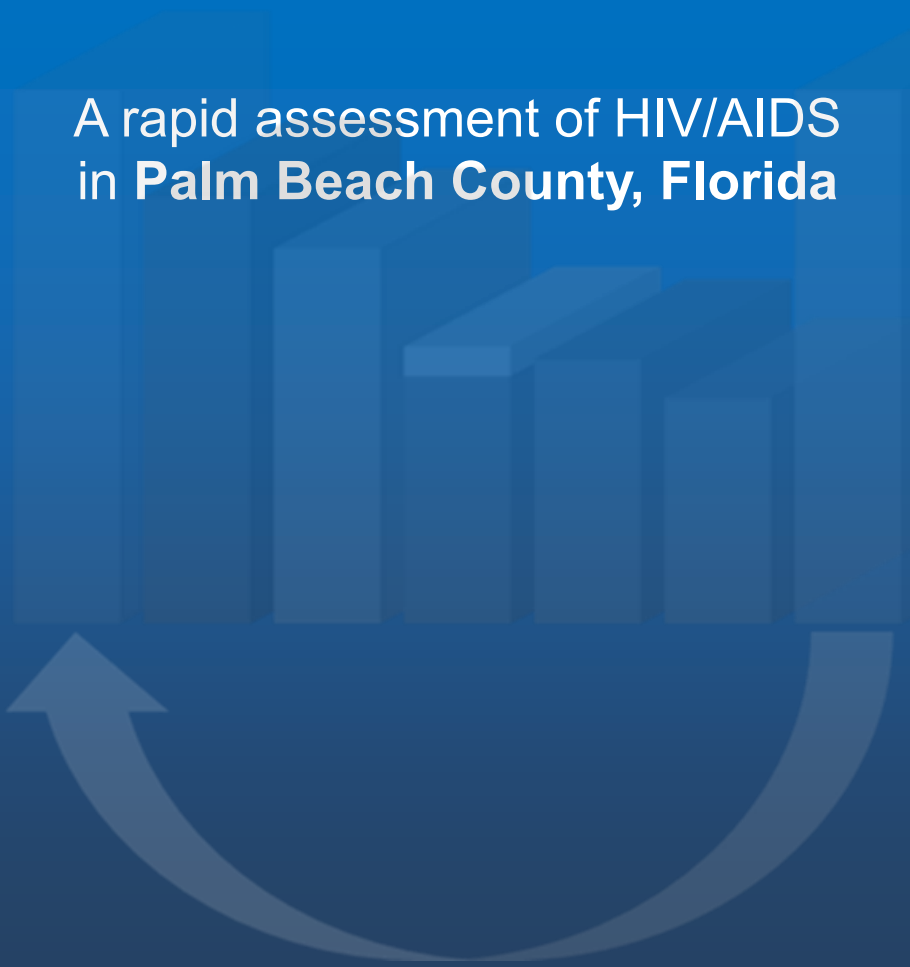
RARE 2015

A rapid assessment of HIV/AIDS
in **Palm Beach County, Florida**



HCSEF
Health Council of Southeast Florida

Florida HEALTH
Palm Beach County

PALM BEACH COUNTY FLORIDA

RARE 2015

A rapid assessment of HIV/AIDS in Palm Beach County, FL

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HCSEF
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The Health Council of Southeast Florida (HCSEF) is one of eleven private Local Health Planning Councils established by Section 408.033 Florida Statutes (F.S.) to conduct regional health planning and implementation activities. Serving the five county area inclusive of Palm Beach, Indian River, St. Lucie, Okeechobee, and Martin, HCSEF is committed to its mission and achieving its vision:

Mission
Improve the health of residents of the Palm Beaches and Treasure Coast by promoting access to quality health and human services.

Vision
The Health Council of Southeast Florida is the region's leading advocate for optimal access to health care through using our collective knowledge experience and commitment in health planning, research and program development

Table of Contents

Table of Tables

Table of Figures

Acknowledgment

The Health Council of Southeast Florida (HCSEF) would like acknowledge all of the community members, survey participants, individuals and families affected by HIV, providers, project staff and interns, funders and all stakeholders that have contributed to this project and the overall effort against HIV/AIDS in Palm Beach County, Florida.

We would also like to especially acknowledge the contributors to the original RARE project conducted in 2000/2001 as well as all current and former Palm Beach County HIV CARE Council members.

Funding and Support

The RARE 2015 project was jointly funded by and in cooperation with Florida Health Palm Beach County and the Palm Beach County Department of Community Services. This collaborative represents a partnership between local Ryan White Part A and B programs.

Executive Summary

The Health Council of Southeast Florida contracted with Florida Health Palm Beach County and the Palm Beach County Department of Community Services to implement RARE 2015, a rapid assessment of the HIV/AIDS epidemic in Palm Beach County. The project is a conceptual follow-up to the original federal RARE study[1] of 2000, conducted locally as well in 10 other metropolitan areas. The RARE model includes the following components: rapid assessment, response and evaluation.

In the fifteen-year time period between these initiatives, there has been significant change related to HIV/AIDS as well as more general societal trends impacting technology and communication. RARE 2015 acknowledges these changes, adapting its framework and areas of focus accordingly. In particular, RARE 2015 was planned and conducted in alignment with the National HIV/AIDS Strategy[2] (2020 update) goals: reducing new HIV infections; increasing access to care and improving health outcomes for people living with HIV; reducing HIV-related health disparities and health inequities, and achieving a more coordinated national response to the epidemic.

Quantitative data was collected on key indicators, selected primarily based on impact and relevance to the phases of the HIV Continuum of Care, which serve as an overall framework for the project: HIV Diagnosis; Ever in Care; In/Retained in Care; On Antiretroviral Treatment (ART), and Viral Suppression. Overall, these quantitative indicators serve as a foundation and context to the qualitative data, which is the core of the RARE 2015 project.

The qualitative data was collected through a systems analysis (including stakeholder and provider input) as well as a community-based analysis. The methodology was based on the Community Identification (CID) framework of the CDC-endorsed Community PROMISE[3] evidence-based model to facilitate deeper access into the community. The primary themes identified and analyzed are indicated below:

Systems-level Themes

- Need for community-level interventions
- Convenience and accessibility of services
- Under-utilization and lack of MSM services
- Eligibility barriers to care
- Stigma of HIV-specific services
- Distrust in government
- Lack of “wellness” conversations
- Problem-focused services, not preventative
- Viral load/ “undetectable” is misunderstood
- Untreated substance abuse
- Untreated and/or stigmatized mental health
- Understanding the “out of care” population
- Homelessness

Community-based Themes

- Disclosure
- Sources of health information
- Accessibility of health information
- Social patterns
- Risk perception (complacency)
- Substance abuse
- Stigma
- Provider support/environment
- Provider referrals
- Travel patterns and Transportation
- Sex partners
- HIV-related knowledge
- Cultural and religious influences

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[1] Trotter, R., Needle, R., Goosby, E. et al. (2001). A Methodological Model for Rapid Assessment, Response, and Evaluation: The RARE Program in Public Health. *Field Methods, Vol 13 (No. 2)* 137-159

[2] Office of National AIDS Policy. National HIV/AIDS Strategy for the United States Updated to 2020. White House; Washington, DC: 2015.

[3] The CDC AIDS Community Demonstration Projects Research Group. (1999). Community-level HIV intervention in 5 cities: Final outcome data from the CDC AIDS Community Demonstration Projects. *American Journal of Public Health* 89, 336-345

- Lack of adherence/self-treatment
- Cultural barriers
- Focus on early identification and linkages
- Complacency with new treatment and/or Pre-exposure prophylaxis (PrEP)
- Consistency of condom use
- Medication adherence
- Understanding of viral load
- Understanding of health

Based on the data and trends gleamed from the quantitative and qualitative data presented throughout this report, which was obtained from providers, stakeholders and community members, the following recommendations are set forth for the Palm Beach County HIV system of care:

- Adopt the “Expanded HIV Care Continuum Model”
- Support the system-wide implementation of the Community PROMISE intervention
- Address the "linkage gap" by reframing how services across the HIV Continuum of Care are evaluated
- Orient all services in the HIV Care Continuum toward viral suppression and whole health
- Develop a client-friendly version of the HIV Care Continuum

Approach

Purpose

The Health Council of Southeast Florida (HCSEF) contracted with Florida Department of Health Palm Beach County and the Palm Beach County Department of Community Services to conduct the RARE 2015 project to assess the HIV epidemic in Palm Beach County. The RARE framework consists of the following components[4]:

- Rapid Assessment
- Response
- Evaluation

RARE 2015 is conceptual follow-up to the original RARE study conducted in 2000 in Palm Beach County as well as ten other metropolitan areas across the nation. While the overall goals of RARE 2015 remain similar to the original study, the approach has been modified and updated to reflect the many HIV-related and societal changes that have occurred since 2000.

Methodology

At its core, RARE 2015 is a community-based assessment and seeks to provide a snapshot of the HIV epidemic through grass-roots qualitative information framed by key quantitative indicators. The Community Identification (CID) Process (a component of the evidence-based Community PROMISE intervention) anchored the collection of the community-based data, providing deeper and more thorough access to the community.

The project is framed by the HIV Continuum of Care, one of the key outcomes of the 2010 National AIDS Strategy. The phases of the continuum was a key factor in determining areas of focus for quantitative indicators, community-based qualitative data, stakeholder feedback and the systems analysis.

RARE 2015 is neither a full-scale or long-term study of HIV in Palm Beach County, but rather a rapid assessment. This approach is designed to allow for a timely dissemination of the most relevant information back to the community, stakeholders and system of care. The project does not include or address every facet of the HIV epidemic, but is instead limited in scope to analyzing key factors affecting progress along the continuum of care. Intended to be a catalyst for future initiatives, this report identifies key themes and makes specific recommendations to improve HIV-related health outcomes and reduce disparities in Palm Beach County.

[4] Trotter, R., Needle, R., Goosby, E. et al. (2001). A Methodological Model for Rapid Assessment, Response, and Evaluation: The RARE Program in Public Health. *Field Methods, Vol 13 (No. 2)* 137-159

Background

Palm Beach County 2000 RARE Study

In 1999, the U.S. Department of Health and Human Services (HHS) was funded by new legislation to investigate and address the impact of HIV/AIDS among racial and ethnic minority populations in 11 metropolitan areas across the nation. Palm Beach County was among those selected, based on the severity of the disproportional impact of HIV/AIDS on these communities, to be included in the Rapid Assessment Response Evaluation (RARE)[5]. Central to the process were multi-disciplinary Crisis Response Teams (CRT), which consisted of both academic researchers and community-based field researchers, assigned to conduct data collection in specific geographic areas of the county.

Changes Impacting HIV/AIDS, 2000-2015

There is a fifteen-year gap between the original RARE study and the current RARE 2015 project. During this time period, there have been significant changes in the epidemic and its treatment, as well as more general societal changes related in particular to communication and information sharing. Key changes include but are not limited to:

- Adoption of combination therapy in place of mono-therapy
- Focus on drug resistance and treatment adherence
- Universal anti-retroviral treatment recommendation
- Early antiretroviral therapy in place of delayed treatment
- Improvements in Viral Load testing
- Change in definition of "undetectable" viral load
- Evidence-based interventions and High Impact Prevention
- Patterns of HIV-related health disparities
- Routine HIV screening recommendations
- Improved rapid testing technology
- Emerging populations of focus (ex. Black Females, Males who have sex with males)
- Changing trends in substance abuse
- Increased longevity among people living with HIV
- Chronic disease status of HIV/AIDS
- Changes in communication, information sharing and media
- Complacency and risk behavior
- Multiple examples of possible "functional cures"
- Healthcare reform and the Affordable Care Act (ACA)
- Repeal of HIV travel ban
- First National AIDS Strategy and HIV Continuum of Care
- Advances in consumer technology
- Availability of pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP)

These factors were considered when building the framework for RARE 2015 as well as in developing the final recommendations. Furthermore, these factors guided the decision to not replicate the 2000 RARE study, but rather build upon it in the current context of the HIV epidemic. For RARE 2015, the most significant changes include an embedded community-based model in place of CRT, a system-wide implementation of qualitative data collection based on the Community PROMISE model and alignment with the NHAS and the HIV Care Continuum.

National HIV/AIDS Strategy

[5] Palm Beach County Response Team (2001). RARE: Rapid Assessment, Response, and Evaluation.

The first National HIV/AIDS Strategy (NHAS) was released in 2010 to coordinate and align HIV-related services, resources and efforts toward a common purpose and vision[6]. In 2015, the strategy was updated to 2020 to reflect the most recent progress and changes and includes the following overarching goals, which heavily influenced the RARE 2015 project[7]:

- Reducing new HIV infections
- Increasing access to care and improving health outcomes for people living with HIV
- Reducing HIV-related disparities and health inequities
- Achieving a more coordinated national response to the epidemic

HIV Care Continuum

A significant outcome of the NHAS was the development of the HIV Care Continuum, which describes and quantifies HIV care into five primary phases[8]. Each phase, according to the most recent update of the continuum currently adopted by Florida Department of Health (and locally in Palm Beach County), is defined in Table 1.

Table 1: HIV Care Continuum Phase Definitions, FL DOH 2014

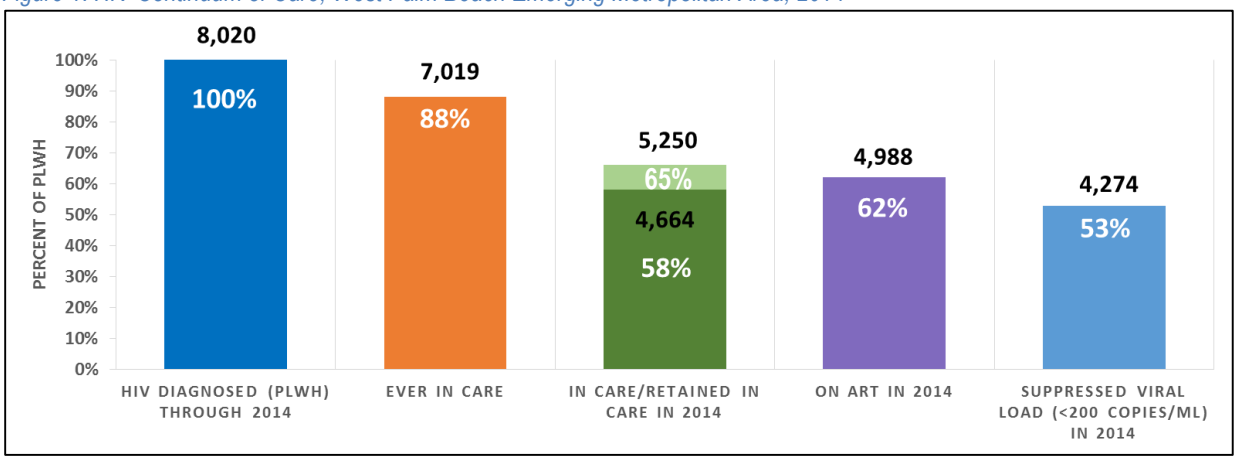
HIV Care Continuum Phase	Definition
HIV Diagnosis	Persons diagnosed and living with HIV in 2014
Ever in Care	Persons living with HIV with at least one documented Viral Load (VL) or CD4 lab, medical visit or prescription.
In Care	Persons living with HIV with at least one documented Viral Load (VL) or CD4 lab, medical visit or prescription in2014
Retained in Care	Persons living with HIV with two or more documented Viral Load (VL) or CD4 labs, medical visits or prescriptions (at least 3 months apart) in 2014
On ART	Persons living with HIV on antiretroviral therapy (ART) in 2014 (estimated from FL MMP data)
Suppressed Viral Load	Persons living with HIV with a suppressed viral load (<200 copies/ml) on last viral load in 2014

In Florida, the third phase of the HIV Care Continuum includes both “In Care” and “Retained in Care”, as defined above.

[6] Office of National AIDS Policy. National HIV/AIDS Strategy for the United States. White House; Washington, DC: 2010.
[7] Office of National AIDS Policy. National HIV/AIDS Strategy for the United States Updated to 2020. White House; Washington, DC: 2015.
[8] Office of National AIDS Policy. National HIV/AIDS Strategy for the United States Updated to 2020. White House; Washington, DC: 2015.

Figure 1 shows the 2014 HIV Continuum of Care for the West Palm Beach Emerging Metropolitan Area (EMA), which covers Palm Beach County.

Figure 1: HIV Continuum of Care, West Palm Beach Emerging Metropolitan Area, 2014



Source: HIV Continuum of Care Slide Set, Florida Department of Health, 2014
Note: Excludes Department of Corrections Cases

Based on the definitions in Table 1, the continuum quantifies the proportion of individuals who meet the criteria for each phase, and depicts the difference between phases for comparison as well as evaluation of services. One focal point of the continuum, sometimes referred to as the "linkage gap", represents the most dramatic drop in percentage between phases. This gap between the "Ever in care" and In/Retained in care" phases has drastic implications for the remainder of the continuum and directly impacts viral suppressions rates. The RARE 2015 project is conceptually framed around the HIV Care Continuum, which has been weaved into the quantitative data analysis, qualitative data analysis and recommendations (which include ways to reimagine, modernize and expand the continuum to integrate prevention and care, and strengthen the system of care in Palm Beach County).

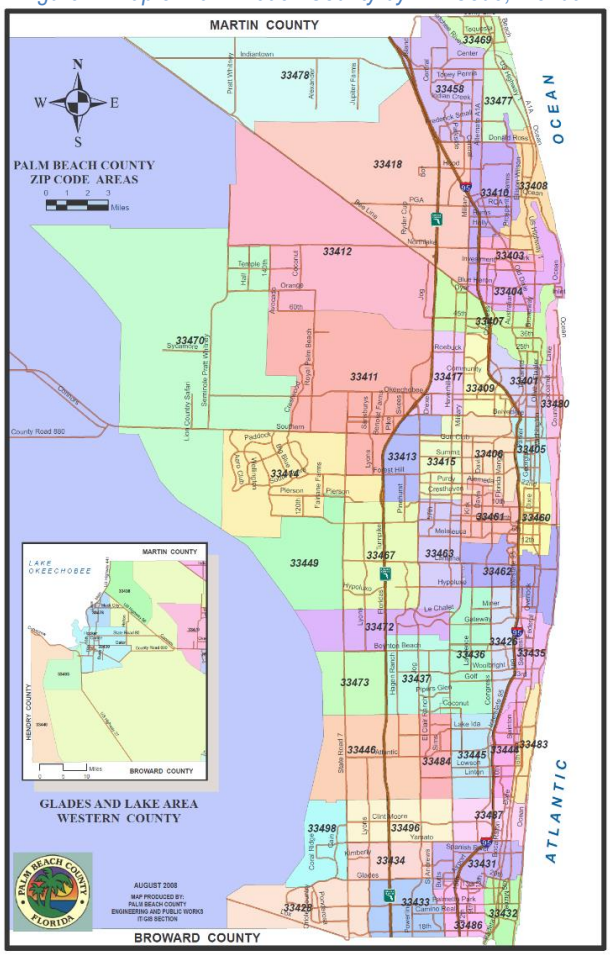
Quantitative Data Analysis

HCSEF compiled and analyzed quantitative data related to HIV/AIDS in Palm Beach County to provide context and a point of reference for the primary qualitative data obtained from the community and the system of care. This analysis includes a demographic and socioeconomic profile of Palm Beach County, HIV/AIDS surveillance data, counseling and testing data, viral suppression rates, co-morbidities, resources and utilization. This report includes the most updated data available at the time of publication (excluding any provisional data). The selected indicators were prioritized based on the greatest relevance to the intent and goals of the project, as previously described.

Demographic and Socioeconomic Profile

Palm Beach County is located along Florida's Atlantic coast, with an area of 2,034 square mileage, it is the largest and the third most populous county in Florida. Figure 2 shows a map of Palm Beach County by zip code.

Figure 2: Map of Palm Beach County by ZIP Code, Florida[9]



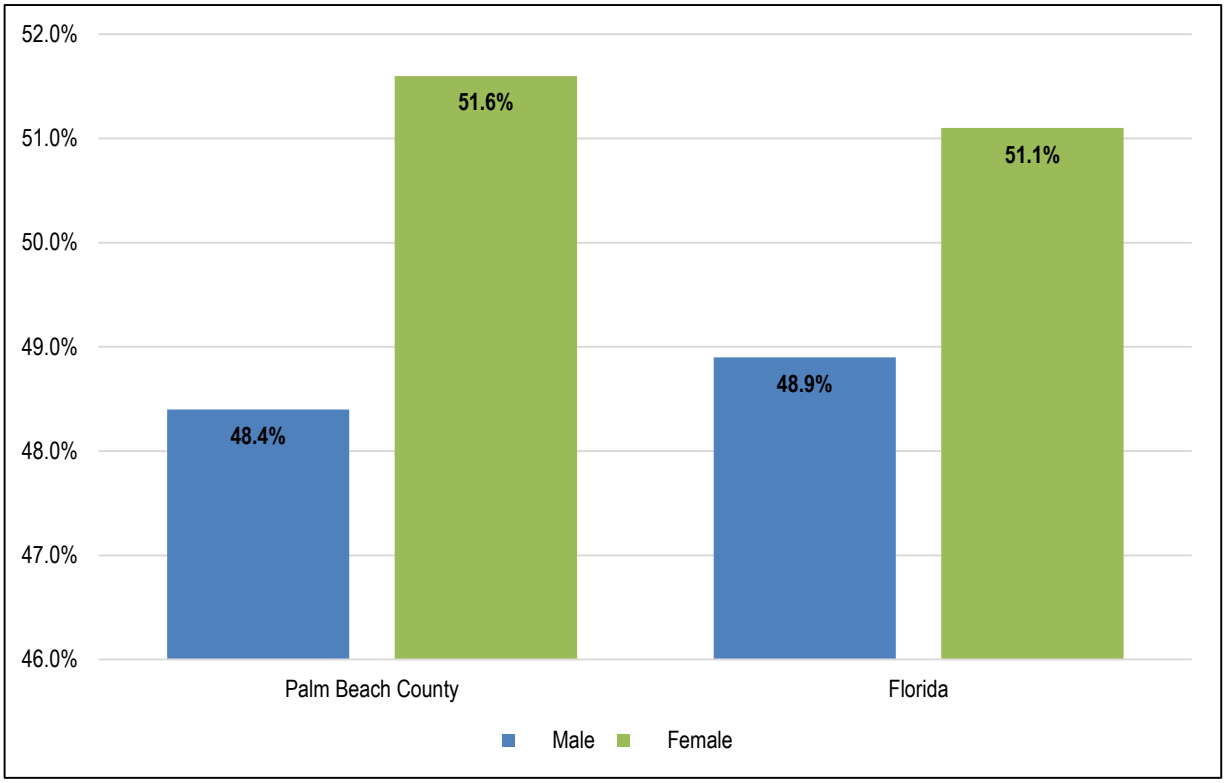
[9] Source: www. pbc.gov

Population Characteristics

Gender

According to the US Census Bureau, Palm Beach County had an estimated population of 1,397,710 in 2014, representing 7.03% of the total state population. The tables and figures below display demographic details of the county. Figure 3 shows the gender distribution in Palm Beach county and Florida. In 2014, the Palm Beach County population was 48.4% males and 51.6% females.

Figure 3: Gender in Palm Beach County and Florida, 2014



Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

Age

The table below shows the population by age groups in 2014. The median age in the county was 44.3, slightly higher than the median age of 41.6 in Florida. Over 80% of the population was 18 years or older during this time period.

Table 2: Population Age in Palm Beach County and Florida, 2014

Age Group	Palm Beach County		Florida	
	Estimate	Percent	Estimate	Percent
Under 5 years	71,049	5.1%	1,077,572	5.4%
5 to 9 years	76,266	5.5%	1,121,370	5.6%
10 to 14 years	76,770	5.5%	1,149,526	5.8%
15 to 19 years	78,885	5.6%	1,196,039	6.0%
20 to 24 years	81,448	5.8%	1,307,594	6.6%
25 to 34 years	163,583	11.7%	2,512,629	12.6%
35 to 44 years	163,181	11.7%	2,432,609	12.2%
45 to 54 years	191,740	13.7%	2,730,745	13.7%
55 to 59 years	91,752	6.6%	1,334,879	6.7%
60 to 64 years	85,404	6.1%	1,239,380	6.2%
65 to 74 years	153,094	11.0%	2,083,890	10.5%
75 to 84 years	108,010	7.7%	1,182,808	5.9%
85 years and over	56,528	4.0%	524,256	2.6%
Median age (years)	44.3	(X)	41.6	(X)
18 years and over	1,125,295	80.5%	15,839,274	79.6%
65 years and over	317,632	317,632	3,790,954	3,790,954

Source: U.S. Census Bureau, 2014
Notes: An '(X)' means that the estimate is not applicable or not available
Compiled by Health Council of Southeast Florida, 2016

Race and Ethnicity

The tables below show population by race and ethnicity. An estimated 75% of the county's population is White and 18.1% identify as Black or African American. Residents of Hispanic and Latino descent made up just over 20% of Palm Beach County's population.

Table 3: Population by Race, Palm Beach County and Florida, 2014

Race	Palm Beach County		Florida	
	Estimates	Percentage	Estimates	Percentage
Total population	1,397,710	1,397,710	19,893,297	19,893,297
One race	1,372,329	98.2%	19,417,492	97.6%
White	1,048,104	75.0%	15,113,860	76.0%
Black or African American	252,336	18.1%	3,221,160	16.2%
American Indian and Alaska Native	2,046	0.1%	53,014	0.3%
Asian	37,234	2.7%	524,583	2.6%
Native Hawaiian and Other Pacific Islander	558	0.0%	15,149	0.1%
Some other race	32,051	2.3%	489,726	2.5%
Two or more races	25,381	1.8%	475,805	2.4%
White and Black or African American	7,925	0.6%	154,913	0.8%
White and American Indian and Alaska Native	3,684	0.3%	67,840	0.3%
White and Asian	4,128	0.3%	85,999	0.4%
Black or African American and American Indian and Alaska Native	481	0.0%	11,540	0.1%

Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

Table 4: Population by Ethnicity, Palm Beach County and Florida, 2014

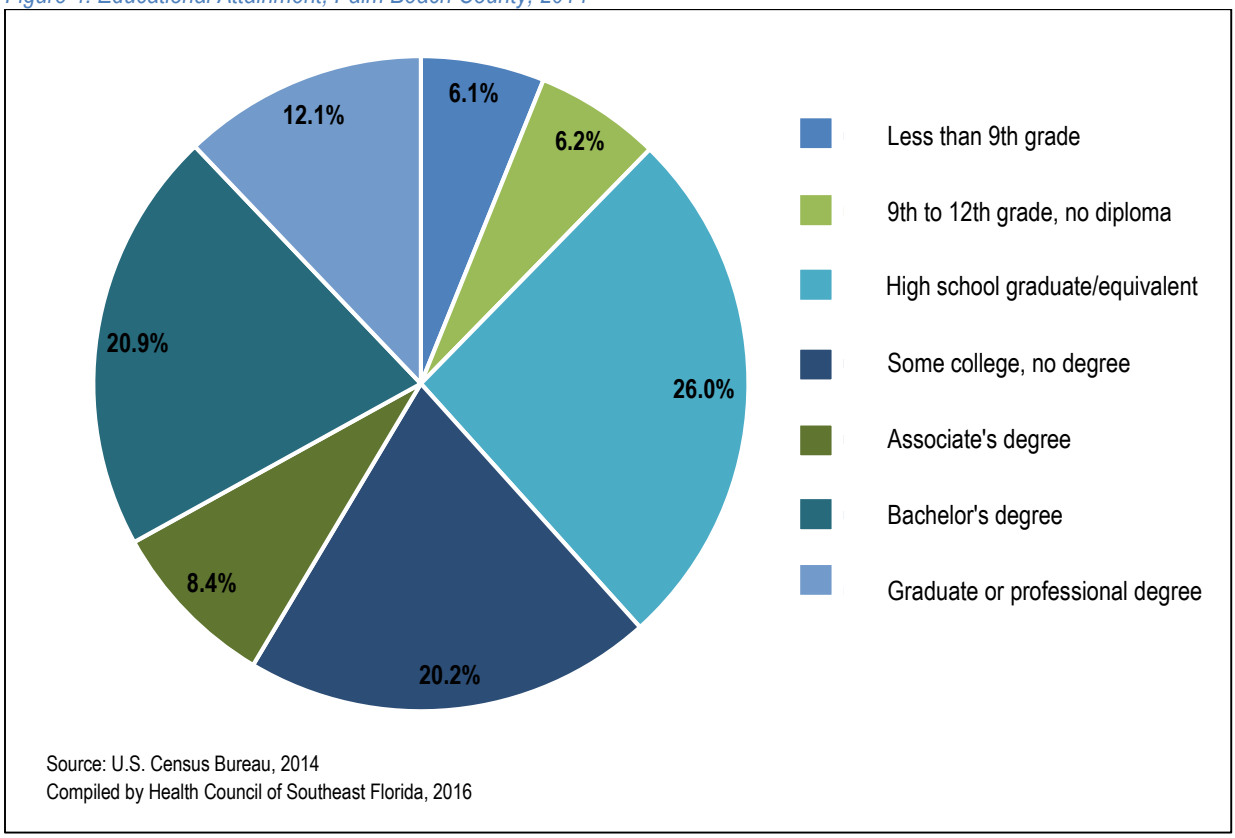
Ethnicity	Palm Beach County		Florida	
	Estimates	Percentage	Estimates	Percentage
Total population	1,397,710	1,397,710	19,893,297	19,893,297
Hispanic or Latino (of any race)	289,802	20.7%	4,788,870	24.1%
Mexican	54,923	3.9%	693,483	3.5%
Puerto Rican	50,275	3.6%	1,006,542	5.1%
Cuban	51,460	3.7%	1,392,605	7.0%
Other Hispanic or Latino	133,144	9.5%	1,696,240	8.5%
Not Hispanic or Latino	1,107,908	79.3%	15,104,427	75.9%

Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

Education

The figure below shows that nearly 90% of the population 25 years and older achieved a high school diploma or equivalent, about a third were college educated and 6% had less than a 9th grade level education.

Figure 4: Educational Attainment, Palm Beach County, 2014



Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

Origin and Citizenship Status

Among the population in Palm Beach County in 2014, 73% were born in the United States, 3% were born in Puerto Rico, U.S. Island areas or born abroad to American parent(s) and 24% were born outside of the U.S. The highest number of foreign born, 72.9%, came from Latin America.

