRA. Florida Medicaid has not expanded eligibility, which has resulted in continued demand for RWHAP services through FY 2015. FL-DCF, the agency handling Medicaid enrollment, is represented on the HIVPC. Part

A collaborates with Medicaid to coordinate fee structures, benefits, and Medicaid eligibility changes. The Agency for Healthcare Administration (AHCA), the Florida agency that finances Medicaid payment systems, provides detailed Medicaid enrollment and expenditure data to the Florida Part A Recipient to further PSRA. The local field office representative also participates on the HIVPC. AHCA cooperates with Part A to link PE to Medicaid enrollment and paid claims files to ensure that Medicaid patients' covered services are not billed to Part A. PE completes a monthly, automated check to determine if Part A clients have enrolled in Medicaid. The process identifies individuals receiving Medicaid services and those who become eligible after intake or six-month recertification are completed.

Medicare (including Part D): The Recipient and HIVPC closely monitor changes in Medicare medication benefits due to the large number of Broward Medicare beneficiaries enrolled in Florida ADAP. CIED staff verify Medicare enrollment through the Florida ADAP. The Centers for Medicare/Medicaid Services (CMS) provides trainings and shares resource materials to the HIVPC and sub-recipients on an annual basis. PE was programmed to identify clients who may potentially qualify for Medicare based on their eligibility criteria. CIED assists with the application process for Medicare enrollment.

State Children's Health Insurance Program (SCHIP)**:** FL-DCF also administers the Florida KidCare Program, which is represented on the HIVPC and provides routine programmatic updates.

ACA Marketplace: Part A closely monitors QHP enrollment in Broward and across Florida and collaborates with CBOs, such as the Epilepsy Foundation and BRHPC, to enroll clients into QHPs and works with ADAP to transition clients into QHPs most suitable to HIV+ individuals.

VA: HAB's VA policy is considered in Part A planning and care coordination. Broward Part A MCMs participated in a mandatory Part A training focusing on HAB's VA policy and specific activities that must be undertaken. Curriculum included advising clients about the voluntary use of VA services, coordinating VA benefits with RWHAP services, and assessing for VA eligibility at which point potentially eligible clients would be referred to the VA site in South FL selected by clients. Part A continues to monitor adherence to the HAB VA policy.

HOPWA: The City of Fort Lauderdale HOPWA recipient participates planning activities for Care and Treatment and Integration. HOPWA staff also collaborates with Part A and the Part B administrative agent to conduct planning and assessment activities, including the consumer and provider surveys. HOPWA providers also participate in Part A QI initiatives and training. HUD has recognized this integration as a model and has highlighted it as a best practice model nationally.

CDC Prevention: DOH-Broward and Broward County HIV Prevention Planning Council (BCHPPC) members participate in the HIVPC and its committees. Moving forward, the close collaboration between Part A and DOH-Broward will be vital. Broward was one of two communities that made presentations at the 2014 Bi-Regional NHAS Meeting and the collaboration was recognized nationally.

Services for Women, Infants, Children, and Youth (WICY): The Parts A and D providers collaborate closely to assess and address the needs of the WICY population. CDTC, the only Part D recipient in Broward, participates on the HIVPC, committees, and Quality Improvement (QI) Networks. Parts A and D conduct monthly meetings to coordinate services and identify trends among HIV+ youth. The FL-DCF, which operates Targeted Assistance for Needy Families (TANF), also participates on the HIVPC. FL-DCF also administers substance abuse treatment programs for pregnant women. FDOH, the agency that administers the Special Supplemental Food Program for WICY, also participates on the HIVPC. FDOH also administers Targeted Outreach for Pregnant Women Act (TOPWA), a program designed to reach Florida high-risk women or HIV+ pregnant women to ensure access to prenatal care and other services that lower their risk of HIV infection or substance abuse. TOPWA-funded providers participate on the HIVPC.

Social Security Administration (SSA): Part A works closely with SSA field staff to undertake processes for verifying enrollment in SSA disability and retirement programs by Part A-funded CIED. SSA staff collaborates with CIED staff to facilitate enrollment of clients in SSA programs.

Local, State, and Federal Funds for Substance Abuse and Mental Health Treatment: The erosion of public substance abuse and mental health treatment funds continues to reduce already limited capacity of those systems. Part A continues to allocate substance abuse and mental health treatment funds for HIV+ clients to promote access, retention,

and adherence to OAMC to the extent that new Part A and MAI funds are available. FL-DCF staff participates in the HIVPC. Staff represents DCF-funded mental health and substance abuse programs, including HIV EIS for HIV+ individuals with substance abuse problems.

Local, State, and Federal Public Health Programs: Part A collaborates closely with the FDOH and DOH-Broward staff responsible for operating the HIV prevention, ADAP, Part B, STI, TB, OHC, and other programs.

Other RWHAP Funding (Parts B-F): As previously mentioned, Part A coordinates closely with Parts B-D. Additionally, Nova Southeastern University is a Part F Community-Based Dental Partnership recipient and receives Part A OHC funds. Parts A and F funds support separate programs to avoid funding duplication. Nova participates in the HIVPC OHC QI Network.

Ongoing analyses of factors affecting program eligibility are reviewed to assess their impact. Broward County has established several mechanisms, including joint planning among all RWHAP recipients to consider funding of core and support services across the Continuum:

- The Recipient and DOH-Broward HIV Prevention Program have worked since FY 2012 to improve integration of HIV prevention, screening, linkage, care, and treatment to increase the number of Broward residents aware of their HIV status and their rapid engagement in care. Broward County Part A and DOH-Broward have established joint planning efforts, integrated data to further planning and evaluation efforts, and developed new strategies for effective HIV screening, linkage, engagement and retention activities.
- RWHAP recipients and key funders provide the HIVPC with monthly funding and utilization reports. The HIVPC reviews monthly updated Part A and MAI expenditure data to minimize over or underutilization of RWHAP funds. The EMA has successfully addressed unexpected service needs by rapid reallocation of funds to service categories with needs or shortfalls. For example, the HIVPC allocated funds to HICP to ensure a smooth transition from RWHAP to QHPs for

approximately 250 clients. Recipient staff conducts "sweeps" and reallocation processes annually to address service shortfalls in core services.

- The HIVPC adopted a process that is similar to the Statewide Coordinated Statement of Need (SCSN) to maximize funds. Part A PSRA activities are closely coordinated with other RWHAP recipients and other funders. Core services are prioritized as essential to supporting the Continuum. To the extent feasible, they are "held harmless" if funds are reduced or "flat." While this policy ensures access to core services, access to support services is subject to reductions based on decreased funds. The Recipient evaluates Part A-funded services to ensure they are cost-effective, achieve their objectives, and of high quality. The Recipient also has provided considerable technical assistance to sub-recipients to enhance capacity, ensure retention of clients in care, and achieve improved quality.
- Key stakeholders and funders, including all RWHAP recipients, meet to discuss policy, legislative, cost, and funding issues that influence the Broward Continuum. Program, service, and utilization trends, as well as emerging issues also are discussed. These ongoing discussions assist policymakers to respond proactively to changes that may affect the Continuum. Press releases, forums, presentations, technical assistance, and training needs are jointly designed and conducted.
- Part A collaborates with DOH-Broward and HOPWA to conduct countywide needs assessments and planning activities. The HIVPC considers the results of these assessments in PSRA. The local ADAP staff prepares monthly reports about enrollment, expenditures, and applicants on the waiting list. They make monthly presentations at HIVPC committee meetings, and meet monthly with Part A staff to coordinate medication and other services.
- Part A staff carefully reviewed the HAB Program and Fiscal Monitoring Standards to ensure compliance. The Recipient has distributed the Standards to Part A sub-recipients to ensure their compliance with the Standards, and provided training to sub-recipients to ensure their understanding and implementation of the Standards.

Needed Resources: Unfortunately, not all needed resources and services are provided in Broward County. Additional gaps exist and they are expanded upon in the

following section “Addressing Needs, Gaps, and Barriers” and steps to secure them are included in Section II.

D. Assessing Needs, Gaps, and Barriers

Strategies used to target, recruit, and retain participants in the HIV planning process: Broward County has a rich history of active recruitment and engagement of participatory involvement, including the BCHPPC and the HIVPC and their respective subcommittees. In the past, needs assessment processes were undertaken independently by each Council. Results were utilized to inform decision making for each funding organization. Beginning in 2011 the principals of DOH-Broward's HIV Prevention Program and Broward County's Ryan White Part A Division began engaging in meaningful, substantive dialogue. This partnership preceded the requirement to integrate planning efforts by CDC/HRSA and included the development of activities and strategies to address the HIV epidemic collectively. In order to develop this Integrated Plan, a coordinated, collaborative course of action was undertaken to identify existing resources as well as needs, gaps, and barriers. The structure that was created included the formation of additional committees. These entities and their representatives are acutely aware of the community's needs, enlisting the support and involvement of individuals representing priority populations as well as those identified as at highest risk. The Councils, subcommittees and Integrated Committee represent providers, funding organizations, and persons living with HIV.

The process of collecting data to identify and assess the needs, gaps and barriers has been conducted in a comprehensive and inclusive manner. In order to formulate the strategies and action steps and to create alignment, the needs of individuals impacted by HIV as well as the community context needed to be assessed. While several methods addressed the general community, others were specific in nature, focusing on the special needs of priority populations. The needs, gaps, and barriers identified through these processes follows.

HIV prevention and care service needs of persons at risk for HIV and PLWH: Recurrent challenges identified through surveys, community forums, focus groups, and key stakeholder interviews emerged during the needs assessment process. These included the need for expanded access to Pre-exposure Prophylaxis (PrEP), for comprehensive education to middle school and high school students, and the need to empower and engage communities disproportionately impacted, as well as to provide

gender-specific prevention and care services to the female and transgender populations. Additional needs included adequate transportation, consistency of providers, and access to necessary referrals.

Specifically, individuals indicated that sexual health education and free condom distribution were extremely important and should be continued, with activities targeted to particular populations, such as women, middle and high school students, older adults, and in culturally and linguistically appropriate and relevant manners. Knowledge of PrEP was limited and therefore, there is a need to educate the broader community, especially physicians. While free HIV testing is widely available, there is a need to empower Hispanic and African American communities with new approaches, to hire community health workers, to engage politicians, and to help people understand that prevention and treatment work.

From a care and treatment perspective, the following needs were most frequently identified: inability (long wait) to get appointments, lack of transportation to get to appointments, inability to receive necessary referrals, difficulty accessing doctors who provide HIV services, and staff not being available at convenient days/hours of the week. Participants spoke specifically about the need to be able to make and cancel appointments and submit eligibility documents through a single portal, and to have eligibility appointments for ADAP and Ryan White services scheduled on the same day.

Service gaps identified by and for persons at higher risk for HIV and PLWH: Throughout the needs assessment process service gaps for prevention, care and treatment, as well as necessary support services were identified. These included housing, transportation, employment, and co-morbid issues (mental health, substance use, and additional physical health conditions). In particular, individuals recognized the need for affordable and sustainable housing, for meaningful employment, and for peer support and mentoring. Participants identified gaps in case management services, and in the linkage to care immediately following diagnosis. They specifically discussed the lack of funding for mental health services and the necessity to address individuals with disparate issues (language, transgender, undocumented immigrants, and rural residents) in a culturally relevant manner.

Barriers to HIV prevention and care services: The needs and gaps portray only part of the larger context of the Broward County community. In addition to the needs and gaps, barriers exist that often prevent or preclude the provision of necessary services. The following provides detail regarding several of those barriers and the circumstances in which they occur.

Social and Structural Barriers

- **Multilingual, multiracial, multicultural barriers:** Broward County is the 16th largest county in the nation, and the 2nd largest county in the state of Florida. It is the 2nd most racially diverse county in Florida and has become a "minority majority." 9% of Florida's population resides in Broward County, which is also a large gay and straight tourist destination, increasing the population particularly in the winter months. Broward County is the 6th largest school district in the country, with over 260,000 students enrolled. 32% of residents are foreign-born, and many households have family members that have limited English proficiency.
- **Racism and Discrimination:** While Broward County is a racially, ethnically, and culturally diverse region, there is a strong history of institutional and structural racism. A recent study conducted by the Children's Services Council of Broward County demonstrates the deep divides that have occurred over decades in educational institutions, housing, and employment. The Vulnerable Footprint map shown in Section I.A exemplifies the areas of Broward County that are not only at greater risk for incarceration, fetal and infant mortality, lower graduation rates and higher unemployment, but that are also more racially segregated.
- **Health Profession Shortage and Medically Underserved:** Broward County has received federal designations of both a Health Professional Shortage Area and Medically Underserved Area and Population in the same geographic areas as the Vulnerable Footprint.
- **Poverty:** 14% of households are living below the poverty level, with an additional 33% considered to be ALICE households. **ALICE,** an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed, are households that earn more than the U.S. poverty level, but less than the basic cost of living for the county. Combined, 47%

of Broward County households are struggling to afford basic needs. 16 of the 31 municipalities in Broward County have a population in which over 50% of households are living below the poverty level or considered ALICE households.

- **Insurance:** The state of Florida has opted not to accept the Federal expansion of Medicaid which would have provided 567,000 nonelderly uninsured adults with access to affordable healthcare. According to a recent report published by the Kaiser Family Foundation (January 2016), 57% of these individuals are people of color and 82% are adults without dependent children. While the ACA has allowed more individuals to purchase their own health insurance, many others cannot afford the subsidy. These individuals are living on the brink of not only poverty, but also physical and health challenges. Taken as a whole, these people are at risk for a number of social and health related issues. Basic needs, such as food, shelter, and clothing are prioritized while personal health is often neglected.
- **Stigma:** The issue of stigma has been discussed in a variety of formats throughout community conversations. In addition to conducting a Stigma Survey, DOH-Broward, Ryan White Part A and their partners collect and review feedback about stigma on a continuous basis. According to participants, individuals are reluctant to disclose their status or even to get tested due to familial and cultural beliefs that are associated with stigma. Seeking, accepting, and remaining in treatment is often difficult due to the stigma attached with the disease.
- **Housing and Homelessness:** Broward County experiences high rates of homelessness, particularly among the young adult population. Human trafficking, runaway youth, access to illegal and dangerous drugs, high rates of removals and foster care placements put an already vulnerable population at greater risk for HIV and other challenges. Many individuals who are homeless sell their medications in order to meet their basic needs. Broward County also has a shortage of affordable housing, placing a significant burden on those individuals who do not fall below the poverty level but who are underemployed and underinsured.
- **In-migration, transient and mobile population:** Broward County experiences high rates of geographic mobility, both from within and outside the county and

state. Older gay retirees are moving to south Florida in large numbers. The aging adult population presents several challenges-individuals not getting tested and young MSM "hooking up" with older men.

Federal, state, or local legislative/policy barriers:

Medicaid expansion: Previously stated, the lack of expansion of Medicaid for adults under the age of 65, with income up to 133% of the federal poverty level, is a barrier for health care coverage for uninsured Broward County residents. Access to care is critical to HIV treatment. The ACA provides the option for states to expand Medicaid coverage; however, the State of Florida has chosen not to. Expanding Medicaid would mean the Federal Poverty Level guidelines would allow more individuals and families, who are currently uninsured, to have health care coverage. Expansion would not only mean access to care but it would also cut costs of uncompensated health care.

Testing Legislation: Current HIV/AIDS rapid site guidelines states, "Non-healthcare sites wanting to become a new rapid test site must demonstrate a successful history of conventional HIV testing for one year, must be in compliance with all state and federal policies, procedures and guidelines, and must have a positivity rate of at least 1% for newly identified positives." This precludes many providers who would be interested in providing this service the ability to do so. Additionally, DOH-Broward continues to anticipate guidance and instruction from the state health office regarding the recently passed Florida HIV Testing Bill (HB 321), which took effect July 1st, 2015. Until the FDOH "Dear Colleague Letter" referencing the July 1st, 2015 HIV "Opt-Out" Testing Law is received, progress in disseminating this important information continues to be delayed.

Harm Reduction: There are many tools for prevention, care and treatment of HIV. One of those is harm reduction by way of needle exchanges. Needle and syringe exchange programs provide sterile needles and syringes in exchange for used sharps to reduce the transmission of HIV and other blood-borne infections associated with the reuse of contaminated needles by injection drug users. This has been a struggle at the federal and local level. Currently, there is only one pilot program in South Florida (in Miami-Dade County) which has not received funding and therefore is responsible for its total costs. This is an opportunity to provide an evidence-based practice to address the epidemic.

