PALM BEACH COUNTY
INTEGRATED HIV PREVENTION AND CARE PLAN

2022-2026

Palm Beach County, Florida

Florida Health Palm Beach County

Palm Beach County Community Services — Helping People Build Better Communities

CPP Community Prevention Partnership

Palm Beach County HIV Care Council

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SECTION I: EXECUTIVE SUMMARY

The Palm Beach County Ryan White Part A Recipient's Office joined efforts with the Planning Committee of the Palm Beach County HIV CARE Council (Planning Council) and the Palm Beach County Community Prevention Partnership (CPP) to draft the PBC Integrated HIV Prevention and Care Plan 2022-2026 (Integrated Plan). This Integrated Plan builds upon the previous Integrated Plan 2017-2021, and the 2020 Palm Beach County Ending the HIV Epidemic (EHE) Plan. The Integrated Plan aligns with the 2022-2025 National HIV/AIDS Strategy (NHAS) and federal initiatives including the Ending the HIV Epidemic (EHE) Initiative in the United States (2019), and the National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021–2025 that all work in unison to achieve national goals.

The impact of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) in Palm Beach County has a wide effect with 8,417 persons with HIV (PWH) living in Palm Beach through 2021, which represents only 88 percent of PWH the remainder of whom are unaware of their status (approximately 12 percent). In 2021, 322 persons received an HIV diagnosis in Palm Beach County and, 78% of newly diagnosed PWH were linked to care within 30 days. Of all PWH, 75% were in care (n=6,348), 68% were retained in care (n=5764) and 65% (n=5,480) were virally suppressed in 2021. The HIV epidemic disproportionately affects Black and Hispanic/Latinx populations. Fifty-two percent (52%) of new HIV diagnoses and 62% of AIDS diagnoses were among Blacks, but Blacks only account for 18.8% of the total population of Palm Beach County. Hispanic/Latinx are also disproportionately represented in the number of new HIV diagnoses (27%) as they make up 24% of the Palm Beach County population.

Palm Beach County is a large and diverse county. The Integrated Plan focuses on a coordinated response to the HIV epidemic. While great progress has been made over the years, HIV prevention and care remains a priority. The Palm Beach County jurisdiction recognizes that no one entity can end the HIV epidemic. The plan is the result of an open community planning process.

Palm Beach County's Integrated HIV Prevention and Care Plan 2022-2026 provides an overview of the current landscape of HIV services in the county and identifies goals and strategies in moving forward to address the epidemic. This Integrated Plan addresses the HIV Care Continuum including mirroring the goals outlined in the National HIV/AIDS Strategy and the EHE Pillars (Diagnose, Treat, Prevent, and Respond).

g. Approach

The development of the Palm Beach County Integrated HIV Prevention and Care Plan (Integrated Plan) builds upon previously submitted Palm Beach County Integrated Plan 2017-2021. The Integrated Plan also incorporates the updated GY 2022 Palm Beach County Ending the HIV Epidemic (EHE) Plan. Additionally, the 2020-2021 Needs Assessment informed the Integrated Plan by highlighting resources, gaps in services and needed services for Persons with HIV (PWH).

The Integrated Plan is organized within the following sections:

1. Section 1: Executive Summary
2. Section II: Community Engagement and Description of Jurisdictional Planning Process
3. Section III: Contributing Data Sets and Assessments including:
    - Data Sharing and Use
    - Epidemiologic Snapshot
    - HIV Prevention, Care and Treatment Resource Inventory
    - Needs Assessment
4. Section IV: Situational Analysis Overview including priority populations/groups
5. Section V: 2026 Goals and Objectives, organized by the goals, strategies, objectives and activities aligned with the National HIV/AIDS Strategy and inclusive of the four pillars of the EHE Initiative: Diagnose, Treat, Prevent, and Respond.
6. Section VI: 2022–2026 Integrated Planning Implementation, Monitoring and Follow-up.
7. Section VII: Letters of Concurrence

The Palm Beach County planning bodies, the HIV CARE Council (Planning Council) and the Community Prevention Partnership (CPP), facilitated plan development. The HIV CARE

Council took the lead in drafting three EHE pillars (Treat, Prevent and Respond). The CPP took responsibility for the first pillar: Diagnose. Both planning bodies engaged community stakeholders, health care providers, substance use and mental health providers, Department of Health, RW Part A, Minority AIDS Initiative (MAI), Housing Opportunities for People with HIV/AIDS (HOPWA), and EHE providers to draft the Integrated Plan. Once the first draft of the plan was completed, the plan was shared at a Town Hall meeting to obtain additional input.

Section II: Community Engagement and Description of the Jurisdictional Planning Process

Jurisdiction Planning Process

The 2022-2026 Palm Beach County Integrated Prevention and Care Plan planning aimed to: (a) create an open public process involving the active participation of the HIV Community Prevention Partnership (prevention body), HIV CARE Council (planning body), PWH, and a wide spectrum of community stakeholders; (b) offer a mechanism to identify community needs, health inequities, disparities in healthcare access and gaps in services for underserved populations across the HIV Continuum of Prevention and Care, and (c) provide a venue to align with the NHAS goals and objectives. The planning process approach was structured to be a data driven process, designed to foster parity, to be inclusive, representative (PIR) and reflective of the communities at risk for or with HIV. Planning members were representative -- reflective of gender, racial and ethnic backgrounds of the populations served by the Palm Beach County jurisdiction.

a. Entities Involved in the Planning Process

Palm Beach County, Ryan White HIV CARE Council

The Palm Beach County (PBC) HIV Planning Council was created through an ordinance issued by the Board County of Commissioners in November of 1993. In August of 1977, the Planning Council and the PBC AIDS Consortium merged and became the Palm Beach County HIV Comprehensive AIDS Resources Emergency (CARE) Council.

The HIV CARE Council consists of 27 voting members who represent the legislative mandates for membership. Thirty-three percent (33%) of the total membership is made up of persons with

HIV (PWH). The HIV Planning Council is representative of the demographics of PWH, and gives special consideration to historically and disproportionally affected populations. The HIV CARE Council has eight standing committees that address the needs of PWH. The CARE Council's structure includes the following committees: Executive, Community Awareness, LGBTQ Health Equity, Local Pharmacy Assistance Program (LPAP), Membership, Priority Setting & Resource Allocation, Quality Management & Evaluation and Planning Committee. See table below for a summary of committee responsibilities.

Table 1

Palm Beach County, Ryan White HIV Planning Council Responsibilities

HIV CARE Council: Develops, monitors, evaluates and advocates for the provision of quality of services provided to PWH receiving RWAHP Part A, MAI, B and HOPWA.
Executive Committee: Provides oversight to grant application processes, implementation of policies, emergency actions.
Community Awareness: Conducts outreach to PWH in the community. Provides input on how to reach PWH, serves as a link between communities and the Planning Council.
Membership: Identifies and participates in the recruitment of new Council members. Mentorship and training of new members.
Priorities Setting and Resource Allocation: Recommends priorities and allocations based on services utilization and epidemiological data.
Planning: Develops the countywide needs assessment and integrated plan. Develops evaluation tools and programs.
Quality Management and Evaluation: Ensures the highest quality of healthcare and support services. Provides oversight to standards of care. Provides QM trainings for service providers.
LGBTQ Health Equity: Provides a platform to identify issues, gaps in care across the HIV prevention and care continuum. Conducts community outreach and engagement of LGBTQ community.
Local Pharmacy Assistance Program: Compiles a written formulary, establishes process and procedures to add or remove medications. Provides input on Statement of Need.

Community Prevention Partnership (CPP)

The Planning Committee of the HIV CARE Council worked in close collaboration with the Palm Beach County (PBC) Florida Department of Health (FDOH), and Community Prevention Partnership (CPP) members. The mission of the Palm Beach County CPP is to promote community participation and involvement in HIV prevention activities. CPP membership includes individuals from the Florida Department of Health, Community Based Organizations (CBOs), Faith-Based Organizations (FBOs), Community Health Centers, Palm Beach County

School District, mental health and substance use providers, PWH and members representatives of historically underserved populations.

The PBC HIV CARE Council and CPP are representatives of PWH. Other planning members represent affected individuals, social service providers, AIDS services organizations, health care organizations, community leaders, and agencies serving communities persons at risk for HIV and PWH.

The responsibilities of the CPP include to: (a) ensure that there is no duplication of prevention services and gaps in the HIV prevention and care continuum; (b) promote coordination of services for priority populations; and (c) ensure collaboration with the HIV CARE Council in planning efforts.