Table 5: Population by Place of Birth, Palm Beach County and Florida, 2014

	Palm Beach County		Florida	
	Estimate	Percent	Estimate	Percent
Total population	1,397,710	1	19,893,297	100%
PLACE OF BIRTH				
Native	1,056,369	76%	15,919,782	80.0%
Born in United States	1,018,560	73%	15,241,452	76.6%
State of residence	419,884	30%	7,176,103	36.1%
Different state	598,676	43%	8,065,349	40.5%
Born in Puerto Rico, U.S. Island areas, or born abroad to American parent(s)	37,809	3%	678,330	3.4%
Foreign born	341,341	24%	3,973,515	20.0%
U.S. CITIZENSHIP STATUS				
Foreign-born population	341,341	341,341	3,973,515	3,973,515
Naturalized U.S. citizen	166,199	48.7%	2,136,462	53.8%
Not a U.S. citizen	175,142	51.3%	1,837,053	46.2%
WORLD REGION OF BIRTH OF FOREIGN BORN				
Foreign-born population, excluding population born at sea	341,341	341,341	3,972,753	3,972,753
Europe	41,759	12.2%	389,866	9.8%
Asia	33,270	9.7%	422,486	10.6%
Africa	5,144	1.5%	64,673	1.6%
Oceania	248	0.1%	8,183	0.2%
Latin America	248,928	72.9%	2,981,581	75.1%
Northern America	11,992	3.5%	105,964	2.7%

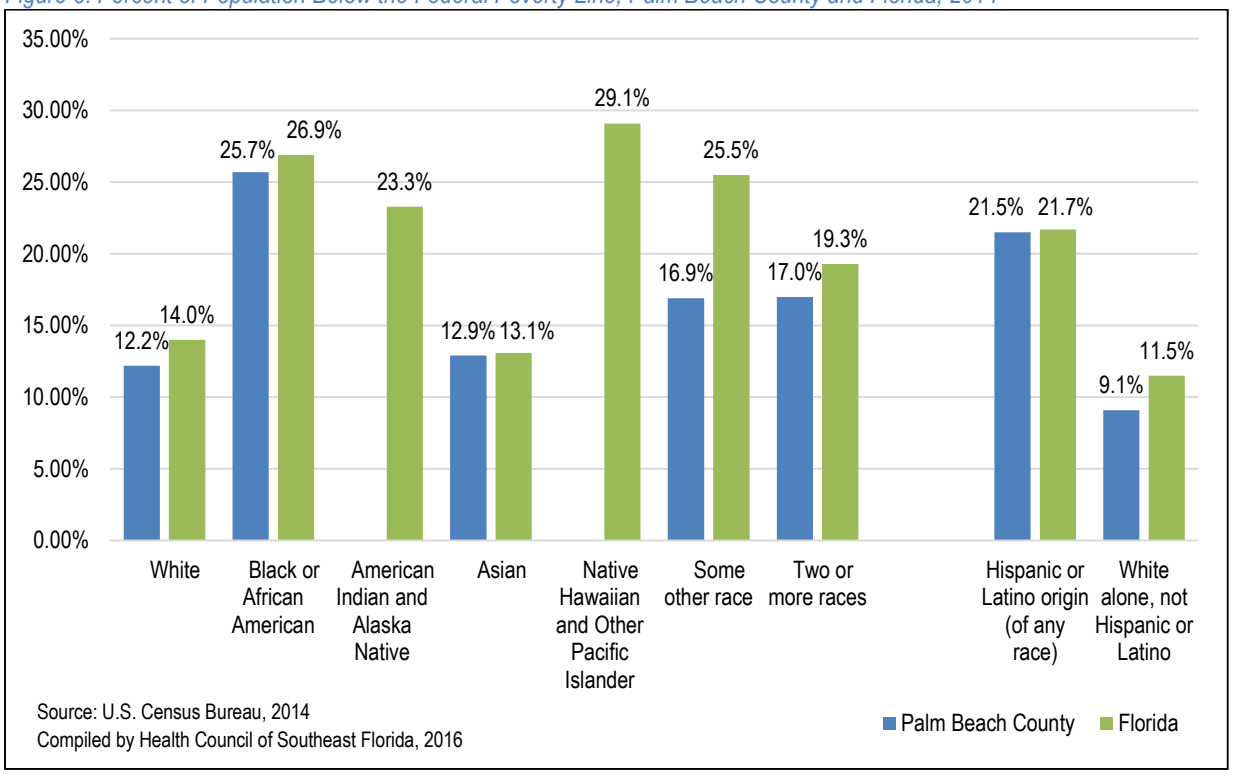
Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

Socioeconomic Characteristics

Poverty

The chart below depicts the percentage of the population living below the federal poverty line in Palm Beach County and Florida. In 2014, the percentage of residents of Hispanic or Latino orgin living below the poverty line was nearly identical in Palm Beach County and Florida. The Black or African American population contributed to 25% of the population living below the poverty level in the county, about 2 times greater than the percentage of White residents. Palm Beach had less population living below the poverty line among all other racial and ethnic group than the state of Florida in 2014.

Figure 5: Percent of Population Below the Federal Poverty Line, Palm Beach County and Florida, 2014



Healthcare Coverage

The table below shows that the highest percentage of the uninsured non-institutionalized population in Palm Beach County and the State were within the 18 to 64 years old age group.

Table 6: Health Insurance status of Total Civilian Non-institutionalized Population

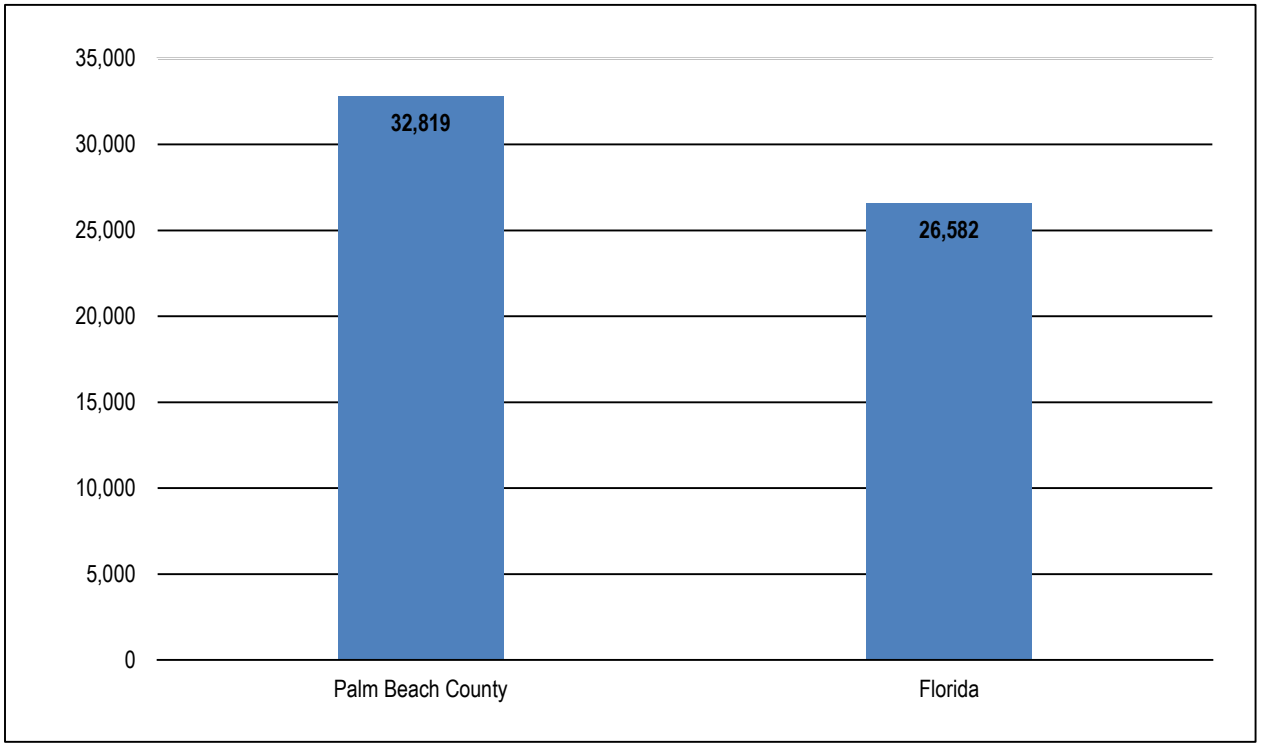
	Palm Beach County			Florida		
	Total	Number Uninsured	Percent Uninsured	Total	Number Uninsured	Percent Uninsured
Total civilian non-institutionalized population	1,385,937	226,177	16.3%	19,583,357	3,245,161	16.6%
AGE						
Under 18 years	272,095	28,673	10.5%	4,046,150	377,987	9.3%
18 to 64 years	801,372	192,363	24.0%	11,813,708	2,812,892	23.8%
65 years and older	312,470	5,141	1.6%	3,723,499	54,282	1.5%

Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

Per Capita Income

Per capita income is a measure of the average income per person living in a particular area. A high per capita income is a measure of productivity and growth. The figure below shows Palm Beach County had a higher per capita income than Florida in 2014.

Figure 6: Per capita Income, Palm Beach County and Florida, 2014



Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

People Living with HIV/AIDS in Palm Beach County

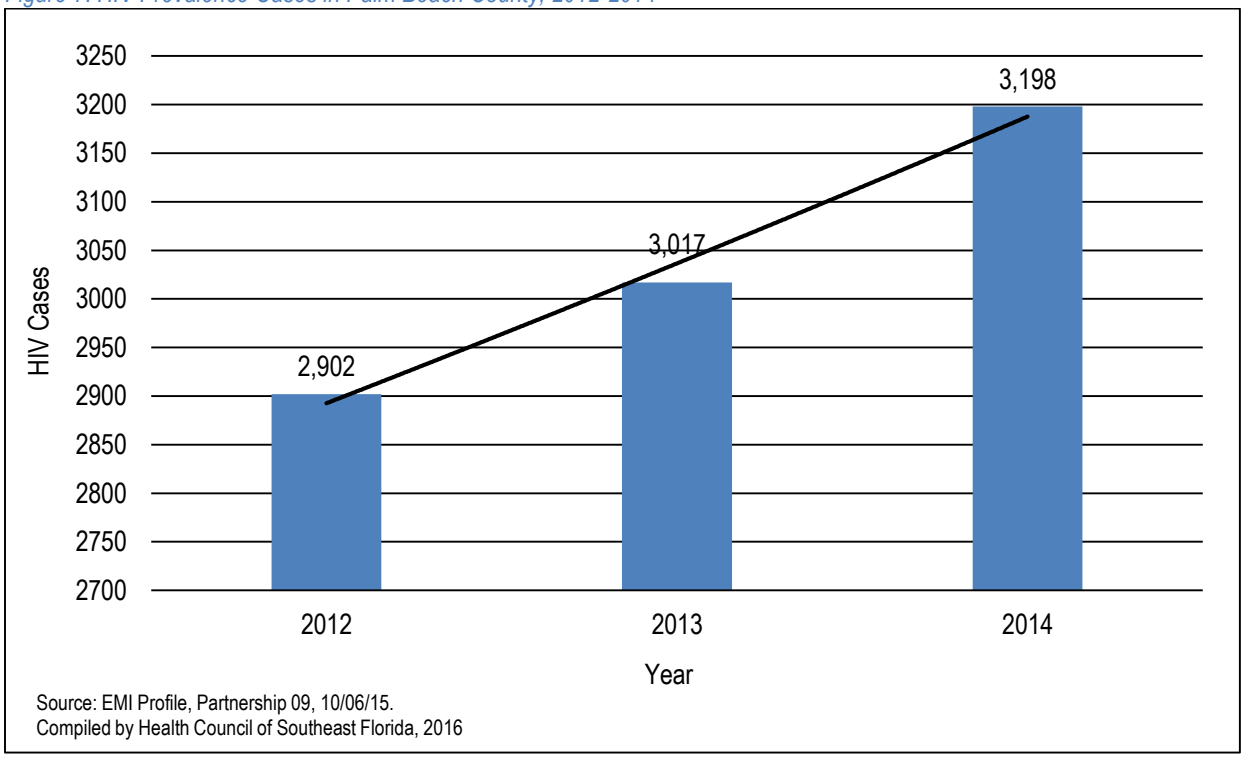
HIV Prevalence Cases

HIV Prevalence Cases are defined as the number of persons living with HIV infection in this area at the end of each respective calendar year. The figures below reflect the prevalence as of June 30, 2015.

Figure 7 displays the total count of HIV infection prevalence cases reported during 2012, 2013 and 2014. There was an upward trend over this 3 year time period. The percent change calculated during time period (3 years percent change) was 10.2%.

Figure 7, table 7 and figure 8 provide detail on HIV Prevalence Cases for 2014 by race, ethnicity and gender.

Figure 7: HIV Prevalence Cases in Palm Beach County, 2012-2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

As shown in the table below, which examines race and ethnicity, the highest number of HIV cases was among Black non-Hispanic residents, 1833 cases, representing more than half of all cases.

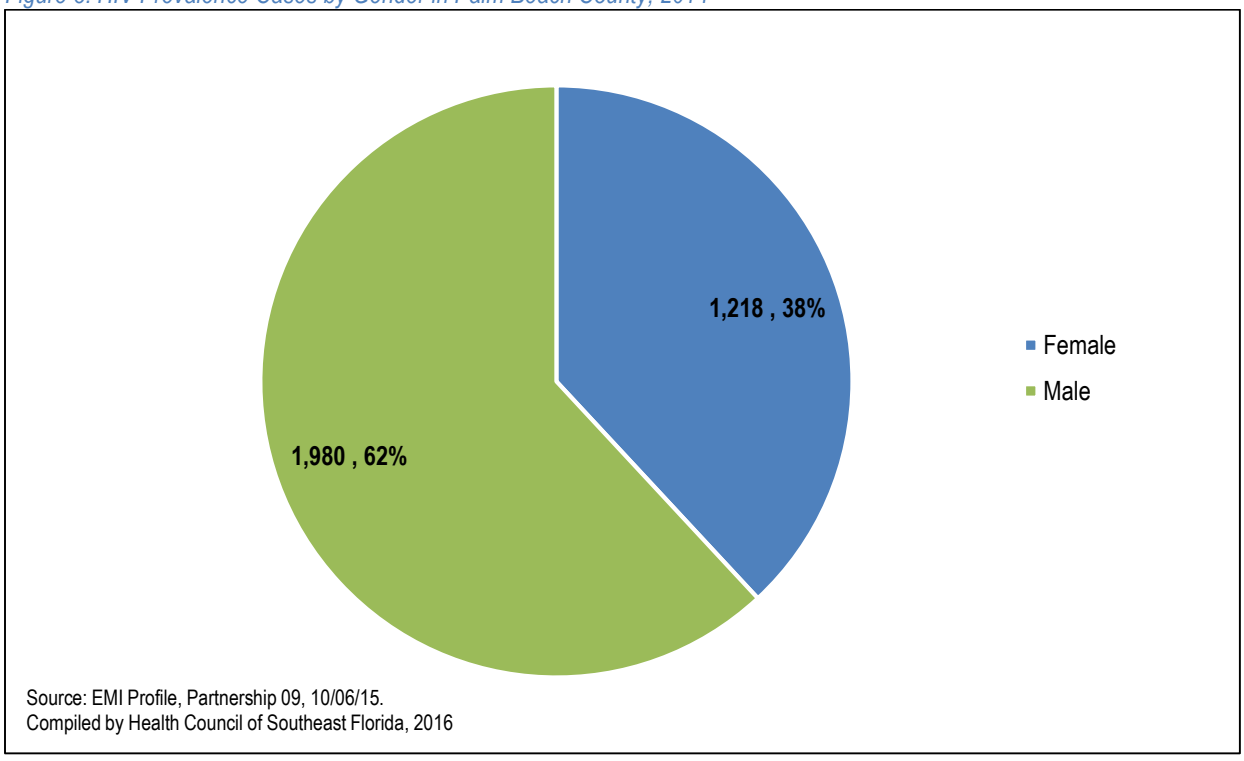
Table 7: HIV Prevalence Cases by Race and Ethnicity in Palm Beach County, 2014

Race/Ethnicity	Number	Percentage
White, not Hispanic	862	27%
Black, not Hispanic	1,833	57%
Hispanic	460	14%
Asian/Pacific Islander	14	0%
America Indian/Alaskan Native	2	0%
Not Specified/Other	27	1%

Source: EMI Profile, Partnership 09, 10/06/15
Compiled by Health Council of Southeast Florida, 2016

When examined by gender, HIV cases are a majority male (62%), as shown in the figure below.

Figure 8: HIV Prevalence Cases by Gender in Palm Beach County, 2014



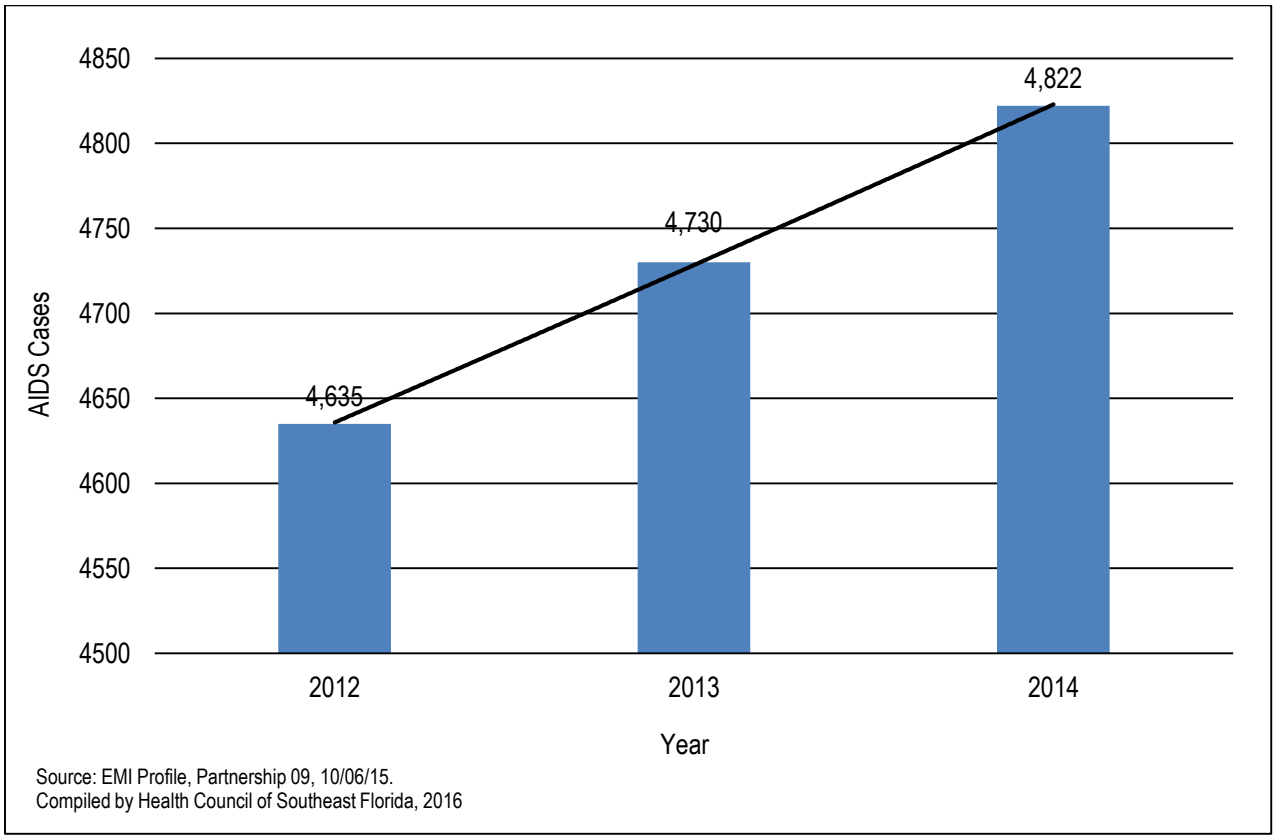
Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

AIDS Prevalence Cases

AIDS Prevalence Cases are defined as the number of persons living with AIDS at the end of each respective calendar year. The figures below reflect the prevalence as of June 30, 2015.

Figure 9 displays the total prevalence count of AIDS cases during 2012, 2013 and 2014. There was an upward trend noted over this 3 year time period. The percent change calculated for this time period was 4.0%.

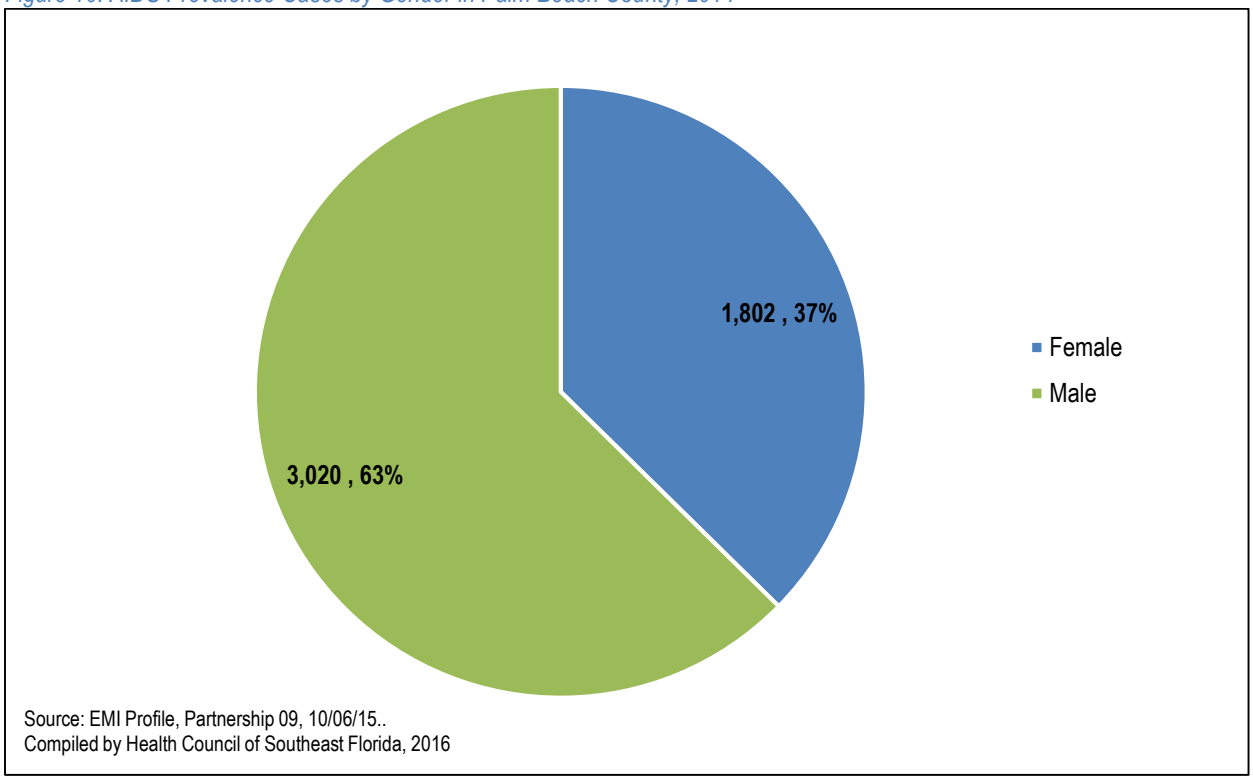
Figure 9: AIDS Prevalence Cases in Palm Beach County, 2012-2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

Below, Figure 10 shows AIDS prevalence cases by gender. In 2014, the majority (63%) of total AIDS cases were males.

Figure 10: AIDS Prevalence Cases by Gender in Palm Beach County, 2014



Source: EMI Profile, Partnership 09, 10/06/15..
Compiled by Health Council of Southeast Florida, 2016

The table below shows AIDS prevalence cases by race and ethnicity. Black non-Hispanic individuals had the highest AIDS case prevalence, with a total of 3062. This population represented 64% of the cases.

Table 8: AIDS Prevalence Cases by Race and Ethnicity in Palm Beach County, 2014

Race/Ethnicity	Cases	Percentages
White, not Hispanic	1,030	21%
Black, not Hispanic	3,062	64%
Hispanic	661	14%
Asian/Pacific Islander	9	0%
America Indian/Alaskan Native	2	0%
Not Specified/Other	58	1%

Source: EMI Profile, Partnership 09, 10/06/15
Compiled by Health Council of Southeast Florida, 2016

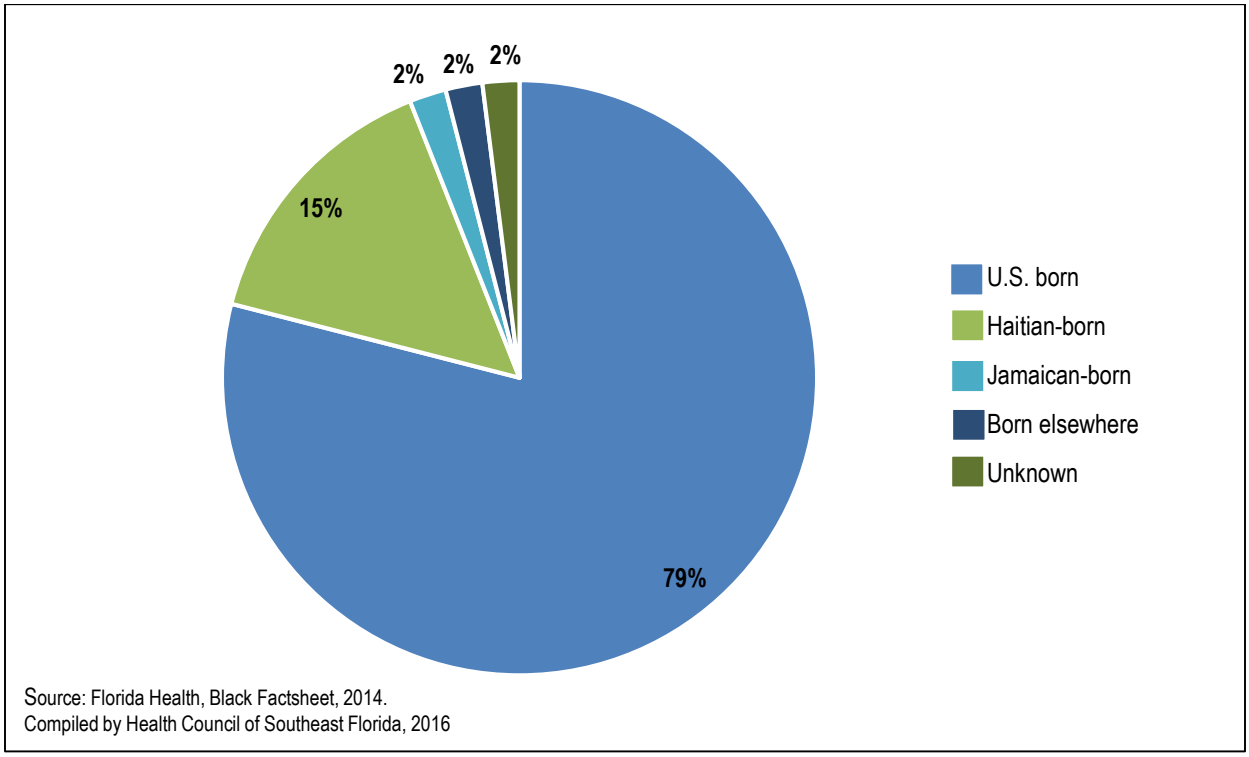
Special Populations

This section provides information on special populations diagnosed in Enhanced HIV/AIDS Reporting System (eHARS). These numbers include cases who currently reside in Palm Beach County despite location of diagnosis. The figures below shows special populations relating to People living with AIDS (PLWA), People living with HIV but not AIDS (PLWH), and People living with HIV or AIDS (PLWHA), which is the sum of PLWA and PLWH.

Black and Hispanic HIV Populations in Florida

In 2014 there were an estimated 49,577 African Americans living with HIV. Of this total 79% were born in the U.S., 15% were Haitian-born, 2% were born in Jamaica and 2% were born elsewhere.

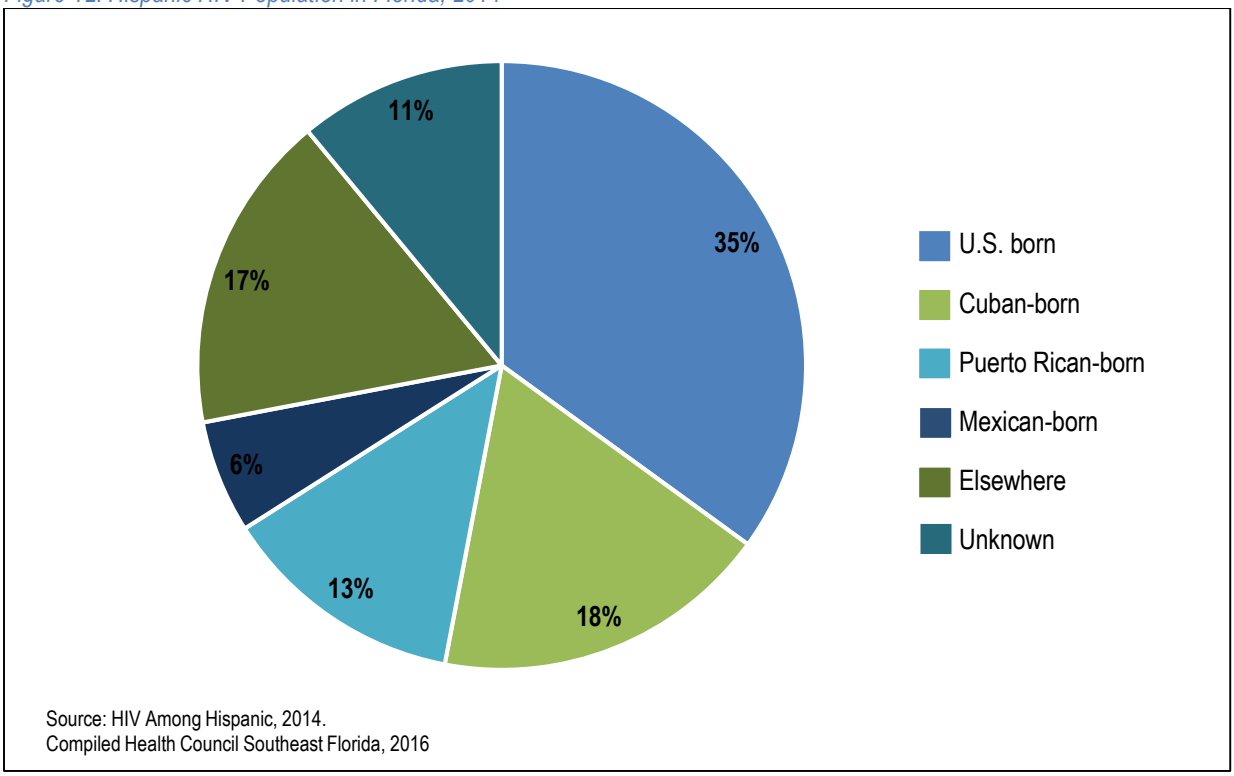
Figure 11: Black HIV Population in Florida, 2014



Source: Florida Health, Black Factsheet, 2014.
Compiled by Health Council of Southeast Florida, 2016

Through 2014, there was an estimated 21,091 Hispanics living with HIV. Of this total, 35% were born in the U.S., 18% were Cuban-born, 13% were Puerto Rican-born, 6% born in Mexico, 17% were born elsewhere and 11% were unknown.

Figure 12: Hispanic HIV Population in Florida, 2014

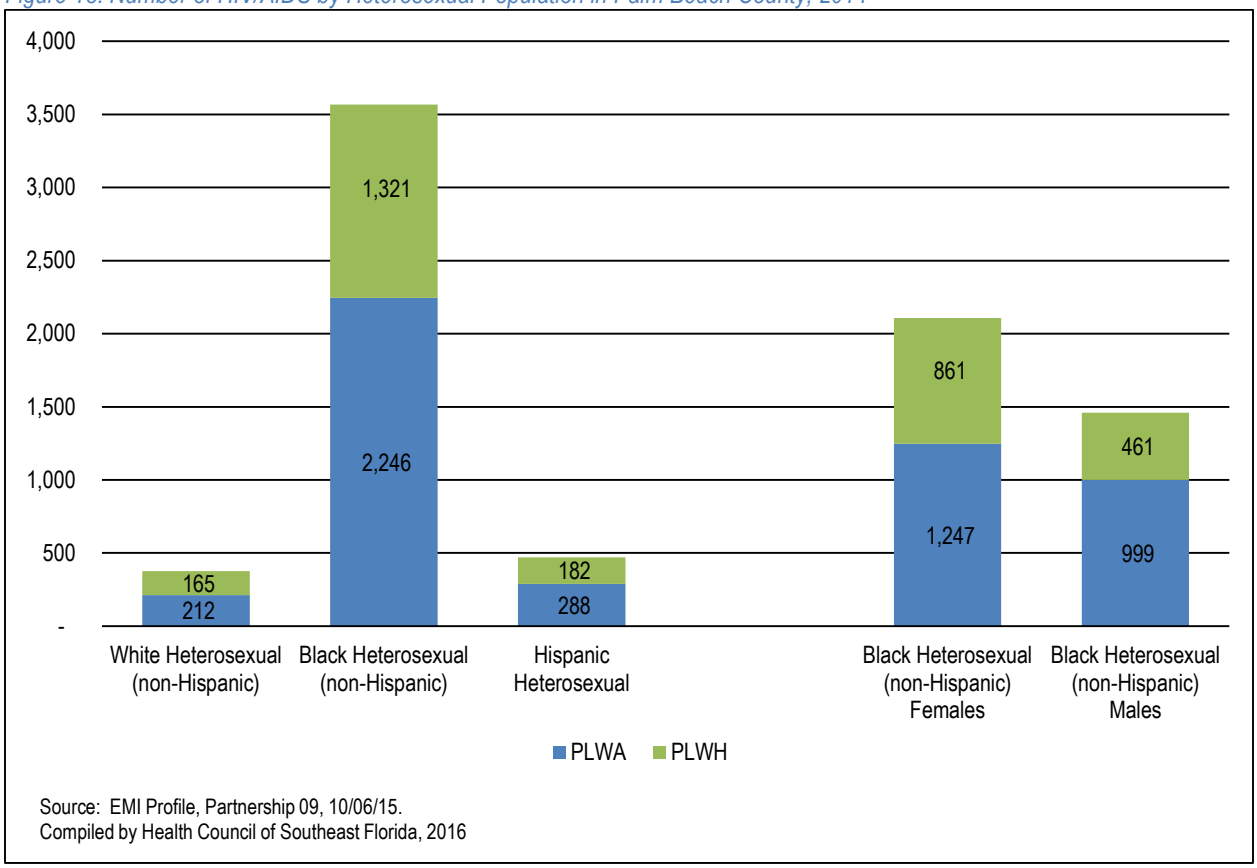


Source: HIV Among Hispanic, 2014.
Compiled Health Council Southeast Florida, 2016

Heterosexual Population

The following figure depicts HIV/AIDS cases by heterosexual population in Palm Beach County. The figure includes a breakdown by select race, ethnicity, and gender. Among the non-Hispanic demographic, a greater number of Black heterosexual individuals are living with HIV/AIDS compared to White individuals. The number of Hispanic heterosexual individuals living with HIV/AIDS is significantly lower than Black heterosexual individuals, but higher than White heterosexual individuals.