Health department barriers: Health Department challenges and barriers are regularly documented in CDC's Annual Progress Reports, which are required for those funded under PS12-1201. The information gathered for these reports include Health Department staff narrative and are provided to the contract managers from organizations receiving funds for High Impact Prevention Implementation. The Department barriers are included below:

Comprehensive Prevention with Positives: Multiple data systems do not interface with each other and are cumbersome to navigate thus it is difficult to ensure that optimal care and treatment is provided.

Social Marketing, Media and Mobilization: Limitations and restrictions on the utilization of social media continues to be one of the greatest barriers to mobilizing and educating the community.

PrEP and Post-Exposure Prophylaxis (PEP) Capacity Building and Technical Assistance: Technical Assistance and database integration needed regarding measuring community viral load.

Social Network and Social Media Strategies: Training on Social Network Strategy (SNS) and social media strategies remains a priority for Broward County. Inability of submitting Capacity Building Assistance Request Information System (CRIS) requests directly leads to decreased effectiveness and timeliness of Capacity Building Assistance (CBA) trainings. DOH-Broward would like to see more training based in Fort Lauderdale as a significant portion of the epidemic in Florida is in Broward County and it is difficult for staff and providers to travel outside the county. This was identified as a high priority need by the community during the HIP Town hall meeting held June 25th, 2015.

Program Planning, Monitoring and Evaluation, and Quality Assurance: Additional resources and staffing are needed to maintain and support various successful initiatives such as Business Responds to AIDS.

Program Barriers: In addition to Department barriers, program barriers have also been identified. These have been assessed and evaluated through a variety of mechanisms, including Provider Surveys, a Workforce Forum and Staff Focus Groups. The duplication of paperwork and the lack of continuous communication processes were identified as barriers for programs and organizations to address the needs of the individuals they

serve. In addition, funding and regulatory challenges such as the lack of Medicaid expansion, the process to access funding in an expeditious manner and to streamline the monitoring of programs were also identified as program barriers. Peer support, the use of community health workers, family engagement, staff training and development, and the delivery of culturally and linguistically competent and relevant services were all noted as areas for improvement. Further, nontraditional hours and venue testing continues to be a challenge for community providers due to staffing, as well as financial and liability insurance cost constraints. Programs also report that identifying new positives continues to be an ongoing challenge despite attempts to increase utilization of observational surveillance techniques and other strategies.

Service Provider Barriers: A collective impact initiative as large as this requires non-traditional partners to be engaged in the process. It also entails continuous evaluation of the needs of service providers, including the resources needed to address prevention and care and treatment more effectively. The challenges faced by service providers and the barriers encountered have been identified through provider surveys, key stakeholder interviews, and workplace forums. A number of non-traditional partners were acknowledged as necessary collaborators in the plan to eliminate HIV in Broward County. These partners included: private physicians, providers of housing services as well as realtors, the business community, media, politicians, faith-based leaders, behavioral health organizations, representatives of the criminal justice system, and non-Ryan White providers of HIV-related services. In addition, the following specialty resources were identified to effectively meet the complex needs of individuals living with HIV: expanded and increased mental health and addiction services, employment counseling, affordable housing, efficient transportation, peer counseling and mentoring, enhanced case management services, development of enhanced Internet capability for easier access to appointments and eligibility determination, and re-entry counseling for formerly incarcerated individuals. Providers identified that access to 4th generation confirmatory testing proves to be a challenge, as providers find it costly to secure the supplies needed. Obtaining organizational buy-in and approval of a new and innovative approach to fiscally sustaining HIV testing into the future is a struggle. Finally, service providers identify that CBOs and/or laboratories need to understand proposed benefits, have a desire to

operationally collaborate, are willing to orient key personnel, and able to introduce additional management processes required in Broward County.

Client Barriers: The assessment of needs related to client barriers was conducted through Focus Groups, Community Forums, Key Stakeholder Interviews, and Satisfaction Surveys. The barriers experienced by individuals living with HIV mirror those previously identified, however are experienced on a very personal level.

- **Housing:** Many individuals identified the lack of affordable, sustainable, and stable housing as an impediment to their health and wellness. They stated that the stress of everyday living is a barrier and the additional concerns about stable housing exacerbate that stress. Unstable housing can lead to increased stigma, with PLWH not wanting their roommates, family members or others to know about their illness while they are trying to maintain a stable living arrangement.
- **Stigma:** Not wanting their families, friends, employers, and others to know about their illness is a significant barrier to accessing care and treatment and to remaining in treatment. This is particularly true for individuals who are working who may need to take time off for medical and other appointments. Many individuals stated that this is a reason why people do not get tested initially and once diagnosed, fail to continue with treatment (particularly in the neighborhoods in which they live). They report that there is a cultural mistrust of institutions serving LGBT and minority populations.
- **Employment:** Most individuals surveyed and interviewed indicated they would like to be self-supporting. While many individuals living with HIV are able to be employed full-time, there are many others who have difficulty finding and maintaining full-time employment. Part-time and flexible employment do not provide a livable income and this complicates the ability to live in adequate housing. Individuals affected by the lack of employment opportunities also include women (who oftentimes have a need for affordable, quality childcare), individuals with criminal backgrounds, and individuals who are receiving disability benefits. For the transgender community, this is of particular concern and often members of the transgender community resort to sex work in order to afford their basic needs.

- **Transportation:** The lack of accessible, convenient, affordable, and efficient transportation was often cited as a barrier or challenge to accessing treatment. Non-public transportation is expensive and inconvenient. While vans are available for testing, they are not available for treatment. Treatment services are not always convenient or in locations that are accessible. At the same time, people don't want to go to neighborhood clinics because of stigma. The time required to spend on public transportation to attend an appointment is an obstacle. Several individuals stated they were concerned about the cleanliness of the public transportation system and did not want to jeopardize their already compromised health by riding in unsanitary conditions.
- **Co-occurrence of other conditions:** The co-morbidity of mental illness, substance abuse, and other physical conditions (diabetes, hypertension, high cholesterol) makes the HIV diagnosis even more challenging and complex. Individuals identified the use of substances as an impediment to their health and wellness (particularly the use of cocaine and methamphetamine). The interaction of medications, side effects, and the need for multiple medical appointments intensifies the barriers already identified.
- **Treatment Adherence and Treatment Fatigue:** Several individuals stated that treatment fatigue occurs after years of being on medication, therefore this requires intensive counseling and case management services. As a result, enhanced monitoring and evaluation efforts for treatment adherence is required.
- **Navigation of the System of Care:** In addition to insurance challenges and affordability, the need for multiple certifications, attendance at numerous appointments, and referrals to specialty care make living with HIV more complicated. The cumbersome process to navigate the system of care makes individuals not want to access care and treatment. Individuals stated they would like to have Part A and ADAP eligibility and re-certification combined and have service providers conduct the eligibility and certification process instead of adding an extra process. They also would like to see the process streamlined and conducted annually rather than every six months. In terms of referrals, some

individuals stated they had difficulty accessing the services they needed and in particular, doctors who provided HIV services.

- **Insurance:** There is a Medicaid coverage gap, particularly among the working poor. Because of the lack of Medicaid expansion in the state of Florida, individuals who do not meet the eligibility requirements are often living just above the federal poverty level, with limited assets. They are underemployed or barely earning a minimum living (income constrained). Faced with competing needs, individuals are faced to make choices based on priorities. Unless they have stable housing, there is no priority to take care of anything else. There is also a perception that Ryan White funding is for gay people only and therefore, others may not attempt to access services.
- **Language:** There are not enough services provided in Creole and medical professionals (nurses, doctors, others) who are proficient in the provision of culturally relevant services to the Creole speaking population. There is a perception that not enough outreach is being conducted in the Haitian community. In addition, individuals stated that service providers should reflect the community they are serving and that translation should be completed by people, not machines.

While multiple barriers and needs exist, the Collective Impact methodology adopted by Broward County will serve to address these challenges. With community and stakeholder engagement, continuous communication, shared measurement systems, and mutually reinforcing activities implemented through the strategic approach to addressing these challenges, Broward's common agenda and goals will be achieved.

E. Data: Access, Sources, and Systems

Main Sources of Data and Data Systems used to conduct the Needs Assessment: The advancing intersection of HIV prevention, care, and treatment has recently prompted Broward County to adopt new HIV service strategies. The Part A Recipient works closely with the DOH-Broward HIV Prevention Program, other funders, and community stakeholders to ensure an integrated Continuum. Integration of planning, reports, and activities between the HIVPC, BCHPPC, and others has helped Broward progress further in reaching the NHAS goals and improving outcomes on the Continuum. Broward uses epidemiologic, utilization, lab, clinical outcomes, consumer assessments, and other data to identify trends, gaps in the Continuum, and to prioritize the needs of HIV+ Broward residents.

It is essential to collect and analyze data in addition to the existing data collected through client databases and surveillance, to appropriately identify and assess the needs, gaps and barriers in a comprehensive and inclusive manner. In order to formulate adequate objectives, strategies and activities for the Integrated Plan, a summary of the findings from past and ongoing needs assessment studies has been summarized in Table 7. The results of these studies help to create alignment, and highlight the needs of individuals impacted by HIV as well as the community context needed to be assessed. While several studies addressed the general community, others were specific in nature, focusing on the special needs of priority populations. The table below provides information about data sources and systems that were utilized to compile the analysis for the Integrated HIV Prevention and Care Plan.

Table 7. Needs Assessment Studies conducted in Broward County, Florida

Needs Assessment Tool	Target Population	Objective
Transgender Needs Assessment (CATCH)	Transgender individuals	To determine services needed or requested by the Transgender Community
Condom Survey Power Point	General Population in Broward County	To gather baseline data on condom use, HIV knowledge, and condom accessibility, acceptability and availability in Broward County
Men's Health Flash Survey	Men who have sex with Men	Gather information on condom accessibility, acceptability, and availability among MSM
BTAN Science and Treatment Evaluation Report	HIV Workforce	Pre and Post surveys measuring workforce knowledge on science and treatment
PrEP Summit Evaluations	HIV Workforce and Community	To measure PrEP knowledge among HIV workforce and community
Men's Health and Wellness Evaluation Report	HIV workforce and Community	Identify HIV and Hep C testing behaviors, PrEP knowledge, other health behaviors and topics of interest concerning Men's Health Wellness and Prevention
Hep C Pilot Data	Medical providers	To evaluate the benefit of incorporation Hep C and HIV dual testing in medical settings
Navigation Surveys	HIV positive community	To evaluate the need for HIV Navigation services and to monitor and evaluate the benefit of HIV Navigation service provision
Linkage Database	HIV positive community receiving DOH-Broward linkage, retention and re-engagement services (PROACT)	To monitor and evaluate the benefit of DOH-Broward PROACT Program on HIV health outcomes along the Continuum of Care
SOS Report	Black Women	Measure of HIV community awareness
2014 HIV Testing Data Summary	Individuals testing at Publicly Funded Testing sites in Broward	Estimated prevalence of demographics and risk behaviors of individuals receiving publicly funded testing services in Broward County
Broward County Schools YBRFSS	Broward County Youth	Estimated prevalence of demographics and risk behaviors of Broward County Youth
Stigma Survey	General Population in Broward County	Qualitative study to describe HIV stigma in Broward County
Broward County HIV Prevention, Care and Treatment Client Survey	General Population in Broward County	Identifying knowledge and awareness about HIV as well as satisfaction of experiences in Ryan White Part A program services and knowledge about prevention in Broward.
Broward County HIV Prevention, Care and Treatment Provider Survey	HIV Workforce	To assess organizational capacity and needs
Part A Quality Management Studies	Broward County Priority Populations	To address special needs of priority populations
Part A Priority Setting and Resource Allocation Process	HIV positive community	To analyze data and identify priority areas to allocate resources
Stakeholder Interviews	HIV Stakeholders	To gather information and feedback about HIV services in Broward County
Satisfaction Surveys	Prevention, Care and Treatment Clients	To determine level of satisfaction of current Prevention, care and Treatment Services
National Workforce Evaluation	HIV Workforce	To determine HIV work force knowledge
Community Feedback Forums	General Population in Broward County (Focus on Blacks and Latinos)	To receive feedback on Broward County's Integrated plan and efforts
Workforce Community Forum	HIV workforce	To receive feedback on Broward County's Integrated plan and efforts
Workforce Focus Groups	HIV workforce	Identify perceived needs and barriers of PLWH
Community Focus Groups	PLWH	Identify perceived needs and barriers of PLWH

Data Policies that facilitated and/or served as barriers to the conduct of the Needs Assessment, including the development of the HIV Care Continuum: The FDOH method focuses on reported AIDS and HIV (not AIDS) cases who were alive through CY 2014 and whose last known residence was in Florida, regardless if the case was initially reported in Florida or out of state (OOS). Cases known to be living *outside* of Florida by December 31, 2014 were excluded from analysis. These data are generated from the merging of the following databases: eHARS, CAREWare, and ADAP. This revised process provides a more complete and accurate snapshot of Florida's unmet need by: 1) excluding cases known to be living outside of Florida; and 2) including cases reported outside of Florida, but obtaining care in Florida. This process addresses in and out-migration of cases in Florida which is an improved process than previous methods.

The majority of all HIV-related lab results are received electronically and imported into eHARS within a week of receipt. Significant efforts were made this past year to ensure that the most current addresses and vital statistics of PLWH are reflected in eHARS. Current addresses are being imported with all lab results. In addition, the current addresses for persons known to have moved OOS are updated accordingly. Ongoing matches with the Florida Office of Vital Statistics and annual matches with the National Death Index (NDI) ensure timely and complete reporting of deaths in eHARS. An in-depth evaluation of several thousand cases diagnosed in 1981 to 1995, and not in OAMC, were manually reviewed to determine the current vital statistics and/or current state of residence. Their current status was updated accordingly. However, several thousand cases were unresolved and remain as presumed alive in eHARS. Finally, significant efforts continue to be made to eliminate duplicate cases in the system. At present the estimated duplication rate in the database is less than 0.1%.

Routine matches are made between eHARS, CAREWare, and ADAP. Staff is dedicated to assist with the validation of the matched data. The merged datasets rely on accurate matching cases by name, date of birth, and social security number (SSN). Other variables including address are used to ensure an accurate match. Probable matches are researched in Lexis Nexus for validation. Missing or incorrect name, birthdate, and/or SSN may restrict the probability of a good match and result in an HIV case not matching with any of the care data, therefore indicating that the case was not in care.

FDOH is identifying care patterns in Broward and Florida. The number of individuals in OAMC was calculated at the EMA-level using both the unmet need and Continuum frameworks. eHARS cases were assumed to live in Florida (regardless of state of report) through 2014 if they were found in ADAP or CAREWare files. Based on the unmet need framework, cases were considered in care if they had at least one documented lab, medical visit, or prescription in the CY. Based on the Continuum framework, cases were considered in OAMC if they had two or more documented OAMC visits, labs, or prescriptions at least three months apart in the CY.

The Part A Recipient funds PE, a web-based relational, integrated data system. PE was designed to ensure alignment with Ryan White Services Report (RSR) reporting and allows direct upload of XML files from PE to HAB's RSR portal. PE collects client-level data on demographic and epidemiologic characteristics, intake and eligibility, detailed procedure-level service units, clinical outcomes, invoices, and payments. PE is designed similar to health insurance eligibility and claims systems, supplemented with electronically transmitted lab results and features common to electronic health record systems. PE has a system-wide clinical management alert and reminder system to ensure continuity of care and coordinated care management. MCM intake, assessment, and progress note screens are integrated in PE to increase MCM efficiency. Sub-recipients add scanned client records such as SSA award letters, health insurance cards, and clinical consultant reports to reduce paperwork. PE updates Florida Medicaid enrollment data via a monthly, automated query. PE is also used by HOPWA and includes client-level housing assessment and housing case management screens. PE's highly secure computing environment protects clients' confidentiality and privacy. The Recipient has developed a process for electronically collecting required data elements for each client served in Broward. Required data elements include client-level data components necessary for Clinical Quality Management (CQM) assessment, including ICD-9 and procedure codes. Entry of required data elements auto populate the necessary data for Part A client-level outcomes and indicators, National Quality Centers In+Care Campaign retention rates, HAB measures, and NHAS indicators.