Table 2

Planning Committee Members by Sex and Race/Ethnic Groups as of GY 2022

Race/Ethnicity	**Sex**		**Age Range**			
	Male	Female	30-39	40-49	50-59	60-70
White	2	2	1	2	1	2
Black/African-American	2	3	1	0	1	1
Hispanic/Latinx	0	1	0	1	0	0
Asian	0	1	1	0	0	0

Table 3

Key Stakeholders Participating in Integrated Planning Meetings in GY 2022

Federally Qualified Health Center (FQHC) representative	Medicaid representative	PWH and co-infected with Hep B or C
Substance use provider	Health planning agency	Community-based Organizations (CBOs) offering HIV-related services
Mental health provider	Non-elected leader	Florida Department of Health (FDOH) staff

HIV clinical providers	Housing Opportunities for Persons with HIV/AIDS (HOPWA)	Ryan White HIV/AIDS Program (RWHAP) Part A staff
Community Prevention Partnership (CPP) representative		

h. Role of the RWHAP Part A Planning Council

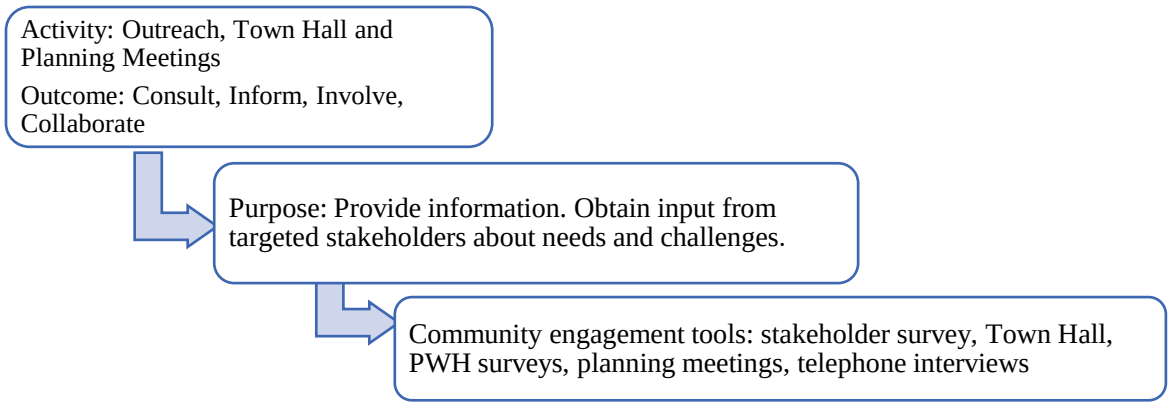
The HIV CARE Council, the Planning and Community Awareness Committees and Community Prevention Partnership (CPP), all joined efforts to reach out and engage the local community. These community engagement events focused on communities at risk for HIV or PWH. Community engagement activities included: interviews with services providers, focus groups, and town hall meetings.

Community engagement events brought together local agencies, health care clinics, HIV testing, mental health and substance providers, employment resources, community social services serving seniors, social services addressing housing and homeless services, and, transportation resources.

All planning activities and meetings were open to the public. The planning process placed an emphasis on addressing the needs of populations experiencing health inequities and disparities in access to care, persons unaware of their HIV status and consumers who were lost to care or not achieving viral load suppression.

Figure 1

Community Engagement Model



1. RWHAP Part A Planning Steps and Roles

Step 1: Organize and Prepare

To facilitate the development of the 2022–2026 Integrated Prevention and Care Plan, the RWHAP Part A Recipient Program Manager provided guidance to the HIV CARE Council, and Community Prevention Partnership (CPP) representatives and also shared with members available guidance documents.

The HIV CARE Planning Council structured planning responsibilities among two work groups: the Community Prevention Partnership (CPP) and the HIV Care Council Planning Committee. The HIV CARE Council Planning Committee assumed the responsibility for drafting goals, objectives and strategies for Prevention, Treatment and Respond Pillars. The CPP agreed to take responsibility for the development of the activities associated with the Diagnose Pillar (goals, objectives, strategies and activities). Both planning bodies used the Integrated Planning Guidance and aligned planning with the NHAS.

Roles

The Ryan White HIV CARE Council provided oversight to the development of the integrated plan and worked with committee members and other planning bodies to ensure a coordinated system of care. The Planning Committee was responsible for the development of the Integrated Prevention and Care Plan. The CPP ensured that the Integrated Plan addressed the gaps in HIV prevention and commitment to improve HIV prevention efforts throughout the community.

Planning Step 2: Prioritization of Activities and Development of Work Plan

The Planning committee developed a work plan centered on identifying goals, objectives, strategies and activities associated with three EHE pillars: Prevention, Treat and Respond as well as the National HIV/AIDS Strategy goals. The work plan established deadlines for the completion of tasks and activities associated with the development of the integrated plan. The CPP members developed a work plan focusing on identifying goals, objectives, strategies associated with the Diagnose Pillar.

Roles

The HIV CARE Planning Council provided oversight over the Planning Committee's development of work plan. The Planning Committee initiated a work plan leading to the development of the Integrated Plan's goals and objectives. The CPP engaged in the same planning activities as the Planning Committee.

Planning Step 3: Implementation

The Planning Committee drafted goals and objectives as well as activities associated with strategies, target population, timeframes, and responsibilities for the implementation of the Integrated Plan. The Planning Committee completed and submitted to the HIV CARE Council the first draft of the Integrated Plan's goals and objectives. The Planning Committee, upon the approval of HIV CARE Council, forwarded the document to the RWHAP Part A Program Manager. The RWHAP Part A Health Planner and two Quality Management Clinicians reviewed the draft for clarity and content.

Roles

HIV CARE Council: Provided approval of the committee's work and coordinated with RWHAP Part A Recipient. The Planning Committee was responsible for completion of tasks according to the Council's By-Laws. The HIV CARE Council, Planning Committee and CPP will continue to provide oversight over the implementation of the Integrated Plan. These entities will give input and seek feedback from PWH and other stakeholders.

Planning Task Steps 4 and 5: Monitoring and Assessment of Progress, Communication.

The RW HIV CARE Council, Planning Committee and Community Prevention Partnership (CPP) in coordination with the RWHAP Part A Recipient's Office Program Manager are responsible for the monitoring and assessing of progress in achieving goals and objectives as well as outcome indicators outlined in the Integrated Plan.

Roles

The HIV CARE Council reviews and approves committee work and coordinates with the RWHAP Part A Program. The HIV CARE Council provides oversight over the process of monitoring the Integrated Plan progress through its HIV CARE Council committees (Planning, Quality Management & Evaluation, Resources Setting & Allocations and Community Awareness Committee). The HIV CARE Planning Council and Community Prevention Partnership (CPP) are responsible for keeping stakeholders up to date on progress made towards

goals and objectives and for soliciting additional feedback as warranted. All of this was provided on a quarterly basis.

c. Role of the Planning Bodies and Other Entities

The HIV CARE Council takes a leading role in the development of the integration plan in the coordination with the RWHAP Part A Recipient. The HIV CARE Council provides oversight, support and guidance to all established committees. It is the role of the HIV CARE Council to assign responsibilities to the most relevant committee. The Planning Committee members works with other planning/funding entities in PBC to ensure inclusion of all needed and available resources. This committee is also responsible for the development and implementation of evaluation tools and programs. The Community Prevention Partnership (CPP) collaborates with the HIV CARE Planning Council to address HIV prevention, education and early intervention efforts throughout the Palm Beach communities. The CPP role is also to promote community participation in HIV prevention services and activities. Other entities participating in the planning process contributed with feedback associated with the specific populations they served. These entities included HOPWA, HIV related medical care providers, social services providers, mental health and substance use providers, Medicaid representative, FDOH staff and HIV prevention stakeholders.

d. Collaboration with RWHAP Parts

The HIV CARE Council reviews needs and gaps in care across the HIV continuum and determine how to best meet the needs in a collaborative manner, and to engage in collaborative work. The HIV CARE Council includes both recipients RWHAP Parts A and B. The South Florida AIDS Education Center (AETC) attends meetings and assists with training needs.

The RWHAP Part A in collaboration with the prevention and care systems aims to: (a) streamline HIV prevention and care planning; (b) enhance the provision of prevention and care services in a seamless manner, and (c) create a coordinated response to the needs of persons at risk for HIV and PWH.

e. Engagement of Persons with HIV (PWH)

The most significant input in the plan was derived from the participation of PWH. PWH participated in all phases of local and state integrated planning. The HIV Council's structure has representation of PWH. PWH plays a critical role in the Planning, Needs Assessment, Community Awareness, and Priority Allocation. PWH also have active participation in the Quality & Evaluation Committee and Membership Committee.

Two PWH members of the HIV CARE Council joined the Florida Comprehensive Planning Network (FCPN) across the state of Florida. They contributed to the statewide planning of needs assessment activities, integrated planning, and also carry the voices of their local PWH community.

PWH also participated and collaborated with local CPP activities. Their input in the areas of prevention was critical to the development of the Integrated Plan prevention strategies and activities. PWH created and enhanced collaborative opportunities for community engagement. The design of the Integrated Plan was based on most current epidemiological data, direct input from PWH, input from the community at large, and persons at risk for HIV, service providers' surveys and consumer's needs assessment. The needs assessment provided information regarding the needs of PWH who are in care, and not in care, as well as people who are at risk for HIV. The HIV CARE Council, CPP and PWH, with the administrative and technical support from the RW Part A office, will collaborate in the implementation, monitoring and improvement process of the Integrated Plan. All HIV CARE Council meetings are open to the public.