Figure 13: Number of HIV/AIDS by Heterosexual Population in Palm Beach County, 2014

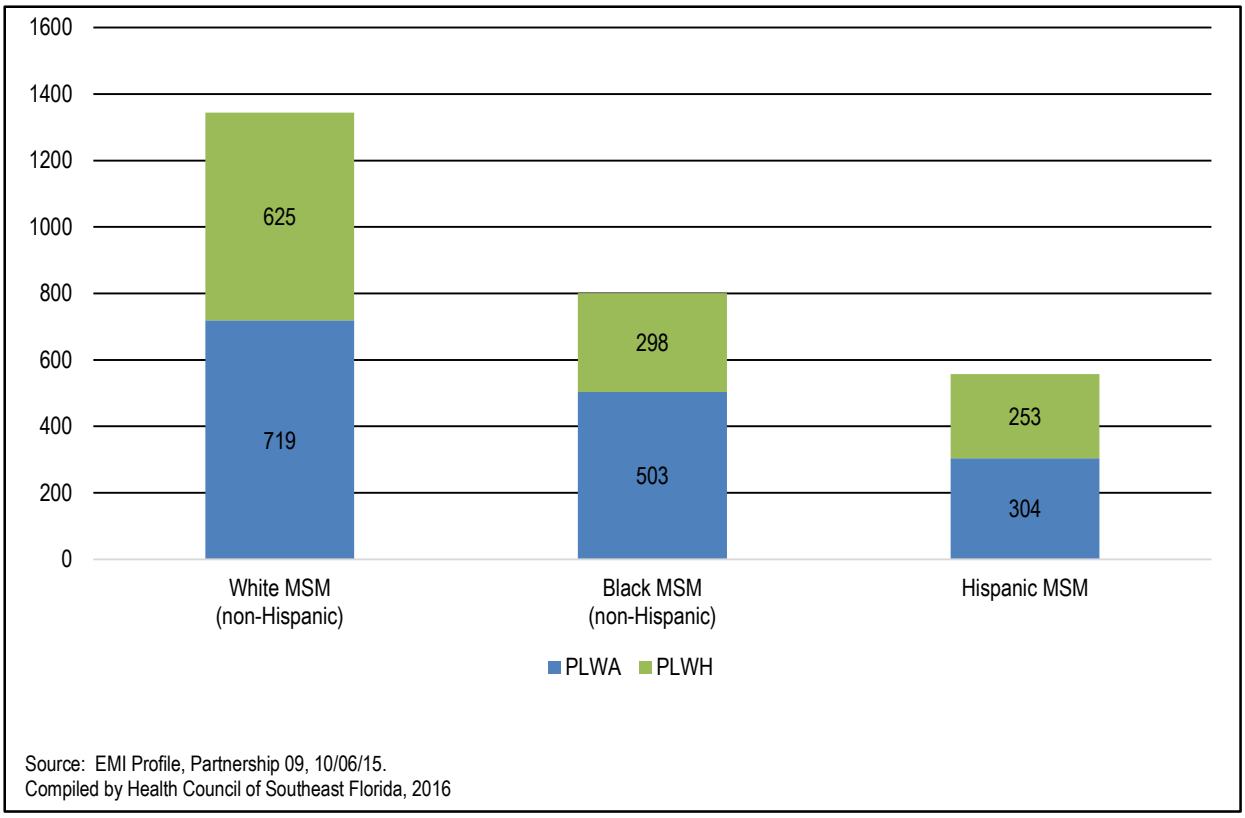


Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

MSM Population

The figure below shows the number of HIV/AIDS cases by MSM population. While the majority of MSM in each HIV category are White, this is primarily due to the larger population of that race compared to the Black population. Proportionally, Black MSM are an emerging population of focus, and experience a higher rate of HIV infections.

Figure 14: Number of HIV/AIDS cases by MSM Population in Palm Beach County, 2014

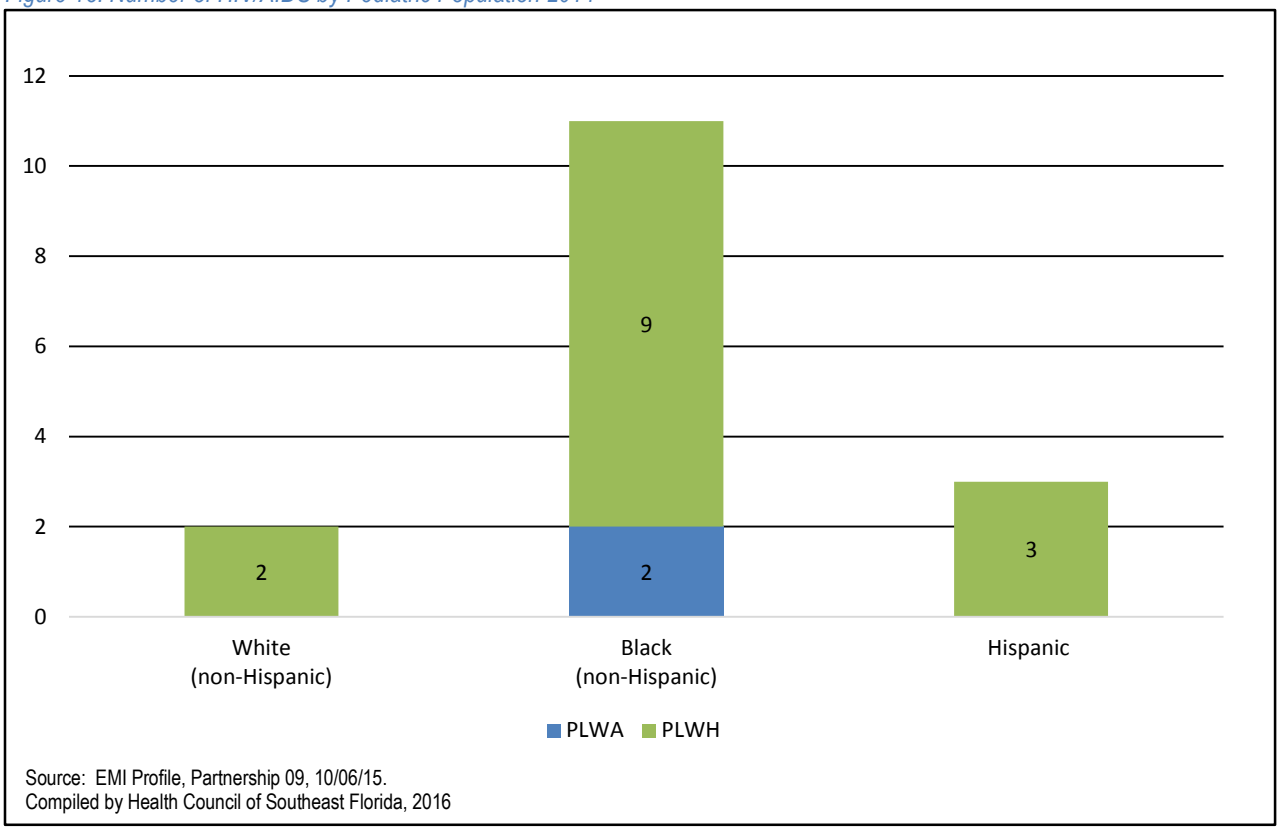


Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

Pediatric Population

The figures below depict pediatric HIV/AIDS cases in Palm Beach County and Florida. There were 14 pediatric HIV (not AIDS) cases and 2 pediatric AIDS cases in Palm Beach County through 2014. As shown in Figure 15, there is a significantly higher number of Black pediatric HIV/AIDS cases compared to White and Hispanic pediatric cases.

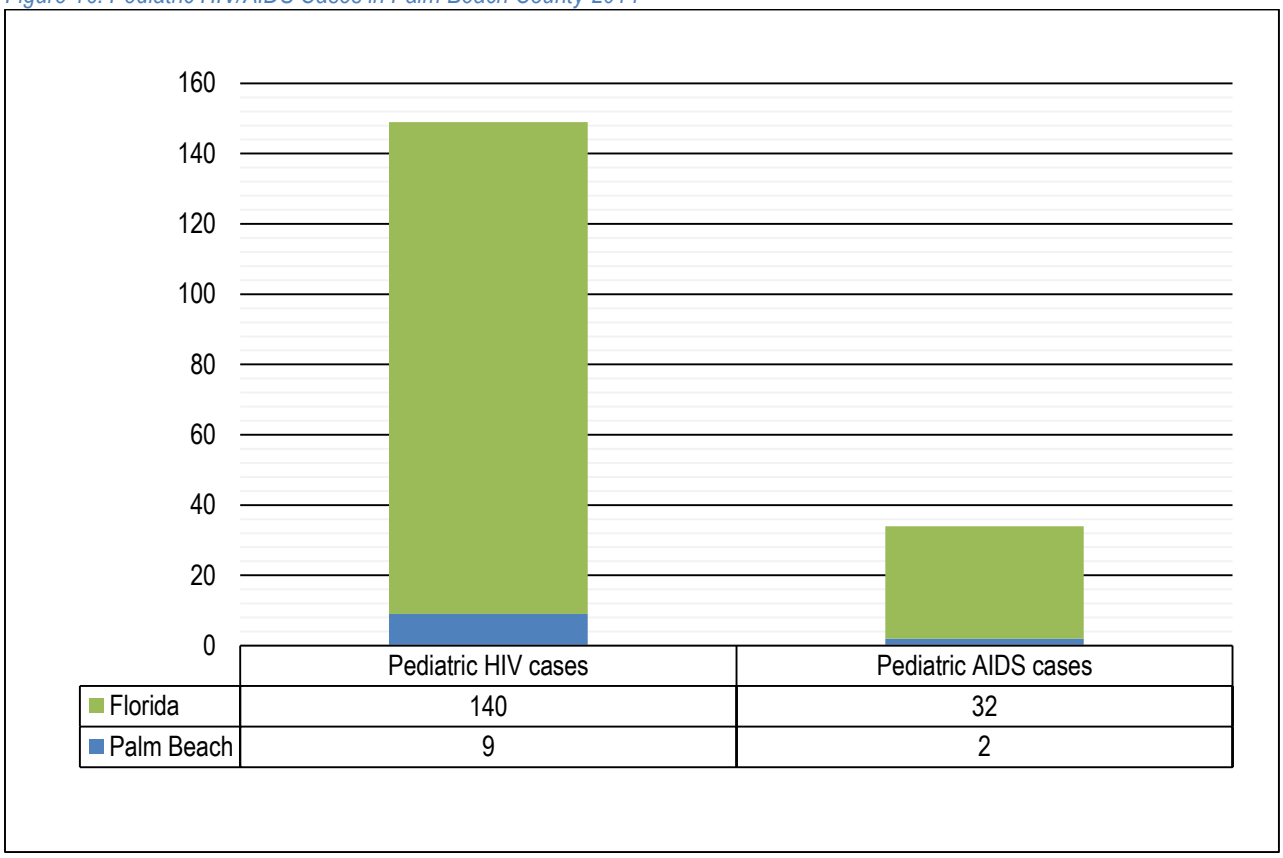
Figure 15: Number of HIV/AIDS by Pediatric Population 2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

Figure 16 shows that Palm Beach County accounts for 6.4% of pediatric HIV cases in Florida and 6.2% of pediatric AIDS cases in Florida.

Figure 16: Pediatric HIV/AIDS Cases in Palm Beach County 2014



	Pediatric HIV cases	Pediatric AIDS cases
Florida	140	32
Palm Beach	9	2

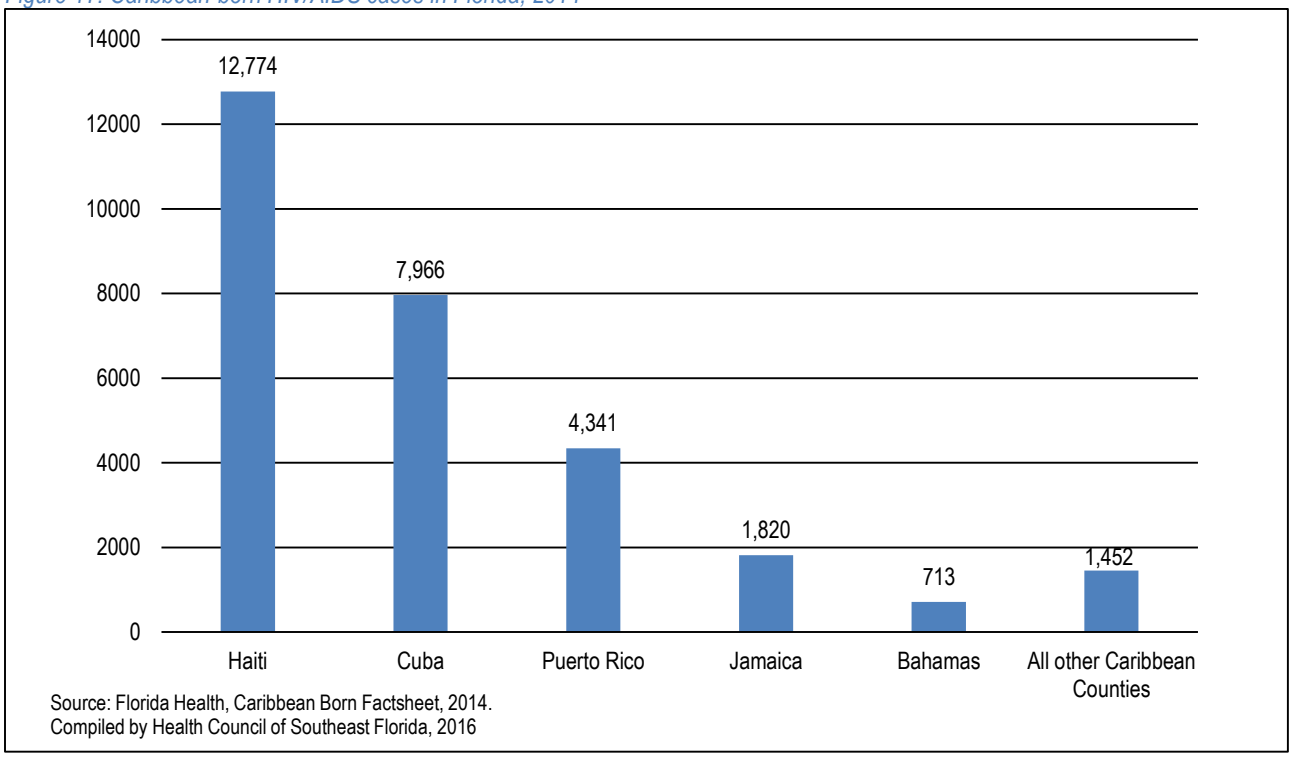
Source: Epi Profile on Pediatric, HIV/AIDS Surveillance in FL, 2014, Revised 06/30/2015.
Compiled by Health Council of Southeast Florida, 2016

Caribbean-born Population

In this section, Caribbean countries include: Aruba, Antigua & Barbuda, Bahamas, Barbados, British Virgin Islands, Cayman Islands, Cuba, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, St. Lucia, St. Vincent & the Grenadines, Trinidad & Tobago, Turks & Caicos, Guadeloupe, Martinique, Netherlands Antilles, Bermuda, St. Kitts & Nevis, Anguilla, Montserrat, US Virgin Islands, and Puerto Rico[10] .

The figure below shows Caribbean-born HIV/AIDS cases by country of birth. In 2014 there were 29,068 diagnosed HIV/AIDS cases among the Caribbean-born population in Florida. Haitian-born represented 44% of the cases among this group. Cuban-born were the next most significant group representing 27% of Caribbean-born cases.

Figure 17: Caribbean-born HIV/AIDS cases in Florida, 2014

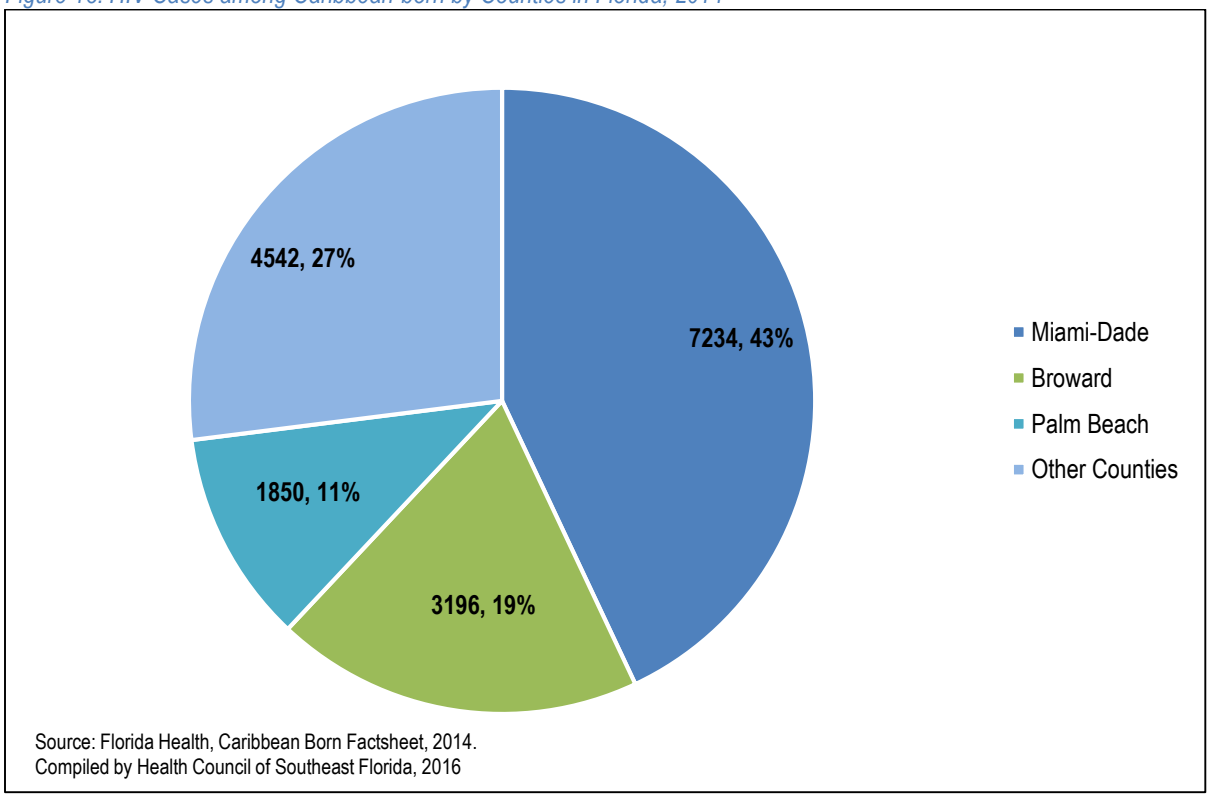


Source: Florida Health, Caribbean Born Factsheet, 2014.
Compiled by Health Council of Southeast Florida, 2016

[10] Source: Florida Health, Caribbean-born Factsheet, 2014.

Figure 18 shows HIV Cases Of the 16,822 Caribbean-born adults living with HIV in Florida in 2014, 12,228 reside in South Florida.

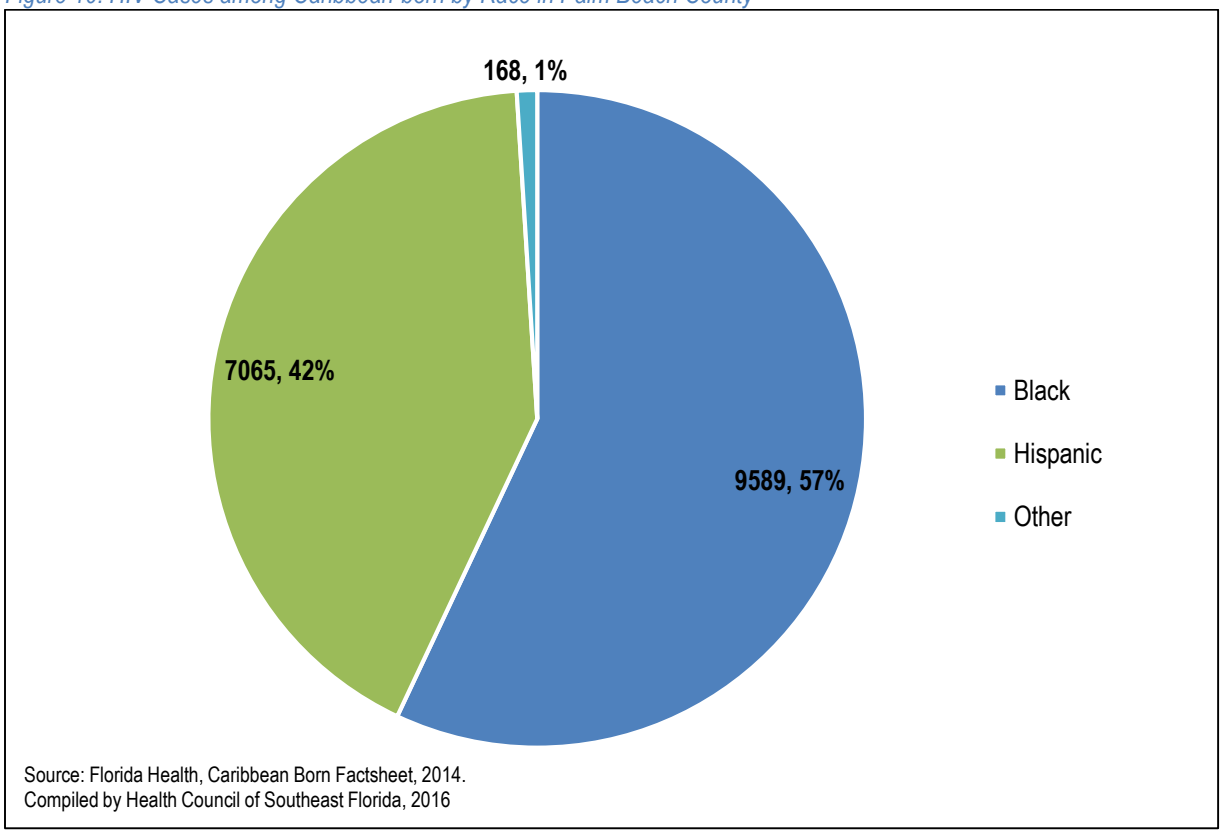
Figure 18: HIV Cases among Caribbean-born by Counties in Florida, 2014



Source: Florida Health, Caribbean Born Factsheet, 2014.
Compiled by Health Council of Southeast Florida, 2016

As shown in Figure 19, the racial composition of this group included 57% Black, 42% Hispanic and 1% other. Palm Beach County was home to 11% of all Caribbean-born HIV cases in Florida.

Figure 19: HIV Cases among Caribbean-born by Race in Palm Beach County

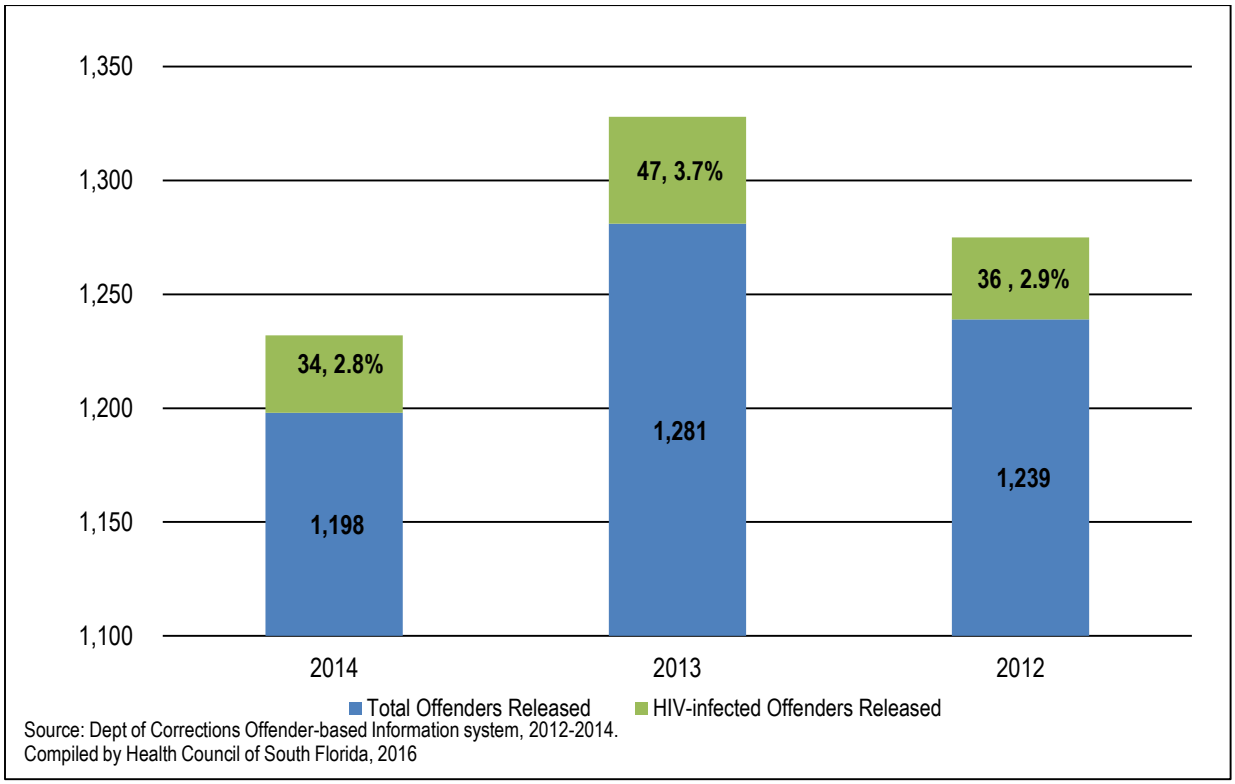


Source: Florida Health, Caribbean Born Factsheet, 2014.
Compiled by Health Council of Southeast Florida, 2016

Recently Released Offenders

The figure below depicts the number of offenders living with HIV released in Palm Beach County in 2012, 2013 and 2014. The data suggest that between 2012 and 2014 over 30 HIV-infected offenders were released. During 2012-2014, at least 2.8% of offenders who were released were HIV positive.

Figure 20: HIV Infected Offenders released in Palm Beach County, 2012, 2013, 2014



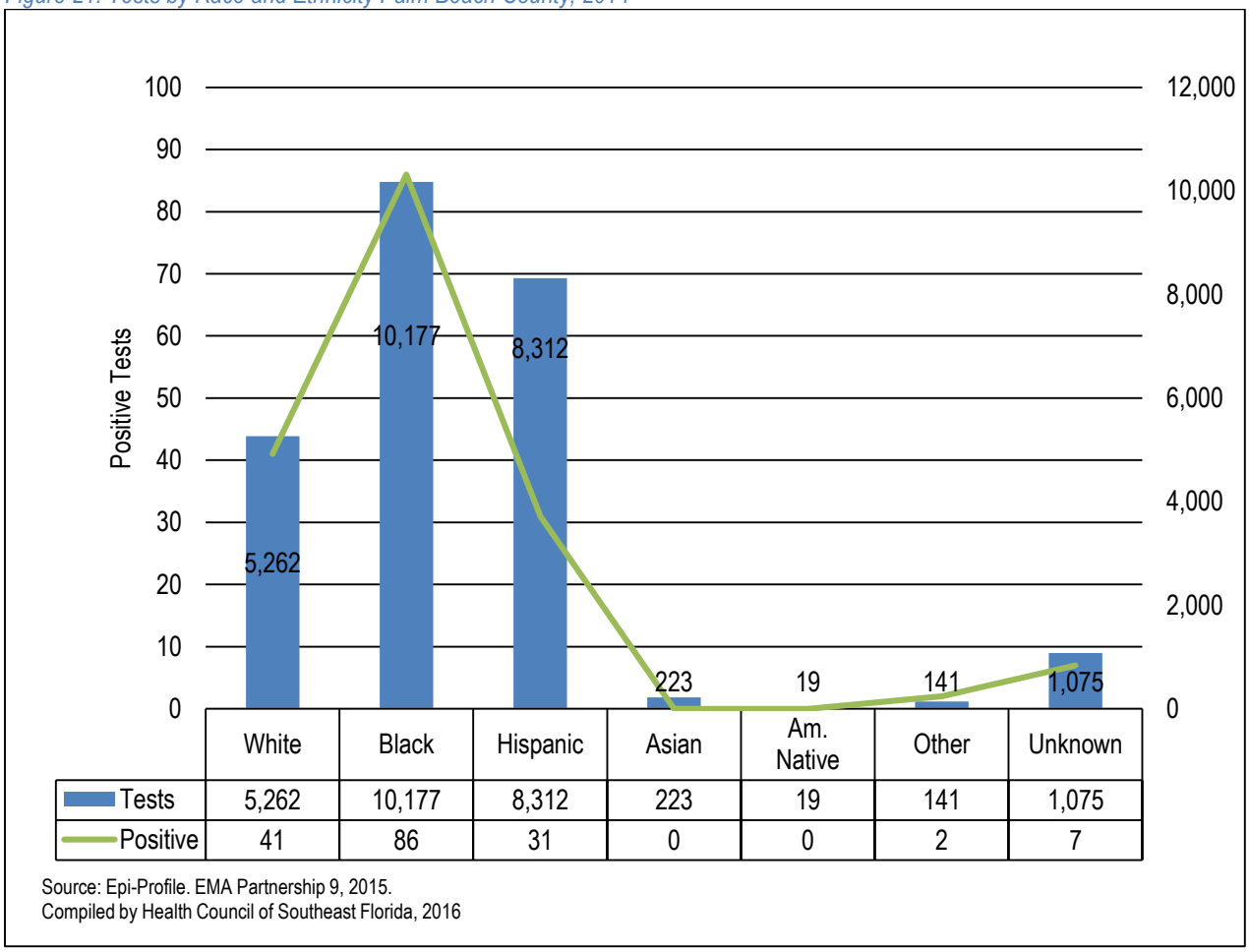
Source: Dept of Corrections Offender-based Information system, 2012-2014.
Compiled by Health Council of South Florida, 2016

Counseling and Testing

The Figures below include the total number of tests performed at the state laboratories from all testing sites in Palm Beach County in 2014.

Figure 21 shows the number of tests completed and the number of individuals that tested positive by race and ethnicity. Compared to white individuals, a higher number of African American or Black and Hispanic individuals tested positive for HIV.