The Recipient works continuously to improve data quality. Clinical outcomes and performance measures are integrated into sub-recipient contracts, monitoring and quality

improvement, Service Delivery Models (SDM) for all funded service categories, and CQM reporting, monitoring, and improvement. The Recipient uses a comprehensive data collection strategy to conduct annual program evaluations, sub-recipient outcome reports, and chart reviews. CQM staff review sub-recipient outcome reports and conduct site visits to assess program accomplishments based on HAB and Part A Care performance and outcome measures. The Recipient will continue to use PE data to assess client-level outcomes and HAB performance measures for Part A service categories. The PE contractor has assisted several OAMC sub-recipients to design routine lab extractions to populate electronically VL and CD4 count data in PE. The Recipient assessed the quality of OAMC PE data by systematically tracking data from health records to automation, PE, and RSR data. All sub-recipients submit client-level data directly to PE or export data from EHRs into PE. All sub-recipients received training and have direct access to assistance from the PE vendor helpdesk. The Recipient and PE staff works with sub-recipients to improve this process even further, including building interfaces between PE, sub-recipient electronic lab data, and Florida Medicaid. The Medicaid interface was particularly helpful in ensuring that the CIED and Part A-funded providers comply with HAB's payer of last resort policy, by linking automatically to Medicaid using clients' Social Security number to determine if clients are enrolled and ascertain their Medicaid numbers. PE includes client-specific alerts aimed at integrating QM measures with retention and adherence efforts for front-line workers' operations. PE alerts facilitate a collaborative system wide approach that ensures efforts are taken to assist patients meet their health outcomes. As outlined in the Integrated Plan, Broward has developed goals that both Part A and prevention recipient staff will continue to address to promote integration from an administrative perspective, sharing programmatic data, and conducting dual monitoring for sub-recipients.

Barriers to Data Collection Methods: Despite improved processes for determining need, there are some data limitations. FDOH acknowledges the limitations of the data on which these estimates are based. At present, the most significant limitation is ensuring that all 110,000 PLWH presumed in eHARS to be alive and living in Florida are completely valid. FDOH strives to eliminate duplicate cases in eHARS, with less than 0.1% of cases estimated to be duplicates. Routine reports are generated to identify possible duplicates

so that they may be resolved in a timely manner. FDOH has dedicated staff assigned to assist in the eHARS de-duplication. Electronic and paper lab reports are imported into eHARS, thus simplifying the matching process. Each year, a greater rate of lab reports is reported via electronic lab reporting (ELR). Routine matches between eHARS and CAREWare are undertaken routinely. The matched databases are merged into a separate database for detailed analysis of viral suppression. The other significant limitation results in assuming that persons not in care, based on the data matches above, are truly not in care. FDOH has determined that the data used and assumptions made are fairly robust in avoiding errors and bias. Each year, Florida strives to improve this method to provide the most reflective analysis of the Florida HIV epidemic.

Data Development: Moving forward, the stakeholders have identified the need for data sharing across systems as well as accurate and timely reporting of data to the county from FDOH. The utilization of a robust system such as PE has afforded Part A and DOH-Broward Prevention Program to collaborate effectively and to address the epidemic using data to inform decision-making processes.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

Integrated HIV Prevention and Care Plan Development: 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. It will also 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. These metrics include the percentage of persons diagnosed and living with HIV, percentage linked to care, percentage retained in care and percentage with suppressed viral load.

This integrated approach to prevention and care has allowed Broward County to develop a clear roadmap to effectively plan for the provision and coordination of services for PLWH. It also allows for the most efficient use of limited resources by minimizing duplication of services. Integration of planning activities between the HIVPC and BCHPPC will help the EMA to progress further in reaching the NHAS goals and improve outcomes along the Continuum.

The attached Integrated Plan (Attachment 5) is reflective of the goals, objectives, strategies and activities of the HIVPC's Part A Comprehensive Plan and BCHPPC's Jurisdictional Prevention Plan. The activities described in the Integrated Plan are overarching coordinated activities that support the individualized efforts of both planning councils and their workgroups, as evidenced in their respective work plans. As such, specific activities for priority populations are addressed in the aforementioned work plans. The HIVPC 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.

In addition to incorporating both planning bodies' previously developed Plans and associated sub-committee work plans, several activities occurred in Broward County that allowed for the inclusion of the voices of persons impacted and affected by the epidemic. Results of Satisfaction Surveys, Focus Groups, Key Stakeholder Interviews, Community Feedback Forums, and a Workforce Forum have been synthesized and integrated into this planning document. Those activities that were the direct result of the input of the aforementioned feedback mechanisms are indicated in *blue and italicized text*.

B. Collaborations, Partnerships, and Stakeholder Involvement

Contributions of Stakeholders and Key Partners in Development of the Plan: The integration process involved the active participation of the prevention and care planning bodies, the BCHPPC and the HIVPC respectively. Both the BCHPPC and the HIVPC are structured to have parity, inclusion and representation (PIR) of the community. Key stakeholders in both groups include PLWH, service providers, County and DOH-Broward staff, and other community members.

The BCHPPC—a government-community partnership—was created in June 2012. The mission of the BCHPPC is to "become a community with a collaborative and coordinated system of HIV Prevention and Care, where new HIV infections are rare and when they do occur, every person regardless of age, gender identity, race/ethnicity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination." It is based on a partnership between the federal government, local and state health department and community participation.

The BCHPPC is comprised of 21 voting members who meet quarterly and are governed by PIR. BCHPPC consists of (7) work groups totaling over 150 active members and four (4) core teams, each of which has a government and community co-chair. The BCHPPC structure includes an Executive Team, Epidemiology Team, High Impact/Core Prevention (HIP) Team and Policy Team. Advisory workgroups of the BCHPPC include the Broward County Schools Advisory Group, the Men who have Sex with Men (MSM) Advisory Group, the Transgender Advisory Group, the Perinatal Group, the Black Treatment Advocacy Network (BTAN), Black AIDS Advisory Group (BAAG), Latinos En Acción Advisory Group and the PrEP Advisory Group. The advisory groups represent the groups disproportionately affected by the HIV/AIDS epidemic in Broward County.

Work groups and teams meet monthly and are structured as open working groups, allowing fluidity of participation, each with its own specific work plan to guide activities and HIP implementation. The HIP Team of the BCHPPC reviews all work plans annually to monitor progress towards the NHAS goals, ensure alignment with the local jurisdictional prevention plan, provide recommendations to improve HIP activities, and streamline prevention work for maximized effectiveness. The work plans provided by the teams and work groups of the BCHPPC feed information back into the jurisdictional

prevention plan. Updates on all work plans are presented publicly at quarterly BCHPPC meetings. The community at-large is provided with opportunities to comment on the jurisdictional activities and is continuously encouraged to participate in the work groups. The following provides an overview of the committees of the BCHPPC:

BCHPPC: Consists of a total of 15-21 voting members. In order to improve coordination of services there are two appointed seats on the BCHPPC: Broward County School District (funded by CDC-DASH) and Academic Research. The membership must achieve Parity, Inclusion and Representation, reflecting the priority populations: African-American, Latino, and MSM (as outlined in the National HIV/AIDS Strategy).
BCHPCC Committee and Team Descriptions
Executive Team - The main responsibility is to conduct and guide the planning required to direct the Full Council (i.e. setting agendas, creating the bylaws, etc.). The Executive Committee is comprised of the community co-chair, the governmental co-chair, representatives from the following advisory groups-MSM, Transgender, Latinos en Accion, BTAN (BAAG), Perinatal HIV, PrEP, and Broward County Schools.
Epidemiology and Research Team - Reviews biomedical, behavioral, and operational research to develop new HIV prevention strategies and improve existing programs. This team also assists the Council with the interpretation of the epidemiological data for prevention planning purposes.
High Impact/Core Prevention Team - Focuses on activities with the greatest potential to prevent the most new HIV infections, to the populations most affected and ensures that the four core prevention components identified in PS12-1201 are implemented.
Policy Initiatives Team - Supports efforts to align structures, policies, and regulations in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts.
Broward County Public Schools HIV Advisory Youth Workgroup - serves the District and Broward County as an advisory and action group. Engages and empowers youth to increase HIV/AIDS/STI awareness and testing. Composed of a group of 10-20 BCPS members whose work is guided by the BCHPPC mission and goals.
MSM (Men who have Sex with Men) Advisory Group - Is implementing the core components of PS12-1201, this group organizes thought leaders and decision-makers to fully mobilize the MSM community in Broward County and build capacity to address the various factors that facilitate HIV infection in the MSM community.
Transgender Health In Action (THIA) - provides peer on peer assistance as well as collaborative educational workshops specific to the transgender community in implementation of the core components of PS12-1201. Addresses issues of health, safety, prevention, testing and stigma and provides mentorship to reinforce a sense of self- worth and positive well-being.
Perinatal Advisory Group - ensures implementation of PS12-1201 core components while providing updated education on perinatal HIV to the community, yearly updates to medical providers, and seeks to increase testing and awareness for all women of child-bearing age.
Black Treatment Advocacy Network/Black AIDS Advisory Group (BTAN/BAAG) - strengthens Black leadership, links Black PLWHA into care, raise HIV science literacy, and mobilizes communities to advocate for policy and research priorities. While implementing core components of PS12-1201, BTAN/BAAG aims to reduce new infections and eliminate racial/ethnic HIV/AIDS disparities within the Black community.
Latinos en Acción Advisory Group- A coalition of Latino community members, representatives from Latino-serving organizations, and the DOH-Broward, Latinos en Acción utilizes HIP strategies to improve HIV health outcomes for Latinos in Florida while implementing core components of PS12-1201.
PrEP Advisory Group – provides recommendations on strategies, goals, and actions for the coordinated implementation of PrEP as a biomedical HIV prevention strategy in Broward County. Components of implementation may include public awareness campaigns, healthcare provider educational efforts, organization of CBO/ASO programs across the County, examination of policy affecting PrEP, or any other aspect of PrEP execution as needed. The PrEP advisory group will all act as a resource/advisor to all other BCHPPC Advisory Groups who include PrEP specific goals in their work plans.

The Part A Recipient works in partnership with the HIVPC to plan, prioritize, and assess the HIV/AIDS service system. The HIVPC is guided by a vision directing a coordinated and effective community response to the HIV epidemic to ensure access to a high quality system of care. The vision of the HIVPC is "to ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care."

There are currently seven (7) standing committees that address needs identified by the HIVPC and an additional three (3) ad-hoc committees that address needs as they arise. The HIPVC Structure includes the Executive Committee, the Priority Setting Resource Allocation Committee, the Needs Assessment Committee, the Quality Management Committee, the Client Empowerment Committee, the Membership Council Development Committee, System of Care, Ad-Hoc By Laws, Ad-Hoc Local Pharmacy Advisory Committee, and the Ad-Hoc Nominating Committee. In total, HIVPC has 29 voting members and over 45 committee members.

The following provides an overview of the committees of the HIVPC:

HIV Health Services Planning Council (HIVPC) - Monitors, evaluates, and continuously improves systematically the quality and appropriateness of HIV care and services provided to all patients receiving Part A and MAI-funded services.
HIVPC Committee Descriptions
Community Empowerment Committee (CEC) - Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting and resource-allocation processes.
Membership/Council Development Committee (MCDC) - Recruits and screens applications based on objective criteria for appointment to the Council in order to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.
Needs Assessment/Evaluation (NAE) Committee - Develops and updates the annual Needs Assessment, including determining focuses for the client survey, provider survey, and client focus groups. Evaluates and updates the Comprehensive Plan to determine progress.
Quality Management Committee (QMC) - Ensures highest quality HIV medical care and support services for PLWHA by developing client and system based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff/client training/education.
Priority Setting Resource Allocation (PSRA) Committee - Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, as well as language on 'how best to meet the need.

System of Care (SOC) Committee - Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWH in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.
Executive Committee - Sets agenda for Council meetings. addresses conflict of interest issues, reviews attendance reports, oversees the planning activities established in the Comprehensive Plan, oversees committee work plans, reviews committee recommendations, ratifies recommendations for removal for cause, and addresses unresolved grievance issues.
HIVPC Ad-Hoc Committee Descriptions
Ad-Hoc By Laws Committee - Periodically reviews, updates and maintains the Council By-Laws
Ad-Hoc Local Pharmacy Advisory Committee (LPAC) - Makes recommendations to the appropriate committees to improve the quality, cost-effectiveness and allocation of resources to pharmacy services. Develops and implements a standardized mechanism for pharmacy services. Efficiently collect and evaluate current pharmacy data. Coordinates pharmacy services in collaboration with other funding streams Reviews current pharmacologic therapeutic regimes and federal guidelines.
Ad-Hoc Nominating Committee - The Ad-Hoc Nominating Committee prepares for and oversees the HIVPC leadership elections process.

South Florida AIDS Network (SFAN) - In addition to the above advisory workgroups and committees of the Planning Councils, the South Florida AIDS Network (SFAN) serves as a Ryan White Part B Care Consortia. The purpose of this Consortia is to "act in an advisory capacity to the state for the purpose of planning and prioritizing the use of Part B funds; provide a forum for the infected individuals and affected communities, providers and others; and facilitate the provision of coordinated, comprehensive health and support services to people infected and affected by HIV/AIDS. A consortium must include people living with HIV/AIDS."

Development of the Integrated HIV Prevention Care and Treatment Plan: Beginning in 2011, discussions around the Early Identification of Individuals with HIV/AIDS (EIIHA) took place. This process was designed to include the input of key stakeholders such as HAB-funded recipients and sub-recipients, public health prevention program, disease control and intervention service, healthcare systems, CBOs, correctional facilities, faith-based community, HIV+ residents, and community leaders. Other notable collaborative efforts include Prevention and Ryan White Part A representatives' attendance at the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition joining the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS), a group in which Prevention participates.

Also in 2011 and 2012, a series of public health leadership meetings, site visits, think tanks and presentations led by DOH-Broward HIV Prevention Program Office were held to develop a new strategic framework for HIV service delivery. At this time, Broward County ranked first in the nation for AIDS case rates. In the first ten months of 2011, Broward County had reported 907 new HIV cases, more than in 2009 and 2010 combined. Initially, site visits and think tanks were convened to assess willingness in changing the way HIV prevention services are implemented in Broward County by both DOH-Broward and community partners. This historic collaborative journey between the Flowers Heritage Foundation, Get Screened Oakland, and the Broward County Health Department HIV Prevention Program resulted in the document "A Vision of Thoughtful Change." The Summary of Recommendations that emerged from those dialogues included the following: 1) Integrated Surveillance-data collection tools, datasets, and reporting processes should be complementary; 2) Technology-building technology for online capacity and supporting the use of peer navigators and community health workers should be enhanced to ensure linkage to care and treatment; 3) Coalitions and Networks-engagement of stakeholders, including unlikely partners should be used as a catalyst for change; 4) Policy and Advocacy-policy is an important tool that should be used to respond to HIV/AIDS and other health concerns; 5) Systems Approaches- scalability and replicability of evidence-based and scientific-based practices should be analyzed and implemented; 6) Building New Leaders-emerging leaders from within the HIV/AIDS community should be provided opportunities for growth and involvement; and (7) Multi-Sector Partnerships-integrating multiple partners from across sectors-government, business, non-profit, faith-based and the media should be seen as an integral component of providing information and reducing stigma.

The implementation of PS 12-1201 (2013) High Impact Prevention (HIP) CDC Funding Opportunity Announcement and the establishment of the BCHPPC by DOH-Broward (2012) was also a part of early integration efforts. In forming the BCHPPC and responding to joint letters from CDC and HAB stressing integration, the stakeholders and HIVPC redoubled their efforts to integrate fully HIV prevention, screening, linkage, care, and treatment. Broward was further prompted to consider new HIV service strategies due to the federal adoption of the Continuum model and the increasing intersection of HIV

prevention, care, and treatment. Additional integration efforts included the development of an integrated quarterly newsletter knows as “POZabilities” to inform the community about integrated planning and keep them updated on the process.