Gaps in Stakeholders Participation in the Planning Process

Palm Beach County jurisdiction would benefit from the regular participation of representatives from state or local enforcement correctional facilities and hospital planning agencies. Efforts to involve these entities are taking place.

f. Priorities

The HIV CARE Council has established the following priorities: (a) Address health inequities and disparities; (b) Improve existent database systems and data sharing practices, and (c) Increase the use of social media platforms

g. Update to other strategic plans

See Table 4 Updated Palm Beach EHE Plan GY 2022

Table 4
EHE Work Plan GY 2022

Palm Beach County Ending the HIV Epidemic Work Plan GY2022			
Goal 1: By the end of GY2024, increase percentage of Newly Diagnosed Persons with HIV linked to care within 30 days to 95%			
GY2022 Objective: Link to care 85% of newly diagnosed PWH within 30 days			
Key Action Steps	Completion Date	Staff Partner Responsible	Progress Measures
Initiate ART within 72 hours of referral receipt for 5-6 persons with HIV who are newly diagnosed per week	February 28, 2023	Rapid Entry to Care (REC) Provider (s)	Tracking progress toward linking newly diagnose PWH at a rate of 60% within 72 hours, and an additional 25% within 30 days (estimated CY 2021=297)
Respond to HIV cluster detection efforts b linking individuals into care rapidly	February 28, 2023	CORE Teams (Community Outreach Response and Engagement Specialists) and FDOH Counterparts	Tracking progress toward linking newly diagnose PWH through HIV cluster detection efforts at a ra of 85% within 72 hours, and an additional 10% within 30 days
Link PWH who inject drugs to care throug SSPs	February 28, 2023	Syringe Services Provider(s)	Tracking progress toward linking newly diagnose PWH who inject drugs through Syringe Services Program efforts at a rate of 85% within 72 hours, and an additional 10% within 30 days.
Link PWH to care through Marketing Campaign	February 28, 2023	Marketing Partner, Social Media Temp	Tracking number of newly diagnosed PWH connected to care through Marketing campaign.
Provide transportation services for PWH who are transportation insecure	February 28, 2023	Transportation Provider, CORE Teams	Tracking progress toward linking newly diagnose PWH using transportation services at a rate of 60% within 72 hours, and an additional 25% within 30 days
Goal 2: By the end of GY2024, increase percentage of PWH who are engaged in care to 91%			
GY2022 Objective: Engage in care 10% of persons with HIV who were out of care in 2019			
Key Action Steps	Completion Date	Staff Partner Responsible	Progress Measures
Generate Data to Care List for 2022	February 28, 2023	Florida Department of Health	Information for out of care individuals received from the Florida Department of Health

Engage in care 9 persons with HIV who are out of care per week	February 28, 2023	CORE Teams (Community Outreach Response and Engagement Specialists) and FDOH Counterparts	Tracking progress toward engaging 90 persons with HIV who are out of care in GY quarter 2, 3, and 4 (GY 2022 n=180)
Initiate ART within 72 hours of referral receipt for 9 persons with HIV who are out of care per week	February 28, 2023	Rapid Entry to Care (REC) Provider(s)	Tracking progress toward initiating ART for 90 persons with HIV who are out of care per GY quarter (GY 2022 n=180)
Engage PWH who inject drugs in care though SSPs	February 28, 2023	Syringe Services Provider(s)	Tracking progress towards PWH who inject drugs that are engaged in care through Syringe Services Program efforts at a rate of 82%
Enroll PWH in expanded health insurance continuation program	February 28, 2023	Community Health Navigator(s)	Tracking number/percentage of PWH who have comprehensive health insurance coverage.
Provide transportation services for PWH who are transportation insecure	February 28, 2023	Transportation Provider, CORE Teams	Tracking progress toward 105 persons with HIV attending scheduled medical and support services appointments per quarter (GY 2022 = 210)
Provide employment counseling and vocational training for PWH who are unemployed & underemployed	February 28, 2023	Community Action Program	Tracking progress toward engagement in care for 21 persons with HIV who increase overall income level through counseling and training every quarter (GY22= 42)
Provide financial literacy skills development for PWH who are low incom	February 28, 2023	Community Action Program	Tracking progress toward viral suppression for 21 persons with HIV who increase overall income level through career counseling and financial literacy (GY 2022 = 42)
Provide STRMU and transitional housing services for PWH experiencing or at risk of homelessness	February 28, 2025	Housing Case Managers	Track progress toward increasing % of PWH who are stably housed to 85% (GY 2022 = 68%)
Goal 3: By the end of GY2024, increase viral suppression rate among persons with HIV to 90%			

GY2022 Objective: Increase viral suppression by 3% among persons with HIV and not virally suppressed			
Key Action Steps	Completion Date	Staff Partner Responsible	Progress Measures
Provide Telehealth adherence counseling t individuals who are in care but not virally suppressed	February 28, 2023	Tele-adherence Counselor	Tracking progress toward 10 new persons who become virally suppressed per GY quarter (GY 2022 = 20)
Provide transportation services for PWH who are transportation insecure	February 28, 2023	Transportation provider, CORE Tea	Tracking progress toward 10 new persons who become virally suppressed per GY quarter (GY 2022 = 20)
Provide employment counseling and vocational training for PWH who are unemployed & underemployed	February 28, 2023	Community Action Program	Tracking progress toward viral suppression for 21 persons with HIV who increase overall income level through career counseling and training every quarter (GY 2022 = 42)
Provide financial literacy skills developme for PWH who are low income	February 28, 2023	Community Action Program	Tracking progress toward viral suppression for 21 persons with HIV who increase overall income level through career counseling and financial literacy (GY 2022 = 42)
Provide STRMU and transitional housing services for PWH experiencing or at risk o experiencing homelessness	February 28, 2025	Housing Case Managers	Track progress toward increasing % of PWH who are stably housed to 85% (GY 2022 = 68%)

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

The contributing data sets and assessment are used to describe and identify how HIV impacts the jurisdiction, HIV trends of infection, affected populations, HIV prevalence, racial disparities and health inequities, and priority populations. The data also highlights gaps and resources. The analysis of the data informs the Integrated Plan strategies, goals and objectives as well as provide the basis to set priorities and resource allocation for prevention and care programs.

1. Data Sharing and Use

1.1 Data Use

The HIV epidemiological snapshot is based on aggregated HIV surveillance data. The Palm Beach County jurisdiction uses the Florida Department of Health (FDOH), Division of Disease Control and Health Protection, Bureau of Communicable Diseases HIV and AIDS surveillance data. HIV surveillance data consist of confidential confirmed HIV cases as well as HIV viral load laboratory results reported to the State of Florida as required by the FL Administrative Code Ann. R. 640-3.029. The surveillance information represents the most recent data available for Palm Beach County. The epidemiological profile data is released annually to the jurisdiction on an expanded excel workbook format with annual tabs for a five-year period. Data includes demographic information, HIV and AIDS diagnosis, deaths, HIV continuum of care, viral suppression, STIs, HBV, HCV and TB.

Additional data sources included the FDOH, Bureau of Community Health Assessment, Division of Public Health Statistics and Performance Management. This source offers a comprehensive database addressing community health conditions including HIV, STD, viral hepatitis, and TB. This data was accessed at FLHealth CHARTS (Florida Community Health Assessment and Resource Tool) set.[1] Other data sources used in this plan include America's HIV Epidemic Dashboard (AHEAD) https://ahead.hiv-gov and NCHHSTP AtlasPlus: https://www.cdc.gov/nchhstp/atlas/index.htm and AIDSVu database[2] is comprehensive in nature and informed the geographical distribution of HIV in Palm Beach County.

[1] https://www.flhealthcharts.gov/charts/CommunicableDiseases/default.aspx.
[2] https://aidsvu.org/local-data/united-states/south/florida/palm-beach-county/

The U.S. Census Bureau and the American Community Survey (ACS) were used to describe the social characteristics of the Palm Beach County population. The Ryan White HIV/AIDS Program (RWHAP) program data report (RSR) was used to describe socio-demographic characteristics of PWH.

1.2 Data Sharing

The Palm Beach County jurisdiction has a newly approved data sharing agreement with the Department of Health (approved in 2022). The agreement facilitates linkage to care activities through sharing active RWHAP Part A client data to FDOH and care status according to FDOH HIV surveillance data through access through the Linkage Module. The jurisdiction also has an agreement with HOPWA. This agreement facilitates the coordination of housing services. All Ryan White funded providers have data sharing agreements among themselves and with the whole Ryan White Part A network. These agreements facilitate communication among providers and coordination of services provision. The data sharing agreements are only valid with an active client coordinated services network agreement on file.

Profile of Palm Beach County, FL

The County of Palm Beach extends along Florida's Atlantic coast with an area of 2,383 square miles of land and water located in the southeast region of the state. Palm Beach County is the third most populated county (out of 67 counties) in Florida. West Palm Beach is the largest city in Palm Beach County. According to the Census Bureau estimates as of July 2021,[3] 1,497,987 people live in Palm Beach County. The population is up 1.9% from the 1.5 million who lived in Palm Beach County in 2017.