Figure 21: Tests by Race and Ethnicity Palm Beach County, 2014

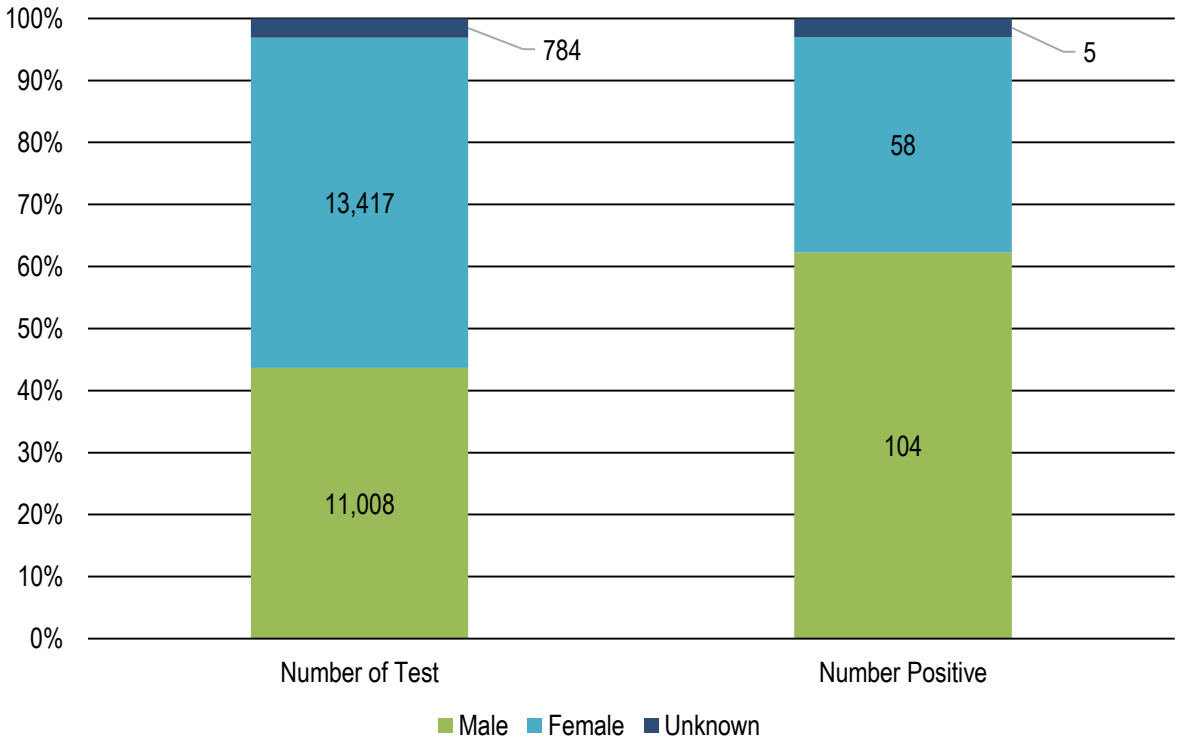


	White	Black	Hispanic	Asian	Am. Native	Other	Unknown
Tests	5,262	10,177	8,312	223	19	141	1,075
Positive	41	86	31	0	0	2	7

Source: Epi-Profile. EMA Partnership 9, 2015.
Compiled by Health Council of Southeast Florida, 2016

In 2014 more Females than Males were tested for HIV/AIDS at testing sites in Palm Beach County, while almost twice as many Males tested positive than Females in the county at that time.

Figure 22: HIV Tests by Gender, Palm Beach County, 2014



Source: Epi-Profile. EMA Partnership 9, 2015.
Compiled by Health Council of Southeast Florida, 2016

The table below shows the total number of state lab tests from testing sites in the county by various exposure categories. In 2014, the MSM and Sex Partner at Risk categories had the highest percentage of positive test results among the exposure categories considered.

Table 9: Total Number of State Lab Test From all Testing Sites by Exposure Category in Palm Beach County, 2014

Exposure Category	Number of Tests	Number Positive	Percent Positive
Male Sex With Male/IDU	136	1	0.7%
Male Sex With Male	2,074	58	2.8%
Injecting Drug User	1,129	5	0.4%
Sex Partner at Risk	682	19	2.8%
Child of Woman with HIV/AIDS	2	0	0.0%
STD Diagnosis	2,007	13	0.6%
Sex for Drugs or Money	223	1	0.4%
Hemophilia/Blood Recipient	0	0	0.0%
Victim of Sexual Assault	18	0	0.0%
Health Care Exposure	0	0	0.0%
Heterosexual	16,028	55	0.3%
No Acknowledged Risk	2,460	14	0.6%
Unknown	450	1	0.2%
Total	25,209	167	0.7%

Source: Epi-Profile. EMA Partnership 9, 2015.
Compiled by Health Council of Southeast, 2016

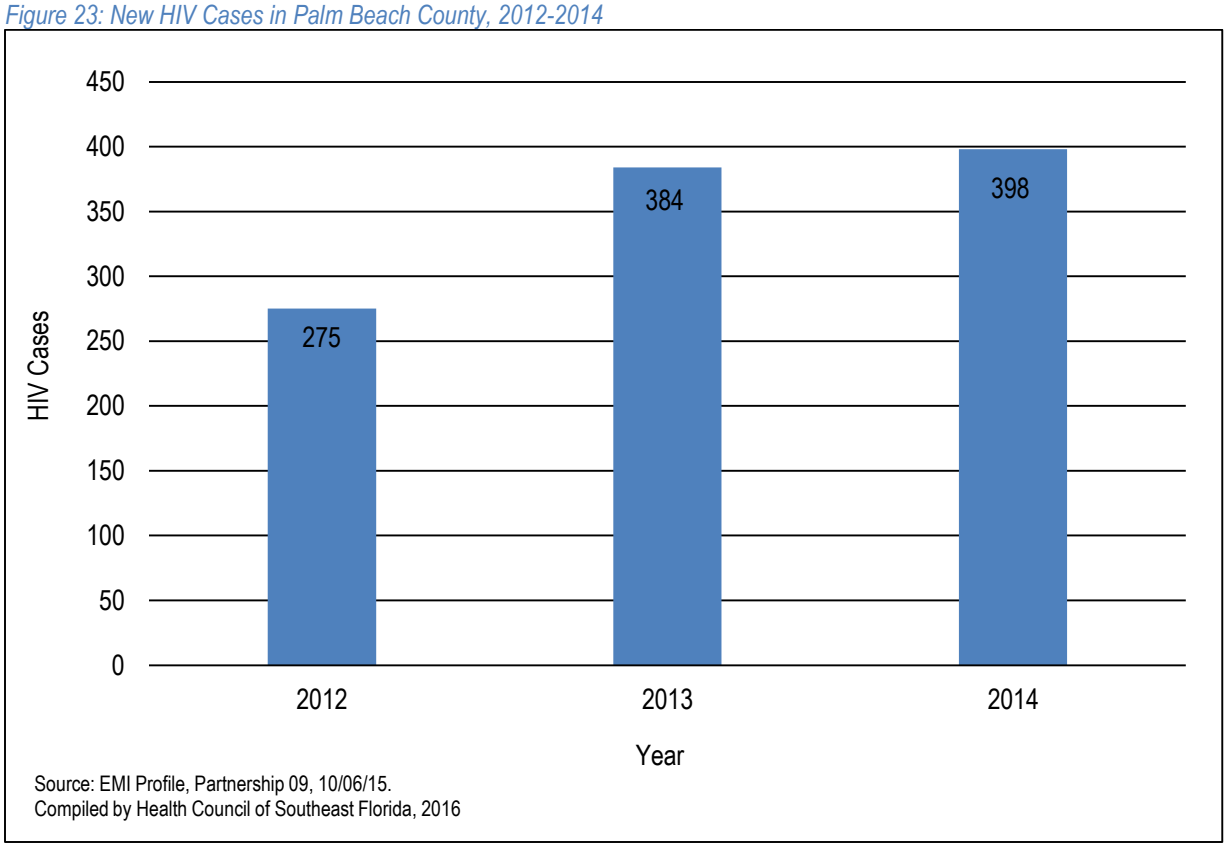
New HIV/AIDS Cases in Palm Beach County

New HIV Infection Cases

New HIV infection cases are defined as the number of new HIV infection cases reported during the period specified.[11] Figure 23 displays the total count of new HIV infection cases reported during 2012, 2013, and 2014. The percent change calculated over this time period (3 years percent change) was 44.7%.

Figure 24, figure 25 and table 10 provide detail on new HIV cases for 2014 by gender, race and ethnicity groups and age group discussed above.

Figure 23: New HIV Cases in Palm Beach County, 2012-2014

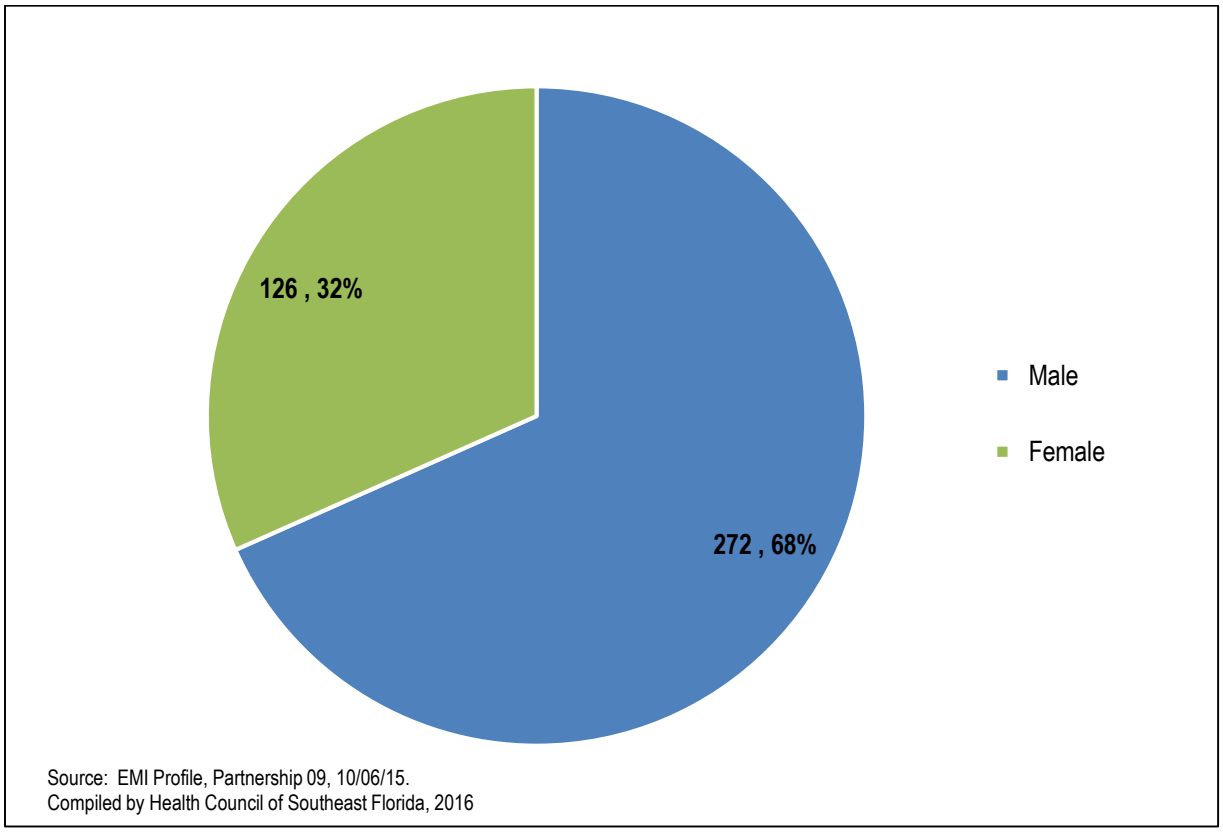


Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

[11] Palm Beach County. EMI Profile, Partnership 09, Revised 10/06/15

As seen in the figures below, in 2014, more than twice as many Males (272) were diagnosed than Females (126).

Figure 24: New HIV Cases by Gender in Palm Beach County, 2014



According to Table 10, the highest number of reported new HIV cases was among Black non-Hispanic residents, 194 cases, representing nearly one-half of all new cases.

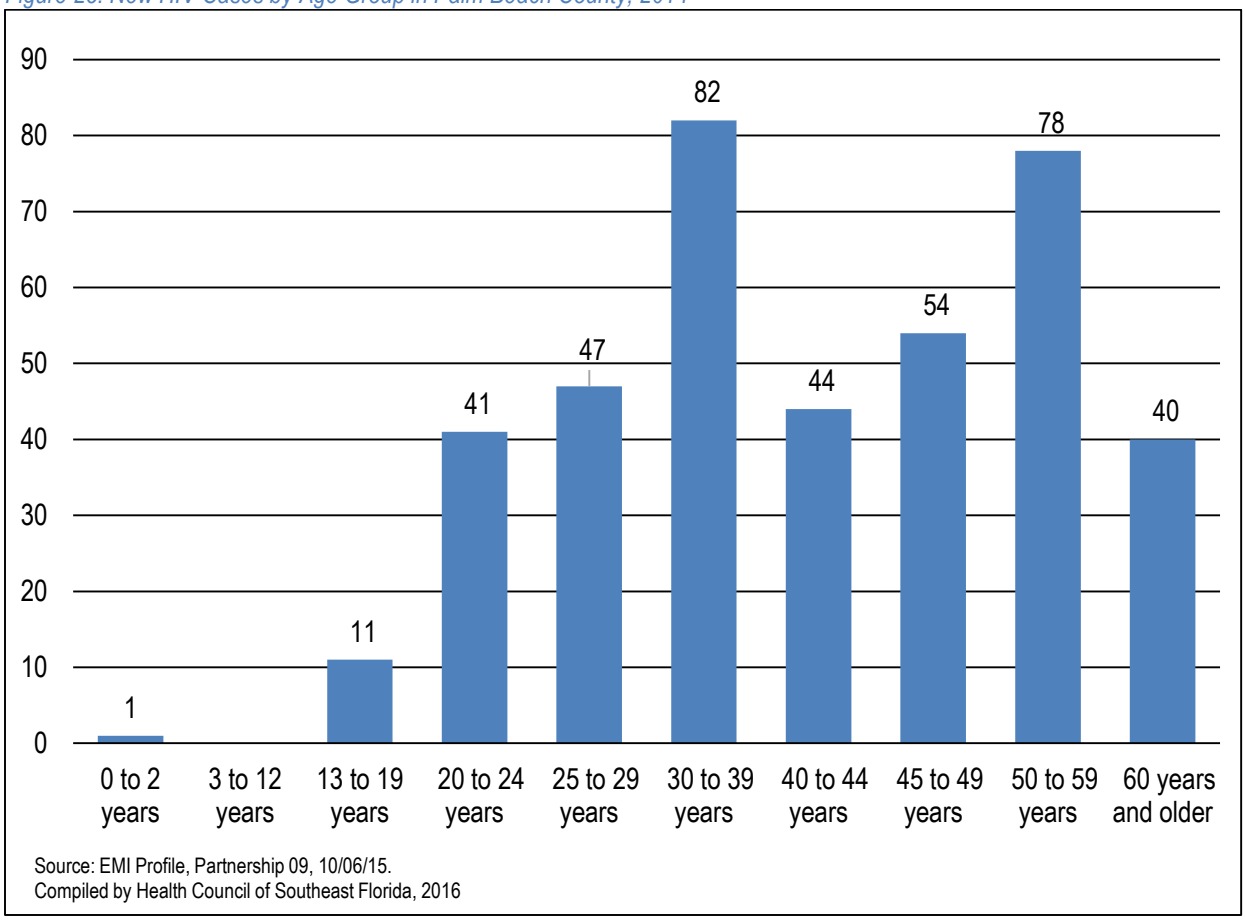
Table 10: New HIV Cases by Race and Ethnicity Group in Palm Beach County, 2014

Race/Ethnicity	Cases	Percentages
White, not Hispanic	121	30%
Black, not Hispanic	194	49%
Hispanic	76	19%
Asian/Pacific Islander	3	1%
America Indian/Alaskan Native	-	0%
Not Specified/Other	4	1%

Source: EMI Profile, Partnership 09, 10/06/15
Compiled by Health Council of Southeast Florida, 2016

The age group that had the highest number of new HIV diagnosis was 30 - 39 years with 20.6% of new cases. The next most significant number of cases ranged between 50 - 59 years with 19.6% of the new HIV cases.

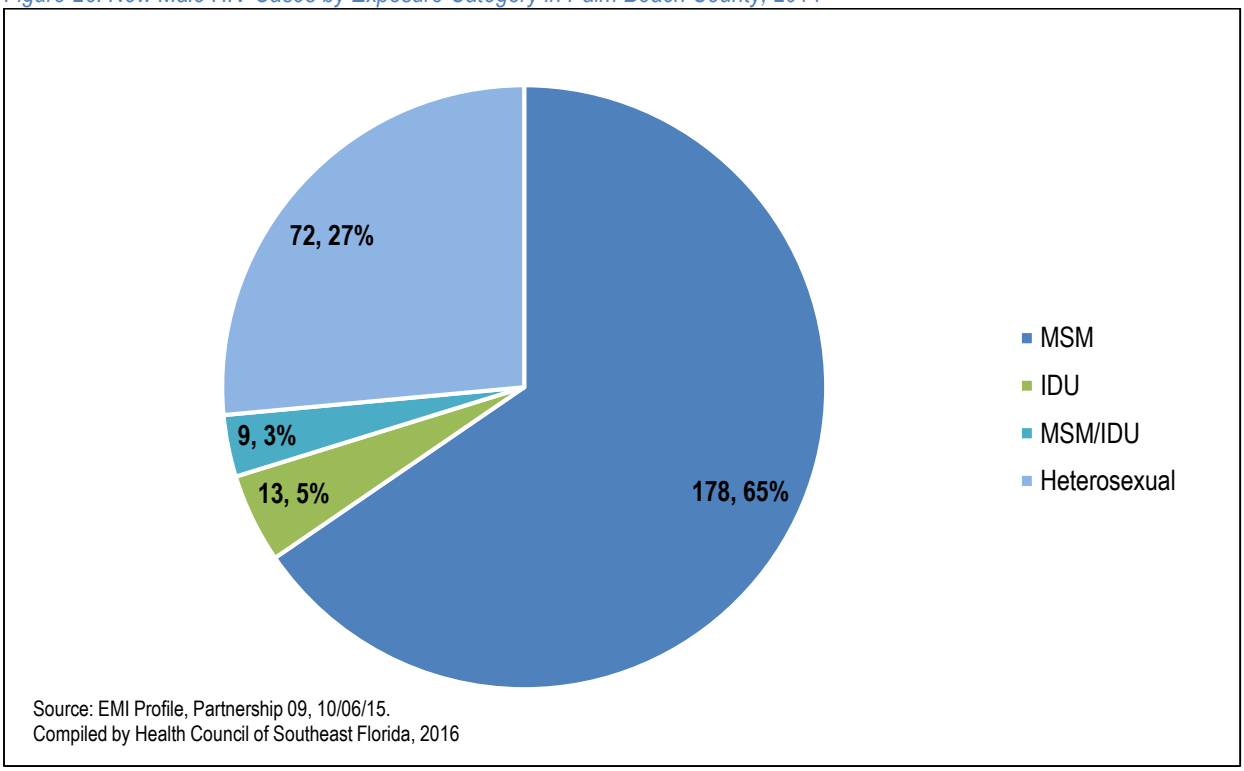
Figure 25: New HIV Cases by Age Group in Palm Beach County, 2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

The figures below depict new HIV cases by exposure category for both males and females. Figure 26 shows that the primary exposure category for males is MSM (65%) followed by heterosexual transmission (27%).

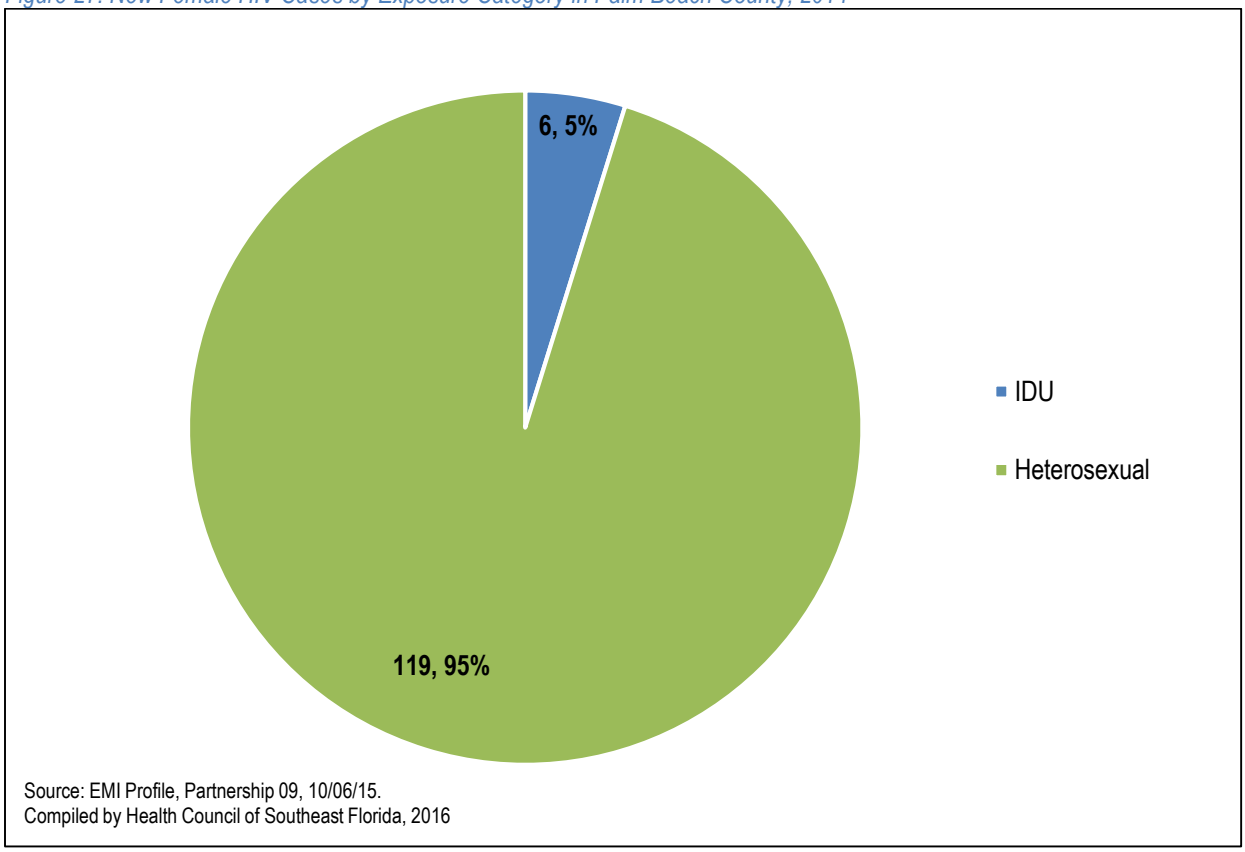
Figure 26: New Male HIV Cases by Exposure Category in Palm Beach County, 2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

Figure 27 shows that the majority of new HIV cases among females is a result of heterosexual transmission.

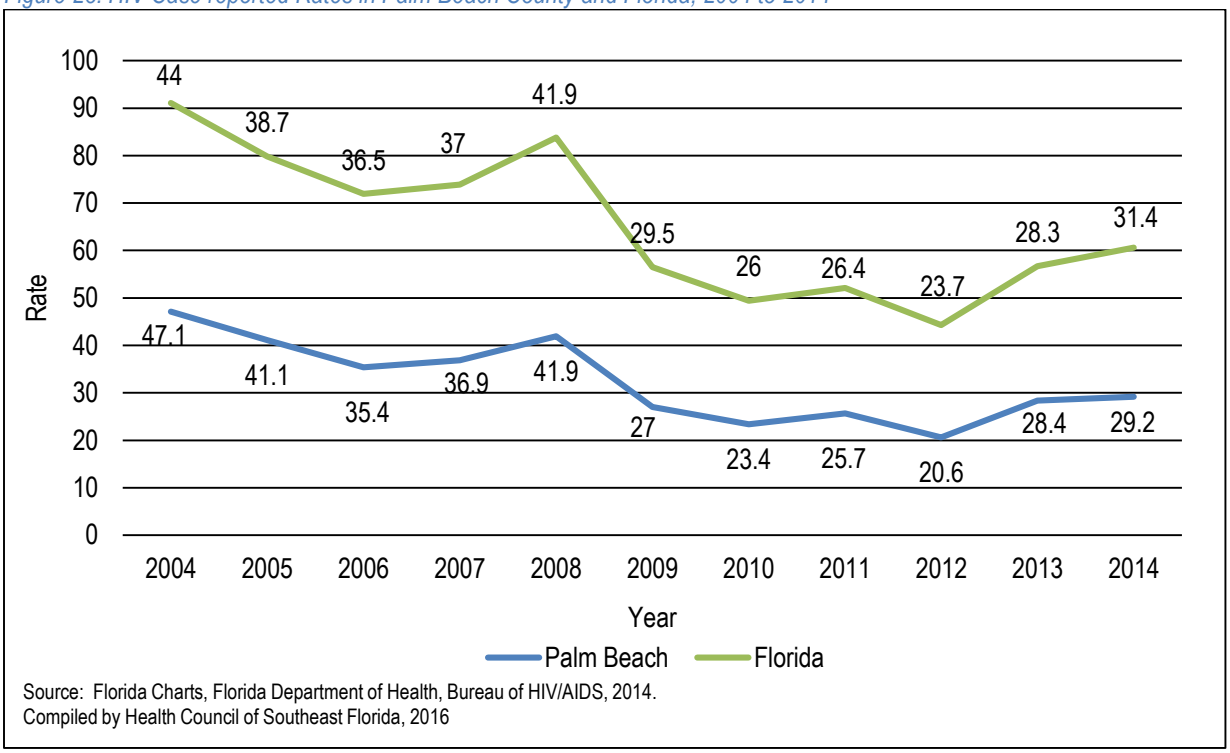
Figure 27: New Female HIV Cases by Exposure Category in Palm Beach County, 2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

The following figures show HIV/AIDS death rates. The death rate associated with HIV/AIDS has steadily declined over the past 10 years in the county and the state.

Figure 28: HIV Case reported Rates in Palm Beach County and Florida, 2004 to 2014



Source: Florida Charts, Florida Department of Health, Bureau of HIV/AIDS, 2014.
Compiled by Health Council of Southeast Florida, 2016

The tables and figures below detail HIV/AIDS population trends over a 10 year period (2004 to 2014). The table below shows newly diagnosed HIV cases over a 3 year period. African Americans account for nearly half (49%) of new cases in Palm Beach County. This disparity is greater than the corresponding State rate of 43%. Heterosexual transmission is higher in Palm Beach County (52%) than in Florida (34%), and represents the most frequent mode of transmission. The second most common exposure category is MSM at 42% in Palm Beach County. As previously indicated in Figure 26, MSM transmission remains the most common exposure category among males.

Table 11: Newly Diagnosed HIV Cases over a 3 year period by Demographic Group and Exposure in Palm Beach County and Florida, 2012-2014

	Palm Beach		Florida	
	Number	Percent	Number	Percent
Race/Ethnicity				
White, not Hispanic	121	30%	1,902	29%
Black, not Hispanic	194	49%	2,404	43%
Hispanic	76	19%	1,594	26%
Asian/Pacific Islander	3	1%	61	1%
American Indian/Alaskan Native	0	0%	12	0%
Not Specified/Other	4	1%	46	1%
Total:	398	100%	6,019	100%
Gender				
Male	126	31.7%	4,768	77%
Female	272	68.3%	1,251	23%
Total:	398	100%	6,019	100%
Age at Diagnosis (Incidence) / Current Age (Prevalence)				
0-12 years	1	0%	15	0.2%
13-19 years	11	3%	177	2.9%
20-44 years	214	54%	3,718	61.8%
45+ years	172	43%	2,109	33.5%
Total:	398	100%	6,019	100%
Adult/Adolescent AIDS Exposure Category				
MSM	178	44.8%	3,743	62.4%
IDU	19	4.8%	277	4.6%
MSM/IDU	9	2.3%	138	2.3%
Heterosexual	191	48.1%	1,829	30.5%
Other	0	0%	16	0.2%
Total:	397	100%	6,003	100%
Pediatric AIDS Exposure Categories (ages 0-12)				
Mother with/at risk for HIV infection	1	100%	15	100%
Risk not Diagnosed/Other	0	0%	0	0%
Total:	1	100%	15	100%

Source: Epi-profile State and Partnership 09, 2014
Compiled by Health Council of Southeast Florida, 2016

Table 12 below shows New HIV cases by race in Palm Beach County. After several years of decline, rates began to rise in 2013. Table 13 shows New HIV cases by ethnicity in Palm Beach County.

Table 12: New HIV Cases by Race in Palm Beach County and Florida, 2004-2014

Year	Palm Beach				Florida			
	Non-Hispanic White		Non-Hispanic Black		Non-Hispanic White		Non-Hispanic Black	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate
2004	154	18.5	324	168.8	2,240	20.5	3,754	144.8
2005	126	15.1	314	157.7	1,969	17.9	3,375	126.8
2006	117	14.1	271	131.4	1,946	17.6	3,160	115.6
2007	116	14.1	276	130.8	2,027	18.3	3,241	116.3
2008	140	17.3	325	150.9	2,340	21.2	3,758	133.0
2009	76	9.5	227	103.2	1,503	13.7	2,747	96.4
2010	58	7.3	195	87.3	1,247	11.4	2,470	85.9
2011	82	10.4	202	89.8	1,388	12.7	2,338	80.5
2012	66	8.4	168	74.2	1,287	11.8	2,119	72.4
2013	111	14.0	205	88.7	1,543	14.1	2,405	80.6
2014	121	15.2	194	83.4	1,926	17.5	2,488	82.2

Source: Florida Charts, Florida Department of Health, Bureau of HIV/AIDS, 2014
Compiled by Health Council of Southeast Florida, 2016

Table 13: New HIV Cases by Hispanic / Non-Hispanic Ethnicity in Palm Beach County and Florida, 2004-2014

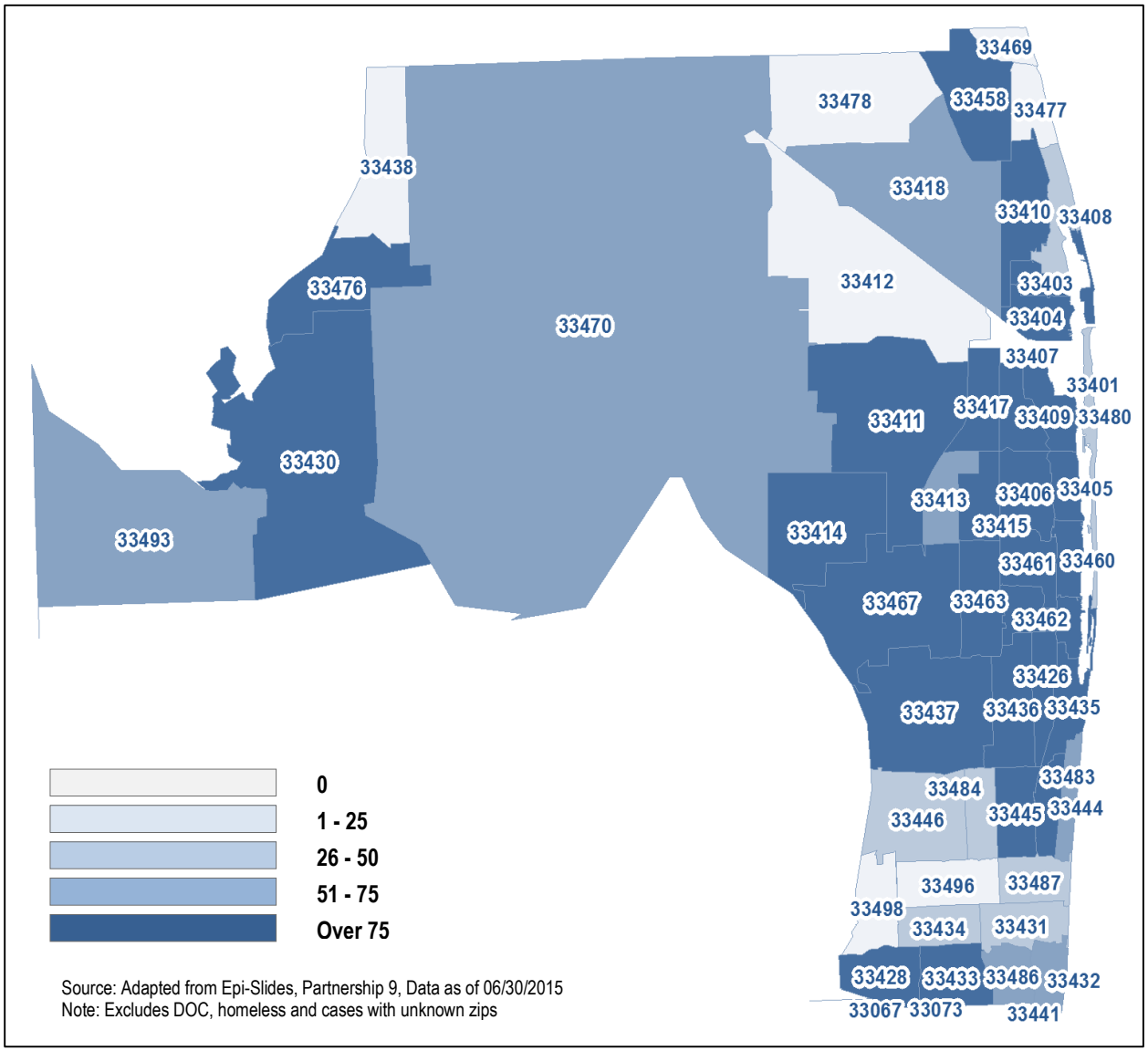
Year	Palm Beach				Florida			
	Hispanic		Non-Hispanic		Hispanic		Non-Hispanic	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate
2004	94	48.8	497	46.7	1,521	45.4	6,169	43.7
2005	75	36.6	451	42.0	1,407	39.7	5,516	38.5
2006	65	30.0	394	36.5	1,401	37.5	5,257	36.3
2007	79	34.8	402	37.3	1,444	36.9	5,409	37.1
2008	74	31.4	475	44.3	1,534	37.9	6,280	43.0
2009	48	19.7	307	28.7	1,165	28.1	4,359	29.9
2010	52	20.6	257	24.1	1,084	25.5	3,812	26.2
2011	52	20.0	289	27.1	1,168	27.1	3,829	26.2
2012	41	15.4	234	21.9	1,027	23.3	3,485	23.8
2013	65	23.8	319	29.6	1,414	31.1	4,053	27.4
2014	76	26.8	322	29.8	1,614	34.4	4,533	30.5

Source: Florida Charts, Florida Department of Health, Bureau of HIV/AIDS, 2014
Compiled by Health Council of Southeast Florida, 2016

HIV Cases by Zip Codes

Figure 29 is a map of Palm Beach County showing adult living HIV cases by zip codes. It is important to note that this figure does not represent proportions, but raw numbers. Therefore, it does not take into account population size. Furthermore, it includes all living cases, and not just new cases.