In May 2013, HAB and CDC released letters supporting integration between Prevention, Care and Treatment. Prior to the release of the letters about integration, the Broward County Prevention and Ryan White Part A Programs had already taken several steps to foster collaborative integration of HIV prevention and care. In December 2013, Technical Assistance (TA) requests were made to the HRSA Project Officer regarding involvement of both Prevention and Care Planning bodies. This decision was based on an assessment of the community and realizing there was a need for additional assistance. By September 2014, a work session on the development of an Integrated Committee for HIV Planning was facilitated by Emily Gantz McKay in response to the TA request. The ultimate goal of the TA efforts helped to streamline HIV Prevention, Care and Treatment planning to increase access to and effectiveness of prevention, care, and treatment services. As a result, The HIVPC collaborated with the BCHPPC to develop a Comprehensive HIV Plan “Crosswalk.” The presentation of the Integrated “Crosswalk” provided a Master Comprehensive Chart of Prevention, Care and Treatment services in Broward County and the progress made to date. The crosswalk was used as a foundation for integration.

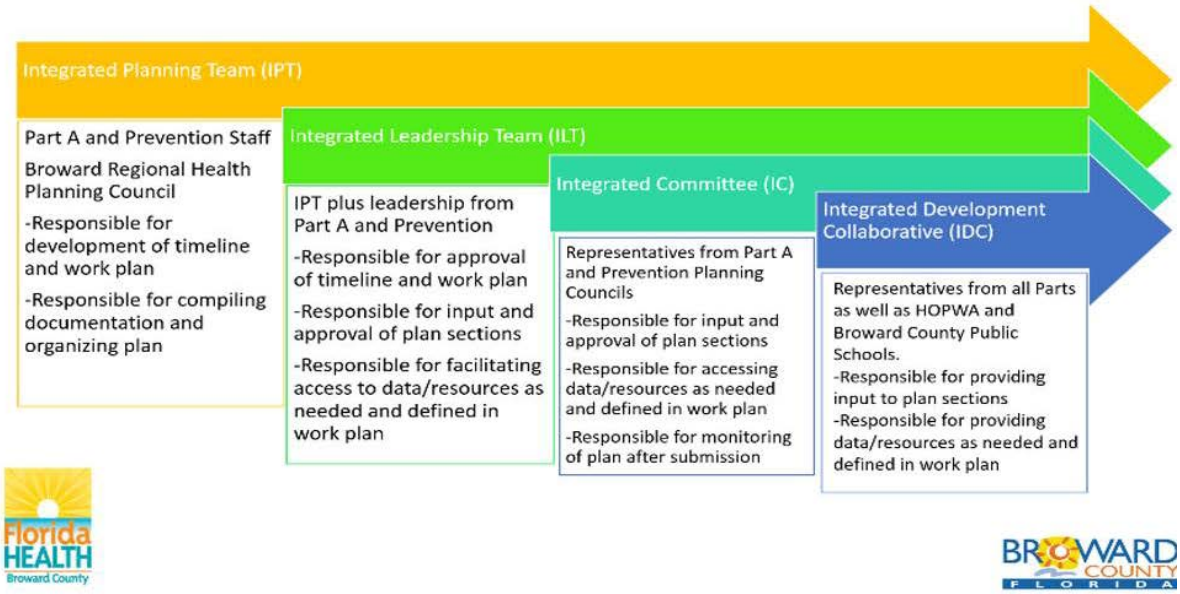
The coordinated approach is further illustrated through recent activities undertaken in Broward: 1) participation from HIVPC and BCHPPC members; 2) retreat presentations focusing on collaboration among the prevention and care sectors, where representatives from both sectors discussed how to accomplish joint NHAS goals; 3) coordinated needs assessments that incorporate care and prevention to fulfill HAB and CDC requirements; and 4) forming an Integrated Committee to develop and monitor the 2017-2021 Integrated HIV Prevention and Care Plan.

A total of five (5) formal integrated retreats and exploratory meetings were held throughout 2014 and 2015 to identify and clearly understand the meaning and purpose of the integrated plan and determine what was needed to move forward with planning. Representatives from the Ryan White Part A Program, DOH-Broward Prevention Program, and Broward County Public Schools were participants of these

meeting and retreats. These retreats and meetings resulted in conversations regarding the necessary infrastructure to be responsible for the development, monitoring and evaluation of the integrated plan. The Integrated HIV Prevention and Care Plan further formalizes relationships and joint planning activities among HIV prevention, other RWHAP recipients and sub-recipients, public and private sector providers conducting HIV screening, and health and support service agencies. The Plan aims to avoid duplication among local HIV prevention, screening, and treatment efforts funded by the CDC, DOH, RWHAP, insurers, and other funders. As both the BCHPPC and the HIVPC function efficiently as separate bodies, with defining organizational cultures, funding parameters and priorities, it was determined that it was not feasible nor necessary to merge both Planning Councils. However, agreement was reached that the integration process required the active participation of Prevention, Care and Treatment planning body members. As a result, an Integrated Committee was formed, representative of members of both the BCHPPC and the HIVPC. In addition, each Planning Council includes integration as a standing agenda item at their meetings.

As a result, an integrated framework was developed that included the development of an infrastructure to support the integrated planning process. This infrastructure includes several groups: 1) Integrated Development Team (IDT): responsible for developing and implementing strategies that strengthen collaboration and coordination among all Ryan White parts, HOPWA, and Prevention; 2) Integrated Leadership Team (ILT): comprised of HIV Prevention and Ryan White Senior Leadership responsible for the direction and guidance of the integrated planning process and has authority to approve final integrated products; 3) Integrated Development Collaborative (IDC): comprised of HIV Prevention, Care and Treatment Recipients including Broward County Public Schools (with established and completed work plans) in Broward County; and 4) Integrated Committee (IC): Comprised of ten members, inclusive of two co-chairs, of community stakeholders and PLWH from each planning body (HIVPC and BCHPPC). This committee is responsible for the oversight and implementation of the Integrated Plan. The Integrated Committee has been responsible for the approval of all integrated planning activities and will continue to oversee the overall progress of the implementation of the Integrated HIV

Prevention and Care Plan. The committee serves as a quality assurance component and will be critical to monitoring the content and execution of the Integrated Plan.



The success of the integrated planning process relies on the support of both Prevention and Care and Treatment planning bodies. Each of these bodies involve stakeholders throughout their own planning and program development as they rely extensively on PIR meaning that both planning bodies represent the communities that are served. Both planning bodies are kept abreast of integrated planning updates and are allotted regular platforms for community feedback. They are also accountable for selecting the individuals responsible for reviewing the plan. The HIVPC and BCHPPC as well as their respective workgroups and committees have reviewed and approved the integrated plan and activities. The monitoring of the success and outcomes of the plan will be conducted by third-party resources and is discussed further in Section III: Monitoring and Improvement.

Between September 2014 and the present, numerous meetings occurred between the Grantees to formalize this process. In addition, staff from both Prevention and Care and Treatment collaborated to provide training at several conferences to present the “Broward Approach” to integration. The following serves to highlight some of the steps that were taken to ensure the collaborative planning process was implemented systematically, thoughtfully, and in a coordinated fashion. ***This approach has been recognized as a***

best practice and received the National Association of County and City Health Officials (NACCHO) Model Award in April 2016.

- By-laws were developed for the Integrated Committee
- Members of the Integrated Committee (a total of 10 members-5 representing BCHPPC, 5 representing HIVPC and one at-large member) were chosen by their respective peers to serve
- A timeline for development of the plan was created as well as a Work Plan with timeframes and action steps
- A public forum was held to announce the Integrated Planning process and to invite community stakeholders to participate in planning efforts
- An Integrated Collaborative was formed that includes members of the Integrated Committee as well as representatives of all Ryan White Parts, HOPWA, the School Board of Broward County, and the South Florida AIDS Network (SFAN).
- In addition to previously collected stakeholder data that informed earlier plans for both Prevention and Care and Treatment, additional data was collected from target populations, including focus groups, surveys, and key stakeholder interviews.
- Both planning bodies were continuously informed about the progress of the planning process and provided feedback through their Integrated Committee representatives.
- Several Town Hall meetings were held to inform the public and community stakeholders about the planning process and to gather feedback and input.
- A structure for continuous monitoring and evaluation post plan submission has been established and will be implemented by the Integrated Committee.

Integrated Presentations:

- Department of Health and Human Services (HHS) Region IV and VI National HIV/AIDS Strategy Meeting. Atlanta, Georgia. August 12, 2014. Panel presentation.
- United State Conference on AIDS (USCA) 2014. San Diego, California. October 2-5, 2014. Oral Presentation.

- American Public Health Association Conference (APHA) October 31-November 4, 2015. Chicago, Illinois. Poster Presentation.
- 2015 Centers for Disease Control and Prevention (CDC) National HIV Prevention Conference. Atlanta Georgia. December 5-9, 2015. Panel Presentation.
- Urban Coalition for HIV Prevention Services (UCHAPS) Technical Assistance Provider on Integration March 2016.

Letter of Concurrence. Attachment 6 includes the Letters of Concurrence from both the HIVPC and BCHPPC Chair, and co-chairs of the Integrated Planning Committee. This includes documented Agreements and Assurances certifying compliance with the goals and objectives of the Integrated HIV Prevention and Care Plan.

C. People Living with HIV (PLWH) and Community Engagement

Stakeholders involved in the development and creation of the Integrated HIV Prevention and Care Plan are fully committed to eradicating the epidemic of HIV/AIDS in the community. The process utilized to create this plan ensured that individuals who participated were inclusive of at-risk groups as well as representative of PLWH. Broward County is diverse as described earlier, and as such participants were characteristic of the varying races, ethnicities, gender identification, sexual orientation, and ages of those impacted by HIV. Both the HIVPC and the BCHPPC and their respective committees and workgroups are also representative of the community and include many PLWH. Multiple activities, meetings, and opportunities for feedback were organized in order to receive input as well as to guide the development of specific strategies to enhance the cooperation and collaboration between the two Planning bodies and other interested stakeholders to achieve the goals outlined in this plan. This section describes the process for engagement and inclusion in plan development.

Multiple individuals, organizations, and groups have been involved in the development of the Integrated HIV Prevention and Care Plan for Broward County. This collaborative effort has included individuals who have been disproportionately impacted by the HIV/AIDS epidemic, whether directly infected or affected as family members, providers, funding organizations, and community members. Both the HIVPC and BCHPPC are reflective of the epidemic in Broward County. In particular, several committees and workgroups exist to reflect the specific needs of the priority populations, as identified in the overviews previously described. In addition to the planning bodies, the other Parts funded by CDC/HRSA have been involved since the beginning of the planning process.

There have been numerous opportunities for community engagement and for the participation of PLWH to contribute to the planning process. These have included focus groups, satisfaction surveys, community forums, planning body and committee meetings, and key stakeholder interviews. By using a Collective Impact framework in the approach to the Integrated Plan development, the emphasis began with and continued to value the voice of persons directly impacted by the epidemic. Having key stakeholders present during the development of this plan, from review of data, to facilitation of community dialogues, to identification of strategies and objectives is considered a hallmark of this

approach. Additionally, continuous communication occurred through ongoing meetings and sharing of feedback. The structure of the overall planning process ensured that members of both Planning Councils participated on the Integrated Committee, with equal representation. Agendas for full Planning Council meetings include an item to provide updates about the planning process and to receive feedback from members. This cycle of communication has helped to enhance and fortify the Integrated Plan by allowing for the inclusion of many diverse voices and viewpoints.

The following serves to provide an overview of the strategies used to include people living with HIV/AIDS in the development of this plan:

- Focus Groups
- Satisfaction Surveys
- Key Stakeholder Interviews
- Community Forums for People Living With HIV/AIDS
- Community Forum for the Workforce
- Stigma Survey
- HIV Workforce Evaluation
- Provider Survey
- Integrated Committee Meetings

Focus Groups: several focus groups were held with a cross-section of the diverse population of individuals living with HIV/AIDS. These included persons served (African American males, African American females, two with MSM) and the workforce. Four of the focus groups were held with individuals living with HIV/AIDS and three were with employees of organizations providing direct services. Several additional focus groups are scheduled and will take place on a continuous basis. These include focus groups with transgender individuals, pregnant HIV+ women, young adults, Hispanic men, and Hispanic women.

Satisfaction Surveys: almost 400 surveys (in English and Spanish) were distributed and returned over a six month period. Of the surveys returned, over 60% were from individuals who were HIV+ and receiving Ryan White Part A services. An additional 12% identified as HIV+ but not receiving Ryan White Part A services.

Key Stakeholder Interviews: Several stakeholder interviews were conducted with individuals representing the HIV community. These individuals included a School Board member, several CEOs, a frontline supervisor, and several persons living with HIV/AIDS. Moving forward, the intent is to continue these dialogues in particular with individuals representing priority and vulnerable populations.

Stigma Survey: Surveys were administered to 106 individuals in the community to gauge their condom use, knowledge of HIV prevention measures, and stigma related to HIV infection. The sample was evenly distributed between genders. The majority of respondents were aged 18-25, born in the United States. Most respondents demonstrated some knowledge about prevention measures such as condom use. Results showed that stigma continues to permeate the community, with frequent comments citing "death", "disease", and the notion of HIV being "scary."

HIV Workforce Evaluation*:* A national HIV Workforce Study regarding HIV Knowledge, Attitudes and Beliefs was conducted and a total of 3,663 individuals participated in the study. In the state of Florida, 210 participated and in the Miami/Ft. Lauderdale area 80 individuals participated. The overall grade for the nation, state, and the local area was a "D." Specific to the Miami/Ft. Lauderdale workforce, of the 80 individuals who participated, 51% identified as male at birth, 49% identified as female at birth. Most respondents were 45-54 years of age, and there were 51% identifying as male currently, 48% female, and 1% transgender. Most respondents identified as heterosexual (58%), 34% as gay or lesbian, and 9% as bisexual. In terms of race and ethnicity, 41% were African-American, 35% were white, and 18% were Hispanic. Most respondents (70%) were HIV negative, while 28% were HIV positive. Most had completed some or all post graduate studies (50%), while 19% had earned their Bachelor's degrees and 31% had earned an Associate's degree or less.

As previously described, Broward County has implemented a Collective Impact framework to approach the complex challenge of developing an Integrated HIV Prevention and Care Plan. The development of the infrastructure, creating an Integrated Committee, and providing continuous feedback through the Planning Council bodies has afforded the community numerous opportunities to create the Goals, Objectives, Strategies, and Activities identified in Section II.A. Broward County believes that it takes

a group of diverse and committed stakeholders to tackle these complex social and health challenges and has provided a number of occasions to offer feedback about such solutions. The following highlights those meetings and dialogues:

Community Feedback Forums: As objectives, strategies, and activities were being developed, the community was engaged to receive feedback and input. A series of three dialogues with persons served took place, followed by a workforce forum. The three community forums with persons served included one focused on the Latino/a community, one focused on the African-American community, and one focused on the general community. A total of 98 individuals participated in those forums. An additional Workforce Community Feedback forum was held, with 96 people in attendance.

Lessons learned from the Community Feedback forums: There was not enough community participation for the persons served forums. Many individuals were employed by HIV service organizations, although they were representative of frontline staff and several were HIV positive. Recommendations moving forward included the need to hold the meetings in geographic locations that are accessible to the population served and at times (such as the late afternoon or early evening) that are convenient. For the Spanish speaking population, information should be distributed in Spanish and all materials should be available as paper distribution. Advertisement of meetings should also be more specific and focused on the community's needs.

Provider Survey: A provider survey was conducted in April 2016 to identify resources available, assets, gaps, and barriers. A total of thirteen (13) providers participated, representing both prevention and care and treatment. The majority of organizations provided HIV prevention education (10 out of 13 providers), counseling and testing for HIV (9 out of 13 providers), and testing for STDs (8 out of 13 providers). Services that were provided by only one or two organizations were: child/family support, employment assistance, food bank/vouchers, home health care, housing assistance, legal support, and inpatient substance use/abuse treatment. All providers surveyed indicated that individuals can walk in and access services the same day and 12 of 13 providers can call and schedule themselves for an appointment. All organizations also provide individuals with referrals for other services. In terms of frequency of core medical service referrals made, HIV medication referrals were the most frequent, followed by case

management/care coordination, and mental health services. Least frequent were home health care and nutritional counseling. When asked about supportive services and the frequency of referrals made, the most frequent referrals were made for housing assistance, food bank/vouchers, and transportation/transportation vouchers. The least frequent referrals were made to translation/interpretation assistance, employment assistance, and legal support.