Palm Beach County Demographic Characteristics and Social Determinants of Health (SDH)

Among all residents of Palm Beach County, the number of females is slightly higher than the number of males. Sex at birth influences health outcomes, including reproductive and sexual health outcomes. The World Health Organization (WHO) also provides evidence that sex has an

effect on multiple disease risks, progression and outcomes through genetic, cellular, physiological and hormonal pathways[4].

Table 5

Percent of Palm Beach County Population by Sex in 2021

	Count	Percent
Total Population	1,492,191	100%
Male	728,189	48.8%
Female	764, 001	51.2%

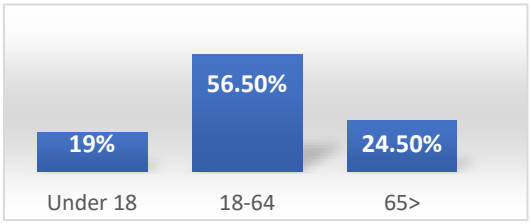
Palm Beach County Population by Age

The process of ageing is not only represented by biological changes (such as hearing loss, changes in vision, diabetes, and dementia) but is also associated with life transitions that may result in depression and other behavioral health issues.

The graph below depicts the Palm Beach County's population estimates by age (2021). Among Palm Beach County residents, 19% were under the age of 18 years. Those who were 18 years old and over made up 81 % of the population.

Figure 2

Percentage of Palm Beach County Residents by Age, 2021



Compared to the state, the Palm Beach County median age of 45 years is about 10% higher. As seen in the chart nearly one fourth of Palm Beach County residents are 65 years of age and older.

Population by Race and Ethnicity

The graph below shows the population by race and ethnicity in Palm Beach County in 2021. According to the 2021[5] to the U.S. Census Bureau, data show that over half of all Palm Beach

[4] https://www.who.int/news-room/questions-and-answers/item/gender-and-health 2021

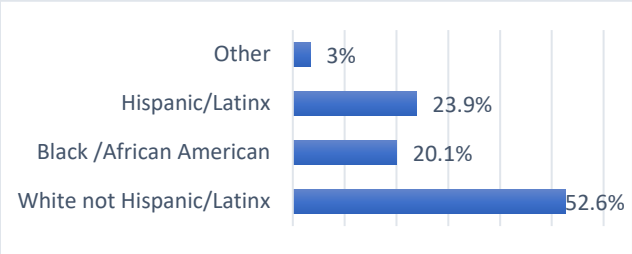
[5] U.S. Census Bureau (2021) https://www.census.gov/quickfacts/palmbeachcountyflorida

County residents were White (52.6%), while 20.1% were Black/African-American and 23.9% Hispanic/Latinx.

The data depicted in Figure 3 is significant given a body of evidence that shows that health disparities exist among certain racial and ethnic groups. The racial and ethnic health care disparities include difference in geography, lack of access to health coverage, communication issues between patient and health care provider or lack of access to a medical provider[6]

Figure 3

Percentage of Palm Beach County Population by Race/Ethnicity in 2021



Between 2017 and 2021, the Hispanic/Latinx population grew the most with an increase of 1.8 percentage points to 24% while the White population had a decrease of 2.5 percentage points to 52.6%.[7]

Nativity

Place of birth influences an individual's cultural preferences and language skills. Thus, nativity is important to gain understanding of health care needs. A quarter (25.4%) of the county residents were born outside of the United States. The majority of those were from Latin America and Caribbean islands, notably Haiti and Cuba.

[6]https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/racial_disparities_issue_brief.pdf

[7] https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/florida/county/palm-beach

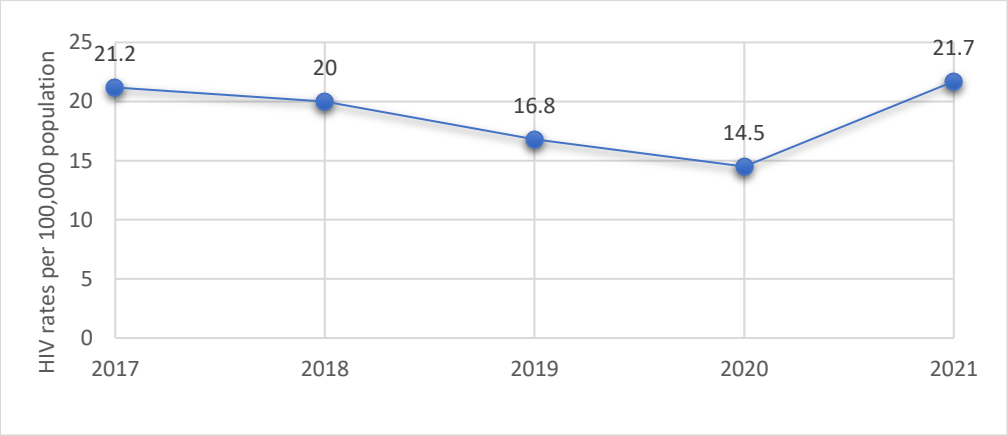
2. Palm Beach County Epidemiological Snapshot

New HIV Diagnoses

HIV diagnoses is one of the six indicators of the Ending HIV Epidemic. The goal is to reduce the number of new HIV diagnoses nationwide. In Palm Beach County the rate of new HIV diagnoses per100,000 population declined steadily from 2017 (21.2) to 2020 (14.5). The number of new HIV diagnoses ranged from a low 213 in 2020 to a high of 322 in 2021 with an average of 274 new diagnoses per year. It is important to note that data from 2020 must be interpreted with caution due to the impact of COVID-19 epidemic on access to HIV testing, care related services, and case surveillance activities.

Figure 4

Rates of New HIV Diagnoses per 100,000 Population by Year in Palm Beach County, 2021



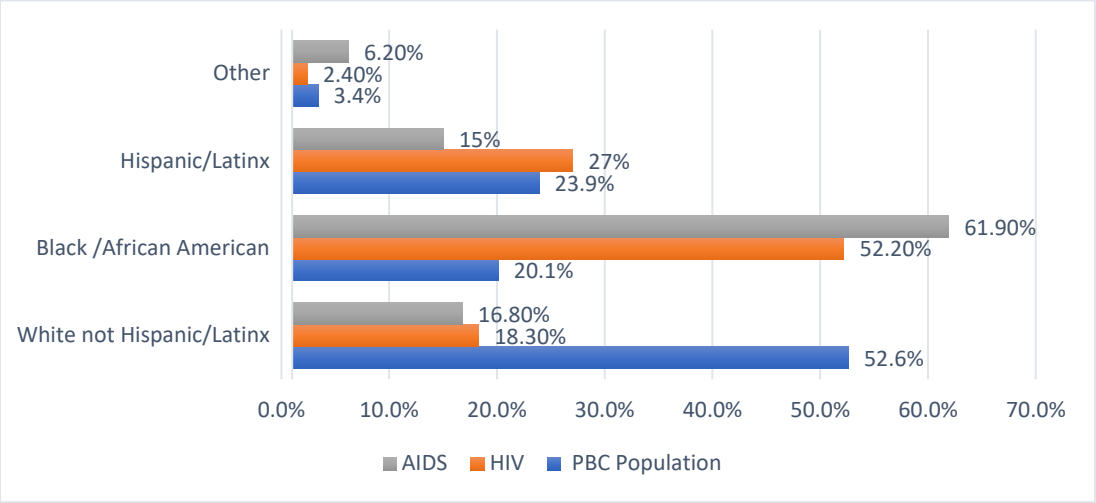
Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

New HIV Diagnoses by Race and Ethnicity

HIV disproportionately affects racial/ethnic groups. As depicted in the chart below, the greatest HIV epidemic burden manifests among Black/African-American and Hispanic/Latinx populations residing in Palm Beach County.

Figure 5

Percent of Newly Diagnosed with HIV and AIDS by Race and Ethnicity, 2021



Source: Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

In 2021, Fifty two percent (52.2%) of the new HIV diagnoses and 62% of new AIDS were among Blacks but they account for just 20% of the total Palm Beach County population. Hispanic/Latinx people are also disproportionately represented for new HIV diagnoses, with 27% of the new HIV diagnoses despite the Hispanic/Latinx population making up only 24% of the population. Although the Non-Hispanic White population represented 53% of the total population, they only accounted for 18% of new HIV diagnoses and 17% percent of new AIDS diagnoses.

New HIV Diagnoses by Sex at Birth and Gender

Over the last five years new HIV diagnosis have disproportionately impacted males residing in Palm Beach County. In 2021, HIV was diagnosed for 323 persons of whom 239 (74.2%) were male and 83 (25.8%) were females.

Table 6

Number of New HIV Diagnoses by Sex at Birth and Gender,2017-2021

Sex at Birth/Gender	Year				
	2017	**2018**	**2019**	**2020**	**2021**
Male	223	199	168	156	239

Female	76	90	77	57	83
Transgender male	0	0	0	0	0
Transgender female	0	1	0	2	1

Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

The rate of diagnosed cases of HIV per 100,000 in Palm Beach County by race and ethnicity is highest for Black persons (38/100,000) compared to White (7/100,000), and Hispanic/Latinx (13/100,000).

The percentage of Black persons with HIV diagnosed in 2021 was five times higher than the percentage of White persons and three times higher than the percentage of Hispanic/Latinx persons.