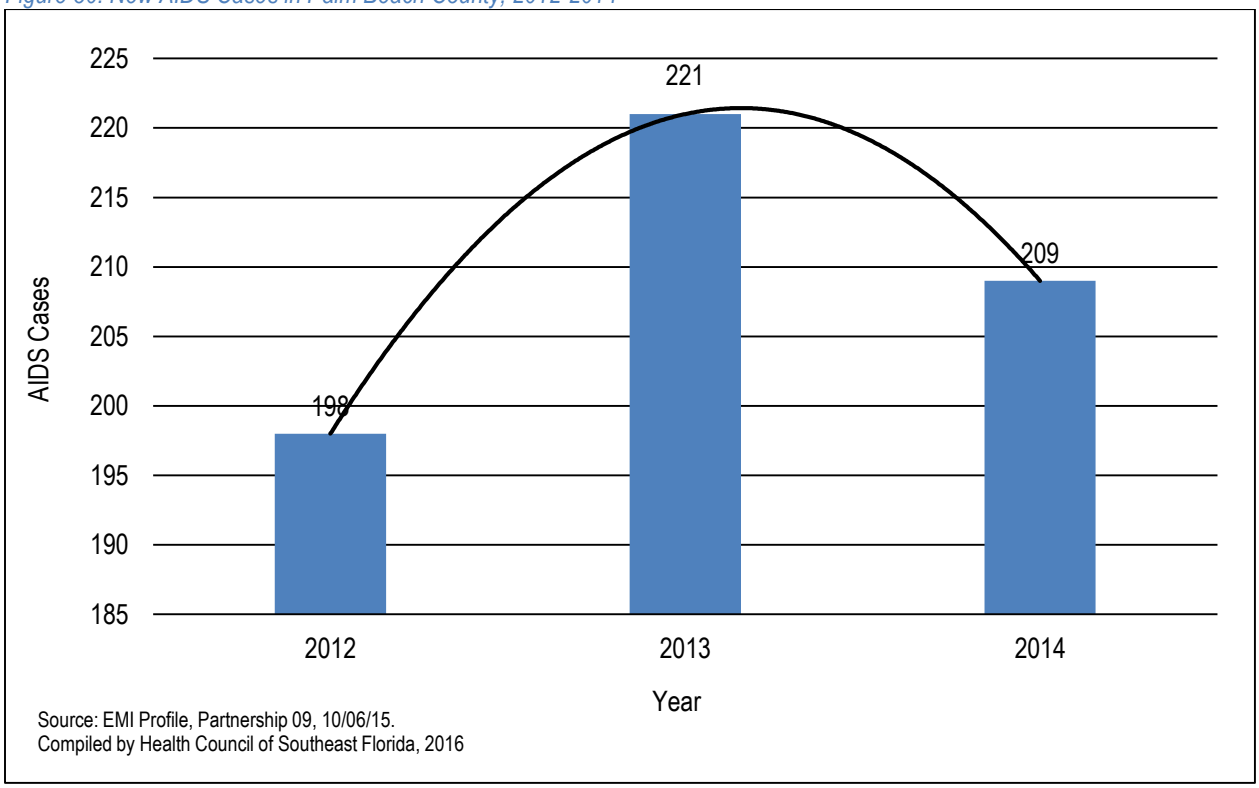
Figure 29: Adults Living with HIV Disease by Zip Code, Diagnosed through 2014, Partnership 9



New AIDS Cases

The following tables relate to new cases of AIDS within a specified time period, as of the end of 2014. The figure below shows the total count of new AIDS cases reported in Palm Beach County in 2012, 2013 and 2014. During this 3 year time period there was an increase in cases from 2012 to 2013, followed by a decrease in the number of reported cases from 2013 to 2014. The percent change calculated for this 3-year time period was 5.6%.

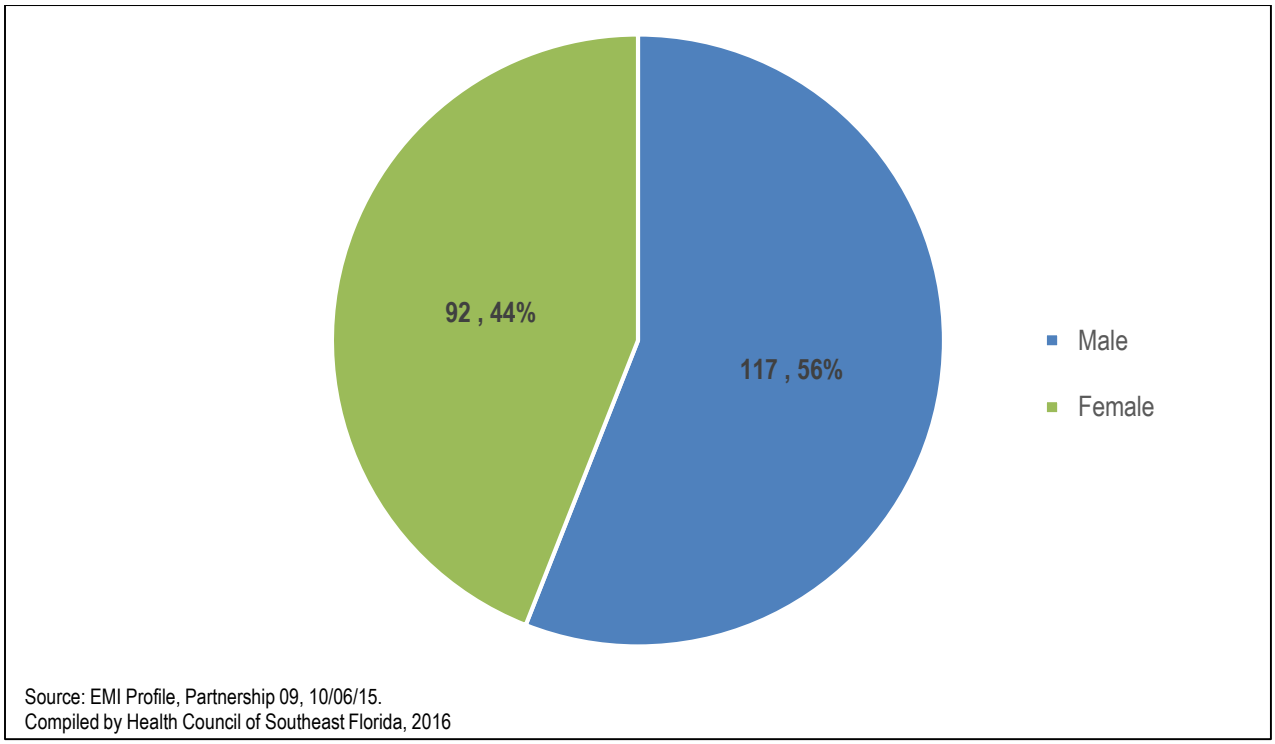
Figure 30: New AIDS Cases in Palm Beach County, 2012-2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

The figure below shows the gender breakdown of new AIDS cases. In 2014, there were more male cases reported than females, 117 males and 92 females presented as new AIDS cases.

Figure 31: New AIDS Cases by Gender in Palm Beach County, 2012-2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

Below, new AIDS cases are shown by race and ethnicity. Comparable to new HIV cases, the highest number of reported new AIDS cases was among Black non-Hispanic residents, 130 cases, accounting for more than a half of all new cases from 2012-2014.

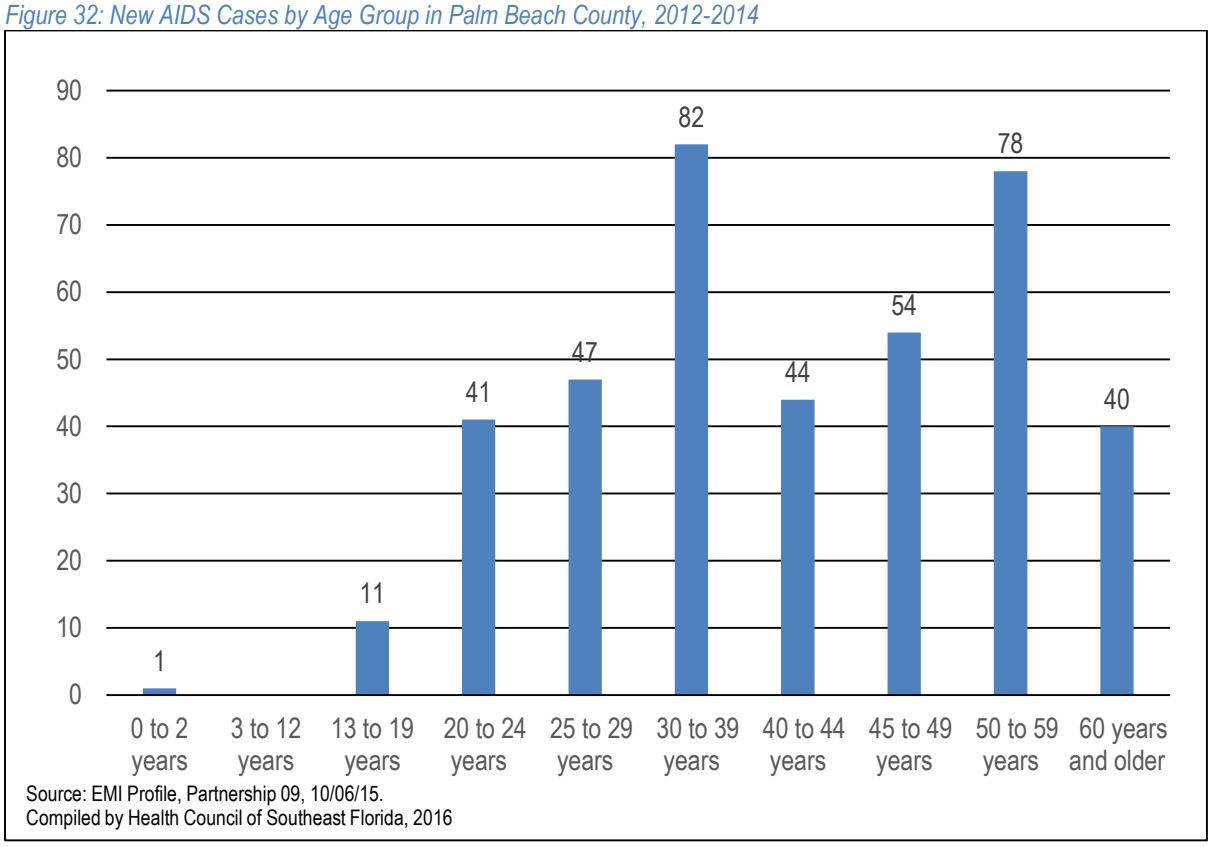
Table 14: New AIDS Cases by Race and Ethnicity Group in Palm Beach County, 2012-2014

Race/Ethnicity	New Cases	Percentage
White, not Hispanic	42	20%
Black, not Hispanic	130	62%
Hispanic	34	16%
Asian/Pacific Islander	2	1%
America Indian/Alaskan Native	-	0%
Not Specified/Other	1	0%

Source: EMI Profile, Partnership 09, 10/06/15
Compiled by Health Council of Southeast Florida, 2016

The figure below breaks down the new AIDS cases by age group, showing that more than a quarter (27.3%) of the new AIDS cases were in 50 - 59 years age group. The 30 - 39 year old age group accounted for 22.5% of new AIDS cases reported.

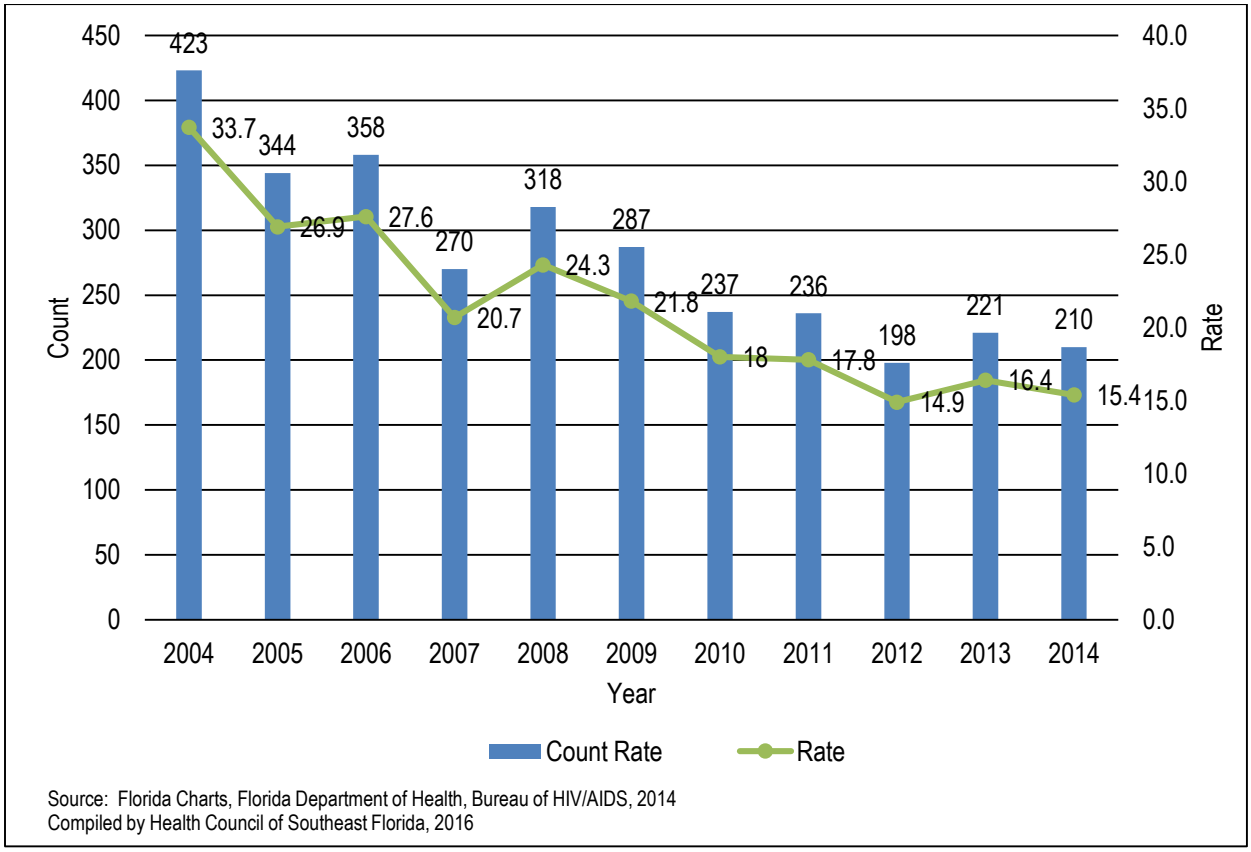
Figure 32: New AIDS Cases by Age Group in Palm Beach County, 2012-2014



Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council of Southeast Florida, 2016

The trend of AIDS incidence by count and rate over a decade between 2004 and 2014 is depicted in the figure below. Noted is a significant decline from 2004 to 2014, with episodes of unsteady trends throughout this time period.

Figure 33: AIDS Incidence, Counts and Rates in Palm Beach County, 2004 - 2014



Source: Florida Charts, Florida Department of Health, Bureau of HIV/AIDS, 2014
Compiled by Health Council of Southeast Florida, 2016

The table below shows newly diagnosed AIDS cases both by demographic group and exposure categories in Palm Beach County and Florida. The majority of new AIDS cases were among Black non-Hispanic individuals, at 65%. Heterosexual exposure has been identified as the most common exposure (67%), followed by MSM at 27%.

Table 15: Newly Diagnosed AIDS Cases over a 3 year period by Demographic Group and Exposure in Palm Beach County and Florida, 2012-2014

Exposure Category	Palm Beach		Florida	
	Number	Percent	Number	Percent
Race/Ethnicity				
White, not Hispanic	42	20%	685	26%
Black, not Hispanic	130	62%	1355	51%
Hispanic	34	16%	534	20%
Asian/Pacific Islander	2	1%	21	1%
American Indian/Alaskan Native	0	0%	3	0%
Not Specified/Other	0	0%	38	1%
Total:	209	100%	2,636	100%
Gender				
Male	117	44%	1,830	69.4%
Female	92	56%	806	30.6%
Total:	209	100%	2,636	100%
Age at Diagnosis (Incidence) / Current Age (Prevalence)				
0-12 years	3	1.4%	12	0.5%
13-19 years	0	0%	31	1.2%
20-44 years	95	45.5%	1,347	51.1%
45+ years	111	53.1%	1,246	47.3%
Total:	209	100%	2,636	100%
Pediatric AIDS Exposure Categories (ages 0-12)				
Mother with/at risk for HIV infection	3	100%	12	100%
Risk not Diagnosed/Other	0	0%	0	0%
Total:	3	100%	12	100%

Source: Epi-profile State and Partnership 09, 2014
Compiled by Health Council of Southeast Florida, 2016

Viral Load Suppression

Viral suppression is achieved when antiretroviral therapy (ART) reduces a person's viral load (HIV RNA) to an undetectable level. Viral suppression does not mean a person is cured; HIV still remains in the body. If ART is discontinued, the person's viral load will likely return to a detectable level.[12] The tables and graph below present detail on PLWHA with and not with a suppressed viral load (VL) at the last VL test in 2014 by special populations in Palm Beach County.

Table 16 shows White Heterosexual individuals are more likely to have a suppressed viral load, as compared to Black Heterosexual individuals.

Table 16: PLWHA with and not with suppressed Viral Load by Heterosexual Population in Palm Beach County, 2014

Special Populations	PLWHA with Suppressed VL	% PLWHA with suppressed VL	% of PLWHA and not with suppressed VL	# PLWHA and not with suppressed VL
White Heterosexual	230	61%	39%	147
Black Heterosexual	1,795	50%	50%	1,773
Hispanic Heterosexual	251	53%	47%	219
Black Heterosexual Females	1,131	54%	46%	977
Black Heterosexual Males	663	45%	55%	797

Epi-Profile Partnership 09, 2014
Compiled by the Health Council of Southeast Florida, 2016

The table below examines viral suppression among MSM. The majority of MSM with an unsuppressed viral load are Black, at 53%.

Table 17: PLWHA with and not with suppressed Viral Load by MSM Population in Palm Beach County, 2014

Special Populations	PLWHA with Suppressed VL	% PLWHA with suppressed VL	% of PLWHA and not with suppressed VL	# PLWHA and not with suppressed VL
White MSM	853	63%	37%	491
Black MSM	427	47%	53%	475
Hispanic MSM	325	58%	42%	232

Epi-Profile Partnership 09, 2014
Compiled by the Health Council of Southeast Florida, 2016

[12] AIDS Info: Education Materials- Viral Suppression. Last updated 02/2016 https://aidsinfo.nih.gov/education-materials/glossary/1650/viral-suppression

Table 18 shows that among male injection drug users, White males have the highest prevalence of living with a suppressed viral load. Conversely, among female injection drug users, White females have the lowest prevalence of living with a suppressed viral load, compared to Black and Hispanic users.

Table 18: PLWHA with and not with suppressed Viral Load by IDU Population in Palm Beach County, 2014

Special Populations	PLWHA with Suppressed VL	% PLWHA with suppressed VL	% of PLWHA and not with suppressed VL	# PLWHA and not with suppressed VL
White Male IDU	68	50%	50%	66
Black Male IDU	97	43%	57%	129
Hispanic Male IDU	36	40%	60%	53
White Female IDU	44	48%	52%	48
Black Female IDU	74	58%	42%	53
Hispanic Female IDU	19	57%	43%	14

Epi-Profile Partnership 09, 2014
Compiled by the Health Council of Southeast Florida, 2016

According to Table 19, 100% of homeless individuals do not have a suppressed viral load. This category is also likely to be underreported.

Table 19: PLWHA with and not with suppressed Viral Load by Homeless Population in Palm Beach County, 2014

Special Populations	PLWHA with Suppressed VL	% PLWHA with suppressed VL	% of PLWHA and not with suppressed VL	# PLWHA and not with suppressed VL
White Male Homeless	0	0%	100%	1
Black Male Homeless	0	0%	100%	7
Hispanic Male Homeless	0	0%	100%	2
White Female Homeless	0	0%	100%	1
Black Female Homeless	0	0%	100%	3
Hispanic Female Homeless	0	0%	100%	0

Epi-Profile Partnership 09, 2014
Compiled by the Health Council of Southeast Florida, 2016

According to the table below, Black male youth and Hispanic female youth both with 38% were found to have the lowest percentage of suppressed VL during this time period. Nearly 80% of male Hispanic youth cases achieved viral load suppression.

Table 20: PLWHA with and not with suppressed Viral Load by Youth (13-24 years Population) in Palm Beach County, 2014

Special Populations	PLWHA with Suppressed VL	% PLWHA with suppressed VL	% of PLWHA and not with suppressed VL	# PLWHA and not with suppressed VL
White Male Youth (current ages 13-24)	7	47%	53%	8
Black Male Youth (current ages 13-24)	41	38%	62%	66
Hispanic Male Youth (current ages 13-24)	16	76%	24%	5
White Female Youth (current ages 13-24)	6	50%	50%	6
Black Female Youth (current ages 13-24)	36	43%	57%	47
Hispanic Female Youth (current ages 13-24)	3	38%	63%	5

Epi-Profile Partnership 09, 2014
Compiled by the Health Council of Southeast Florida, 2016

Table 21 shows Black women of child bearing age (WCBA) as having the highest prevalence of those living with a non-suppressed viral load.

Table 21: PLWHA with and not with suppressed Viral Load by WCBA Population in Palm Beach County, 2014

Special Populations	PLWHA with Suppressed VL	% PLWHA with suppressed VL	% of PLWHA and not with suppressed VL	# PLWHA and not with suppressed VL
White WCBA* (current ages 15-44)	72	52%	48%	67
Black WCBA* (current ages 15-44)	438	47%	53%	486
Hispanic WCBA* (current ages 15-44)	70	51%	49%	66

Epi-Profile Partnership 09, 2014
Compiled by the Health Council of Southeast Florida, 2016
*Women of Child-Bearing Age

The table below viral suppression among pediatric populations in Palm Beach in 2014. There was 100% suppressed viral load among Hispanic pediatric cases, however there sample size is small.

Table 22: PLWHA with and not with suppressed Viral Load by Pediatric Population in Palm Beach County, 2014

Special Populations	PLWHA with Suppressed VL	% PLWHA with suppressed VL	% of PLWHA and not with suppressed VL	# PLWHA and not with suppressed VL
White Ped Cases (current ages 0-12)	s	50%	50%	1
Black Ped Cases (current ages 0-12)	5	45%	55%	6
Hispanic Ped Cases (current ages 0-12)	3	100%	0%	0
DOC Cases	81	56%	44%	64

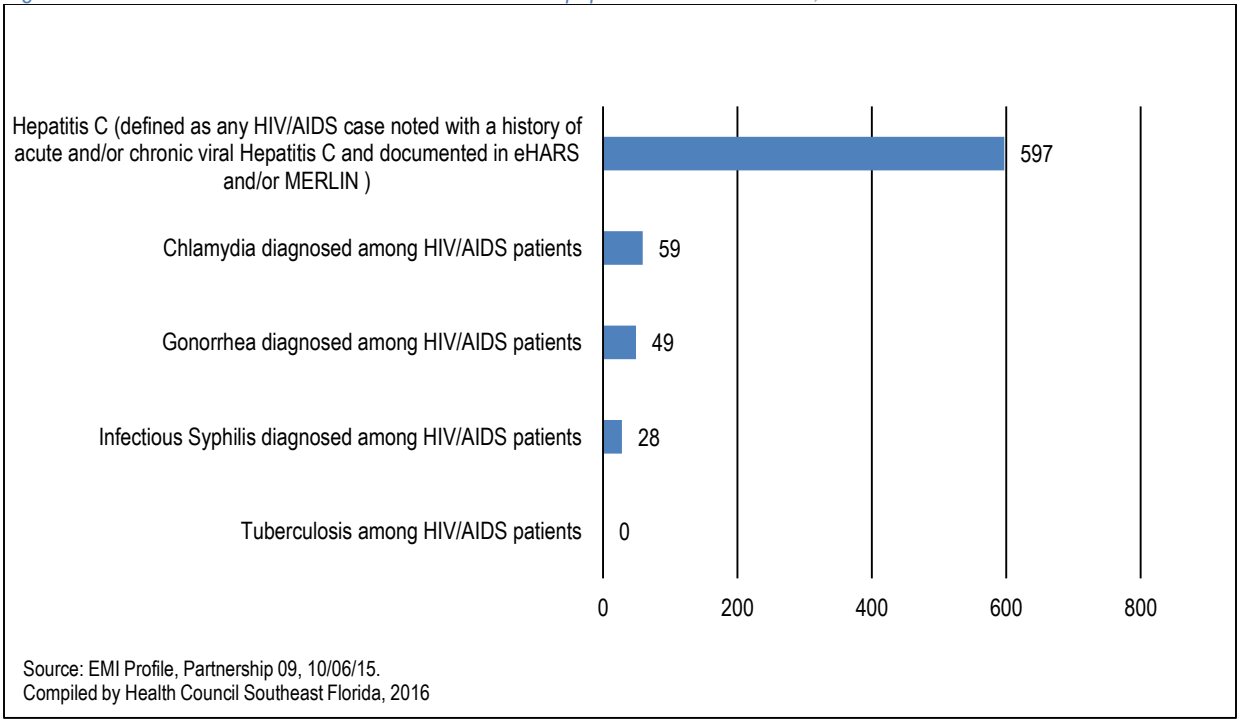
Epi-Profile Partnership 09, 2014
Compiled by the Health Council of Southeast Florida, 2016

Co-morbidities

The term co-morbidity describes two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both.[13]

Figure 34 shows the prevalence of documented co-morbidities in Palm Beach County among people living with HIV and in care. The most common co-morbidity was with Hepatitis C. Hepatitis C co-morbidity cases represented in the figures below are defined as any documented HIV/AIDS case noted with a history of acute or chronic Hepatitis C.

Figure 34: Co-morbidities Prevalence of in care HIV/AIDS population in Palm Beach, 2014

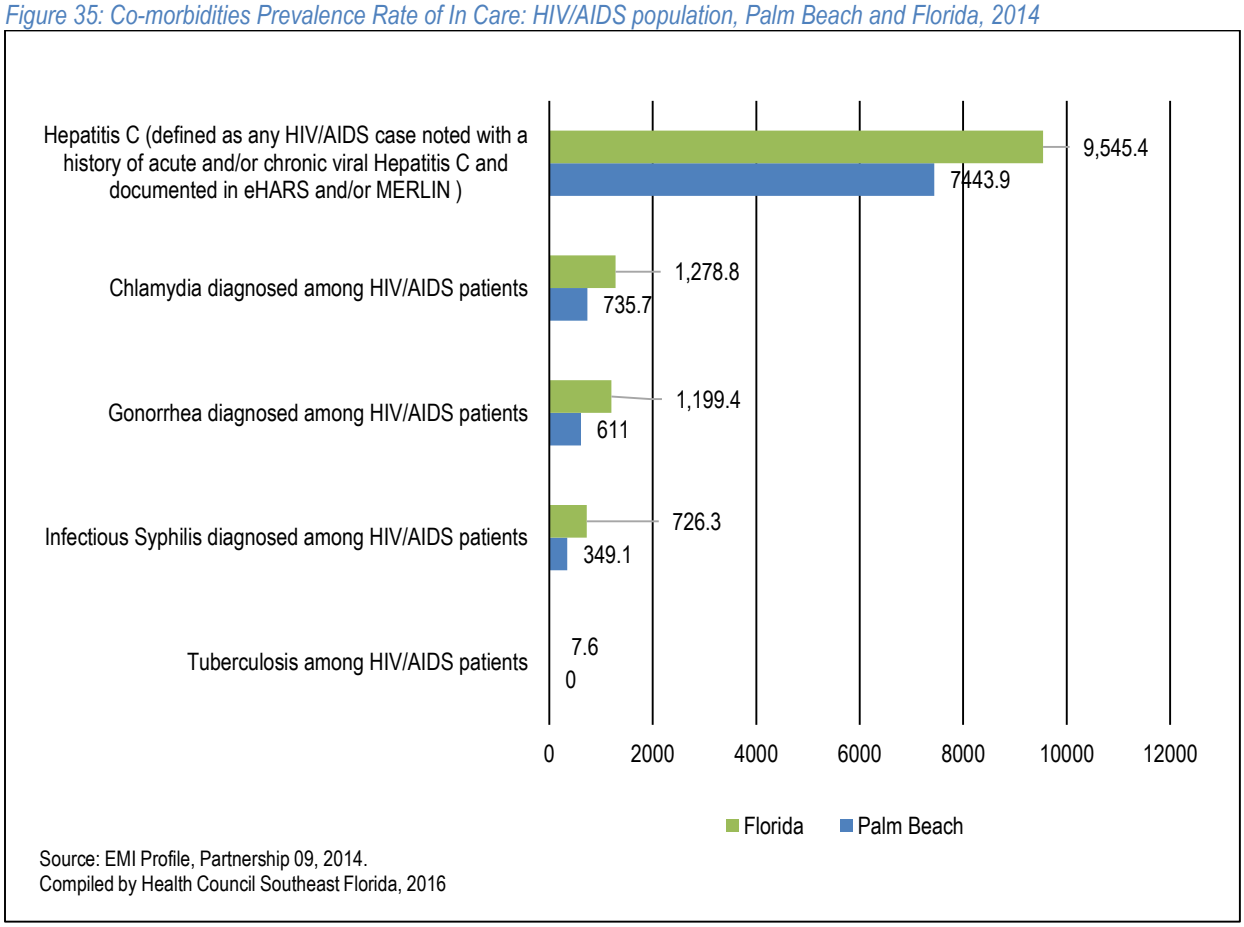


Source: EMI Profile, Partnership 09, 10/06/15.
Compiled by Health Council Southeast Florida, 2016

[13] NIH: National Institute on Drug Abuse (2012) "Comorbidity" NIH http://www.drugabuse.gov/related-topics/comorbidity

The figure below shows a comparison of the co-morbidity prevalence rates of the in care HIV/AIDS population in Palm Beach County and Florida. Again, the most common comorbidity was with Hepatitis C both in the county and state, however the rates in Florida exceeded those in Palm Beach County.