Integrated Committee meetings: As described previously, the infrastructure for the planning process included the development of an Integrated Committee that is representative of both planning bodies. This group of individuals met regularly to review the document as well as to provide input regarding the Goals, Objectives, Strategies, and Activities. Members of the Integrated Committee facilitated all of the Community and Workplace Forums. In addition, members provided continuous updates to their respective planning bodies and presented the plan upon completion for consensus. The development of this plan and its ensuing action steps has truly been a collaborative community process and has resulted in strategies and activities that will promote the achievement of the NHAS goals.

Section III: Monitoring and Improvement

Broward County supports the National HIV/AIDS Strategy for the United States (NHAS) related to: reducing new HIV infections; increasing access to care and improving health outcomes for people living with HIV; reducing HIV-related disparities and health inequities; and achieving a more coordinated national response to the HIV epidemic. In order to achieve these goals, the jurisdiction is committed to the provision of effective prevention and care strategies to the populations and geographic areas most affected by HIV, utilizing local resources to achieve a maximum level of impact, and 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, percentage linked to care, percentage retained in care and percentage with suppressed viral load.

Proposed monitoring and improvement steps include the creation of several additional continuums that reveal more specific information such as 1) an HIV Incidence continuum; 2) an HIV Prevalence continuum; 3) an HIV Prevention continuum for 'high risk' negative individuals; and 4) a Ryan White only continuum. Common definitions for each continuum measure will also be developed between both Prevention, Care and Treatment and a local monitoring and evaluation report will be produced outlining Prevention, Care and Treatment progress towards the goals of the NHAS. This evaluation will also include local data sources including Active Strategy (DOH-Broward's Performance Indicator database), PE, PRISM, ADAP and eHARS. Examining outcomes across the Continuum is necessary to be able to evaluate program effectiveness and monitor program utilization.

In order to accomplish this a PROACT Database has been created in addition to the regular monitoring of monthly program performance through DOH-Broward's Internal Review System, Active Strategy Enterprise. As part of the Integration of Prevention, Care and Treatment in Broward County, proposed plans are being developed to enhance these two programs by implementing data-to-care activities that utilize eHARS in addition to the existing database to identify clients in need of being re-engaged in care and monitoring viral suppression.

Additionally, process objectives of the integrated approach include achieving a mutual understanding of the local health departments, Ryan White Recipients, and local planning bodies in HIV integrated planning, creating a comprehensive work plan, maximizing collaboration during implementation, and identifying the critical elements of integrated planning. This is accomplished by using the Collective Impact framework and methodology and documenting lessons learned for continuous improvement as well as for use by other jurisdictions. Collective Impact, a framework for solving complex social problems, was applied by the partners, creating a mechanism through which achieving a coordinated response to the HIV epidemic could be addressed.

Outcome objectives to measure the progress of integration in achieving the goals of the NHAS have been developed and are shown in Table 8. Monitoring progress on objectives and activities in this plan is critical in ensuring the advancement in the access to quality HIV prevention and care services in Broward County. The Broward County HIV Integrated Prevention, Care & Treatment Indicators Report is aligned and supports national initiatives from the NHAS 2020 updates published July 2015. Indicators were developed to represent measurable outcomes and are derived from existing data/other sources of information. Data sources have identified data that can be comparable across the years and are readily available to monitor progress toward the strategy goals. Using available 2014 data sources as the baseline year, progress will be measured throughout the five years of the plan. Performance data will be derived from available data sources such as Active Strategy (DOH-Broward's Performance Indicator database), PE, PRISM, ADAP and eHARS. Additional data sources are also described in Section I.E. As monitoring and evaluation is enhanced, measures may concurrently evolve to capture relevant information and activities that reflect current science.

Table 8: Indicators to Measure Progress of Broward's Integrated Prevention, Care and Treatment Plan, Updated 2021 Targets

Indicator	2014 Baseline	Data Source	2021 Target
Reduce the number of new infections by 25%	993	eHARS	745
Reduce the number of pediatric transmission cases to zero	0	eHARS	0
Increase the number of Broward county residents who have not previously tested for HIV by 5% each year.	13,028	1628 Testing and Counseling Database	16,627
Increase the percentage of newly diagnosed individuals who are linked to HIV medical care within 1 month of diagnosis to 85%.	53.7%	eHARS	85%
Increase the percentage of PLWH who are retained in medical care to 90%.	65%	eHARS	90%
Reduce disparity in the rate of HIV-related mortality among Black males by at least 15%.	17.0	Vital Statistics	14.5
Reduce disparity in the rate of HIV-related mortality among Black females by at least 15%.	16.4	Vital Statistics	13.9
Reduce disparity in the rate of HIV-related mortality among White males by at least 15%.	10.1	Vital Statistics	8.6
Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%	61%	eHARS	80%

Evaluation findings are critical for the identification of best practices and opportunities for advancement which then provide 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 impact of the Integrated Plan on the local HIV epidemic. A Scientific Advisory Group (SAG), comprised of university and research partners, will provide an external evaluation to the Integrated Plan to provide additional feedback

needed to improve prevention and patient care efforts and drive decision making in the Broward County area. The results of this evaluation will be submitted for academic publishing and then larger dissemination. The SAG will also be responsible for presenting to both planning bodies on the outcomes of their evaluation.

Stakeholder Engagement: Having the right stakeholders and subject matter experts from the appropriate organizations is necessary to establish community ownership for a plan that impacts such a large amount of people. The integration of prevention, care and treatment is not an easy process and requires collective input and efforts from all those involved. Continuous communication between key stakeholders and organizations in the form of regularly scheduled integrated retreats and meetings, joint project officer calls, co-authored published articles, co-presentation on the integration process, and regular updates at both planning meetings is a core component of the Collective Impact methodology. Having the Collective Impact methodology to help drive the process, engage stakeholders and guide integration early in the development has resulted in a comprehensive and organized approach. Having stakeholder buy-in and representation from the appropriate organizations not only assists in communication of integration updates, it also facilitates the engagement and support of the overall community by building trust, addressing community perceptions, and incorporating community representation.

The success of the integrated planning process relies on the support and commitment of both the HIVPC and BCHPPC. Both planning bodies are kept abreast of integrated planning updates and are allotted regular platforms for community feedback. Both planning bodies have been responsible for selecting the individuals responsible for reviewing the plan (Integrated Committee) and have provided a letter of concurrence for the Integrated Plan.

The indicators listed above will serve as a guide for an *Integrated Progress Report* that will be created by DOH-Broward and Ryan White Part A Program Recipient Office. This annual report will serve as a vehicle for communication, including a summary of lessons learned, and will be disseminated to each respective planning council, the community at large, and other interested stakeholders. The Integrated Committee, comprised of ten members, inclusive of two co-chairs, of community stakeholders and

PLWH from each planning body (HIVPC and BCHPPC) will be responsible for reviewing the monitoring and evaluation of the plan (*Integrated Progress Report*) and thus serve as a quality assurance component in evaluating activities that are to be executed by the respective responsible parties. Ongoing facilitated meetings among the committee throughout the year will be necessary in providing feedback on the implementation of the plan. The activities described in the plan are coordinated activities that will be supported by DOH-Broward, Ryan White Part A Program Recipient Office, Broward County Public Schools, BCHPPC and HIVPC planning councils and their workgroups. BCHPPC and HIVPC work group work plans will also provide information and data back into the monitoring of the Integrated Plan. Both planning councils will continue to review and monitor their respective work plans to evaluate progress towards the NHAS goals, ensure continued alignment with the local jurisdictional plan, provide recommendations to improve activities, and streamline prevention and care work for maximized effectiveness.

Engaging partners is vital in this collective impact approach. The community at-large will be provided with opportunities to comment on the jurisdictional activities and is continuously encouraged to participate in the planning bodies work groups which ultimately deliver the necessary feedback and assess strategies for improvement. Utilizing feedback from stakeholders will assist in evaluating whether the strategies and activities promote a coordinated, collaborative, and seamless approach to increased access/linkage to prevention, care, and treatment services; improve health outcomes for PLWH; and move the jurisdiction towards a decrease in new HIV infections. As previously mentioned, all planning bodies will be regularly updated on the progress of the plan implementation conducted through BCHPPC and HIVPC at quarterly council meetings.

Concluding Statement: The primary lesson learned from the integration of prevention, care and treatment in Broward County is that integration guidance cannot be prescriptive. What works well in one jurisdiction may not work for another. For example, the merging of Prevention and Care and treatment planning bodies is not recommended for Broward County and is not necessary to complete an integrated plan. The culture, directives, organizations and priorities for BCHPPC and HIVPC are not easily merged, which would be a large challenge within itself. Both bodies function efficiently as separate bodies to complete the tasks required for the integrated process. However, members do

actively participate on both planning bodies and each planning body has integration as a standing agenda item. Knowledge of the local epidemic and landscape including available resources and key stakeholders is essential and fundamental to the integration process in order to include the appropriate individuals, organizations and activities into the integration process and plan. Integration is not an easy process and there are very few models and best practices to follow as guidance. CDC and HRSA have provided support for integrated activities; however, they have provided very general guidance as to how this process should be executed at the local level. Therefore, it is imperative to document the integrated process as is occurs, including the outcomes of integrated meetings and best practices. From the integrated meetings held to date, one of the best practices is the inclusion of external facilitators to structure and moderate some of the meetings and or retreats between all individuals and organizations represented at integrated meetings. Having outside facilitators allows for meetings to stay on task, to manage and resolve conflict effectively as it arises, and to ensure that objectives are met.

The integrated planning process has provided an opportunity for multiple system partners to work together towards a common goal. While there have been challenges along the way, utilizing the collective impact approach has provided a blueprint for the work completed. Recognizing that multiple system partners have a common agenda led to utilizing common language. This resulted in better communication and a way to overcome conflict. As an integrated team, Broward County has been able to bring multiple different perspectives to the table to solve the complex challenges in the community. Identifying shared measurement will assist in the future as the Integrated Plan will be utilized to improve the lives of Broward County residents living with HIV.

Attachment 1: List of Commonly Used Acronyms

AACTG: Adult AIDS Clinical Trials Group
ACA: The Patient Protection and Affordable Care Act 2010
***ADAP**: AIDS Drugs Assistance Program**
***AETC:** AIDS Education and Training Center**
AHCA: Agency for Health Care Administration
AHF: AIDS Health Care Foundation
AHRQ: Agency for Healthcare Research and Quality
AICP: AIDS Insurance Continuation Program
AIDS: Acquired Immuno-Deficiency Syndrome
AIMS: Advice and Information Management System
ALICE: Asset Limited, Income Constrained, Employed
ASO: AIDS Service Organization
ARV: Antiretroviral
BARC: Broward Addiction Recovery Center
BCBCC: Broward County Board of County Commissioners
BCFHC: Broward Community and Family Health Centers
BCHSD: Broward County Human Services Department
***BCHPPC:** Broward County HIV Prevention Planning Council**
BH: Behavioral Health
BMSM: Black Men Who Have Sex with Men
BRHPC: Broward Regional Health Planning Council, Inc.
CAEAR: Communities Advocating Emergency AIDS Relief
CAP: Corrective Action Plan
CBA: Capacity Building Assistance
CBO: Community-Based Organization
CDC: Centers for Disease Control and Prevention
***CDTC:** Children's Diagnostic and Treatment Center**
CHC: Community Health Center
***CIED:** Client Intake and Eligibility Determination**
CLAS: Culturally and Linguistically Appropriate Services
***CLD:** Client Level Data**
CM: Case Management
CMS: Centers for Medicare/Medicaid Services
***CQI:** Continuous Quality Improvement**
CQM: Clinical Quality Management
CRIS: Capacity Building Assistance Request Information System
CTS: Counseling and Testing Site
CY: Calendar Year
DCM: Disease Case Management
DOH-Broward: Florida Department of Health in Broward County
eHARS: Electronic HIV/AIDS Reporting System
EIIHA: Early Intervention of Individuals Living with HIV/AIDS
EIS: Early Intervention Services
EMA: Eligible Metropolitan Area
FDOH: Florida Department of Health
FPL: Federal Poverty Level
FQHC: Federally Qualified Health Center
FL-DCF: Florida Department of Children and Families
FY: Fiscal Year
HAB: HIV/AIDS Bureau
HCV: Hepatitis C Virus
HHS: U.S. Department of Health and Human Services
HICP: Health Insurance Continuation Program
HIP: High Impact Prevention
HIV: Human Immunodeficiency Virus
***HIVPC:** Broward County HIV Health Services Planning Council**
HMSM: Hispanic Men who have Sex with Men
HOPWA: Housing Opportunities for People with AIDS
HRSA: Health Resources and Service Administration
HUD: U.S Department of Housing and Urban Development
***IC:** Integrated Committee**
***IDC**: Integrated Development Collaborative**
IDU: Intravenous Drug User
***ILT:** Integrated Leadership Team**
***IPT:** Integrated Planning Team**
***JLP:** Jail Linkage Program**
***LPAP:** Local AIDS Pharmaceutical Assistance Program**
MAC: Minority AIDS Coordinator
MAI: Minority AIDS Initiative
MCM: Medical Case Management
MH: Mental Health
MOE: Maintenance of Effort
MOU: Memorandum of Understanding
MSA: Metropolitan Statistical Area
MSM: Men Who Have Sex with Men
NBHD: North Broward Hospital District (Broward Health)
NHAS: National HIV/AIDS Strategy
nPEP: Non-Occupational Post Exposure Prophylaxis
NSU: Nova Southeastern University
OAMC: Outpatient Ambulatory Medical Care
OHC: Oral Health Care
OOS: Out of State
PAC: Project AIDS Care
***PE:** Provide Enterprise**
PEP: Post-exposure Prophylaxis
PIR: Parity, Inclusion, Representation
PLWHA: People Living with HIV/AIDS
PrEP: Pre-Exposure Prophylaxis
PRISM: Patient Reporting Investigating Surveillance System

PROACT: Participate, Retain, Observe, Adhere, Communicate and Teamwork is DOH-Broward's treatment adherence program.
PSRA: Priority Setting & Reallocation
PTC: Prevention Training Consultant
QHP: Qualified Health Plan
QI: Quality Improvement
QIP: Quality Improvement Project
QM: Quality Management
RSR: Ryan White Services Report
RWHAP: Ryan White HIV/AIDS Program
SA: Substance Abuse
SAETC: Southeast AIDS Education and Training Center
SAG: Scientific Advisory Group
SBHD: South Broward Hospital District (Memorial Healthcare System)
SCHIP: State Children's Health Insurance Program
SCSN: Statewide Coordinated Statement of Need
SDM: Service Delivery Model
SEQY: Summary Earnings Query
SFAN: *South Florida AIDS Network**
SPNS: Special Projects of National Significance
SSA: Social Security Administration
SSDI: Social Security Disability Income
SSI: Supplemental Security Income
STD/STI: Sexually Transmitted Diseases or Infection
TA: Technical Assistance
TANF: Temporary Assistance to Needy Families
TasP: Treatment as Prevention
TB: Tuberculosis
TGA: Transitional Grant Area
TOPWA: Targeted Outreach to Pregnant Women Act
TPQY: Third Party Query
UCHAPS: Urban Coalition for HIV/AIDS Prevention Services
VA: United States Department of Veteran Affairs
VL: *Viral Load**
WMSM: White Men who have Sex with Men
WICY: Women, Infants, Children, and Youth

**Also in Integrated Lexicon of Terms (Attachment 2)*

ATTACHMENT 2: Integrated Lexicon

Integrated Lexicon

ACRONYM	*TERM*	*COMMON DEFINITION** **Language approved by Integrated Planning Team*
ADAP	**AIDS Drug Assistance Program**	Administered by States and authorized under Part B of the Ryan White Treatment Modernization Act. Provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured Ryan White HIV/AIDS Program clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.
	ADAP Premium Plus	A component of the AIDS Drug Assistance Program that assists with private and public insurance coverage for persons living with HIV/AIDS (PLWHA)
AETC	**AIDS Education and Training Center**	Regional centers providing education and training for primary care professionals and other AIDS-related personnel. Part F (AETC)s are authorized under Part F of the Ryan White HIV/AIDS Program and administered by the HRSA HIV/AIDS Bureau's Division of Training and Technical Assistance (DTT).
BCHPPC	**Broward County HIV Prevention Planning Council**	This is a government-community partnership to enhance High Impact Prevention (HIP) for the highest risk populations and includes key stake holders in HIV Prevention and care and related services and organizations that support the development and implementation of a jurisdictional HIV prevention plan. Leadership is guided by the co-chairs.
	Broward County Priority Populations:	The top 9 priority populations, in the most recent year, for primary and secondary HIV prevention based on persons living with HIV disease.
CD4	**Cluster of differentiation 4**	Also known as a T-cell or T4-cell. HIV destroys the CD4 cells and weakens the immune system. The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal adult range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. (The normal range for infants is considerably higher and slowly declines to adult values by age 6 years.) CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm3. If the count is lower, testing every 3 months is advised. (In children with HIV infection, CD4 values should be checked every 3 months.) A CD4 count of 200 or less is an AIDS-defining condition.