Furthermore, in the last five years (2017-2021) while the number of new HIV diagnoses decreased for Whites (-13.2) the percentage increased for Hispanic/Latinx (40.3%) and Black persons (3.7%)

Table 7

HIV Diagnoses and Rates among PWH in Palm Beach County by Race/Ethnicity, 2021

Race/Ethnicity	No	Percent	Rate	2017-2021 Percent Change
White	56	26.3%	7.1	-13.2%
Black	105	49.3%	38.3	3.7
Hispanic	46	21.6%	13.4	40.3%

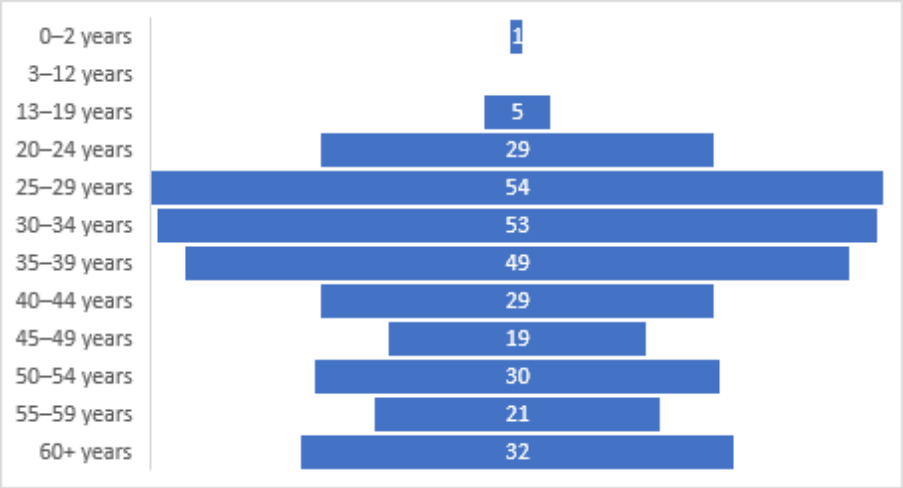
Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

New HIV Diagnoses by Age

In 2021, diagnoses of HIV were made for 323 persons in Palm Beach County. Among all persons a higher proportion of the diagnoses (16.8%) were for persons in the age ranges 25-29 and 30-34 (16.5%). Older adults (age 50+) comprised 25% of all HIV diagnoses.
Eleven percent of new HIV diagnoses were among youth in the age range 13-24. Women of child bearing ages 15-44 (WCBA) represented 16.5% of all new HIV diagnoses

Figure 6

Number of New HIV Diagnoses in Palm Beach County by Age Range, 2021



Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

HIV Prevalence

In 2021, 8,417 persons were living with HIV. In 2021, the prevalence rate per 100,000 population in Palm Beach County was 565.9 for all modes of HIV transmission and age groups.

Prevalence estimates vary by demographic groups. The HIV prevalence rate per 100,000 population by sex shows that the rate for males (7,62.1) was two times higher than the rate for females (381.6). There are also differences in HIV prevalence rates per 100,000 by race and ethnicity. The rate per 100,00 population for Black persons (1,745/100,000) was seven times higher than the rate for Whites (243.0/100,000) and four times than the rate for Hispanic/Latinx (417.7/100,000). Over the last five years (2017-2021) the percentage of HIV cases have decreased for White (-5.6) and to a lesser extent for Black persons (-0.6). However, the percentage has increased for Hispanic/Latinx persons. Overall, among adults/adolescents PWH, Blacks are disproportionately impacted by HIV. Blacks accounted for 58% of all HIV cases, and 63% of AIDS cases.

Table 8

Number, Percent and Rates of Adult HIV Cases by Race and Ethnicity, 2021

Race/Ethnicity	N	%	Rate	% Change 2017-2021
White	1,927	22.9%	243.0	-5.6
Black	4,875	57.9%	1,745.5	-0.6
Hispanic/Latinx	1,455	17.3%	417.7	12.3%

Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

HIV Prevalence among persons by Country/Territory of Origen

HIV prevalence among persons in Palm Beach County also vary by country or territory of birth. As depicted in TABLE 9, Haitians represent 20% of persons living with HIV and Latin born account for nearly 10 percent of PWH.

Table 9

Persons Living with HIV by Country/Territory of Birth, Palm Beach County, 2021

Country /Territory of Birth	No	Percent
United States	5,106	60.7%
Haiti	1,643	19.5%
Cuba	135	1.6%
Venezuela	26	0.3%
Puerto Rico	114	1.4%
Colombia	83	1.0%
Mexico	147	1.7%
Brazil	116	1.4%
Jamaica	58	0.7%
Other/Unknown	989	11.8%

Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

HIV Transmission Category-Cisgender Male Adult/Adolescent

Prevalence also varies by mode of transmission. In 2021, among cisgender males, the male-to-male sexual contact (MMSC) was the primary mode of exposure for HIV (58.8%) followed by heterosexual contact (32.2%), injection drug use (IDU) (4.6%) and MMSC/IDU (3.6%).

The trend over past five years (2017–2021) by exposure, shows a slight increase (3.3%) for MMSC and heterosexual (0.1%) and declines for MMSC/IDU (-22.6%), IDU (12.2%) and

heterosexual (23.3%). For Black cisgender women and cisgender men the predominant mode of transmission was heterosexual contact and for Whites and Hispanic/Latinx males was MMSC.

Table 10

Number and Percent of Cisgender Male Adult/Adolescent by Mode of Transmission, 2021

Cisgender Male by Mode of Transmission	Count	Percent of Total
MMSC	3,185	58.8%
IDU	252	4.6%
MMSC/IDU	199	3.6%
Heterosexual	1,764	32.2%
Other risk	70	1.3%

Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

Transmission Category Cisgender Women/Adult Adolescent

Heterosexual contact is the primary mode of exposure for HIV among cisgender women (89%) in 2021, followed by IDU (8.5%). Over the past five years (2017–2021), HIV diagnoses among cisgender women have slightly decreased for both IDU (-4.2) and heterosexual contact (-0.3) mode of transmission. Heterosexual contact was the predominant exposure mode for Black males and females, and for Hispanic/Latinx and White females. MMSC was the predominant mode of transmission for White and Hispanic/Latinx males.

Table 11

Number of PWH by Mode of Transmission, Race, Sex and Gender, 2021

	Males			Female			Transgender		
	White	Black	Hispanic	White	Black	Hispanic	White	Black	Hispanic
Heterosexual	104	1,387	242	240	2,036	279			
MMSC	1,309	1,014	791						
IDU	63	129	54	101	118	24	2	0	0
MMSC/IDU	86	68	42						

Sexual contact							5	7	4

Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

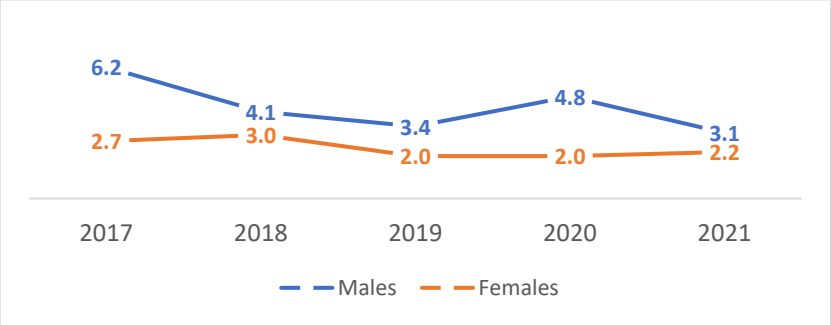
HIV/AIDS-Related Deaths

As depicted in Figure 7 the HIV-related death rate per 100,000 population by sex at birth has fluctuated over the last five years (2017-2021). Overall, in the last five years (2017-2021) the percentage of HIV-related death have decreased for males (-47.6%) and for females (-15.0%).

However, disparities are observed when HIV-related deaths rates per 100,000 population are compared between Black, White and Hispanic/Latinx populations. In 2021, HIV/AIDS-related death rate per 100,000 population for Black persons (9.3/100,000) was eight times higher than the rate for Whites (1.1/100,000) and 10 times higher than the rate for Hispanic/Latinx population (0.9/100,000).

Figure 7

HIV/AIDS-Related Death Rate by Sex and Year, 2017-2021



Source: Florida Department of Health Epidemiological Profile, Palm Beach County 2022

HIV Related Disparities and Social Determinants of Health (SDHD)

The demographic and socioeconomic characteristics of PWH residing in Palm Beach County who are receiving Ryan White services provides an additional insight on the health care needs of the community including of those who are risk for HIV and Persons with HIV (PWH).

Poverty and Income

In 2021, Palm Beach County 11.4% of all residents were living below the poverty level[8]. The annual median household income was $70,002. However, 36% of households had an income under 50,000 and 29% under 100,000.

Demographic information regarding poverty among PWH is only available for those who were receiving services through a Ryan White funded-agency. Higher levels of poverty are associated with a greater number of diagnoses and fewer PWH who engage in care and treatment. In 2021, 3,744 persons received Ryan White services.[9] More than half of (58%) of client's household income was below the 100% of Federal poverty level (below $13,590 for a family size of one).