Figure 35: Co-morbidities Prevalence Rate of In Care: HIV/AIDS population, Palm Beach and Florida, 2014



Source: EMI Profile, Partnership 09, 2014.
Compiled by Health Council Southeast Florida, 2016

HIV/AIDS Resources and Utilization

Service Location

The following HIV providers were identified based on services offered. The tables below represent those providing HIV Counseling, Testing, and Referral (CTR) and Ryan White-funded core medical services.

The following table lists the 26 registered CTR sites in Palm Beach County.

Table 23: Registered HIV Counseling, Testing and Referral sites in Palm Beach County, 2015

Name	Address	City	Phone	Type
AHF Palm Beach County Mobile Unit	110 S.E. 6th St., Suite 710	Ft. Lauderdale	954-522-3132	C*,R*
Community Health Center	2100 W. 45th St., Ste. A8 and A9	West Palm Beach	561-840-8681	C,R
Compass, Inc.	201 N Dixie Hwy	Lake Worth	561-533-9699	C,R
Delray Beach Health Center	225 South Congress Avenue	Delray Beach	561-274-3100	A*
Drug Abuse Foundation of Palm	400 South Swinton Avenue	Delray Beach	561-278-0000	C
Drug Abuse Treatment Association	1720 E Tiffany Drive, #102	Mangonia Park	561-844-3556	C
Families First of Palm Beach County	3333 Forest Hill Blvd., 2nd Floor	West Palm Beach	561-721-2887	C
FDOH Palm Beach County	225 South Congress Avenue	Delray Beach	561-274-3105	C
FDOH Palm Beach County	38754 SR 80	Belle Glade	561-996-1600	A
FDOH Palm Beach County	38754 SR 80	Belle Glade	561-996-1600	C
FoundCare, Inc.	1500-A N.W. Avenue L	Belle Glade	561-996-7059	C,R
FoundCare, Inc.	220 Congress Park Dr., Suite 100	Delray Beach	561-274-6400	A
FoundCare, Inc.	220 Congress Park Dr., Suite 100	Delray Beach	561-274-6400	C,R
FoundCare, Inc.	2330 S. Congress Ave	West Palm Beach	561-472-2466	A
FoundCare, Inc.	2330 S. Congress Ave.	West Palm Beach	561-472-2466	C,R
Genesis Community Health, Inc.	2815 S. Seacrest Blvd.	Boynton Beach	561-735-6553	C,R
Lantana Health Center	1250 Southwinds Drive	Lantana	561-547-6800	A
Lantana Health Center	1250 Southwinds Drive	Lantana	561-547-6800	C
Minority AIDS Initiative Network, Inc.	1216 Pioneer Road	Mangonia Park	561-201-4009	C
Partnership for a Drug-Free	1489 N. Military Trail, Suite 216	West Palm Beach	561-693-5299	C,R
Planned Parenthood-Boca Raton	8177 Glades Road, Bay 25	Boca Raton	561-226-4116	C,R
Planned Parenthood-Wellington	10111 Forest Hill Blvd, Suite 340	Wellington	561-296-4919	C,R
Planned Parenthood-West Palm	931 Village Blvd., Suite 904	West Palm Beach	561-683-0302	C,R
Saint James Missionary Baptist	1524 West 35th Street	Riviera Beach	561-842-5971	C,R
Triple H Community Center	3600 Broadway	West Palm Beach	561-766-1769	C,R
West Palm Beach Health Center	1150 45th Street	West Palm Beach	561-514-5300	A,C

*A-Anonymous, C-Confidential, R-Rapid
Source: www.floridahealth.gov
Compiled by Health Council of Southeast Florida, 2016

The table below identifies the Ryan White-funded providers of core medical services in Palm Beach County. Services are provided county-wide to PLWHA. Service locations are not limited to the primary site locations listed below.

Table 24: Ryan White Core Medical Service Providers, Palm Beach County, 2015

Name	Primary Site Location(s)
AIDS Healthcare Foundation	Delray Beach
Compass, Inc.	Lake Worth
Families First of Palm Beach County	West Palm Beach
Florida Department of Health-Palm Beach County	Belle Glade, Delray, West Palm Beach
FoundCare, Inc.	Palm Springs
Health Care District of Palm Beach County	West Palm Beach
Health Council of Southeast Florida	Palm Beach Gardens

Source: www.carecouncil.org/theredbook/

The following table presents HIV/AIDS cases treated by emergency room visits in Palm Beach County, which relates to utilization patterns among those out of care. The rate among African Americans is greater (68.6%) than the Florida rate (55.5%). Additionally, when compared to White individuals, African American individuals experience significantly more HIV related hospitalizations, 68.6% and 23.8% respectively.

Table 25: HIV/AIDS cases treated by ER in Palm Beach County and Florida, 2013

ER Diagnosis* of HIV/AIDS	Palm Beach County		Florida	
	Cases	Percentage	Cases	Percentage
Total ER Hospitalizations	344	100%	5914	100%
SEX				
Male	161	46.8%	2657	44.9%
Female	183	53.2%	3257	54.8%
AGE				
0-12	2	0.6%	10	0.2%
13-19	2	0.6%	49	0.8%
20-24	13	3.8%	285	4.8%
25-29	26	7.6%	442	7.5%
30-39	52	15.1%	1167	19.7%
40-49	108	31.4%	1896	32.1%
50-59	107	31.1%	1599	27.0%
60+	34	9.9%	466	7.9%
RACE				
Black or African American	236	68.6%	3281	55.5%
White	82	23.8%	2272	38.4%
Other	25	7.3%	336	5.7%
Unknown	1	0.3%	25	0.4%
ETHNICITY				
Hispanic/Latino	27	7.8%	896	15.2%
Non-Hispanic/Latino	314	91.3%	4968	84.0%
Unknown	3	0.9%	50	0.8%

Source: MediDat, 2014

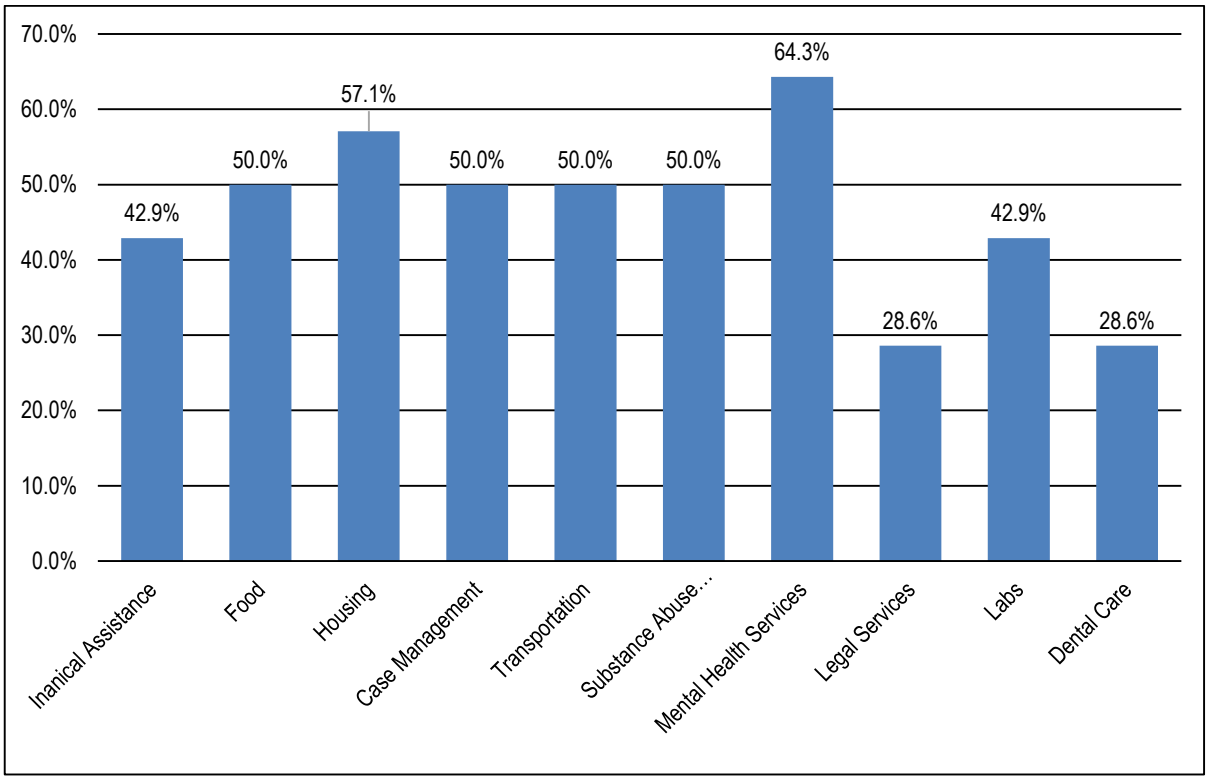
*ER Diagnosis defined as ICD-09 Code 042 = Human immunodeficiency [HIV] disease (Acquired immune deficiency syndrome, Acquired immunodeficiency syndrome, AIDS, AIDS-like syndrome, AIDS-related complex, ARC, HIV infection symptomatic) for Primary Diagnosis, Other Diagnosis 1, Other Diagnosis 2 or Other Diagnosis 3.

Compiled by Health Council Southeast Florida, 2016

Service Needs

According to the Ryan White Part A Comprehensive Needs Assessment 2011-2014, providers feel mental health services and housing services rank highest among the services needed for PLWHA to obtain care. The figure below shows the response from 14 providers regarding the 10 services that providers feel clients needed for PLWHA to obtain care.

Figure 36: Service Needs from Palm Beach County Provider Respondents, CHA 2011-2014



Source: PBC, EMA Comprehensive Plan 2012 -2015.
Compiled by Health Council Southeast Florida

The diversity within an area is another important consideration for health planning, as health behavior, health care utilization, and subsequently health outcomes often differ between races and ethnicities. The Palm Beach County, HIV CARE Council, Comprehensive Needs Assessment, 2011-2014 reported utilization of services among HIV/AIDS persons both in and out of care. Table 26 displays the services which were most significantly utilized between 2000 and 2013 by in care responders.

Table 26: Service Categories that Significantly Increased in Utilization 2000, 2003, 2007, 2010, 2013

Service categories	2000		2003		2007		2010		2013		
	N=271		N=400		N=252		N=296		N=211		
	Rank	%	Rank	%	Rank	%	Rank	%	Rank	Number	%
Primary Medical Care	3	59.0%	8	52.8%	4	56.3%	2	76.0%	2	196	92.9%
Medications*	8	53.0%	7	56.3%	17	31.0%	1	76.4%	3	190	90.0%
Medical Specialist	n/a	n/a	n/a	n/a	8	40.1%	4	61.1%	6	159	75.4%
Transportation	24	27.0%	15	44.8%	6	45.6%	7	40.2%	9	103	48.0%

Source: PBC, HIV CARE Council, Comprehensive Needs Assessment, 2011-2014
*No category "Medications" prior to 2010; most closely resembled "Drug Reimbursement" in 2007.
Compiled by Health Council of Southeast Florida, 2016

The following tables highlight the most highly ranked service priorities among the following populations: In Care African American heterosexuals, MSM, Hispanics, recently incarcerated and Age 50+ and all in care respondents identified in the Palm Beach County, Comprehensive Needs Assessment 2011-2014.

Table 27 shows that African American Heterosexuals in care prioritize service categories at similar rates compared to all in care respondents.

Table 27: Five most highly ranked service priorities among in care African American and all in care respondents

Service Category	In Care respondents		African American Heterosexuals In Care Respondents	
	N=211		N=122	
	Number	Percent	Number	Percent
Primary Medical Care	127	60.2%	68	55.7%
Laboratory Diagnostic Testing	114	54.0%	66	54.1%
Medications	112	53.1%	62	50.8%
Case Management	100	47.4%	51	41.8%
Food Bank and Food Vouchers	80	37.9%	52	42.6%

Source: PBC, HIV CARE Council, Comprehensive Needs Assessment, 2011-2014
Compiled by Health Council of Southeast Florida, 2016

Table 28 shows that MSM in care rank Laboratory Diagnostic Testing has the highest priority service category.

Table 28: Five most highly ranked service priorities among in care MSM and all in care respondents

Service Category	In Care respondents N=211		MSM In Care Respondents N=22	
	Number	Percent	Number	Percent
Primary Medical Care	127	60.2%	13	59.1%
Laboratory Diagnostic Testing	114	54.0%	15	68.2%
Medications	112	53.1%	12	54.5%
Case Management	100	47.4%	12	54.5%
Food Bank and Food Vouchers	80	37.9%	9	40.9%

Source: PBC, HIV CARE Council, Comprehensive Needs Assessment, 2011-2014
Compiled by Health Council of Southeast Florida, 2016

Among Recently Incarcerated in care individuals, Medications is the highest priority category, following closely by Primary Medical Care.

Table 29: Five most highly ranked service priorities among in care Recently Incarcerated and all in care respondents

Service Category	In Care respondents N=211		Recently Incarcerated In Care Respondents N=17	
	Number	Percent	Number	Percent
Primary Medical Care	127	60.2%	9	52.9%
Laboratory Diagnostic Testing	114	54.0%	6	35.3%
Medications	112	53.1%	10	58.8%
Case Management	100	47.4%	8	47.1%
Food Bank and Food Vouchers	80	37.9%	6	35.3%

Source: PBC, HIV CARE Council, Comprehensive Needs Assessment, 2011-2014
Compiled by Health Council of Southeast Florida, 2016

Table 30 shows that Age 50+ in care individuals prioritize service categories at similar rates compared to all in care respondents.

Table 30: Five most highly ranked service priorities among in care Age 50+ and all in care respondents

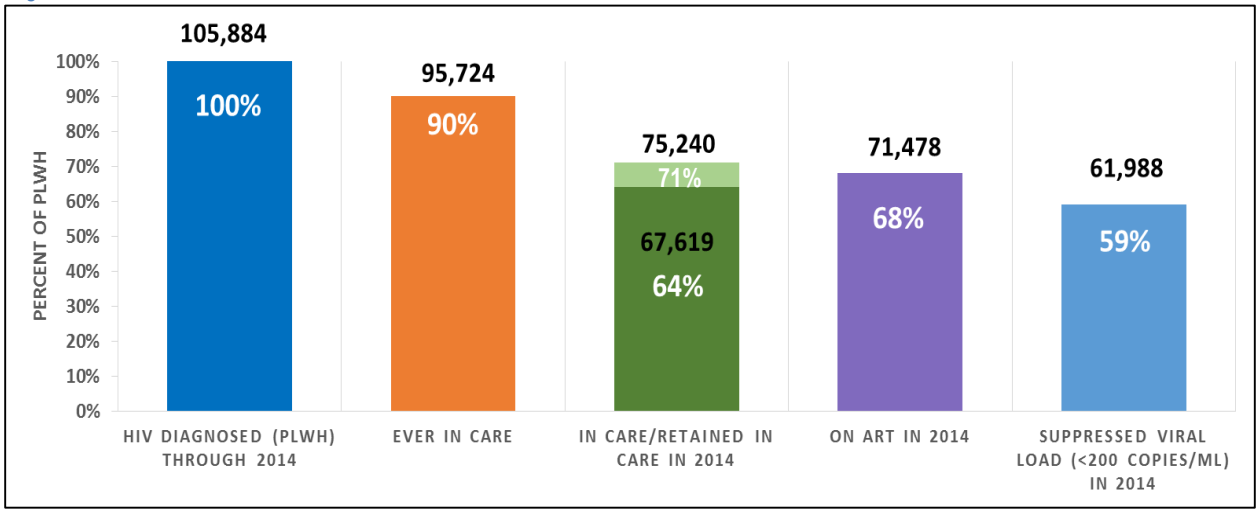
Service Category	In Care respondents N=211		Age 50+ In Care Respondents N=90	
	Number	Percent	Number	Percent
Primary Medical Care	127	60.2%	63	70.0%
Laboratory Diagnostic Testing	114	54.0%	59	65.6%
Medications	112	53.1%	48	53.3%
Case Management	100	47.4%	43	47.8%
Food Bank and Food Vouchers	80	37.9%	39	43.3%

Source: PBC, HIV CARE Council, Comprehensive Needs Assessment, 2011-2014
Compiled by Health Council of Southeast Florida, 2016

HIV Continuum of Care

The statewide number and percentages of persons living with HIV in each phase of the HIV Care Continuum is presented in the figure below. These figures do not include Department of Correction (DOC) cases. There is a decrease in percentage following each phase, with greatest difference occurring between the "Ever in Care" and "In/Retained in Care" phases.

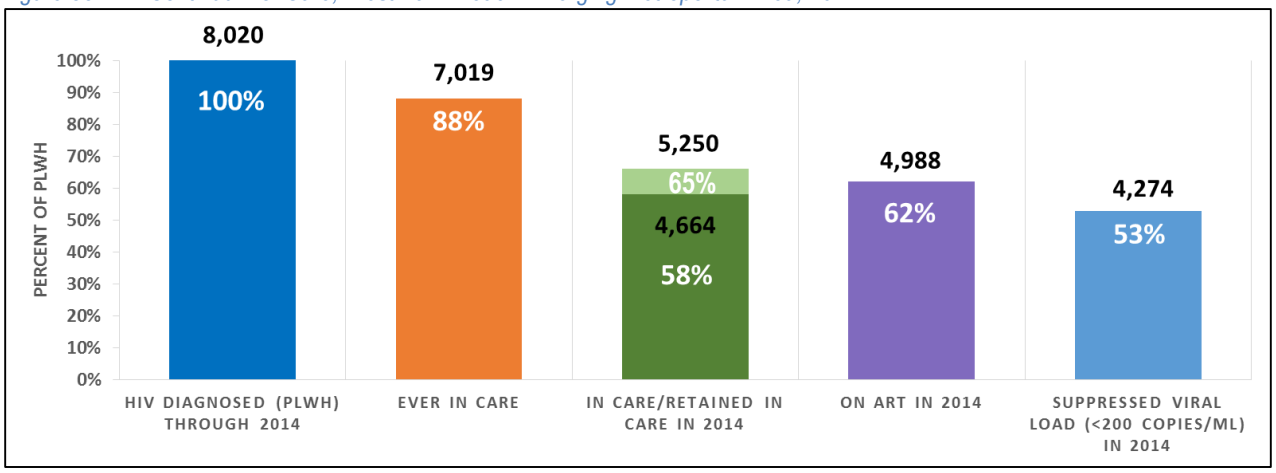
Figure 37: HIV Continuum of Care, Florida, 2014



Source: HIV Continuum of Care Slide Set, Florida Department of Health, 2014
Note: Excludes Department of Corrections Cases

The figure below depicts the local HIV Continuum of Care for Palm Beach County. As is the case with the State, the greatest decrease in percentage occurs between the "Ever in Care" and "In/Retained in Care" phases. Additionally, these figures demonstrate that the percentages in each phase of the continuum are lower in Palm Beach County as compared to the State of Florida. While the statewide and Palm Beach County rates for "Ever in Care" are similar (a variance of 2%), a greater variance (6%) occurs in the "Retained in Care", "On ART" and "Viral Suppression" phases.

Figure 38: HIV Continuum of Care, West Palm Beach Emerging Metropolitan Area, 2014



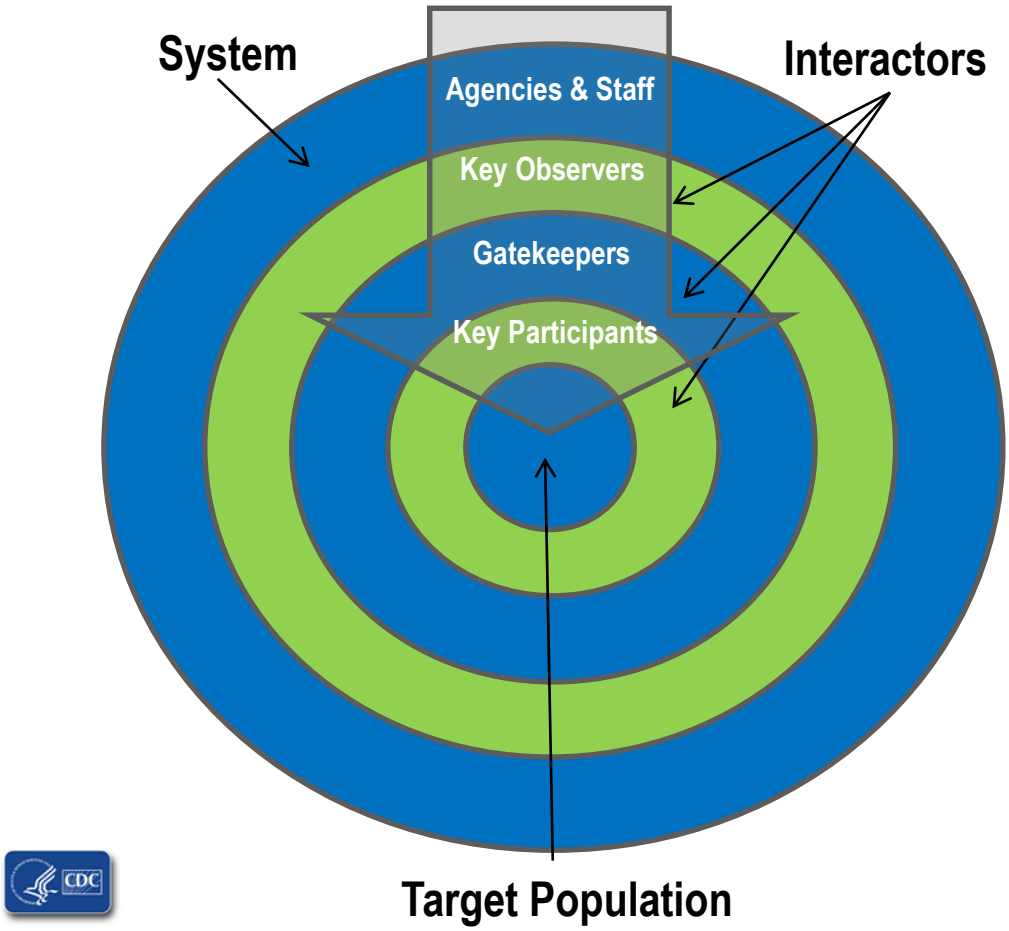
Source: HIV Continuum of Care Slide Set, Florida Department of Health, 2014
Note: Excludes Department of Corrections Cases

Qualitative Data Analysis

Methodology

Qualitative Data was collected to better understand the HIV epidemic in Palm Beach County, beyond the quantitative data previously presented. The qualitative data is inclusive of two components: systems-level and community-level data. The systems-level data was obtained through conversations with providers of HIV-related services in the county, guided by a Systems Analysis survey tool. The community-level data was obtained using a community-based survey tool, administered to gatekeepers, observers, interactors, and key participants. In both cases, the data was collected based on the evidence-based frame work of the Community PROMISE model's Community Identification (CID) process[14].

Figure 39: Community Identification (CID) Process, Community PROMISE Model



Adapted from the CDC Community PROMISE Model

[14] The CDC AIDS Community Demonstration Projects Research Group. (1999). Community-level HIV intervention in 5 cities: Final outcome data from the CDC AIDS Community Demonstration Projects. *American Journal of Public Health* 89, 336-345

The Community Identification (CID) Process is a core element of the Community PROMISE evidence-based intervention endorsed by the Centers for Disease Control and Prevention (CDC). In this context, it serves as a mechanism to obtain qualitative information from the key members of the system of care and the community. As depicted in the figure above, there are various level or layers to the process, starting from the outer "ring", or systems-level. The systems-level may include providers, staff, and volunteers at entities such as AIDS service organizations, community-based organizations, medical/health facilities, health departments and social service agencies. In addition to providing primary qualitative information, respondents of the systems analysis play a key role in identifying key "Interactors" to begin the community-level analysis. All of the terms referred to in the CID process are defined below

- Systems: providers, agencies, staff, and volunteers who serve the target population or community
- Interactors: Any individual who "interacts" with the target population or community
- Key Observers: Any individual who observes the behaviors, customs and patterns of the target population or community
- Gatekeepers: Any individual who can provide or facilitate access to the target population or community
- Key Participants: Individuals who provide qualitative information regarding the target population or community.
- Target Population: The particular community of interest. In the case of the RARE 2015 project, the target population is broadly defined as any community members or resident of Palm Beach County.

Systems-level Data Analysis

Stakeholder Input

Methodology

The first RARE 2015 stakeholder meeting was convened on February 26, 2015 at the Florida Department of Health administrative building in West Palm Beach, Florida. This initial meeting was designed to introduce the project and help shape its structure. During this formative process, certain areas of focus were identified as starting points. Participants in this process included representatives from Florida Health Palm Beach County, Palm Beach County Department of Community Services (Ryan White Part A), the Palm Beach County Ryan White CARE Council and the local HIV Community Prevention Partnership (CPP). The meeting was facilitated by the Health Council of Southeast Florida. Participants were divided into 3 breakout groups and presented with a series of questions to answer, discuss, and report on. The session included 2 rounds of questions consisting of 3 questions each. The discussion time was limited to 10 minutes per question. For each question, the corresponding responses of the participants are outlined below.

Analysis

The first round of questions explored the HIV epidemic in Palm Beach County from a retrospective and broad point of view, asking participants to reflect on the greatest successes and challenges.

Question 1:
Based on your experience, what is the single greatest success we have achieved in combatting the HIV/AIDS epidemic in Palm Beach County?

- Responses:
  - Reduced Perinatal HIV transmission
  - Viral Suppression
  - Funding
  - Collaborations & Partnerships

Question 2:
Based on your experience, what is the single greatest challenge we face in combatting the HIV/AIDS epidemic in Palm Beach County?

- Responses:
  - Competition/Lack of true collaboration
  - Stigma
  - Difficulty in Changing Behaviors
  - Disclosure of HIV Status
  - Substance Abuse/Mental Health
  - Homelessness
  - Funding & Resources
  - Multiple simultaneous issues (including those listed above)
  - Out of care individuals

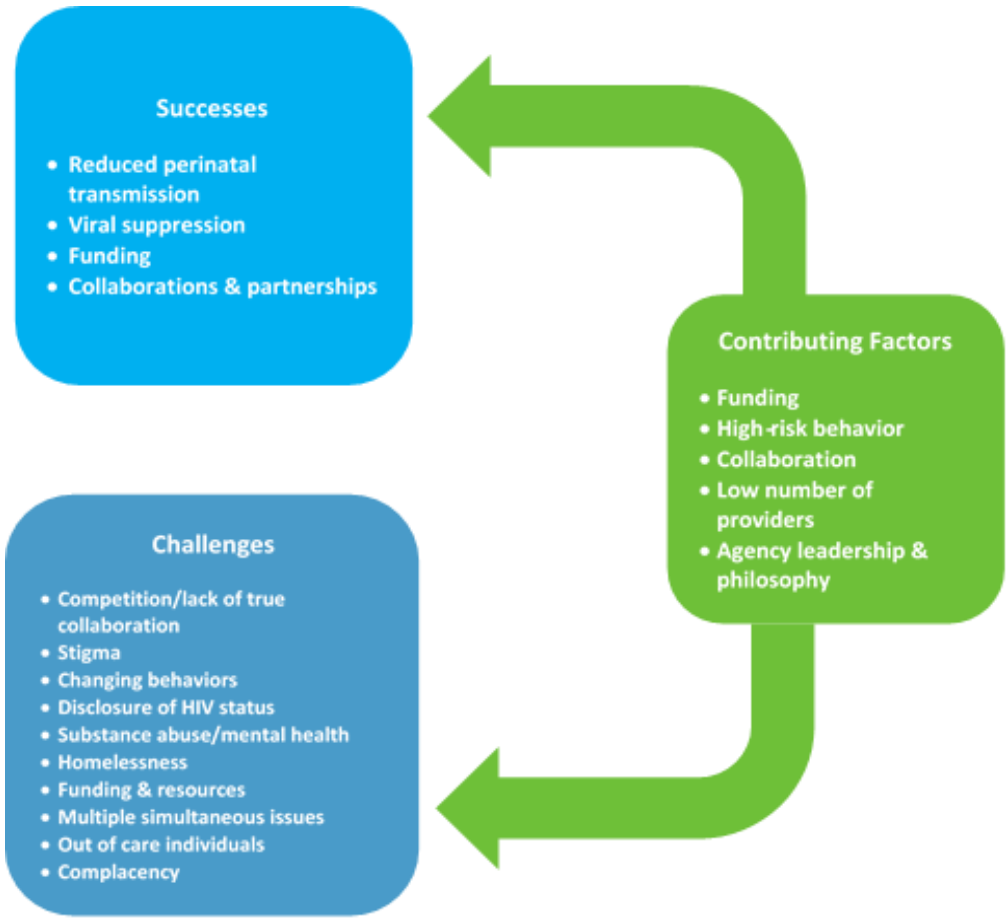
- Complacency
- Empowering Youth

Question 3:
Based on your answers to the previous questions, what are the major contributing factors to those successes and challenges?

- Responses:
  - Funding
  - High-risk Behaviors
  - Collaboration
  - Low number of Providers
  - Agency Leadership/Philosophy

The figure below summarizes the responses of all Round 1 questions, demonstrating how the contributing factors influence both the identified HIV-related challenges and successes in Palm Beach County. It is noteworthy that issues related to "Funding" and "Collaboration" were identified as both successes and challenges. Furthermore, stakeholders identified that the contributing factors all influenced the successes and challenges.

Figure 40: Contributing Factors to Successes and Challenges



The second round of questions examined more specific behaviors, strategies, and influencing factors affecting the HIV Epidemic in Palm Beach County.

Question 1:
Based on the discussion from Round 1, which behaviors (both positive and negative) should be focal points for the community assessment component of the RARE project?