ACRONYM	*TERM*	*COMMON DEFINITION** **Language approved by Integrated Planning Team*
CIED	**Centralized Intake and Eligibility Determination**	Entry point for Broward County HIV positive residents accessing Part A medical and support services.
CLD	**Client Level Data**	A client record including demographic status, HIV clinical information, HIV-care medical and support services received, and the client's 'UCI', an encrypted, unique client identifier.
	Community	Representatives of HIV/AIDS care in community, including but not limited to consumers, providers, regulators, businesses, and Broward County Schools.
	Data to Care	Data to Care is a new public health strategy that aims to use HIV surveillance data to identify HIV-diagnosed individuals not in care, link them to care, and support the HIV Care Continuum.
	HIV Care Continuum	The HIV Care Continuum is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression, and shows the proportion of individuals living with HIV who are engaged at each step. It provides a frameworks to better understand HIV care and treatment in the United States.
	HIV Prevention Care Continuum	The HIV Prevention Care Continuum builds on HIV testing as its foundation followed by linkage of HIV-uninfected persons to prevention services, retention in services, and adherence to services to prevent HIV acquisition and transmission. The common desired endpoint of the prevention continuum is ensuring that individuals remain HIV-uninfected.
	HRSA Continuum of Care	The continuum focuses on several steps of HIV service delivery, including diagnosis, linkage to care, retention in care, ART, and viral load suppression. It encompasses the fluid nature of HIV health care delivery and patient experience.
HIVPC	**Broward County HIV Health Services Planning Council**	A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to assess needs, establish a plan for the delivery of HIV care in the EMA, and establish priorities for the use of Ryan White HIV/AIDS Program Part A funds. Created in Chapter 21, Part X, Broward County Administrative Code, and mandated by the Ryan White ACT.
IC	**Integrated Committee**	Comprised of eight members, inclusive of two co-chairs, of community stakeholders and consumers from each planning body (HIVPC and BCHPPC) responsible for the general oversight and implementation of the integrated plan.
IDC	**Integrated Development**	Comprised of HIV Prevention, Care and Treatment grantees (with established and completed work plans) in Broward County, including but not limited to Florida

ACRONYM	*TERM*	*COMMON DEFINITION** **Language approved by Integrated Planning Team*
	Collaborative (Stakeholder)	Department of Health in Broward County, Ryan White Part A-F, HOPWA, and CDC/DASH.
ILT	**Integrated Leadership Team**	Comprised of HIV Prevention and Ryan White senior leadership responsible for the direction and guidance of the Integrated planning process and has authority to approve final Integrated plan products.
IPT	**Integrated Planning Team**	The core committee responsible to develop and implement strategies that strengthen collaboration and coordination among all Ryan White Parts, HOPWA, and Prevention. This committee also oversees the overall progress of all integrated planning activities
JLP	**Jail Linkage program**	Interventions in providing linkages to HIV primary care services for jail releases, and integrating services for them within the community's HIV continuum of care.
LPAP	**Local Pharmaceutical Assistance Program**	A supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria. It is operated by a Ryan White Part A or B recipient or sub-recipient.
	Mathematical Modeling	A methodology used to estimate the costs necessary to achieve the NHAS Goals on the epidemiologic and economic importance of the National AIDS Strategy for the United States.
PE	**Provide Enterprise**	Provide Enterprise developed by Groupware Technologies, Inc. (GTI) is a web-based relational, integrated data system used by Broward County Ryan White Part A program to collect client-level data on sociodemographic and epidemiologic characteristics, intake and eligibility, detailed procedure-level service units, clinical outcomes, invoices, and payments. This software is used system-wide across a network of providers to collect data that is subsequently utilized for electronic reporting as well as synchronized real time care coordination of Broward County Ryan White Part A Clients.
	Public Health Detailing	A primary care provider outreach initiative modeled on pharmaceutical detailing.
	Ryan White Comprehensive Plan	The process of determining the organization and delivery of HIV Services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PLWH.
	Ryan White CARE Act	CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act) is a federal legislation created to address the unmet health care and service needs of people living with HIV (PLWH) disease and their families. It was enacted in 1990 and reauthorized in 1996 and 2000. Reauthorized in 2006 as the Ryan White Treatment Modernization Act.

ACRONYM	*TERM*	*COMMON DEFINITION** **Language approved by Integrated Planning Team*
	Ryan White HIV/AIDS Treatment Modernization Act of 2006	(Public Law 109-415, December 19, 2006)
	Ryan White Part A	The part of the Ryan White HIV/AIDS Program (formerly, Title I) that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV/AIDS epidemic. This includes outpatient medical care, AIDS Pharmaceuticals Assistance, Oral Care, Health Insurance premiums and cost sharing assistance, mental health services, Medical Case Management, Outpatient Substance Abuse, Food Bank/home delivered meals, and legal services.
	Ryan White Part B	The part of the Ryan White HIV/AIDS Program (formerly, Title II) that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PLWHA and their families. This includes ADAP, Health Insurance Premium and cost sharing assistance, Home and Community Based Health Services, and Medical Transportation Services.
	Ryan White Part C	The part of the Ryan White HIV/AIDS Program (formerly, Title III) that supports outpatient primary medical care and early intervention services to PLWHA through grants to public and private non-profit organizations. Part C also funds capacity development and planning grants to prepare programs to provide Early Intervention Services. This includes Early Intervention Services, Non-medical Case Management, Treatment Adherence Counseling, and HIV Testing.
	Ryan White Part D	The part of the Ryan White HIV/AIDS Program (formerly, Title IV) that supports coordinated services and access to research for children, youth, and women with HIV disease and their families. This includes Outpatient Medical Care, Mental Health Services, Medical Nutrition Therapy, medical Case Management, Non-medical Case Management, Health Education/Risk Reduction, Outreach Services, and Psychosocial Support Services.
	Ryan White Part F	Oral Health Care.
VL	**Viral Load**	In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.
SFAN	**South Florida AIDS Network**	Consortia act in an advisory capacity to the state for the purpose of planning and prioritizing the use of Part B funds; provide a forum for the infected individuals and affected communities, providers and others; and facilitate the provision of coordinated, comprehensive health and support services to people infected and affected by HIV/AIDS. A consortium must include people living with HIV/AIDS.

		Responsibilities include: participation in the needs assessment process; development of service priority funding recommendations; participation in the development of the comprehensive; Promotion of the coordination and integration of community resources.
	Transgender	Umbrella term for those who identify or express themselves in a manner different than that which was assigned at birth.
	Vulnerable Populations	A subset of the Broward County Priority Populations that has documented disparities in either the receipt of HIV related services or outcomes along either the HIV Prevention and HIV Care Continuums.

Provider list:

Broward Addiction Recovery Center
Children's Diagnostic and Treatment Center
North Broward Hospital District (Broward Health)
Nova Southeastern University
South Broward Hospital District (Memorial Healthcare System)

Attachment 3: Availability of Public Funds for HIV services in FY 2016

Coordination of Services and Funding, Broward County FY 2016																																				
Funding Source	**FY 2016 Budget**	**HIV Care Continuum**					**Core Medical Services**											**Support Services**																		
		HIV Diagnosed	Linkage to Care	Retained in Care	Antiretroviral Use	Viral Suppression	OAMC (Outpatient /Ambulatory Medical Care	ADAP	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home & Community-based Health Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing	High Impact Prevention
	$ Amount																																			
Part A	$14,833,220	x	x	x	x	x	x		x	x		x		x		x					x			x												
Part B	$1,814,776	x	x	x	x	x						x	x				x				x					x					x					
Part C	$452,547	x	x	x	x	x					x							x													x	x				
Part D	$1,896,580	x	x	x	x	x	x							x	x	x		x				x					x	x								
Part F	$235,000	x	x	x	x	x				x																										
CDC PS12-1201 (High Impact Prevention)	$5,523,405	x	x	x	x	x																														x
CDC – PS13-1308 (School Based HIV/STD Prevention)	$578,000	x																													x				
SAMHSA	$499,886	x	x	x	x	x												x													x				
HOPWA	$6,799,511			x														x		x			x	x					x	x				

Coordination of Services and Funding, Broward County FY 2016																																
		HIV Care Continuum					**Core Medical Services**											**Support Services**														
Funding Source	**FY 2016 Budget**	HIV Diagnosed	Linkage to Care	Retained in Care	Antiretroviral Use	Viral Suppression	OAMC (Outpatient /Ambulatory Medical Care	ADAP	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home & Community-based Health Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing	High Impact Prevention
Total	$32,632,925																															

Attachment 4: Provider and Service Inventory

AGENCY NAME	AGENCY ADDRESS/TELEPHONE NUMBER	Ryan White Services											Prevention Services									
		Centralized Intake (CIED)	Medical	Pharmacy	Dental	Mental Health	Substance Abuse	Case Management	Medical Case Management	Health Insurance Continuation Program	Legal Services	Food Services	Referral for Health Care Services	HIV Testing	STI Testing	Outreach	Condom Distribution	Intervention	BRTA/FRTA	Pregnancy Testing	TOPWA Enrollment	Social Marketing
AIDS Healthcare Foundation (AHF)	AHF Wellness Center & Pharmacy Wilton Manors - 954-494-8013 2097 Wilton Dr, Wilton Manors 33305			●										●	●	●	●					
	Northpoint Healthcare Center - 954-772-2411 6405 N. Federal Highway, # 2015 Ft. Laud. 33308	●	●	●				●	●					●			●					
	Out of the Closet & Pharmacy Sunrise 954-462-9223 1785 E. Sunrise Blvd., Ft Lauderdale 33304			●										●		●	●					
	Oakland Park Healthcare Center - 954-561-6900 1164 E. Oakland Park Blvd., 3rd Floor Ft. Lauderdale 33334	●	●	●				●	●					●			●					
	Broward Wellness Center - 954-767-0273 200 SE 3rd Ave, 4th Floor Ft. Lauderdale 33316													●		●	●					
	One River Plaza Healthcare Center - 954-767-0687 305 S. Andrews Ave., #601, Ft. Lauderdale 33301	●	●					●	●					●			●					
Broward Community & Family Health Centers	Health Center - 954-970-8805 368 North Powerline Road, Pompano 33069	●	●					●	●					●	●							
	Central Broward Community Health - 954-583-4710 1229 NW 40th Avenue, Lauderhill 33313		●																			
Broward Health (NBHD)	Comprehensive Care - 954-467-0880 1101 N.W. 1st Street, Ft. Lauderdale 33311	●	●					●	●					●		●	●	●				
	Children's Diagnostic & Treatment - 954-728-1088 1401 S. Federal Highway, Ft. Lauderdale 33316	●	●											●			●			●	●	
	Bernard P. Alicki Health Pharmacy - 954-527-6042 1101 W. Broward Blvd., Ft. Lauderdale 33312			●																		
	Broward Health Medical Center - 954-522-3355 1600 S. Andrews Ave., Ft. Lauderdale 33316			●																		
	Cora E. Brayson Family Health - 954-759-6600 200 NW 7th Ave., Ft. Lauderdale 33311		●	●																		
	Annie L. Weaver Health Center 2011 N. W. 3rd Avenue, Pompano Beach, 33060 Medical: (954) 786-5903 Case Management: (954) 786-5929		●						●													
	Specialty Care Center 1111 W. Broward Blvd., Ft. Laud, 33312 Medical: - 954-463-7313 Pharmacy - 954-463-7313 Case Management: - 954-527-6064	●	●	●					●													
	Comprehensive Care at Broward House - 954-522-4749 1726 SE 3rd St., Ft. Lauderdale 33316		●					●														
Broward County Health Department	Paul Hughes Health Center - 954-213-0638 205 NW 6th Ave, Pompano Beach, 33060	●		●	●									●			●			●		
	Fort Lauderdale Health Center - 954-467-4700 2421 SW 6th Ave., Ft. Lauderdale 33315	●		●	●		●			●		●	●	●		●	●	●	●	●		●
	S. Regional Health Center 4105 Pembroke Rd, #C107, Hollywood 33021 Dental - 954-372-4818 2				●																	
Broward Regional Health Planning Council	Broward Regional Health Planning - 954-566-1417 200 Oakwood Lane # 100 Hollywood 33020	●								●												
Broward House	501 S.E. 18th Court, Ft. Lauderdale 33316 954-523-8454					●		●						●	●	●	●					
	2600 N. Andrews Ave., Wilton Manors 33311 954-568-2373	●						●														
Care Resource	871 W. Oakland Park Blvd, Oakland Park 33311 954.567.7141	●	●			●		●						●	●	●	●	●				
Legal Aid Services of Broward County	954 765-8950 491 North State Road 7, Plantation, FL 33317										●											
Memorial Healthcare System (SBHD)	Memorial Regional Hospital Campus - 954-265-6130 1130 N. 35th Avenue, Hollywood 33021	●	●			●	●	●						●								
	Memorial Center for Behavioral Health - 954-276-3422 3400 N 29th Ave., Hollywood 33020					●	●															
Nova Southeastern University	954 568-7709 3200 S University Drive, Ft. Laud 33328				●																	
	954-568-7709 830 E Oakland Park Blvd #103, Oakland Park, 33334				●																	
Poverello Center	954.561.3663 2156 N. Dixie Hwy Wilton Manors 33305	●										●										
Holy Cross Hospital	4725 N Federal Hwy, Fort Lauderdale, FL 33308													●								
The Pride Center	2040 N Dixie Hwy, Fort Lauderdale, FL 33305												●	●		●	●	●	●			●
Latinos Salud	2330 Wilton Dr, Wilton Manors, FL 33305												●	●	●	●	●	●				

Attachment 5: Broward County's Integrated HIV Prevention and Care Plan 2017-2021

Broward County's Integrated Prevention and Care Plan 2017 – 2021					
Our VISION: *A transformative and transparent integrated planning process that embraces local funding, leverages opportunities for collaboration with strategic alliance, into a singular process to achieve National HIV/AIDS Strategy (NHAS) goals and objectives.* ***Our MISSION:*** *We are committed to the stewardship of public funds through efficient, deliberate, and innovative processes that maximize the use of resources to reduce new HIV infections and community viral load in Broward County.*					
Goal 1: Reduce New HIV Infections					
Objective 1.1 **Reduce the number of new infections by 25%.**			***2021 Target:*** **745**	***2014 Baseline Measure: 993***	
Strategy 1.1.a	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Provide education to medical providers and community based organizations to promote HIV routine testing	1. Establish a partnership with the Broward County Medical Association to promote HIV testing as part of routine medical care. 2. Provide professional development and technical assistance to build skills and increase knowledge to promote routine HIV screening and testing in clinical and non-clinical settings. 3. Develop and disseminate Provider Toolkits to enable	1. Broward County Medical Association 2. Medical and non-medical providers 3. Medical providers 4. Prevention and Ryan White providers; Medical associations; Southeast AETC	1. Year 1 2. Year 1-5 3. Year 1-5 4. Year 1-5 5. Year 1-5 6. Year 1-5 7. Year 1-2 8. Year 2 9. Year 1-5	1. DOH-Broward; BCHPPC 2. DOH-Broward 3. DOH-Broward 4. DOH-Broward; BCHPPC 5.DOH-Broward 6.DOH-Broward 7.DOH-Broward; BCHPPC 8. DOH-Broward; Ryan White Part A	1. Partnership Established 2. Number of medical providers that received technical assistance 3. Number of provider toolkits disseminated 4. Number physician ambassadors recruited and retained 5. Number of HIV/STIs/HCV education and testing events 6. Number outreach and education sessions provided

	effective implementation of routine HIV testing, including state and local "Dear Colleague" letters referencing the new Florida HIV testing law. 4. Recruit and retain physician ambassadors from Prevention and Ryan White providers, medical associations and Southeast AETC to promote routine HIV/STI/HCV screening and testing in clinical settings. 5. Conduct education and testing events each year that screen for HIV/STIs/HCV in conjunction with medical providers and community-based organizations. 6. Provide outreach and education to healthcare providers about innovations in funding HIV testing in clinical settings and third party billing reimbursement. 7. Develop and support culturally sensitive and linguistically appropriate social marketing and media campaigns for effective messaging and interventions, for example, CDC Campaign "Razones"	5. Broward County Priority Populations 6. Medical providers 7. Broward County Priority Populations 8. Medical providers 9. Broward County Priority Populations		Program Recipient Office 9.DOH-Broward; BCHPPC	7. Number of culturally sensitive and linguistically appropriate social marketing and media campaigns 8. Number of developed aggregate reports 9. Measure of availability, accessibility, and acceptability of condoms