Education and Language

Educational attainment is an indicator also associated with Social Determinants of Health. In Palm Beach County, 89.9% adults have earned a high school diploma and 39.7% obtained a Bachelor's degree. Thirty-two percent (32.1%) of the population speaks a language other than English at home. Among PWH receiving Ryan White services, most 46.2% completed education between 8th and 12th grade and 12.1% education level was 8th grade or less.[10]The majority (54.8%) of Ryan White recipients of services spoke English. Fourteen percent spoke Haitian Creole and 9.4% Spanish[11].

Housing/Homelessness

Homelessness is associated with increased rates of morbidity. Persons experiencing homelessness often experience poorer health outcomes due to a lack of routine medical care, neglected chronic conditions, and direct complications as a result of being unsheltered. From 2019 to 2020, Palm Beach County experienced an increase in persons experiencing homelessness by 1.2%. In 2021, most PWH receiving Ryan White services were living in stable housing, but 7.0% were living in temporary housing and 4.7% in unstable housing[12].

[8] https://censusreporter.org/profiles/05000US12099-palm-beach-county-fl/ACS 2021
[9] RSR Clinical Summary Report, 2021
[10] Provide Enterprise database,
[11] Data abstracted from Provide Enterprise Database, 2022
[12] RSR Clinical Summary Report, 2021

Health Insurance

According to the United States Census Bureau, 18.1% of people under the age of 65 years living in Palm Beach County in 2020 did not have health insurance[13]. There is evidence that people who lack health insurance are less likely to have a primary care provider, which often results in delayed care, less preventative health screenings, and worsening health conditions. In 2021, 30% of PWH receiving RW services also were lacking health insurance coverage.[14] For those who had public insurance, 22% had Medicaid, and 19% had Medicare. Other type of insurance coverage included private employer health insurance (21%) and private individual health insurance (5.7%)[15]. The Ryan White program assisted with insurance premiums, co-pays and deductibles.

Substance Use and Mental Illness

Substance use and mental illness as HIV co-occurring conditions can have a negative impact on health outcomes when left untreated. People with HIV are at higher risk for mental illness such as depression, anxiety and other mood disorders. In 2021, in Palm Beach County there were 142 PWH who had a history of mental illness condition (16.9 rate per 1,000 population) and 1,074 had a record of substance use (127.6 rate per 1,000 population).[16] As of December 31, 2021 there were 75 Ryan White clients receiving mental health Services (Source: RSR Clinical Summary). Persons experiencing mental health and/or substance use disorders are at increased risk for HIV and frequently lack access to HIV/STI education, prevention, and care services[17]. This prompts the need to expand partnerships with mental health and substance use providers regardless of funding source and facilitate access to PWH.

Transportation

Transportation is often cited in the literature as a barrier for clients attempting to access HIV care services and can lead to missed appointments, decreased medication adherence, and

[13] https://www.census.gov/quickfacts/fact/table/palmbeachcountyflorida/POP060210
[14] https://www.kff.org/report-section/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-ch
[15] RSR Clinical Summary,2021
[16] FDOH Epi Profile Tables for Palm Beach County.
[17] Mental Health and Substance Abuse Issues among People with HIV, Lessons from HCSUS https://www.rand.org/pubs/research_briefs/RB9300.html

disengagement from care[18]. The county's size and lack of affordable, safe, and timely transportation options are also factors contributing to barriers in accessing care. Ryan White clients with transportation needs can access bus passes. However, bus schedules do not meet the needs of clients. Persons attending a Town Hall indicated that transportation choices such as UBER should be available to clients.

Racism, Discrimination, HIV stigma and Medical Mistrust

Persons experiencing racism and discrimination are less likely to remain adherent to care and more likely to have poorer health outcomes[19].[20]There is evidence indicating that medical mistrust tends to be higher among Black/African-Americans. Seventy two percent of Ryan White clients receiving services in 2021 were Black/African American and 21% Hispanic/Latinx. This highlights the need for education capacity building for providers and faith-based leaders.

Nativity/Immigration

[21]Nativity is associated with disparities in access to health care[22]. Twenty eight percent of PWH in Palm Beach County were born outside of the United States, 20% were born in Haiti, and 7.4% were born in a Latino-American Country including the U.S. Territory of Puerto Rico and 0.7% born in Jamaica. This presents a need for increased cultural humility training to ensure health education, prevention, and care services are delivered in a culturally and linguistically appropriate manner.

Persons Age 50+ and LGBTQ+ Populations

Persons aged 50 and older living with HIV face several health challenges, including HIV-related and other comorbidities (e.g., cardiovascular and liver disease, neurocognitive impairment),

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[18] https://www.ajmc.com/view/for-persons-living-with-hiv-transportation-barriers-adversely-affect-hrqol

[19] Earnshaw VA, Bogart LM, Dovidio JF, Williams DR. Stigma and racial/ethnic HIV disparities: moving toward resilience. Am Psychol. 2013 May-Jun;68(4)

[20] Padilla M, Patel D, Beer L, et al. HIV Stigma and Health Care Discrimination Experienced by Hispanic or Latino Persons with HIV — United States, 2018–2020. MMWR Morb Mortal Wkly Rep 2022;71:1293–1300

[21] McGee SA, Claudio L. Nativity as a Determinant of Health Disparities Among Children. J Immigr Minor Health. 2018 Jun;20(3):517-528

[22] Black Nativity and Health Disparities: A Research Paradigm for Understanding the Social Determinant of Health, 2022

concurrent use of multiple medications (i.e., polypharmacy), oral health problems and mental health and substance use disorders. LGBTQ+ communities also have unique health challenges. LGBTQ+ communities have a higher prevalence for risk factors for breast cancer, cardiovascular disease and mental health conditions. This presents the need for capacity building to effectively

HIV Care Continuum

The HIV Care Continuum is a diagnosis-based model that shows each step of the continuum as a percentage of PWH as of the end of 2021. The HIV Care Continuum has three main stages: (1) HIV diagnosis, (2) in care, (3) retention in care, and (3) viral suppression. This model assists the Palm Beach County jurisdiction to identify issues and opportunities related to improving the delivery of services to PWH and prioritization of program activities across the entire continuum. Each stage has a performance indicator that falls under the responsibility of the integrated system of prevention and care.

The target for these indicators are set by the National HIV/AIDS Strategy (NHAS) and the National Strategy for Ending the HIV Epidemic (EHE). The diagnoses-based continuum of care informs the steps that can be taken to assist PWH with rapid access to care, retention and viral suppression.

Step 1: Diagnosis

In 2021, a total of 8,417 PWH were diagnosed and living with HIV in Palm Beach County regardless of where they were diagnosed.

Step 2: In Care

In 2021, 75% of PWH (N=6,348) were reported to be in care. In care is defined as having at least one documented VL or CD4 lab, medical visit, or HIV-related prescription in 2021.

Step 3: Retained in Care

PWH were considered to be retained in care if they had HIV-related care 2 or more times at least 3 months apart. Sixty-eight percent (N=5,764) were retained in care.

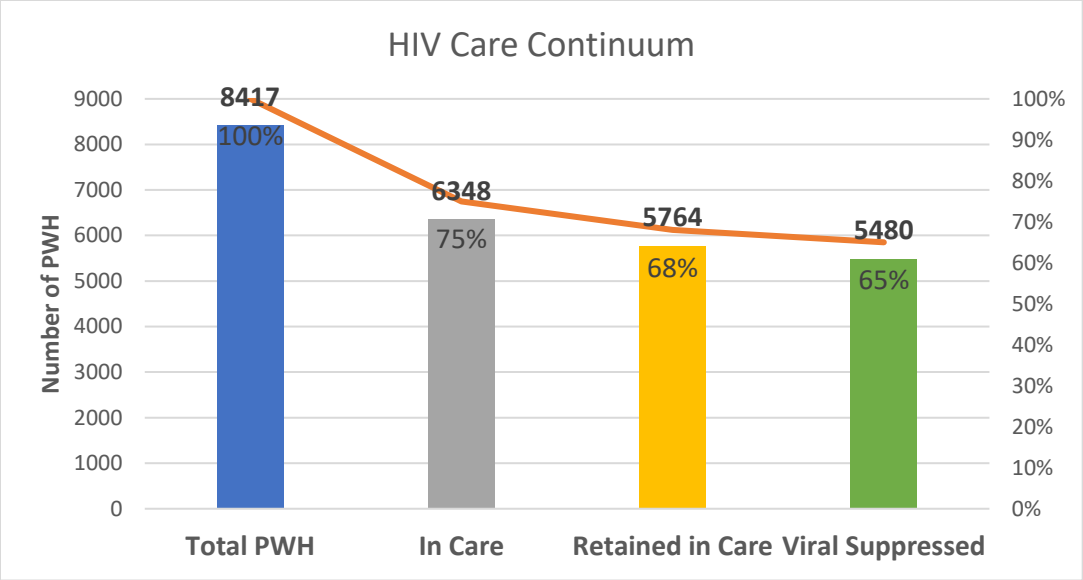
Step 4: Viral Suppression

In 2021, 65% of PWH (n 5,480) achieved viral suppression. Viral suppression is defined as the number of individuals whose most recent viral load test in 2021 is <200 copies/ml.