- Responses:
  - Medication Adherence
  - High-risk sexual behavior
  - Accessing care
  - Healthy Communication
  - Commercial Sex work
  - Substance Abuse
  - Stigmatizing Behavior

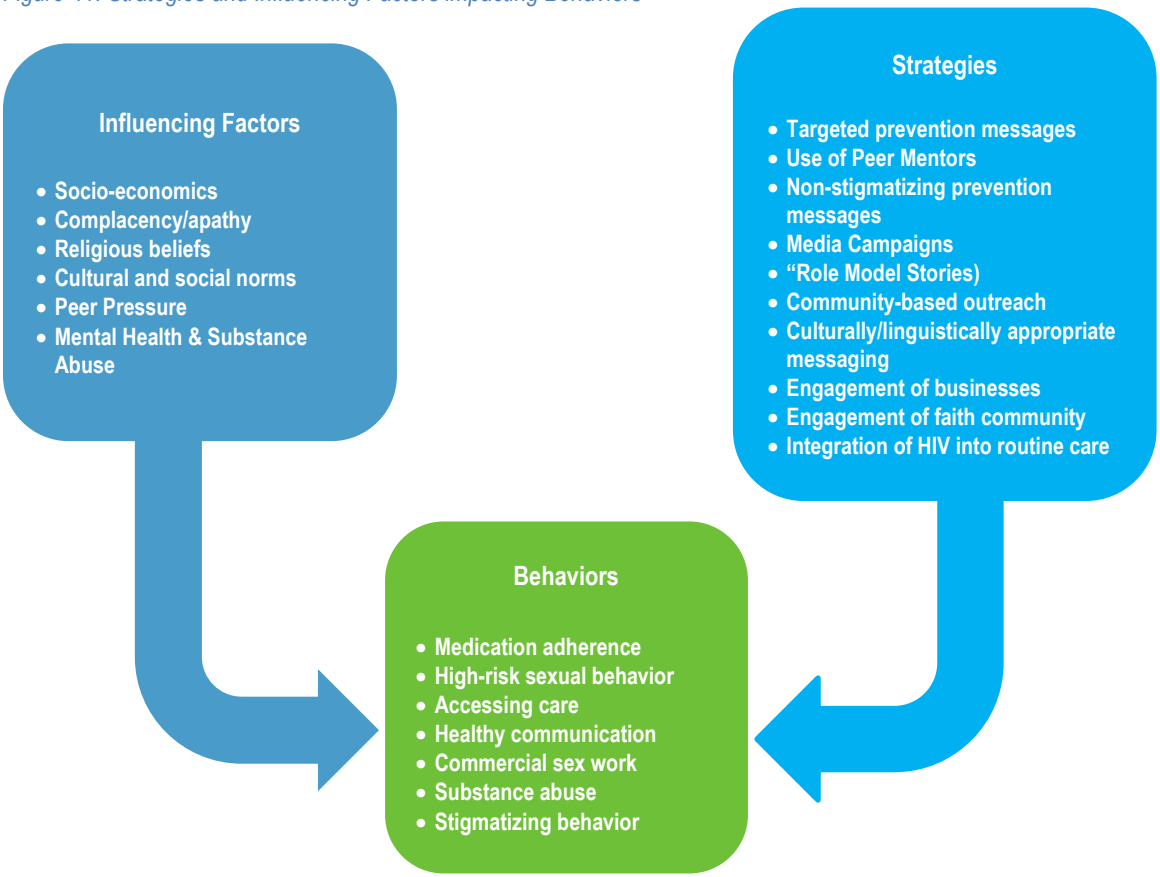
Question 2:
Based on your experience, which strategies are effective in promoting positive behaviors and reducing negative behaviors?

- Responses:
  - Targeting prevention messages to younger age groups
  - Use of peer mentors (field & clinic settings)
  - Positive (non-stigmatizing) prevention messages
  - Media campaigns
  - "Role Model Stories"
  - Culturally and linguistically appropriate messages
  - Community outreach
  - Engage businesses, ex. Business Responds to AIDS (BRTA)
  - Engage faith community, ex. Faith Responds to AIDS (FRTA)
  - Integration of HIV services into routine care

Question 3:
What are the specific influencing factors (risk/protective) for these behaviors, which you would like to see included in the community assessment component of the RARE project?

- Responses:
  - Socio-economic factors
  - Complacency/apathy
  - Religious beliefs
  - Cultural & social norms
  - Peer pressure
  - Mental Health & Substance abuse (*also behaviors)

Figure 41: Strategies and Influencing Factors impacting Behaviors



The responses obtained from Round 2 are depicted in figure above, showing the interaction of influencing factors, strategies, and behaviors. In summary, the identified behaviors are impacted by both the influencing factors and the identified strategies. Thus, a strategy that does not substancially ackowledge related influencing factors (not limited to those identified) may be inherently flawed.

A follow-up stakeholder meeting was convened on March 3, 2015. The findings from the intial meeting, as well as the initial structure of the RARE project was presented for feedback. All six of the original questions and responses were posed and discussed, and all participants were given an opportunity to add their own responses.

Through this process, the following additional "Successes" were identified:

- More survivors
- Social media used for education and information
- High efficacy of medications
- Department of Education's HIV/AIDS curriculum
- Rapid testing improvements
- Improved Data Collection

Additionally, stakeholders identified the following additional "Challenges":

- Limited use of social media
- High cost of medications
- High risk sexual behavior
- Lack of data for specific sub-populations
- Effective linkage to care

No additional "Contributing Factors" to these successes and challenges were identified.

The following additional "Behaviors" were identified:

- Utilization of PrEP
- Health seeking behaviors and attitudes towards health system
- Negative
- Cultural behaviors
- Access to sex easier (through phone, text, internet, apps)

Additional "Strategies" identified by participants included:

- Improving awareness of resources
- Reinforcement of positive behaviors

Finally, the participants identified the following additional "Influencing Factors":

- Stigma specific to separation of HIV treatment from general medical care
- Integration of services

Overall, feedback and data obtained through the stakeholder meetings was utilized to design the structure of the project and to guide specific areas of focus moving forward, including the final recommendations. In particular, the selection of the Community PROMISE model as a mechanism for community-level qualitative data collection was informed and validated at this stage, as all ten originally identified strategies (from Round 2, Question 2) were either core elements of the Community PROMISE intervention or compatible components of the evidence-based model.

Systems-level Qualitative Interviews

Methodology

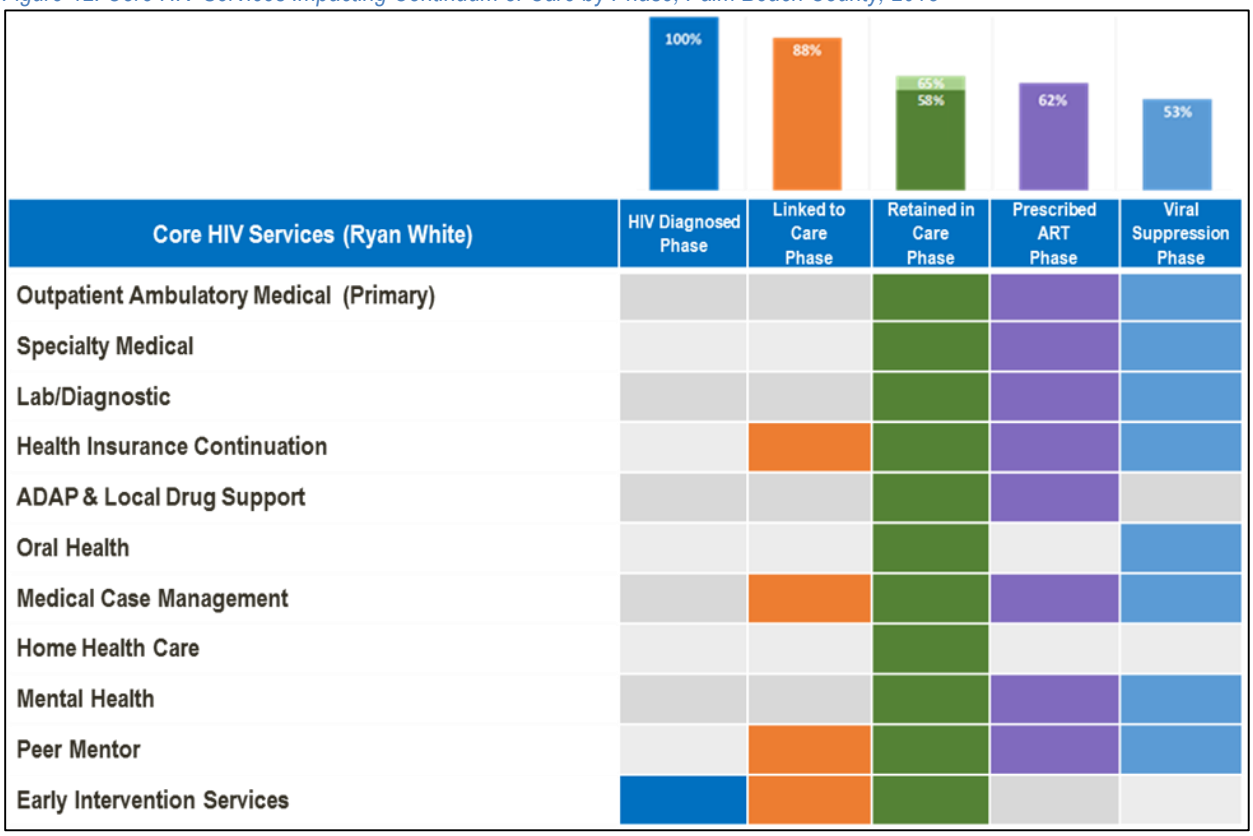
In addition to stakeholder input, qualitative data was obtained directly from providers within the HIV system of care. These interviews were conducted in an open dialogue format by HCSEF staff, guided by the Systems Analysis survey tool, adapted from the Community PROMISE CID model. The intent of this component was to give providers flexibility and opportunity to discuss issues important from their perspective. A total of twelve systems-level interviews were conducted. Respondents were assured that the survey was anonymous and were not obligated to provide their names or employment information.

Analysis

The following table outlines the Core Ryan White-funded HIV services currently offered in Palm Beach County. For each service category the corresponding phase of the HIV Continuum of Care, where there is the most direct impact has been indicated. This information was determined through service category descriptions in the Ryan White Provider Manual[15], the Palm Beach County EMA Comprehensive Plan[16], stakeholder meeting feedback, and systems-level qualitative interviews. While it is likely that all service categories indirectly impact each phase of the continuum to some extent, the intent of the table is to identify the areas of greatest direct impact. As Ryan White-funded services are primarily treatment oriented, the Early Intervention Services (EIS) is the sole service category identified as directly impacting the "HIV Diagnosis" phase. Additionally, EIS directly impacts the subsequent two phases: "Ever in Care" and "In/Retained in Care". The "In/Retained in Care" phase was the only phase directly impacted all identified themes. It is noteworthy that this is also the phase which has the sharpest decrease from the previous phase in Palm Beach County.

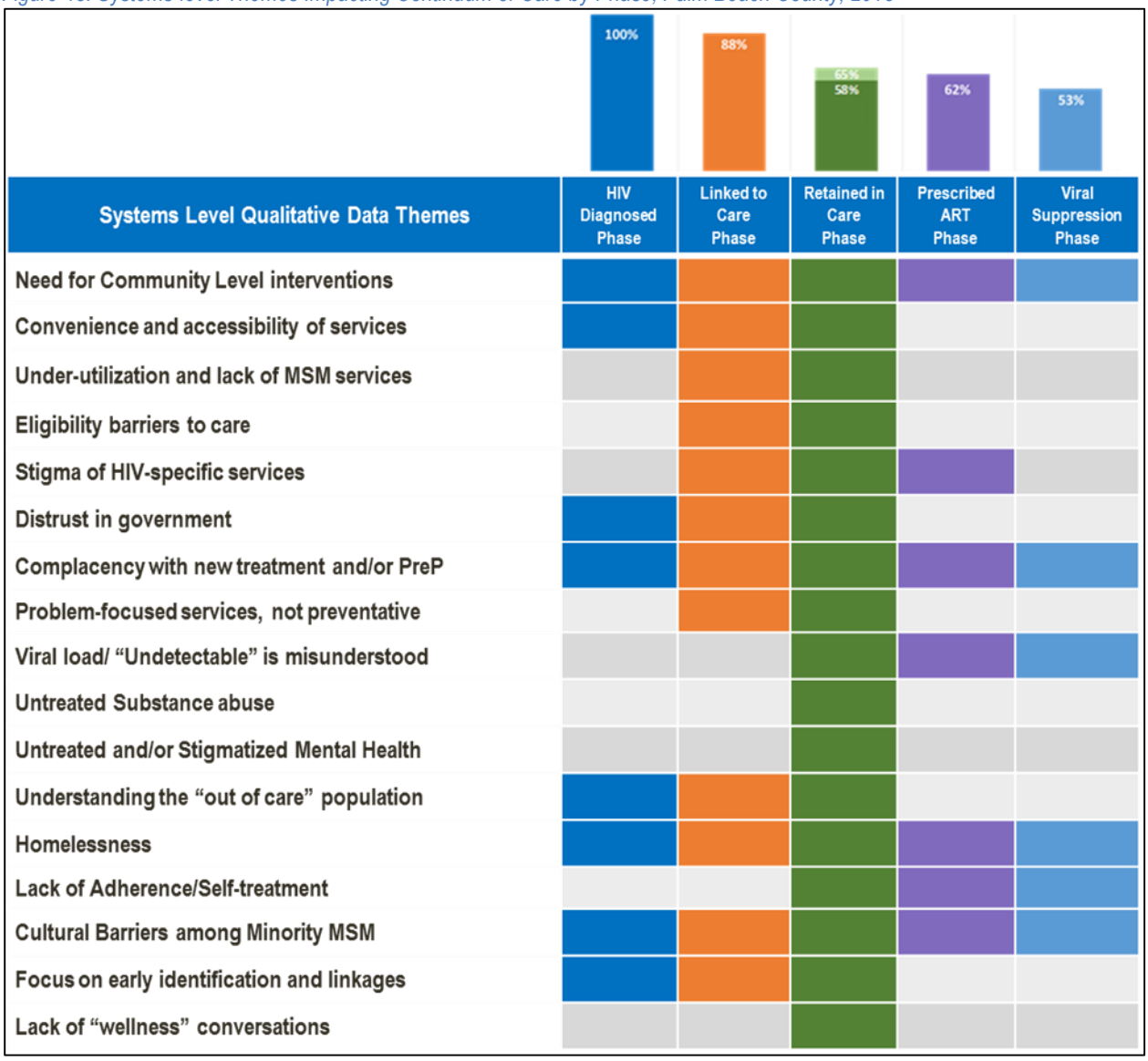
[15] Retrieved from www.carecouncil.org/providermanual/, Accessed 12/2015.
[16] Retrieved from http://www.carecouncil.org/planningforcare/. Accessed 12/2015.

Figure 42: Core HIV Services Impacting Continuum of Care by Phase, Palm Beach County, 2015



The table below also analyzes the various themes of the HIV Care Continuum. In this case, the impact of the qualitative themes identified through the systems-level data collection is depicted. Several themes stand out as they impacted every phase of the continuum, including "Need for "Community-level Interventions", "Complacency with new Treatment and/or PrEP" and "Cultural Barriers among Minority MSM". In addition, the "In/Retained in Care" phase was directly impacted by all identified themes.

Figure 43: Systems-level Themes Impacting Continuum of Care by Phase, Palm Beach County, 2015



Community-based Data Analysis

Methodology

A total of 202 community-based interviews were conducted through the use of the Community Analysis survey tool. The survey tool was developed by HCSEF and adapted from the Community PROMISE CID model. In accordance with the CID guidance, an effort was made to have as many surveys as possible conducted by community members themselves among their peers, neighbors, co-workers, and family/friends. Furthermore, the survey tool was a guide to a more open-ended discussion, and it was not required that every question be answered. This approach benefitted the project by allowing for deeper access into the community and the advantages of having a trusted peer administer the survey in a comfortable and natural manner. Participants were assured that the study was completely anonymous and were not obligated to provide their names or signatures. The limitations of this approach include the fact that the surveys were not administered by trained staff and there were instances of blanks and non-traditional responses. Completed surveys were returned to HCSEF. Data was compiled using Survey Monkey and analyzed using Microsoft Excel.

Participant Demographics

The table below shows the respondents by race/ethnicity. Due to the nature of the survey and the overall intent of the CID process, race and ethnicity are presented together exactly as reported by the respondents. For example, many Hispanic respondents self-identified only as "Hispanic or Latino" (a category typically classified as an ethnicity, not a race). Also, many respondents preferred to identify as Black Caribbean and not "African American". The result is a non-traditional combination of race, ethnicity and geographic/national origin. These personal preferences are noteworthy and relevant as strategies are developed to reach and serve various populations of interest.

Table 31: Comparison of Palm Beach County 2014 Population and RARE Survey Respondents by Race/Ethnicity, 2015

Race/Ethnicity	Palm Beach County		RARE Survey	
	Estimates	Percentage	Number	Percentage
Total Respondents	1,397,710		200	
One race	1,372,329	98.2%	196	98.0%
White	1,067,335	76.4%	23	11.4%
Black or African American	266,300	19.1%	136	67.3%
Hispanic	289,802	20.7%	10	5.0%
Black Caribbean	-	-	27	13.4%
Asian	45,087	3.2%	1	0.5%
Native Hawaiian and Other Pacific Islander	1,917	0.1%	1	0.5%
Some other race	37,406	2.7%	2	1.0%
Two or more races	25,381	1.8%	4	2.0%

Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

The age distribution was generally representative and at least one response was received from each age bracket. The most common age group was age 45-54 (13.7%).

Table 32: Comparison of Palm Beach County 2014 Population and RARE Survey Respondents by Age Group, 2015

Age Group	Palm Beach County		RARE Survey	
	Estimates	Percent	Number	Percent
15 to 19 years	78,885	5.6%	7	3.5%
20 to 24 years	81,448	5.8%	19	9.4%
25 to 34 years	163,583	11.7%	38	18.8%
35 to 44 years	163,181	11.7%	30	14.9%
45 to 54 years	191,740	13.7%	42	20.8%
55 to 59 years	91,752	6.6%	32	15.8%
60 to 64 years	85,404	6.1%	15	7.4%
65 to 74 years	153,094	11.0%	13	6.4%
75 to 84 years	108,010	7.7%	3	1.5%
85 years and over	56,528	4.0%	1	.5%

Source: U.S. Census Bureau, 2014
Compiled by Health Council of Southeast Florida, 2016

Respondents were balanced in terms of male and female genders, at 51.5% and 46% respectively. Transgender individuals were represented at 0.5% each for Male to Female and Female to Male. Although transgender respondents account for only 1.0% of survey participants, this population is disproportionately impacted by HIV[17] (site CDC.gov HIV among transgender people). Furthermore, while county-level data is not currently available, and self-reported Transgender data is limited due to a myriad of confounding factors, a study conducted by the U.S. Census Bureau estimates that the likely transgender population in Florida is between 3.4 and 4.7 per 100,000[18]. Thus, the qualitative information obtained from these respondents is valuable despite the small sample size.

Table 33: Respondents by Gender, RARE Survey, 2015

Gender	Number	Percent
Male	104	51.5%
Male to Female Transgender	1	0.5%
Female	93	46.0%
Female to Male Transgender	1	0.5%
Blank	3	1.5%

[17] HIV Among Transgender People. (2015, December 17, 2015). Retrieved from http://www.cdc.gov/hiv/group/gender/transgender/

[18] *Likely Transgender Individuals in the U.S. Federal Administrative records and the 2010 Census, 2015*

Though not a demographic category, the indicator of "last sexual partner" was intentionally selected in place of "sexual orientation" to better capture HIV-related risk behavior, particularly among males who had sex with males but do not identify as gay or bi-sexual or those individuals who identify as gay but are not sexually active.

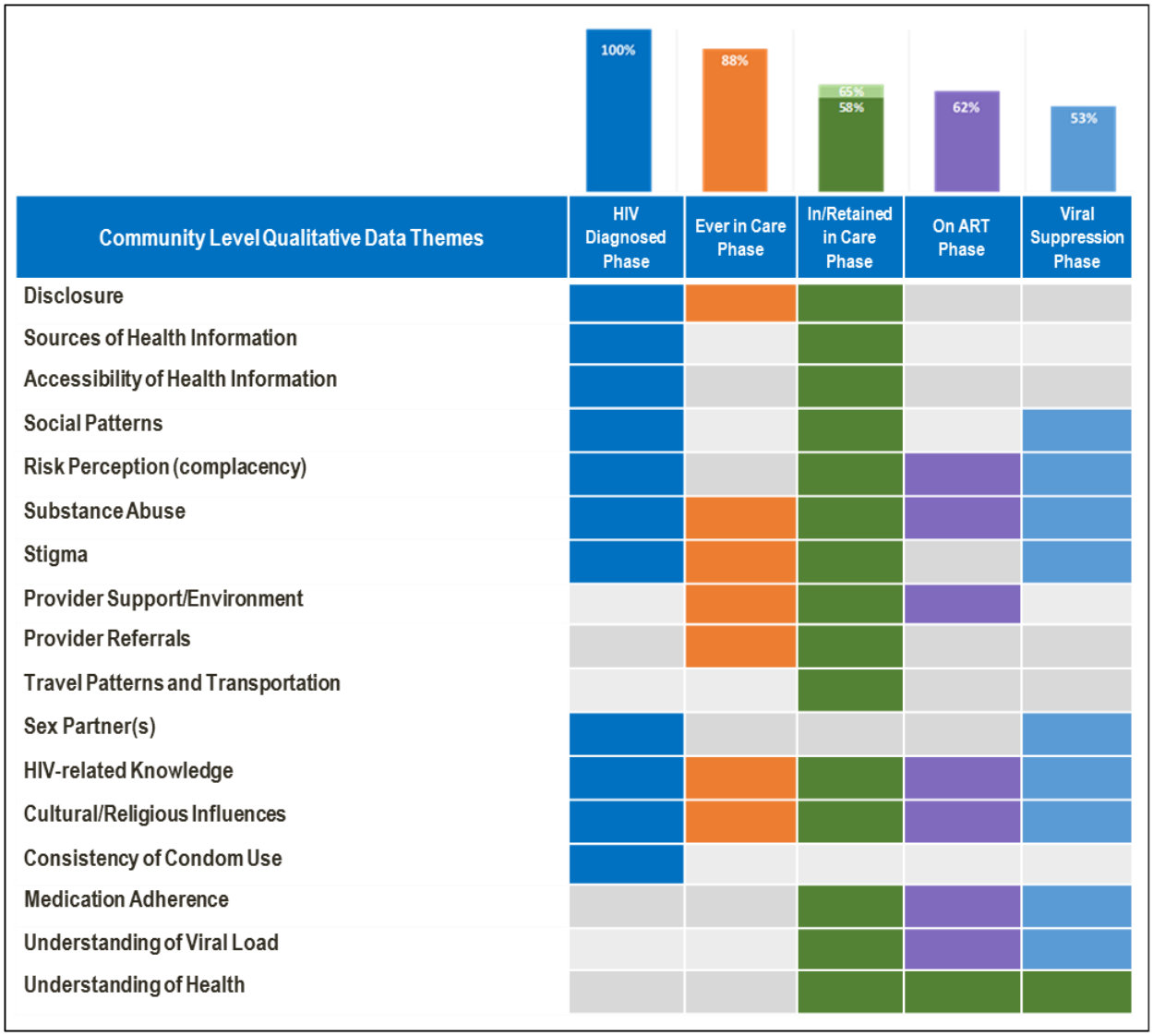
Table 34: Reported gender of last sexual partner, RARE Survey, 2015

Last sexual partner	Number	Percent
Male reporting Female	72	45.2 %
Male reporting Male	16	10.1 %
Female reporting Male	67	42.1 %
Female reporting Female	4	2.5 %
Total	159	100.0%

Summary of Community-based Themes

Participants in the community-based data collection were engaged to obtain their perspective regarding factors which relate to each phase of the HIV Care Continuum. The figure below summarizes the common themes among the 202 respondents, and identifies which phases of the continuum are primarily impacted.

Figure 44: Community-based Themes Impacting Continuum of Care by Phase, Palm Beach County, 2015



The community-based qualitative data which resulted in the identification of these themes is presented and analyzed below.

HIV Knowledge, Perception of Risk and Risk Behavior

HIV Knowledge

The responses to the question "how do you think people contract HIV" suggest a generally accurate knowledge of modes of HIV transmission. None of the responses directly identified any non-infectious fluids (although the response of "body fluids" is general), examples of "casual contact", or singled out any particular sub-population. Furthermore, the most frequent response was "unprotected sex" (84.2%), which is the most common mode of transmission.

Table 35: Responses to how people contract HIV, RARE Survey, 2015

How do you think people contract HIV?	Number	Percentage
Unprotected Sex	170	84.2%
Needles	105	51.9%
Blood	66	32.7%
Body Fluids	17	8.4%
Blood Transfusion	14	6.9%

*percentages do not total 100% as multiple responses were possible

Complacency and Risk Perception

Participants were asked several questions regarding risk perception and associated behaviors. Table 36 shows general risk perception.

Table 36: Respondents who think they could contract HIV, RARE Survey, 2015

Do you think you could contract HIV?	Number	Percent
Yes	98	51.3%
No	93	48.7%
Total	191	100.0%

The following table presents HIV protective behavior among those who think they could contract HIV. While a majority of respondents are protecting themselves, 18.4% report not protecting themselves. This may be evidence of complacent behavior among at-risk individuals.

Table 37: HIV Protective Behavior among those respondents who think they could contract HIV, RARE Survey, 2015

If yes, are you doing anything to protect yourself?	Number	Percent
Yes	74	75.5%
No	18	18.4%
Sometimes	2	2.0%
No response	4	4.1%
Total	98	100.0%

The following tables report reasons why respondents think they could or not could not contract HIV. Though 18.4% reported not protecting themselves (Table 37), 61% of respondents identified unprotected sex as a risk behavior (Table 38). This may underscore the complacency of some individuals. Also noteworthy, 12% of respondents think they can contract HIV because of a cheating partner, compared to 28% of respondents who think they cannot contract HIV because they only have one partner. While this is not a direct comparison, it may be evidence of underlying issues and perception of risks. Other social, cultural, or religious factors may also influence these behaviors.

Table 38: Reasons why respondents think they could contract HIV, RARE Survey, 2015

Why do you think you could contract HIV?	Number	Percentage
Mentioned unprotected sex	59	61%
Cheating partner	12	12%
Mentioned drugs	4	4%
"Lifestyle"	3	3%
Anyone can	3	3%
Total	81	100.0%

Table 39: Reasons why respondents think they could not contract HIV, RARE Survey, 2015

Why do you think you could NOT contract HIV?	Number	Percentage
Using condoms	25	29%
Not having sex	18	21%
Only one (1) partner	24	28%
Total	67	100.0%

Table 40 shows protective behaviors based on risk perception. Though a majority (76%) of individuals who think they could contract are protecting themselves, nearly one-fifth of people who think they can contract HIV are not protecting themselves.

Table 40: Protective behaviors and perception of risks, RARE Survey, 2015

Do you think you could contract HIV?	Number	Percent
Yes	96	50.3%
Protecting	73	76.0%
Not protecting	18	18.8%
Sometimes protecting	2	2.1%
No	95	50.3%
Protecting	59	62.1%
Not protecting	28	29.5%
Sometimes protecting	1	1.1%

For participants who think they could contract HIV, and are not protecting themselves, there were very limited reasons cited for not using protection. Responses included the following:

- "not sure"
- "I am on birth control and my boyfriend won't wear condoms".

Overall, these responses suggest a generally low perception of HIV risk.

For participants who think it is not likely they could contract HIV and are not protecting, reasons were almost exclusively related to marriage, trust, and being faithful to their partner.

Risk Behavior

The table below shows last reported sexual partner by gender.

Table 41: Last reported sexual partner, RARE Survey, 2015

Last sexual partner	Number	Percent
Male reporting Female	72	45.2 %
Male reporting Male	16	10.1 %
Female reporting Male	67	42.1 %
Female reporting Female	4	2.5 %
Total	159	100.0%

Among females, only 3 (3.2%) reported a "not steady" partner, while 28 (30.1%) did not respond. Conversely, among males, 25 (24%) reported a "not steady" partner, and 15 (14.4%) did not answer the question. These gender differences may relate to social norms, stigma and religious/cultural influences related to sexual behavior.

Table 42: Responses to steadiness of last sexual partner, RARE Survey, 2015

Was your last sexual partner a steady partner?	Female		Male		Transgender		Gender not reported		Total	
	#	%	#	%	#	%	#	%	#	%
Steady	46	47.9%	46	47.9%	1	1.0%	3	3.1%	96	47.5%
Steady and specified Spouse	16	47.0%	18	52.9%	0	0.0%	0	0.0%	34	16.8%
Not Steady	3	10.3%	25	86.2%	1	3.4%	0	0.0%	29	14.4%
Blank	28	65.1%	15	34.9%	0	0.0%	0	0.0%	43	21.3%
Total	93	46.0%	104	51.5%	2	1.0%	3	1.5%	202	100.0 %

A majority of participants (69.3%) did not respond to this question. There are many social factors which may influence this, including societal norms, privacy, embarrassment and culture. It is also worth noting that 2% of participants have opinions on sexual activity framed as the "regular" or "correct way".

Table 43: Last type of sex, RARE Survey, 2015

The last time you had sex, what type of sex did you have?	Number	Percentage
No Response	140	69.3%
Vaginal	37	18.3%
Oral	18	8.9%
Anal	11	5.4%
"regular" or "correct way"	4	2.0%

*multiple answers possible

Consistency of Condom Use

The table below depicts condom use at the time of last sex for both males and females. The percentage of "No response" for females compared to males is significantly higher, 32.3% and 15.4% respectively, and may reflect gender differences related to social norms and sexual behavior.

Table 44: Condom use at time of last sex, RARE Survey, 2015

The last time you had sex, did you use a condom?	Number	Percent
Females	93	
Yes	26	28.0%
No	37	39.8%
No Response	30	32.2%
Males	104	
Yes	45	43.3%
No	43	41.3%
No Response	16	15.4%

The table below explores condom use by gender and sex partner. The percentage of participants who report "Never" using a condom is high for both males and females who reported sex with opposite gender. Males who have sex with males reported a low percentage of "Never" using a condom (1.9%) and a high percentage (19.2%) of "Always" using a condom. It is also worth noting that among males and females reported sex with the opposite gender, the percentage of using a condom "Sometimes" was significant (57.9% for males and 36.8% for females). This may suggest of low efficacy for condom negotiation for both populations. Overall, the data suggest a difference in consistency of condom use among sex partners of the same gender as compared to opposite-gender sex partners.

Table 45: Frequency of condom use in the last month by gender and sex partner, RARE Survey, 2015

In the last month, when you had sex, how often did you use a condom?	Males reporting sex with Females		Females reporting sex with Males		Males reporting sex with Males		Transgender reporting sex with Males		Total	
	#	%	#	%	#	%	#	%	#	%
Always	24	46.2%	16	30.8%	10	19.2%	2	3.8%	52	47.5%
Sometimes	11	57.9%	7	36.8%	1	5.3%	0	0.0%	19	16.8%
No Sex	7	50.0%	4	28.6%	3	21.4%	0	0.0%	14	14.4%
Never	24	44.4%	29	53.7%	1	1.9%	0	0.0%	54	21.3%
Total	66	46.0%	56	40.3%	15	10.8%	2	1.4%	139	100.0%

When asked "why do you not use a condom every time", responses included:

- "girls don't like it"
- "he doesn't like to"
- "I'll wear a condom if a woman insist"
- "not allowed to"

This data underscores the need for condom negotiation and healthy relationship training. These responses further suggest that the decision whether to use a condom or not is primarily influenced by the sexual partner rather than the respondent themselves.

The table below shows frequency of condom use in the last month by race. White individuals had a higher percentage of respondents reporting "always" using condoms.

Table 46: Frequency of condom use in the last month by race, RARE Survey, 2015

In the last month, when you had sex, how often did you use a condom?	African American N=136		Black Caribbean N=29		Caucasian/White N=20	
	Number	Percent	Number	Percent	Number	Percent
Always	32	23.5%	8	27.6%	7	35.0%
Never	43	31.6%	10	34.5%	3	15.0%
No Sex	10	7.4%	4	13.8%	2	10.0%
Sometimes	17	12.5%	5	17.2%	1	5.0%
No response	34	25.0%	2	6.9%	7	35.0%

In addition to the tables above, responses to why a condom was not used every time included the following:

- "We got caught up in the moment"
- "I messed up"
- "Because I didn't want to"
- "I don't like them"
- "No reason"
- "Don't want to"
- "Rushing"
- "No need, my partner and I are married"
- "I trust my partner"

Respondents were also asked what things would make it more likely that they would use condoms. The responses included the following:

- "more education about why condoms are important"
- "how to use them"
- "providing free condoms"
- "having one with you at all times"

Based on these responses, education and access appear to be contributing factors to consistent condom use.

The table below shows percentage of condom use among respondents reporting being HIV positive. While the most frequent response was “yes”, at 37.8%, it is noteworthy that 33.8% did not respond to this question. While the reasons for this lack of response are not known, it is possible that either stigma or embarrassment among people living with HIV who do not use condoms impacted the responses. Furthermore, the fact that 20% of respondents indicated that they only “sometimes” use condoms relates to the issues of consistency in condom use as an important facet of prevention among HIV positive individuals.

Table 47: Condom Use among those HIV Positive respondents, RARE Survey, 2015

The last time you had sex, did you use a condom?	Number	Percentage
Yes	17	37.8%
No	3	6.7%
Sometimes	9	20%
No response	15	33.3%
Total	44	100.0%

Substance Abuse Behaviors

The following tables show responses and behaviors regarding substance use. Table 48 shows respondents who reported injectable drug use.