	8. Develop aggregate reports to include provider score cards regarding key processes, performance measures and outcomes. 9. Increase the availability, accessibility, and acceptability of condoms.				
Strategy 1.1.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Increase education and access to PrEP/nPEP for persons at highest risk of HIV acquisition.	1. *Conduct a demonstration project involving the direct provision of PrEP/nPEP through STD clinics or with community clinical partners with specific emphasis on minority communities.* 2. Create social marketing and social media campaigns to inform individuals living with HIV and the general community about the appropriate use of PrEP/nPEP. 3. Develop and implement PrEP community ambassadors program and marketing materials to disseminate information and available PrEP resources to individuals who are at-risk of new HIV infections. 4. Conduct public health detailing and companion	1. Broward County Priority Populations; STD Clinics; Community clinic partners 2. Broward County Priority Populations 3. Broward County Priority Populations 4. Medical and non-medical providers	1. Year 2 2. Year 2 3. Year 3 4. Year 5	1.DOH-Broward; BCHPPC 2. DOH-Broward; BCHPPC 3.DOH-Broward; BCHPPC 4. DOH-Broward	1. Demonstration project conducted 2. Number of social marketing and social media campaigns created 3. PrEP community ambassadors program implemented; Number of marketing materials distributed. 4. Number of public health detailing and workshops conducted

	workshops to support implementation of PrEP throughout Broward County.				
Strategy 1.1.c	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Increase provider knowledge of PrEP and other bio medical interventions.	1. Include PrEP/nPEP as a core competency in provider-focused HIV prevention education and training with special emphasis on clinical settings and emergency departments. 2. Develop a PrEP/nPEP toolkit for dissemination to the provider community. 3. Increase provider web-based content about PrEP/nPEP on the www.BrowardGreaterthan.org website with links to clinical guidelines. 4. Develop a Broward PrEP/nPEP Referral Network and provide technical assistance to sites wishing to participate. 5. Monitor the uptake of PrEP/nPEP in Broward County through the use of surveys, provider report forms, databases, etc. to further guide program implementation.	1. Medical providers 2. Medical providers 3. Broward County Priority Populations; medical providers 4. Medical providers 5. Broward County Priority Populations	1. Year 1-5 2. Year 1-2 3. Year 1-5 4. Year 1-3 5. Year 1-5	1. DOH-Broward; 2.DOH-Broward; BCHPPC 3. DOH-Broward 4. DOH-Broward 5. DOH-Broward	1. Number of provider-focused HIV prevention education and trainings that include PrEP/nPEP as a core competency 2. PrEP/nPEP toolkit developed 3. Number of provider we-based content added or updated on PrEP/nPEP 4. Broward PrEP/nPEP Referral Network developed; Number of sites that received technical assistance. 5. Monitoring and Evaluation plan conducted

Objective 1.2 Reduce the number of pediatric HIV transmission cases to zero			***2021 Target: 0***	***2014 Baseline Measure: 0***	
Strategy 1.2.a	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Engage and educate medical providers	1. Provide education and training to birthing centers and venues that support alternative birthing methods to provide rapid HIV testing. 2. Distribute Perinatal HIV toolkits to all delivery hospitals, OB/GYN, and Pediatrician offices in Broward County. 3. Provide perinatal symposiums to the medical provider community on emerging issues and trends facing positive pregnant women.	1.Birthing centers 2. Delivery hospitals, OB/GYN, and Pediatrician offices 3. Medical providers	1. Year 1-5 2. Year 1-5 3. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward	1. Number of trainings provided 2. Number Perinatal HIV toolkits distributed 3. Number of perinatal symposiums provided
Strategy 1.2.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Provide effective case management services to positive pregnant women to ensure compliance with medication and monitoring of viral load.	1. Expand visits to birthing centers, venues that support alternative birthing methods and OB/GYN offices to foster collaboration and communication. 2. Conduct prenatal classes to help prepare women for childbirth. 3. Provide education and training to partners as appropriate to promote	1. Birthing centers 2. Pregnant individuals 3. Medical providers 4. Pregnant individuals	1. Year 1-5 2. Year 1-5 3. Year 1-5 4. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward 4. DOH-Broward	1. Number of visits conducted 2. Number of prenatal classes 3. Number of training sessions provided 4. Number of pregnant clients who are contacted by Linkage to Care Coordinators (PROACT Staff)

	healthy pregnancy and birth outcomes. 4. Maintain and document contact with pregnant individuals who are HIV positive to ensure compliance with treatment and medication adherence.				
Strategy 1.2.c	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Provide timely follow-up to positive delivering women and exposed newborns immediately upon delivery.	1. Conduct chart reviews at delivery to further reduce mother to child transmission. 2. Conduct post-delivery follow-ups to ensure mother and child are continuing with treatment and medication as prescribed. 3. Expand postnatal classes to provide education and support for mothers and their partners.	1. Medical providers; pregnant individuals 2. Medical providers; pregnant individuals 3. Pregnant individuals	1. Year 1-5 2. Year 1-5 3. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward	1. Number of chart reviews conducted 2. Number of post-delivery follow-ups conducted 3. Number of postnatal classes conducted
Objective 1.3 Increase the number of Broward county residents who have not previously tested for HIV by 5% each year.			***2021 Target: 16,627***	***2014 Baseline Measure: 13,028***	
Strategy 1.3.a	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Increase the number of routine testing sites in publicly funded healthcare, and	1. Provide education and promote adherence to operate under the guidance of the new Florida HIV Testing Law (Statute 381.004). 2. Establish a collaborative agreement to model routine	1. Medical providers 2. Medical providers 3. Broward County Priority Populations	1. Year 1-5 2. Year 1-2 3. Year 1-5 4. Year 1-5 5. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward 4. DOH-Broward; Ryan White Part A	1. Number of educational sessions provided 2. Collaborative agreements established 3. Number of testing activities conducted in

non-healthcare settings.	testing in accordance with the new Florida HIV Testing Law (Statute 381.004). 3. Use geo mapping to identify areas that are underserved by HIV/STI/HCV testing staff in order to coordinate testing activities by using geo-mapping and other methodologies. 4. *Expand the number of community providers for the delivery of key sexual health services, with a focus on HIV/STIs/HCV testing and treatment for vulnerable populations (i.e. adults over 50, youth, transgender, etc.)* 5. Develop education strategies for testing and treating vulnerable populations.	4. Community providers 5. Broward County Priority Populations		Program Recipient Office 5. DOH-Broward; BCHPPC	underserved areas identified 4. Number of community providers 5. Number of developed strategies for testing and treating vulnerable populations
Strategy 1.3.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Inform 100% of positive individuals of their diagnosis within 30 days of testing.	1. Provide expanded opportunities for on-site rapid testing. 2. Identify individuals testing positive who have not returned for their results, engage them through outreach efforts to inform them of their diagnosis and provide linkage to care and follow-up services.*	1. Broward County Priority Populations 2. PLWH 3. PLWH	1. Year 1-5 2. Year 1-5 3. Year 1-5	1. DOH-Broward 2. DOH-Broward 3.DOH-Broward	1. Number of on-site rapid testing with timely results and counseling 2. Number of clients who are contacted by HIV DIS within 14 days of diagnosis; Number of positive clients linked to care by DIS and linkage coordinators

	3. Monitor and evaluate the numbers of individuals testing positive who have not returned for their results and track activities to engage.*				3. Monitoring and Evaluation conducted
Strategy 1.3.c	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Identify opportunities to expand HIV testing efforts in non-traditional settings.	1. Develop and implement concierge in-home HIV testing. 2. *Identify and collaborate with agencies to create and promote social marketing platforms on HIV testing.* 3. Conduct geo mapping and ethnographic methodologies to identify underserved areas	1. Broward County Priority Populations 2. Agencies in Broward County 3. Underserved areas	1. Year 1-5 2. Year 1-5 3. Year 1	1. DOH-Broward 2. DOH-Broward; BCHPPC 3. DOH-Broward; BCHPPC	1. Number of in-home HIV testing conducted 2. Number of collaborations with agencies on social marketing platforms on HIV testing 3. Number of identified underserved areas through the use of geo mapping and ethnographic methodologies

Goal 2: Increase Access to Care and Improve Health Outcomes					
Objective 2.1 **Increase the percentage of newly diagnosed individuals who are linked to HIV medical care within 1 month of diagnosis**			***Target: by 85%***	***2014 Indicator: 53.7%***	
Strategy 2.1.a	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Establish a seamless system between testing and care and treatment to facilitate access and ensure linkage.	1. Design a Ryan White/Prevention Collaborative model that ensures a seamless continuum for PLWH to transition from testing and counseling sites to linkage, treatment and retention in Medical Care. * 2. Implement "Test and Treat" immediately following a positive HIV test result to reduce transmission and improve morbidity and mortality in all stages of infection. * 3. Design and/or modify data reporting systems to track PLWH along the HIV Care Continuum from time of diagnosis.* 4. Develop targeted strategies and interventions for individuals who may not seek care or who may fall out of care. *	1. Broward County Priority Populations; PLWH 2. PLWH 3. PLWH 4. PLWH 5. Ryan White Providers 6. PLWH 7. Ryan White medical providers	1. Year 1-2 2. Year 1-5 3. Year 1-5 4. Year 1-2 5. Year 1-5 6. Year 1-5 7. Year 1-5	1. BCHPPC; HIVPC 2. DOH-Broward; Ryan White Part A Program Recipient Office 3. Ryan White Part A Program Recipient Office; HIVPC 4. Ryan White Part A Program Recipient Office; HIVPC 5. Ryan White Part A Program Recipient Office; HIVPC 6. BCHPPC; HIVPC 7. Ryan White Part A Program Recipient Office; HIVPC; All Ryan White Grantees	1. Design a model that ensures a seamless continuum 2. Number of clients that received ART following the "Test and Treat" model 3. Data reporting system designed 4. Number of developed interventions for vulnerable populations who may not seek care or who may fall out of care. 4. Number of targeted strategies and interventions 5. Pilot project established 6. Barriers and limitations identified 7. Contract monitoring and reporting

	5. Establish pilot project for integrated electronic medical record sharing across providers. 6. Identify access barriers and limitations to HIV medical care related to other support services, such as housing, transportation, employment, education, behavioral health, intimate partner violence, incarceration, and childcare.* 7. Ensure MOUs between testing and Ryan White funded medical care and treatment providers are implemented.				
Strategy 2.1.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Strengthen the delivery of integrated services through the provision of training, technical assistance, and access to community resources.	1. Refine roles and responsibilities and develop competencies for linkage providers, peer education, eligibility, non-medical/medical case management, clinical, and ancillary personnel. 2. Provide training and coaching in culturally sensitive and linguistically	1. Linkage providers, peer education, eligibility, non-medical/medical case management, clinical, and ancillary personnel.	1. Year 1-2 2. Year 1-5 3. Year 1-5 4. Year 1-5	1. Ryan White Part A Program Recipient Office; HIVPC 2. Ryan White Part A Program Recipient Office; HIVPC 3. DOH-Broward; Ryan White Part A Program	1. Competencies developed 2. Number of trainings and coaching provided 3. Community Resource Guide developed 4. Capacity building assistance received

	appropriate competencies with pre and post testing to assess knowledge acquisition and skill development. 3. Develop and maintain a Community Resource Guide inclusive of all available services by priority population and geographic location. 4. Request capacity building assistance on evidence based biomedical interventions, public health strategies and behavioral interventions	2. Medical Providers 3. Medical services in Broward County 4. HIV prevention workforce		Recipient Office; BCHPPC; HIVPC 4. DOH-Broward	
Strategy 2.1.c	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Support retention in care to achieve viral suppression that can maximize the benefits of early detection and reduce transmission risk.	1. Develop and implement standardized Patient Navigator tool. * 2. Research the development of a Patient Assistance mobile device application.*	1. Medical providers 2. PLWH	1. Year 1-5 2. Year 1-5	1. DOH-Broward; BCHPPC 2.DOH-Broward; Ryan White Part A Program Recipient Office	1. Number of service providers utilizing Patient Navigator tool 2. Research on mobile device application conducted
Objective 2.2 **Increase the percentage of PLWH who are retained in medical care.**			***Target: by 90%***	***2014 Indicator: 65%***	
Strategy 2.2.a	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***

Increase retention in care and viral load suppression through coordinated and integrated activities between and among prevention and care and treatment providers.	1. Utilize engagement reports to identify areas of improvement, including characteristics of individuals who are not retained in care as well as those who have unsuppressed viral loads. * 2. Conduct utilization focused evaluation of the HIV Care Continuum to identify and address the "drop-offs" along the stages specific to testing site, service provider, geographic location, and individual characteristics. * 3. Develop data sharing agreements among all HIV prevention, care and treatment providers for designated MIS system.	1. PLWH 2. PLWH 3. HIV Prevention, Care and Treatment providers	1. Year 1-2 2. Year 1-2 3. Year 1-5	1. Ryan White Part A Program Recipient Office; Ryan White grantees 2. Ryan White Part A Program Recipient Office; DOH-Broward 3. Ryan White Part A Program Recipient Office; DOH-Broward	1. Areas of improvement identified 2. Utilization focused evaluation conducted 3. Data sharing agreements developed
Strategy 2.2.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Identify individuals who have fallen out of care and implement strategic interventions to re-engage.	1. Create a system to obtain real-time, client level data for all ADAP clients. 2. *Develop and implement a plan to provide simultaneous certification for ADAP and Ryan White Part A services.*	1. ADAP 2. ADAP and Ryan White Part A clients 3. Ryan White Part A receipts 4. MCMs, pharmacists, and Part A clinician	1. Year 1-5 2. Year 1-5 3. Year 1-5 4. Year 1-5 5. Year 1-2 6. Year 1-3 7. Year 1-5 8. Year 1-2 9. Year 1-2	1. Ryan White program 2. Ryan White Part A Program Recipient Office; Ryan White grantees 3. Ryan White Part A Program	1. System created 2. Number of clients certified simultaneously 3. Emergency ART provided 4. Number of MCMs, pharmacists, and Part A clinicians

	3. Provide emergency ART through Part A and other community resources to ensure clients do not experience disruption in treatment.* 4. Educate MCMs, pharmacists, and Part A clinicians about the availability of emergency ART. 5. Develop feedback mechanisms with individuals who have fallen out of care as well as those with unsuppressed viral loads to determine root causes.* 6. Enhance and expand the linkage and retention program (PROACT) module in the MIS system to allow data sharing and develop aggregate reports of Ryan White Part A clients and for referral mechanisms. 7. Monitor and evaluate the use of linkage and retention services and conduct analysis of the services to identify trends, challenges with data reporting, and areas for improvement.*	5. PLWH 6. Ryan White Part A clients 7. Linkage and retention services 8. Disease Intervention Specialists 9. Peer Network 10. PLWH 11. Case managers, peers, and community health workers 12. PLWH	10. Year 1-2 11. Year 1-5 12. Year 1-3	Recipient Office; Ryan White grantees 4. Ryan White Part A Program Recipient Office; HIVPC 5. Ryan White Part A Program Recipient Office; HIVPC 6. Ryan White Part A Program Recipient Office 7. Ryan White Part A Program Recipient Office 8. DOH-Broward 9. Ryan White Part A Program Recipient Office 10. Ryan White Part A Program Recipient Office; HIVPC 11. Ryan White Part A Program Recipient Office 12. DOH-Broward	5. Feedback mechanisms developed 6. Aggregate reports developed 7. Monitoring and Evaluation of linkage and retention services 8. Number of individuals re-engaged by DIS 9. Outreach and engagement activities provided 10. Opportunities created 11. Number of case managers, peers, and community health workers that participated in training modules 12. Evaluation conducted