In 2021, health disparities were observed among PWH. A lower percentage of Blacks and Hispanic/Latinx were in care, retained in care and virally suppressed than their White counterparts.

Figure 8

Palm Beach County HIV Care Continuum, 2021



Source: FDOH Epi Profile, Palm Beach County, 2021

Viral load suppression for Blacks was below 65% percent. A low percentage of achieving viral load suppression is associated with decrease survival and increased HIV transmission rates. The following PWH populations had the lowest percent of viral load suppression.

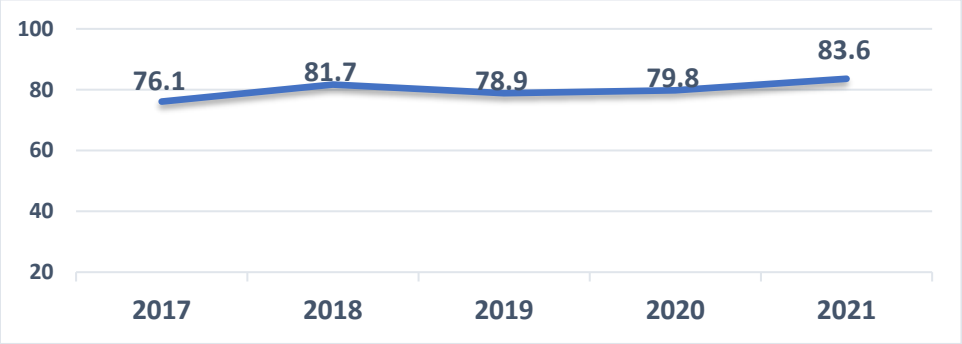
1. By Race/Ethnicity: Black (60.9%)
2. By Gender Identity: Transgender women (63.1%)
3. By Transmission Category: Black cisgender male IDU (48.8$); Hispanic/Latinx cisgender male IDU (44.4%)
4. By Age: (a) Women of Child Bearing Age (WCBA) 15-44 (59.1%); (b) Age range 40-44 (63.1%)
5. By Country of Birth: (a) Haiti (56.0%); Mexico (53.1%)

Retention in care and HIV viral load suppression is the primary treatment goal. In 2021, there were differences by race/ethnicity for PWH who were retained in care with viral load suppression. Among Whites who were retained in care, 94.3% achieved viral load suppression, compared to 85.7% of Blacks and 93.4% of Hispanic/Latinx.

Linkage to Care

Linkage to Care is a critical step to engagement in HIV treatment. Linkage to Care is a critical step to engagement in HIV treatment for newly diagnosed individuals

Figure 9
Percent of PWH Linked to Care Within 30 days (2017-2021)



Source: FDOH Epi Profile, Palm Beach County, 2021

Rapid linkage to treatment shortens the time to achieve viral load suppression. The data above represents the percentage of HIV diagnoses during the past five years (2017-2021) the percentage of PWH who received medical care within 30 days of receiving a diagnosis. Since 2019, the percentage of PWH who are linked to care within 30 days of receiving diagnosis has been steadily increasing.

The Palm Beach County jurisdiction is committed to working in collaboration with community partners, Florida Department of Health (FDOH), and health care providers to improve performance at every step of the continuum. Services are in place to rapidly link persons with a positive HIV test to care, such as the Test and Treat Clinic at the Florida Department of Health. However, expansion of services and new strategies to engage persons at risk for HIV are required to address disparities and health inequities.

Comorbidities

Reports of communicable and sexually transmitted diseases is important for the purpose of planning and assessment of prevention activities. Most common comorbidities that place persons at risk for HIV include Viral Hepatitis and Sexual Transmitted Infections (STIs). These comorbidities also present great risks to the health of PWH. PWH with underlying liver conditions are at risk for severe disease from Hepatitis A and Hepatitis B virus (HBV). In 2020, the CDC recommended that all PWH be vaccinated against Hepatitis A and HBV. Hepatitis B and HIV are bloodborne viruses transmitted primarily through sexual contact and injection drug use. A high proportion of adults at risk for HIV infection are also at risk for HBV infection. Hepatitis C (HCV) is a bloodborne virus transmitted through direct contact with the blood of a person with HCV. Co-infection with HIV and HCV is most common among persons who inject drugs (PWID)[23].

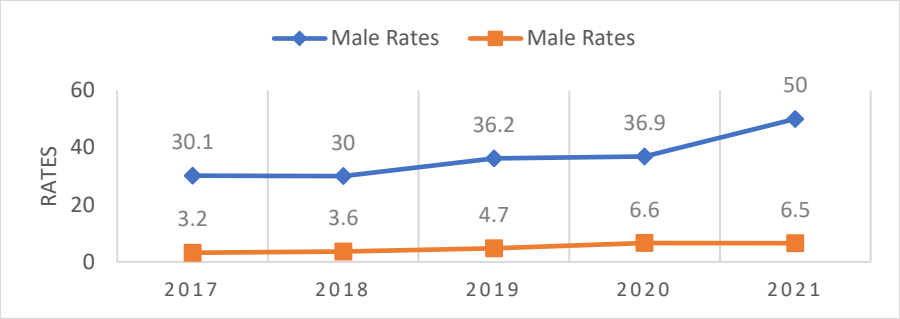
Over the last five years (2017-2021), the overall rates for hepatitis B (HBV) and hepatitis C (HCV) have declined in Palm Beach County. On the other hand, STIs such as early syphilis, gonorrhea and chlamydia rates have been steadily increasing in Palm Beach County over the same period of time. Increases in sexually transmitted diseases is of concern. Persons who get syphilis and gonorrhea are at a high risk for contracting HIV.[24] In the last five years (2017-2021), increases in diagnoses rates per 100,000 population for syphilis and gonorrhea were disproportionately greater among men. Early syphilis among males were sevenfold higher than females, gonorrhea rates were almost two times higher for males (171.8/100,000) than for females (99.1/00,000). The rate for chlamydia among women was higher (504.6 per 100,000) than for men (304.1/100,000).

Figure 10

Rates of Early Syphilis among Men and Women, Palm Beach County (2017-2021)

[23] Yehia BR, Herati RS, Fleishman JA, Gallant JE, Agwu AL, Berry SA, et al. Hepatitis C virus testing in adults living with HIV: a need for improved screening efforts. PLoS ONE 2014;9(7):e102766. https://doi.org/10.1371/journal.pone.0102766external icon

[24] Cohen MS, Council OD, Chen JS. Sexually transmitted infections and HIV in the era of antiretroviral treatment and prevention: the biologic basis for epidemiologic synergy. Journal of the International AIDS Society 2019, 22(s6)e25355.

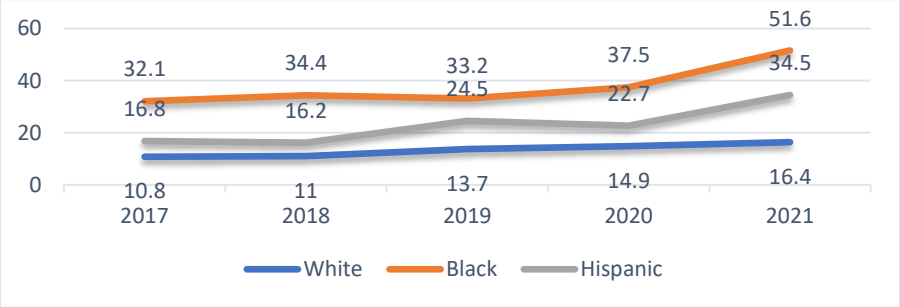


Source: FDOH Epi Profile, Palm Beach County, 2021

In 2021, disparities are also observed when comparing rates of early syphilis by race and ethnicity. Increased rates are noted among Blacks and Hispanic/Latinx.

Figure 11

Rates of Early Syphilis per 100,000 by Race/Ethnicity (2017-2021), Palm Beach County



Source: FDOH Epi Profile, Palm Beach County, 2021

Table 12

Number of Gonorrhea, Chlamydia and TB cases, Palm Beach County, 2021

	Males	Females
Gonorrhea	1238	762
Chlamydia	2,191	3,869
TB	25	16

Source: FDOH Epi Profile, Palm Beach County, 2021

Co-occurring conditions with HIV

Co-occurring conditions with HIV have also prevention and care implications. Among PWH, there were 41 persons with viral hepatitis, and 451 with STIs.

Table 13

Rates of Co-occurring Conditions with HIV per 1,000 PWH, Palm Beach County, 2021

Co-occurring Conditions	Count	Rate
Hepatitis B	15	1.8
Hepatitis C	26	3.1
TB	4	0.5
Early Syphilis	165	19.6
Gonorrhea	147	17.5
Chlamydia	139	16.5

Source: FDOH Epi Profile, Palm Beach County, 2021

HIV Transmission Clusters and Networks

The Florida Department of Health (FDOH) takes the lead in the detection and response to rapidly growing HIV transmission clusters and networks. The FDOH routinely conducts surveillance and conducts monthly analysis to detect rapidly growing molecular clusters and time-space clusters of public health significance. FDOH uses data and laboratory results collected through routine public health surveillance. Cluster network analyses are conducted using data from point-of-care HIV-1 genotypic resistance testing to identify genetic (molecular) links of similar virus strains by comparing those with similar HIV genetic sequences; those data are then used to identify networks of recent and rapid transmission for prevention and linkage-to-care interventions.