Table 48: Respondents who reported substance abuse, RARE Survey, 2015

Do you shoot drugs? Have you ever shot drugs?	Number	Percent
Yes	1	0.5%
No	152	75.5%
Used to	2	0.5%
No Response	47	23.5%
Total	202	100.0%

While only a small percentage of respondents reported using drugs (2.5%), the percentage of "No response" was 25.7%. These responses may be impacted by stigma and secrecy related to substance abuse, particularly illegal drugs.

Table 49: Respondents who reported substance or alcohol use when having sex, RARE Survey, 2015

When you have sex, do you sometimes use drugs or alcohol	Number	Percent
Alcohol	36	17.8%
Drugs	5	2.5%
No to both	109	54.0%
No Response	52	25.7%
Total	202	100.0%

Only a single respondent (0.5%) reported "having sex for drugs, money or other things", while 42.1% did not respond to the question. Due to the confounding stigma of both substance abuse and commercial sex, this question may be particularly uncomfortable to answer for some respondents, possibly impacting the responses.

Table 50: Respondents who reported having sex to get drugs, money, or other things, RARE Survey, 2015

In the last month, have you had sex with anyone to get drugs, money, or other things?	Number	Percent
Yes	1	0.5%
No	116	57.4%
Blank	85	42.1%
Total	202	100.0%

HIV Diagnosis

HIV Testing and Disclosure

As the first phase of the HIV Care Continuum, HIV testing, early identification and disclosure are important factors in the treatment of HIV. The following tables show participant responses related to these issues.

Table 51 shows testing history of respondents. It is noteworthy that 13.9% reported never being tested for HIV.

Table 51: Respondents reporting having ever been tested for HIV by test outcome, RARE Survey, 2015

Have you ever been tested for HIV/AIDS? (Reported by Test Outcome)	Number	Percent
Never Tested	28	13.9%
Tested, chose not to disclose	18	8.9%
Tested, Positive	45	22.3%
Tested, Negative	103	51.0%
No Response	8	3.9%
Total	202	100.0%

Table 52: Respondents reporting having ever been tested by HIV by gender, RARE Survey, 2015

Have you ever been tested for HIV/AIDS? (Reported by Gender)	Number	Percent
Female	90	100%
Yes	82	91.1%
No	8	8.9%
Male	99	100%
Yes	79	79.8%
No	20	20.2%

For those who have not been tested, reasons most often cited were variations of the following phrases:

- "don't need to"
- "don't' want to know".

Overall, these findings may be evidence of the stigma related to an HIV diagnosis, as well as complacency, low perception of risk and/or misinformation regarding treatment. Additionally, a higher percentage of males (19.2%) compared to females (8.6%) have never been tested. Of those who have been tested, 100% of respondents received their results, which may indicate the use of rapid testing.

Participants were also asked, “who have you/would be comfortable disclosing your status to?” Answers included family, friends, and provider. It is noteworthy that only one respondent mentioned the “person who put me at risk”. No other answers included a sexual partner, spouse, person who may have transmitted it to them, or someone they shared a needle with. A limited number of people responded “no one”. Additionally, some responses mentioned “someone who is going through what I am going through”, which supports the value of peer-based support services.

Accessibility of Health Information

Accessibility of health information can impact many factors of an individual’s health. Respondents were asked a variety of questions to determine the availability of health information.

Table 53 shows a majority of participants (83.3%) reported that “Yes” health information is available. Additional comments recorded are: “if you look for it”, “if you ask for it”, “they just have to work for it”, and “yes, but not many people take the time to find it”. All of these comments suggest potential barriers.

Table 53: Respondents who feel health information is readily available, RARE Survey, 2015

Do you feel health information is readily available?	Number	Percent
Yes	155	83.3%
No	17	9.1%
It Depends	14	7.5%
Total	186	100.0%

Participants were also asked more generally, “Where do you find out what is happening in your neighborhood?” A wide variety of responses were given, including the following:

- Community Centers
- Sports United Club
- Jerome Golden”
- Compass Gay Lesbian Community Center
- Sports United Club
- Jamaicans of the Palm Beaches
- Internet
- Social media
- Bulletin boards
- Friends
- Word of mouth
- Community TV Channel
- Riviera Town Center
- Vickie’s House
- Library

These responses support the idea that for health information to be more accessible, it needs to be disseminated in a wider variety of venues.

Ever in Care/Linkage to Care

Provider Referral and Linkage

The table below depicts post-diagnosis referral patterns among HIV positive respondents. According to the data, a combined 97.4% of respondents report being referred to various providers. While this represents a high rate, it is important to note that these reflect referrals but not necessarily linkages. Furthermore, this data should be considered in the context of the "linkage gap" which is observed between those linked to care and those who are retained in care.

Table 54: Reported agency referred to when diagnosed, RARE Survey, 2015

When diagnosed, where were you referred?	Number	Percent
Not Specified "doctor"	24	63.2%
Health Department	6	15.8%
No where	1	2.6%
Community-based HIV Provider	5	13.2%
Other	2	5.2%
Total	38	100.0%

The data below suggests that respondents (not limited by HIV status), prefer to obtain health and HIV-specific information from a medical provider. While this increases the chances of a client receiving accurate information, it may not be as accessible, convenient or culturally and linguistically relevant as other sources of health information, which may partially account for the 23% who don't go to a provider for both healthcare and HIV/AIDS related questions.

Table 55: Locale reported by respondents for healthcare and questions about HIV/AIDS, RARE Survey, 2015

Where do you go for healthcare? and Where would you go if you had a question about HIV/AIDS?	Number	Percentage
Doctor for both	149	77.7%
Provider for healthcare and Family member for HIV/AIDS info	12	6.2%
Provider for healthcare and internet for HIV/AIDS info	11	5.7%
Provider for healthcare and a different community center for HIV/AIDS info	8	4.1%
Total	192	100.0%

In Care/Retention in Care

Provider Support

Provider support is an important component of HIV care. The table below shows responses regarding care seeking behavior. A majority of respondents reported visiting a "doctor" for healthcare (64.9%). When asked "how do you feel you are treated by staff (at the place where you go for healthcare)?" all but 3 responses were favorable. The negative responses were:

- "Fair, because they know me. I know they treat other people badly"
- "Fine, but sometimes you can be discriminated against"
- "It wasn't a good experience, they didn't know what they were doing!"

It is worth noting that all three of these respondents were African American. No specific doctor or facility was named.

Table 56: Reported locale of respondents seeking healthcare, RARE Survey, 2015

Where do you go for healthcare?	Number	Percentage
Doctor	131	64.9%
Clinic	31	15.3%
Health Department	28	13.9%
Hospital/Emergency Room	8	4.0%
No where	4	2.0%
Total	202	100.0%

When asked why they used the internet for questions about HIV/AIDS, participants responded with several answers:

- "Convenient for information"
- "Easy access"
- "You can get everything you need"
- "Updated information"

When asked why they would go to a provider with questions about HIV/AIDS, participants answered:

- "They have the right information"
- "I trust him"
- "It is the best place"

Table 57: Reported locale of respondents with questions about HIV/AIDS, RARE Survey, 2015

Where would you go if you had a question about HIV/AIDS?*	Number	Percentage
Doctor	92	46.5%
Internet	25	12.6%
Health Department	24	12.1%
Clinic	24	12.1%
Compass	11	5.6%
FoundCare	11	5.6%
Family	8	4.0%
Ask anyone	3	1.5%
Total	198	100.0%

*multiple answers possible

Social Patterns

The following table shows responses regarding social groups. Family and Friends were the most frequent responses. A small but noteworthy percentage, 4.5% of respondents reported they associate with "no one".

Table 58: Social groups reported by respondents, RARE Survey, 2015

Whom do you hang out with?*	Number	Percent
Friends	91	45.0%
Family	48	23.8%
Significant Other	13	6.4%
Children	9	4.5%
No One	9	4.5%
Church Friends	8	4.0%
Blank	53	26.2%

*percent may add up to more than 100% because participants can name more than 1.

The following table shows where respondents reporting "hanging out".

Table 59: Locale reported where respondents hang out, RARE Survey, 2015

Where do you hang out?*	Number	Percent
Social Club	32	17.8%
Church	30	16.7%
Neighborhood	30	16.7%
Home	26	14.4%
"Don't hang out"	20	11.1%
Other	17	9.4%
Friend/Family's house	12	6.7%
Provider Agency	11	6.7%
Bars/Clubs	7	3.9%

*multiple answers possible

Overall, the pattern of social behaviors vary among all populations, but significant differences did not exist between gender and racial groups. Given that "church" was cited by 16.7% of participants as a common "hang out", this may further underscore the religious influence over other themes and behaviors.

The non-specific nature of other responses, such as "neighborhood" and the home of family and friends makes it difficult to target outreach activities for specific populations.

Table 60: Respondents length of time living in Palm Beach County, RARE Survey, 2015

How long you lived here?	Number	Percent
Less than 2 years	32	16.9%
2-10 years	61	32.3%
11-30 years	48	25.4%
More than 30 years	48	25.4%
Total	189	100.0%

Table 61: Reported household residents of respondents, RARE Survey, 2015

Who do you live with?	Number	Percent
Alone	50	31.6%
Other Family	26	16.5%
Spouse/Partner	25	15.8%
Children only	18	11.4%
Spouse/Partner and Children	15	9.5%
Boyfriend/Girlfriend	11	7.0%
Roommate/Friend	5	3.2%
Group home	4	2.5%
Homeless	2	1.3%
Boyfriend/Girlfriend and Children	2	1.3%
Total	158	100.0%

Travel Patterns and Transportation

Travel patterns and transportation likely affect retention in care. This qualitative data can assist in informing decisions around service delivery sites as well as non-traditional, flexible and/or mobile models of care.

The table below explores travel patterns among respondents. It is noteworthy that that nearly half (46.5%) of respondents report either "Never" or "Rarely" travelling outside their neighborhood.

Table 62: Frequency of traveling outside of neighborhood, RARE Survey, 2015

How often do you go outside of your neighborhood?*	Number	Percent
Never	16	11.1%
Often (>3x/week)	55	38.2%
Rarely (<1x/week)	51	35.4%
Sometimes (1-3x/week)	33	22.9%

*multiple answers possible

Transportation can be a significant access to care issue. As presented in the table below, a significant percentage of respondents utilize modes of transportation other than a personal vehicle, including 19.8% who take the bus, and a combined 11.4% who either bike or walk.

Table 63: Transportation by type, RARE Survey, 2015

How do you get around?	Number	Percent
Rely Friends/Family	12	5.9%
Bus	40	19.8%
Car	101	50.0%
Walk	13	6.4%
Bike	10	5.0%

*multiple answers possible

Furthermore, as presented in the table below, only 33.5% of respondents report that they have a car. Thus the distance to a service provider may be a limiting factor to retention in care.

Table 64: Respondents reporting having a car, RARE Survey, 2015

Do you have a car?	Number	Percent
Yes	49	33.5%
No	97	66.5%
Total	156	100.0%

While these factors are presented in the context of retention in care, they certainly affect all phases of the continuum, especially impacting adherence and viral suppression.

Anti-retroviral Therapy (ART)

Medication Adherence and Untreated HIV

Among HIV positive respondents, 86.7% reported being on HIV medication, while 8.9% of respondents are not. As a reference, according to the 2014 HIV Care Continuum statistics, the percentage of individuals in care who are not on Anti-retroviral treatment is only about 3%. The difference in those percentages, although a small sample size, is evidence of other contributing factors.

Table 65: HIV Positive respondents reporting any HIV medication, RARE Survey, 2015

Are you on any HIV medication?	Number	Percentage
Yes	39	86.7%
No	4	8.9%
No response	2	4.4%
Total	45	100.0%

In addition, only 55.6% of respondents reported consistency in taking the medication, while 33.3% reported "sometimes forgetting", which can impact both viral resistance and suppression.

Table 66: Respondents reporting forgetting to take medication among those on HIV medication, RARE Survey, 2015

If yes, do you sometimes forget to take your meds?	Number	Percentage
Yes	13	33.3%
No	22	53.4%
No response	4	10.3%

When asked for reasons for not being on HIV medication, the following responses were provided:

- "Just diagnosed"
- "don't know"
- "I'm homeless"
- "not yet"

While not a significant sample size, these qualitative responses each provide unique insight into the reasons for people living with untreated HIV. The response of "just diagnosed" specifically relates to the role of Early Intervention Services in identifying and linking the newly diagnosed to care, as a critical point in the continuum. The response of "don't know", speaks to lack of awareness, knowledge and/or perception of risk of untreated HIV infection. The response of "I'm homeless", validates a priority sub-population at an elevated risk for poor HIV-related outcomes (including increased transmission risk) due to multiple confounding factors. Finally, the response of "not yet" relates

to awareness and possible lack of knowledge of the latest treatment guidelines which recommend universal Anti-retroviral Therapy as well as an emphasis on the need to treat early. It is possible that some patients are making decisions based on outdated guidelines, underscoring the need for current and readily available health information.

Viral Suppression

Knowledge of Viral Load

The following questions were only asked of those respondents who reported being HIV-positive.

Table 67: HIV Positive Respondents reporting knowledge of what viral load means, RARE Survey, 2015

Do you know what viral load means?	Number	Percentage
Yes	37	90.2%
No	4	9.8%
Total	41	100.0%

Table 68: HIV Positive Respondents reporting they viral load means, RARE Survey, 2015

Are you aware of your viral load?	Number	Percentage
Yes	38	97.4%
No	1	2.6%
Total	39	100.0%

Among HIV-positive respondents, the vast majority reported "knowing what viral load means" and being aware of their own viral load (90.2% and 97.4% respectively). Additionally, 100% of respondents report that knowing their viral load is important to them.

While these figures seem to suggest a strong grasp of viral load among respondents, this data is self-reported, and thus the knowledge and competency is self-evaluated. Any misconceptions regarding viral load, would therefore not be captured here. This is further validated by the qualitative data obtained through the systems analysis, in which providers and stakeholders reported a high frequency of myths and misinformation surrounding viral load and being "undetectable".

Whole Health and Wellness

Defining and Becoming "Healthy"

Respondents were asked general open-ended questions related to health and wellness, without any particular HIV/AIDS context. When asked "How do you remain healthy?" the responses included:

- "Eat right"
- "Exercise"
- "Go to doctor"
- "Pray"
- "Get good sleep"
- "Practice safe sex"
- "Take meds"
- "Meditate"

When asked "what does healthy mean to you?" respondents identified themes relating to whole health, including mental, physical and spiritual wellness. It is noteworthy that although the entire survey had an unambiguous HIV-focus up to this point, the responses reflected a broader and more comprehensive understanding of health and wellness. This supports the idea that people living with HIV may no longer feel "defined" by their illness. This insight is critical in framing services across the HIV Continuum of Care for this population and improving health outcomes and reducing disparities.

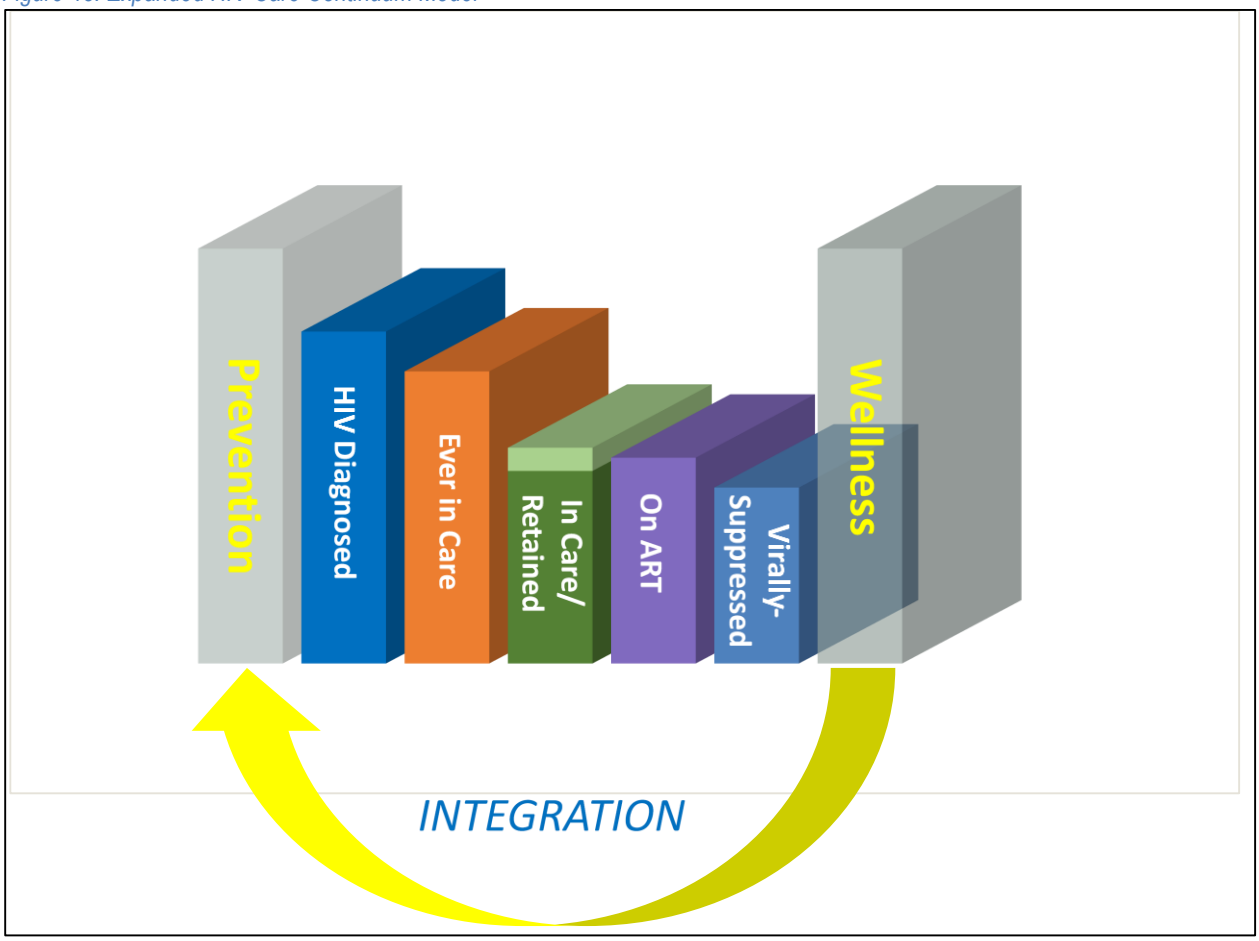
Recommendations

Based on the data and trends gleamed from the quantitative and qualitative data presented throughout this report, which was obtained from providers, stakeholders, community members, including individuals living with HIV, the following recommendations are set forth for the Palm Beach County HIV system of care:

Recommendation 1: Adopt the Expanded HIV Care Continuum Model

Currently, Palm Beach County utilizes the standard HIV Care Continuum model, in accordance with CDC and HRSA guidelines. This model incorporates the following components or phases: HIV Diagnosis, Ever in Care, In/Retained in Care, On Anti-retroviral Therapy (ART) and Viral Suppression. The proposed expanded model builds upon this core framework with several key enhancements resulting in a more comprehensive depiction of the Continuum of Care. While the "height" of each phase continues to represent the proportion of clients in each phase, the depth serves to visually represent all of the contributing qualitative factors, such as those identified in this report.

Figure 45: Expanded HIV Care Continuum Model



A "pre-phase" has been added to the left of the continuum representing Prevention activities, which impact the period of time prior to an HIV diagnosis. Here, activities such as risk reduction interventions, education, outreach, counseling testing and referral (CTR) activities, condom distribution programs, social marketing campaigns, and early intervention services are captured. While these activities are often planned and conducted independently of treatment services, they are very much a part of the HIV continuum of care and impact each subsequent phase.

Additionally, a "post-phase" has been added to the right of the continuum to represent Wellness and Whole Health. The final phase in the standard continuum is Viral Suppression, but does not include any other health conditions, both HIV-related and non-HIV related. This recommendation seeks to include the treatment of chronic conditions in the HIV Care Continuum. Finally, because the concept of wellness is routed in preventative care, the concept of integration (prevention and care) is represented through this expansion.

Recommendation 2: Support the system-wide implementation of the Community PROMISE intervention

The Community PROMISE intervention is a community-level, CDC endorsed evidence-based model which is particularly compatible with High Impact Prevention guidelines. Its core elements include a community identification (CID) process, peer advocates, and role model stories which support incremental behavior change. The model is ideally suited to diverse communities and is designed to be adopted to particular communities and populations. The CID process was the basis for the qualitative data collection, both systems and community, for the RARE 2015 project. An ongoing system-wide implementation would build upon this project, continuing the vital 2-way dialogue between the system and the community and increase its scale, scope, and reach.

Recommendation 3: Address the "Linkage Gap" by reframing how services across the HIV Continuum of Care are evaluated

In Palm Beach County, as is the case at the state level, the largest gap in the HIV Continuum of Care exists between the "Ever in Care" and "In/Retained in Care" phases, referred to in this report as "the linkage gap". The low outcomes observed in the viral suppression phase can be directly traced to this gap. If the linkage gap were reduced to reflect the average difference between the other phases, the resulting HIV Care Continuum would be drastically different. Thus, this particular point in the continuum is critical. Additionally, in the traditional HIV Care Continuum, it is common to evaluate services based on a particular phase. For example linkage services are often evaluated by the “Ever in Care” phase, which was 88% in Palm Beach County in 2014. However, the “linkage gap” is drastic when considering that the percentage retained in care is only 58%. Therefore, it is recommended that while the quantity of services continue to be evaluated by a particular phase corresponding directly to that service, the following phase be used as a measure of quality. Thus, in the case of linkage, the quality and impact of these services are best measured by examining the “Retained in Care” phase.

Recommendation 4: Orient all services in the HIV Care Continuum toward Viral Suppression and Whole Health

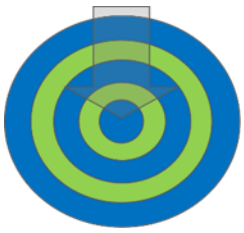
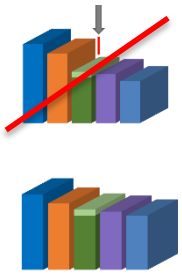
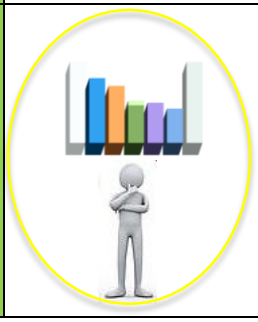
It is recommended that all providers in the system of care orient their services toward Viral Suppression and Whole Health, regardless of the particular phase their primary focus is. For example, linkage programs should be planned, implemented and evaluated with the overall goal of Viral Suppression and Whole Health taken into account. This approach will help to foster more meaningful collaboration among providers and lead to improved health outcomes for clients. This recommendation is based on the premise that the phases are truly a continuum and do not exist in isolation.

Recommendation 5: Develop a client-friendly version of the HIV Care Continuum

While the expanded HIV Care Continuum and related recommendations above would address many systematic limitations and improve the delivery of HIV care in Palm Beach County, a critical element remains- ensuring that the client fully understands the continuum and its implications on his/her health. The HIV Care Continuum, while representative of the HIV population as a whole, from the client-perspective also represents the individual journey from HIV diagnosis to viral suppression and beyond.

A client friendly version of the HIV Care Continuum will address the knowledge gap between providers and patients, specific to viral suppression, whole health and the steps to achieve those outcomes. This publication should summarize the various phases of the continuum and present them as tangible steps that clients can take to achieve viral suppression and whole health. Particular attention should be given to ensure that the publication is meaningful in terms of being culturally and linguistically appropriate. Furthermore, it is recommended that the publication be disseminated through a variety of modalities, both hard copy and electronic. In particular, this recommendation includes the development of a mobile app which would allow clients convenient access to information, tools and support, specific to their particular stage in the process.

The table below summarizes these five recommendations for Palm Beach County, indicating the impact on and by the following elements: the client, the system of care and the community. All recommendations are in alignment with the National AIDS Strategy, with the community impact specifically reflecting the NHAS goals.

Recommendations for Palm Beach County		Client impact	System Impact	Community Impact
Adopt the Expanded HIV Care Continuum Model		• Improved HIV-specific and chronic disease health outcomes • Enhanced understanding of "whole health" • Improved quality of life	• Integrate prevention & care services • Orient of all stages of the continuum "to the right" towards whole health • Recognize socio-cultural & environmental factors affecting each stage	• Reduced Health disparities • Increased utilization of preventative care • Reduced untreated chronic conditions • Reduced number of new HIV infections
Support the system-wide implementation of the Community PROMISE model		• Reduced high risk behavior • Increased testing • Increase adherence & utilization of health services • Reduced instances of discrimination/stigma • Increased knowledge of HIV related issues	• Maximize available resources • Leverage expertise & skills across agencies • Deliver consistent, culturally-appropriate HIV prevention and care messaging • Enhance impact of existing interventions & programs	• Reduced Number of New HIV Infections • De-stigmatization of populations, health conditions and behaviors • Improved quality of culturally-appropriate messaging
Address the "linkage gap" by reframing how services across the continuum are measured		• Improved timely linkage to care for newly diagnosed clients • Increased access to health services • Increased likelihood of viral suppression • Improved health outcomes	• Enhance quality of linkage & case management services • Improve health outcome monitoring • Increase efficiency of service delivery	• Increased access to care • Increased Retention in care • Increased Viral Suppression rates • Reduced number of new HIV infections
Orient all services toward the right side of the continuum		• Increased likelihood of viral suppression • Improved health outcomes • Improved quality of life	• Build a more coordinated system of care, oriented towards a common goal • Educate clients on the importance of retention and adherence in the context of viral suppression and whole health	• Increased Viral Suppression rates • Reduced number of new HIV infections • Reduced Health disparities • Increased utilization of preventative care • Reduced untreated chronic conditions
Develop a client-friendly HIV Care Continuum to serve as an educational tool		• Enhanced understanding of viral suppression, health & the steps required to achieve those outcomes • Increased empowerment by education & motivation	• Motivate clients about their own health through education • Provide clients with the necessary tools to promote empowerment • Support clients across the Continuum of Care	• Increased Viral Suppression rates • Reduced Health disparities • Increased utilization of preventative care • Reduced untreated chronic conditions

Appendices

System Survey Tool

RARE 2015

Systems Analysis Survey

This form may be used for interviewing any individual involved in the system of care (including line staff, management, leadership, administrators, volunteers, interactors and gatekeepers). Questions should be used as a guide and only asked when appropriate.

1. Position or title:

   _____

   _____

2. How long have you been in this position? _____
3. We are interested in learning more about the clients/patients you serve as it relates to the HIV/AIDS epidemic in Palm Beach County. When you think about the clients you serve do you divide them into different groups such as males/females or older/younger or users of different drugs, or anything else? What are those groups? Which of these groups would you say you know the most about?

   _____

   _____

   _____

   _____

   Now I am going to ask you questions only about the specific groups you mentioned

4. How do you/have you had contact with specific group?

   _____

   _____

5. Where can this specific group be found in this community? (specific areas)

   _____

   _____

6. What phrases or vocabulary does this specific group use that are unique?

   _____

   _____

7. What barriers are there that would make it hard to talk to this specific group?

   _____

   _____

   _____

   _____

1

Risky Behaviors

8. What behaviors does this specific group have that put them at risk for HIV infections and STD's and what do you think is motivating them to continue practicing these high risk behaviors in spite of all the information that's out there?

Testing

9. What motivates this specific group to get tested and seek care?

Linkage

10. What reasons do you hear/feel are barriers for specific group to not stay in care?
11. What are your organizations methods for linking clients/keeping clients in care?

Medication

12. What reasons do you hear/feel are barriers for specific group not adhering to medication regime?

Viral Suppression

13. Do your clients feel it is important to be virally suppressed? Why or why not?

Health

14. What HIV related health disparities do your clients have?

RARE 2015

Community Analysis Survey

This form may be used for interviewing any individual involved in the community (including clients, interactors and gatekeepers). Questions should be used as a guide and only asked when appropriate.

Basic Information

Age: _____ Location: _____

Ethnicity: _____ Date: _____

Gender: _____ Time of Day: _____

Interviewer: _____

Information Attainment

I want to ask you some questions about where you get information.

1. Where do you go, and/or what do you do to find out about what is happening in the community or your own neighborhood? Is there someplace or someone you seek to get information?

   _____

   _____

2. Do you feel health related information is readily available? _____

Networks

I want to ask you some questions about yourself and the community.

3. How long have you lived around here? How much do you go outside of your own neighborhood where you live (*hang out*)? How do you get around? Do you have a car?

   _____

   _____

   _____

4. Where do you hang out? Whom do you usually hang out with?

5. Is your family here? Your friends? Whom do you live with? How long have you lived with these people? Do you have children? Do they live with you?

6. Whom do you talk to about personal problems or other things that bother you? Is this a friend, or someone in your family? *(Get relationship, not name.)*

7. How do you get money? *(Probe for multiple sources.)*

HIV Information

Now I'd like to ask you some questions about HIV.

8. How do you think people contract HIV?

9. Do you think it is likely you could contract HIV? Why do you think you could or could not?

10. Are you doing anything to protect yourself from contracting HIV? What? If nothing, why not?

Risky Behaviors

Now I want to ask you some questions about risky behaviors.

11. The last time you had sex, did you use a condom? Why or why not? What kind of sex did you have? (for example, oral, anal, vaginal)

12. Was this person (were any of these people) someone you would say is your main or steady sex partner? *(If not main partner, who?)*

13. Is your main partner a man, a woman or transgender? *(If no main partner, were partners mostly men, women, or transgender?)*

14. In the last month, when you had sex, how often did you use a condom? Why did you use it (not use it)? What type of sex were you having?

15. What would you say is the reason you didn't use a condom every time?

16. In the last month, have you had sex with anyone to get drugs, money, or other things? (*If "no," skip to condoms section.)*

17. How often did you use a condom when you had sex in these situations? What kind of sex did you have? Did you use a condom for some kinds of sex and not others?

18. What would you say is the reason you did not (did) use a condom every time in these situations?

19. Now tell me the kinds of things that would make it more likely that you would use a condom whenever you have sex. What about other people—what would make it easier for them? Is there anything else that would make it more likely that you or others would use a condom whenever you had vaginal sex?

20. When you have sex, do you sometimes use alcohol or drugs? Which drugs, etc.? How often?

21. How often do you drink alcohol or use drugs at other times? Which drugs, etc?

22. Do you shoot drugs? Have you ever shot drugs? When was the last time?

23. Does your main sex partner shoot drugs? Which? Does he/she try to hide it from you? Does he/she ever shoot with other people? Does he/she share needles? Does he/she use bleach? Have the two of you talked about AIDS?

_____

_____

Awareness of Services

Now I want to find out where you would get information about health for you and your family.

24. Where do you go for health care?

_____

_____

25. How do you feel you are treated by staff here?

_____

_____

26. Where would you go if you wanted family planning services?

_____

_____

27. Where would you go if you had a question about HIV/AIDS? Why would you go there?

_____

_____

28. Where would you go if you wanted to be tested for HIV/AIDS?

_____

_____

29. Have you seen or heard anything about how to protect yourself from HIV/AIDS?

_____

_____

30. Do you think you have ever been in a situation where you might have caught HIV? Do you believe you might be infected with the AIDS virus now?

_____

_____

Testing

31. Have you ever been tested for the AIDS virus? *(skip to last question if has not been tested/does not want to disclose status)*

_____

_____

32. Did you go back to get your test results? Would you share the results with us? What were they?

_____

_____

Linkage

33. Once you received your test results where were you referred?

34. Who have you/would you be comfortable disclosing your status to?

Medication

35. Are you on any HIV medication? Why or why not? Do you ever forget to take your medication?

Viral Suppression

36. Do you know what viral load means?

37. Are you aware of your viral load? Is this important to you?

Health

38. What does healthy mean to you?

39. How important is it you to remain healthy?

40. How do you remain healthy?

41. Is there someone else that we should talk with about HIV/AIDS that can give us information to make our program better? If so, can we contact them? Can we mention your name?

Those were all of my questions. Thank you very much for your time. Your contribution will help us develop interventions that will have an impact.