	8. Expand the use of Disease Intervention Specialists to re-engage individuals who have fallen out of care.* 9. *Enhance Peer Network to provide outreach and engagement activities through case management services.* 10. *Create Community Health Worker certification and Peer Specialist certification opportunities for individuals working with PLWH.* 11. Design and implement a Ryan White System of Care training modules for local case managers, peers, and community health workers. 12. Evaluate the efficacy of prevention for positives evidence-based interventions in Broward County				
Strategy 2.2.c	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Expand collaborative partnerships with support service providers to reduce	1. Strengthen coordination with support services providers through case management models to	1. Ryan White Care Providers 2. Medical and support service providers	1. Year 1-3 2. Year 1-2 3. Year 1-3 4. Year 1-2	1. Ryan White Part A Program Recipient Office; All Ryan White grantees; HIVPC	1. Percent of clients retained in medical care 2. Strategy developed 3. Barriers identified; Strategies developed

the risks associated with social determinants of health.	maintain retention in medical care.* 2. Develop a strategy to provide comprehensive care including access to both medical and support services not covered by insurance plans.* 3. Identify barriers through satisfaction surveys and develop strategies to address those barriers.* 4. Develop relationships and MOUs with ancillary providers-housing, transportation, correctional health, education, employment, behavioral health, domestic violence, childcare, food and nutrition services and faith-based communities.	3. Support service providers 4. Ancillary providers		2. Ryan White Part A Program Recipient Office; HIVPC 3. Ryan White Part A Program Recipient Office; HIVPC 4. Ryan White Part A Program Recipient Office	4. relationships and MOUs developed

Goal 3: Reduce HIV-Related Disparities and Health Inequities					
Objective 3.1 Reduce disparities in the rate of HIV-related mortality among Black males, Black females and White males by at least 15%.			***2021 Target: 14.5, 13.9 and 8.6 respectively***	***2014 Baseline: 17.0, 16.4 and 10.1 respectively***	
Strategy 3.1.a	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***

Provide targeted interventions to populations and geographic locations identified as high risk for HIV.	1. Develop strategies specific to the needs, attitudes, and behaviors of the identified priority populations. 2. Develop a recruitment plan to increase the number of individuals applying for certification as Community Health Workers/Peer Specialists who may represent the people being served.	1. Broward County Priority Populations 2. Broward County Priority Populations	1. Year 1	1. BCHPPC 2. BCHPPC	1. Strategies developed 2. Recruitment plan developed
Strategy 3.1.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Provide culturally sensitive and relevant training to healthcare providers in the provision of scientifically proven, evidence-based care.	1. Continue education for all Care and Treatment Providers on HAB/Public Health standards. 2. Provide training to medical providers to address sexual health history, sexual orientation, gender identification, and social determinants of health. 3. Expand the Partnership for Health (PFH) model to train medical providers and contracted HIP medical providers to engage patients in discussions on sexual history, health, and disclosure.	1. Care and Treatment Providers 2. Medical Providers 3. Medical providers	1. Year 1 – Year 5 2. Year 2 3. Year 2	1. HIVPC 2. BCHPPC	1. Education sessions provided 2. Trainings provided 3. Medical providers trained on the expanded PFH model

Strategy 3.1.c	*Activity/Intervention*	*Target Population*	*Timeframe*	*Responsible Parties*	*Data Indicators*
Increase access to community resources that support the reduction of risk due to social determinants of health in areas of greatest disparity.	1. Develop pilot projects to address critical social and structural determinants of health. 2. Provide training to increase awareness and develop a response to structural and institutional racism in Broward County to medical and non-medical providers.	1. Broward County Priority Populations 2. Medial and non-medical providers	1. Year 3 2. Year 4	1. HIVPC; BCHPPC 2. DOH-Broward; Ryan White Part A Program Recipient Office	1. Pilot project developed 2. Trainings provided
Objective 3.2 Reduce stigma and discrimination against PLWH through implementation of at least 75% of identified strategies.			***2021 Target: 75% implementation***	***2014 Baseliner: 0%***	
Strategy 3.2.a	*Activity/Intervention*	*Target Population*	*Timeframe*	*Responsible Parties*	*Data Indicators*
Increase community engagement to promote education and awareness to affirm support for PLWH.	1. Coordinate feedback mechanisms that address HIV prevention, stigma, and treatment to assess HIV literacy. 2. Develop and implement education and awareness strategies that incorporate results from feedback mechanisms to increase HIV literacy. 3. Coordinate and train peer specialists and community ambassadors to educate and disseminate messaging to combat HIV-related stigma.	Broward County Priority Populations	1. Year 1 – 5 2. Year 2 3. Year 2 4. Year 3	1. HIVPC; BCHPPC 2. HIVPC; BCHPPC 3. HIVPC; BCHPPC 4. DOH-Broward; Ryan White Part A Program Recipient Office	1. Feedback mechanisms coordinated 2. Strategies developed and implemented 3. Number of peer specialists and community ambassadors trained 4. Social media and marketing strategies developed

	4. Develop social media and marketing strategies to target priority populations.				
Strategy 3.2.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Identify priorities related to legislation, regulations, and funding to promote opportunities for advocacy efforts to support individuals living with HIV.	1. Work with local, state, and federal leaders to identify legislative priorities. 2. Develop training opportunities for PLWH to learn how to become effective advocates for change. 3. *Identify funding opportunities to enhance the existing system and to develop collaborative partnerships with ancillary providers.*	1. Broward County Legislative Officials 2. Broward County Priority Populations 3. Ancillary Providers	1. Year 3 2. Year 3 3. Year 3	1. HIVPC; BCHPPC 2. DOH-Broward; Ryan White Part A Program Recipient Office	1. Legislative priorities identified 2. Training opportunities developed 3. Funding opportunities developed
Strategy 3.2.c	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Increase leadership opportunities for individuals living with HIV.	1. Identify emerging leaders representative of the HIV community. 2. Develop and implement an HIV Leadership Academy. 3. Promote opportunities for advocacy and leadership within the HIV community.	Broward County Priority Populations	1. Year 2 2. Year 3 3. Year 2-5	1. DOH-Broward; Ryan White Part A Program Recipient Office 2. DOH-Broward; Ryan White Part A Program Recipient Office	1. Number of Leaders identified 2. Number of individuals graduating from HIV Leadership Academy 3. Opportunities for advocacy and leadership promoted

				3. HIVPC; BCHPPC	

Goal 4: Achieve a More Coordinated Response to the Local HIV Epidemic					
Objective 4.1 Establish mechanisms for integration of cross-sector collaboration by implementing at least 50% of the identified strategies.			***2021 Target: 50% implementation***	***2014 Baseline: 0%***	
Strategy 4.1.a	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Develop a coordinated and integrated priority setting and resource allocation process and combined funding initiatives.	1. Establish formalized collaborative structure with stakeholders to ensure the community is meeting the needs of individuals and families. 2. Develop a combined data review process specific to integrated services and utilization. *3.* Establish integrated priority setting and resource allocation protocols.	Broward County Prevention, Care and Treatment Stakeholders	Year 4	DOH-Broward, All Ryan White Grantees, and Broward County Public Schools	1. Formalized collaborative structure established 2. Data review process developed 3. Protocols established
Strategy 4.1.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Create a system for standardized data	1. Develop strategies to	Funders and providers of	Year 5	DOH-Broward, All Ryan White	1. Strategies developed

collection and reporting.	streamline reporting requirements for funders of prevention, care, and HOPWA. 2. Develop and implement Shared Data Agreements between funders and providers to collect and analyze data in a more comprehensive manner.	prevention, care and treatment in Broward County		Grantees, and Broward County Public Schools	2. Shared data agreements developed and implemented
Strategy 4.1.c	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Cultivate a streamlined process for program monitoring and evaluation using Collective Impact Methodology.	*1. Develop strategy for coordinated RFP response.* *2. Establish comprehensive monitoring tool across funders to reduce duplication and increase efficiency.* *3. Foster shared outcomes across funders.*	Funders and providers of prevention, care and treatment in Broward County	Year 5	DOH-Broward, All Ryan White Grantees, and Broward County Public Schools	1. Strategy developed 2. Comprehensive monitoring tool established 3. Shared outcomes fostered
Strategy 4.1.d	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***

Provide networking and communication opportunities to address the epidemic.	1. *Create forums for Community Summits to identify strengths, challenges, opportunities and barriers for individuals living with HIV in Broward County.* 2. *Develop and disseminate multi-lingual and culturally sensitive information and forums to address the Latino community and other targeted populations.* 3. *Establish a multi-lingual Broward County Prevention, Care and Treatment Services website and social media strategy to comprehensively address the epidemic with*	Broward County Priority Populations	1.Year 1 2.Year 2 3.Year 3	1. HIVPC; BCHPPC 2. HIVPC; BCHPPC 3. DOH-Broward, Ryan White Part A Program Recipient Office and Broward County Public Schools	1. Strengths, challenges, opportunities and barriers identified 2. Information disseminated; Forums developed 3. Broward County Prevention, Care and Treatment Services website and social media strategy established

	consistent messaging across media outlets.				
Objective 4.2 Establish a structure for integrated continuity of care by implementing at least 50% of the identified strategies			***2021 Target: 50% Implementation***	***2014 Baseline: 0%***	
Strategy 4.2.a	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Develop opportunities for an integrated electronic healthcare record that is shared across providers.	1. *Create an Ad Hoc Task Force to identify essential elements to include in integrated healthcare record.* 2. *Identify funding opportunities to support integrated healthcare record model.* 3. *Identify vendor to create integrated healthcare record and opportunities to share across providers.*	Broward County's Care and Treatment Providers	Year 4	DOH-Broward and Ryan White Part A Program Recipient Office	1. Ad Hoc Task Force created 2. Funding opportunities identified 3. Vendor identified; Integrated healthcare record created
Strategy 4.2.b	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Create career paths for peer advocates and peer leaders.	1. *Define roles for peers that include both specific*	HIV positive persons	Year 1	HIVPC, BCHPPC and Integrative Collaborative	1. Roles defined 2. Number of individuals who attended peer training sessions

	responsibilities and follow-up to case managers. 2. *Develop and implement peer training sessions to equip individuals with the needed skills to serve in the capacity on health care teams.*				
Strategy 4.2.c	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Establish competency standards for all levels of providers and provide opportunities for workforce development.	1. *Identify competency standards for all levels of staff.* 2. *Develop training curriculum with pre and post testing to assess increase in knowledge and skills.* 3. *Assess the need for training and coaching follow-up sessions for all levels of providers.*	1. HIV Prevention, Care and Treatment workforce 2. HIV Prevention, Care and Treatment workforce 3. HIV Prevention, Care and Treatment providers	1. Year 1 2. Year 2 3. Year 1	HIVPC, BCHPPC and Integrated Collaborative	1. Competency standards identified 2. Training curriculum developed 3. Completed assessment
Strategy 4.2.d	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***

Promote cross-system, cross-sector collaboration.	1. *Strengthen coordination across data systems and the use of data to inform decision making among grantees and local organizations.* 2. *Establish ongoing networking and communication with HIV and ancillary providers to identify prospects for collaboration and challenges related to barriers.*	HIV prevention, care and treatment providers; ancillary providers	Year 3	DOH-Broward, All Ryan White Grantees, and Broward County Public Schools	1. Data systems strengthened; Data systems used to inform decision making 2. Ongoing networking and communication established
Strategy 4.2.e	***Activity/Intervention***	***Target Population***	***Timeframe***	***Responsible Parties***	***Data Indicators***
Commence a local implementation plan for "Getting to Zero" initiative.	1. Receive technical assistance for International Association of Providers of AIDS Care (IAPAC). 2. Obtain support from public and private sector stakeholders (i.e. elected officials	1. Broward County Priority Populations 2. Public and private stakeholders 3. Broward County Priority Populations	1. Year 1 2. Year 2 3. Year 3	DOH-Broward, All Ryan White Grantees, and Broward County Public Schools	1. Technical assistance received 2. Number of stakeholders providing support 3. Mathematical modeling evaluation conducted

	and corporations) to gain consensus around attaining the Fast Track Cities Initiative targets. 3. Utilize mathematical modeling to evaluate the resources needed to end AIDS in Broward County				

Table 2: Indicators to Measure Progress of Broward's Integrated Prevention, Care and Treatment Plan, Updated 2021 Targets

Indicator	*2014 Baseline*	*Data Source*	*2021 Target*
Reduce the number of new infections by 25%	993	eHARS	745
Reduce the number of pediatric transmission cases to zero	0	eHARS	0
Increase the number of Broward county residents who have not previously tested for HIV by 5% each year.	13,028	1628 Testing and Counseling Database	16,627
Increase the percentage of newly diagnosed individuals who are linked to HIV medical care within 1 month of diagnosis to 85%.	53.7%	eHARS	85%

Increase the percentage of PLWH who are retained in medical care to 90%.	65%	eHARS	90%
Reduce disparity in the rate of HIV-related mortality among Black males by at least 15%.	17.0	Vital Statistics	14.5
Reduce disparity in the rate of HIV-related mortality among Black females by at least 15%.	16.4	Vital Statistics	13.9
Reduce disparity in the rate of HIV-related mortality among White males by at least 15%.	10.1	Vital Statistics	8.6
Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%	61%	eHARS	80%

Attachment 6: Letters of Concurrence

Dear Ms. Greene and Mr. Young:

The Broward County HIV Health Services Planning Council (HIVPC) and the Broward County HIV Prevention Planning Council (BCHPPC) concur with the following submission by the Ryan White Part A Program and Florida Department of Health-Broward County HIV Prevention Program in response to the guidance set forth for the health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

Both the HIVPC and BCHPPC have reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. Both planning bodies concur that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1202 and the Ryan White HIV/AIDS Program legislation and program guidance.

The HIVPC and the BCHPPC identified members from their respective planning bodies to form the Integrated Committee (workgroup); responsible for developing, monitoring, and updating the Integrated Prevention and Care Comprehensive Plan for Broward County. The committee conducted a comprehensive analysis and review of data from both Part A and Prevention used to develop the plan and to provide robust recommendations to the Prevention and Care planning bodies. The committee received information from both planning bodies, synthesized the information, and served as the feedback loop for collaborative implementation of the Plan.

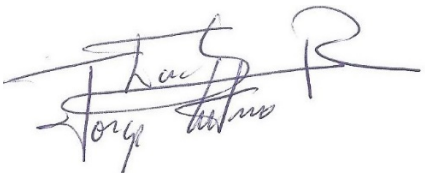
Based on the review of the Integrated HIV Prevention and Care Plan for 2017 through 2021, the HIVPC and BCHPPC reached consensus and concurrence with the priorities and strategies proposed in the Plan.

The HIVPC Chair and BCHPPC Community Co-Chair are designated as signatories to this letter of concurrence.

Sincerely,

_____ 9/16/2016

Brad Gammell, Chair — Date
Broward County HIV Health Services Planning Council



_____ 9/16/2016

Jorge Gardela, Community Co-Chair — Date
Broward County HIV Prevention Planning Council

Dear Ms. Greene and Mr. Young:

It is with great pleasure that we submit this letter of concurrence as Co-Chairs of the Integrated Committee (Workgroup), designated by the Broward County HIV Health Services Planning Council (HIVPC) and the Broward County HIV Prevention Planning Council (BCHPPC) in response to Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Integrated Committee (Workgroup) worked diligently to ensure planning activities encompassed comprehensive needs assessment, information and data sharing, cross representation on prevention and care planning bodies, and coordinated/combined projects. Members of the Integrated Committee (Workgroup) met monthly to ensure all HIV planning approaches were streamlined to increase access to and effectiveness of prevention, care and treatment services within the jurisdiction. Community involvement was an essential component for planning comprehensive and effective HIV prevention and care programs. This was exhibited through client and provider surveys, focus groups representing disproportionately affected populations, and several forums obtaining information directly reflected in the goals, objectives, activities and strategies identified in the Plan.

Furthermore, the Integrated Committee (Workgroup) concurs that the Plan demonstrates alignment with the goals of the National HIV/AIDS Strategy to effectively depict and address the HIV epidemic within Fort Lauderdale/Broward County.

The signatures below confirm the concurrence of the Integrated Committee (Workgroup) with the Integrated HIV Prevention and Care Plan.

Sincerely,

_____ 9/16/2016

Will Spencer, Co-Chair (Part A) Date
Integrated Committee (Workgroup)

_____ 9/16/2016

Jorge Gardela, Co-Chair (Prevention) Date
Integrated Committee (Workgroup)