HIV Testing and Knowledge of HIV Status

Table 14

Knowledge of HIV Status in Palm Beach County, 2017-2019

Year	Percentage
2017	87.7
2018	87.4
2019	87.6

The knowledge of status is defined as the estimated percentage of people with HIV status who have received an HIV diagnosis. The America's HIV Epidemic Analysis (AHEAD) dashboard reports[25] the percentage of persons who have knowledge of their HIV status

[25] https://ahead.hiv.gov/data

for each year in a three-year period of time. On average, 87.5% of the population in Palm Beach County know if they have HIV.

Knowledge of one's HIV status leads to changes that can improve health and prevent HIV. The NHAS goals aims for 95% of people having the knowledge of their HIV status.
The most recent report of the Florida Behavioral Risk Factor Surveillance (FBRFS) for the years 2017-2019 released by the Florida Department of Health indicated that 1,064 residents of Palm Beach County completed the FBRFS survey[26]. Overall, 44% of male adults and 46% of female adults had ever been tested for HIV. Overall, a greater percentage of adults Black males (62.7%) had ever been tested for HIV in comparison to Hispanic/Latinx (53.8%) and Whites (36.1%).

Table 15

Percent of Adults Who Have Ever Been Tested for HIV by Sex, Race and Ethnicity (2017-2019), Palm Beach County

Race/Ethnicity	Male	Female
White	36.1.4%	36.4%
Black	62.7%	74.5%
Hispanic	53.8%	48.6%

Source: Florida Behavioral Risk Factor Surveillance, 2017-2019

3 HIV Prevention, Care and Resource Inventory

The following section provides a comprehensive list of agencies providing HIV care and prevention services including HRSA, Community Health Centers programs, HOPWA, and SAMSHA funded services. The components of the inventory include but are not limited to federal and statewide public and private funding sources for HIV prevention, care, and treatment services; the dollar amount and the percentage of the total available funds for each funding source; program or service delivery; and the impact on each step of the Palm Beach County HIV Continuum.

[26] https://www.floridahealth.gov/statistics-and-data/survey-data/behavioral-risk-factor-surveillance-system/2019county/Palm Beach BRFSS

The purpose of this inventory is to provide a snapshot of HIV prevention and patient care funding available in Palm Beach County. The inventory facilitates the assessment of HIV prevention and patient care resources, across the continuum of care.

a. Strengths and Gaps

There is evidence indicating that HIV care engagement is strongly associated with viral load suppression. The availability of ancillary services is critical to support HIV medical services. The lack or limited support services is associated with adverse clinical outcomes[27]. Palm Beach County offers to PWH participating in Ryan White Funded program a robust range of HIV-health care related services including ancillary services. Prevention resources are available for persons at risk for HIV. Additionally, there is a large network of health care providers not funded by RW serving PWH.

b. Approaches and Partnerships

Disparities in HIV care engagement and viral load suppression requires defining new strategies to reach out to Black and Hispanic/Latinx populations, and MMSC of all racial and ethnic backgrounds. In order to maximize the quality of health and support services for PWH and person at risk for HIV, there is a need to identify new strategies and approaches to address social determinants of health, stigma, discrimination and barriers to access health care. One strategy is to increase the number of new partnerships. Community engagement activities (e. g. Town Hall meetings) and collaborative work with services providers regardless of funding sources can lead to identify new partners and strengthen the existent continuum of care. Involvement of PWH and priority populations is critical in the development of new partnerships and strengthening of existent ones. PWH and at risk for HIV need to be part of health care teams thus enhancing peer support necessary to remove barriers and engage priority populations in care. Capacity building and education of providers requires strengthening partnership with Academic Institutions, and AETC. Identification of new partners, collaboration and integration of services across prevention and care areas will be needed to improve overall health outcomes of PWH residing in Palm Beach County.

[27] Monroe AK, Lesko CR, Chander G, Lau B, Keruly J, Crane HM, Amico KR, Napravnik S, Quinlivan EB, Mugavero MJ. Ancillary service needs among persons new to HIV care and the relationship between needs and late presentation to care. AIDS Care. 2019 Sep;31(9):1131-1139.

Table 16

HIV Prevention, Care and Treatment Resources, GY 2022

Funding Source	Funding amount	Percent of the total funding	Services Delivered/Priority Population Served	Impact on HIV Care continuum steps
HRSA EHE Ryan White Part A	1,396.646	71%	Linkage services for PWH who are either newly diagnosed, or are diagnosed but currently not in care, to essential HIV care and treatment and support services.	Linkage to Care
HRSA EHE Primary Care HIV Prevention Florida Community Health Centers, Inc. (West Palm Beach)	276,697	14%	Expand access to medication to prevent HIV (including PrEP and related services), connect people to care, and ensure care services are well coordinated.	Diagnose, Linkage to Care
HRSA EHE Primary Care HIV Prevention FoundCare	268.470	14%	Expand access to medication to prevent HIV including PrEP related services, link people to care and ensure coordination of services.	Diagnose, Linkage to Care
HRSA RW Part A MAI funded service providers	**753,835**	**100%**	**Support Services for racial/ethnic minorities who are either newly diagnosed, or are diagnosed but currently not in care, to essential HIV care and treatment and support services.**	**Linked to Care In Care Retention Viral Suppression**
FoundCare	147,050.00	23%	Early intervention services	Linkage to Care
FoundCare	180,138.00	28%	Medical case management	Retention in Care
FoundCare	39,489.00	6%	Non-Medical case management	Retention in Care
FoundCare	97,966.00	15%	Psychosocial support services	Retention in Care
HCSEF	154,438.00	24%	Early Intervention Services	Linkage to Care

HCSEF	60,066.00	9%	Medical Case Management	Retention In care, Viral Suppression
HCSEF	27,822.00	4%	Non- Medical Case Management	Retention in Care
HCSEF	46,866.00	7%	Psychosocial Support Services	Linkage to Care
HRSA RW Part A Funded providers	**6,461,689**	**100%**	**Health care and support services to facilitate retention in care and viral suppression for PWH**	**Retention in Care Viral Suppression**
AHF	9,829.00	0.14%	AIDS Pharmaceutical Assistance	Retention in Care/Viral Suppression
AHF	75,642.00	1.09%	Early Intervention Services	Linkage to Care
AHF	26,343.00	0.38%	EFA-Prior Authorizations	Retention in Care
AHF	4,930.00	0.07%	Food Bank/Nutritional Supplements	Retention in Care
AHF	51,057.00	0.73%	Laboratory/Diagnostic Testing	Retention in Care
AHF	157,442.00	2.26%	Medical Case Management	Retention in Care
AHF	33,102.00	0.48%	Non- Medical Case Management	Retention in Care
AHF	2,632.00	0.04%	Medical transportation	Retention in Care
AHF	80,070.00	1.15%	Outpatient/Ambulatory Medical Care	Diagnose, Retention/Viral Suppression
AHF	7,410.00	0.11%	Continuous Clinical Quality Management Program	Clinical Quality Management
Compass	100,088.00	1.44%	Early Intervention Services	Linkage to Care
Compass	70,754.00	1.02%	Emergency Financial Assistance	Retention in Care
Compass	446,445.00	6.42%	Health Insurance	Retention in Care
Compass	330,881.00	4.76%	Medical Case Management	Retention in Care
Compass	20,959.00	0.30%	Medical Transportation	Retention in Care
Compass	100,049	1.44%	Mental Health Services	Retention in Care
Compass	153,150.00	2.20%	Non -Medical case Management	Retention in Care
Compass	166.058.00	2.39%	Emergency Housing Services	Retention in Care
Compass	15,000.00	0.22%	Continuous Quality Management	Clinical Quality Management
FoundCare	90,521.00	1.30%	Early Intervention Services	Linkage to Care
FoundCare	144,926.00	2.08%	Food Bank/Home Delivered Meals	Retention in Care
FoundCare	1,225,072	17.62%	Health Insurance	Retention in Care
FoundCare	92,477.00	1.33%	Laboratory Diagnostic Testing	Diagnose
FoundCare	548,043.00	7.88%	Medical Case Management	Retention in Care
FoundCare	36,217.00	0.52%	Medical Transportation	Retention in Care
FoundCare	22,913.00	0.33%	Mental Health Services	Retention in Care

FoundCare	274,999.00	3.95%	Non- Medical Case Management	Retention in Care
FoundCare	73,398.00	1.06%	Oral Health Care	Retention in Care
FoundCare	66,609.00	0.96%	Outpatient/Ambulatory Medical Care	Diagnose/Retention/Viral Suppression
FoundCare	15,000.00	0.22%	Continuous Clinical Quality Management Program	Clinical Quality Management
HCSEF	99,570.00	1.43%	Early Intervention Services	Linkage to Care
HCSEF	450,000.00	6.47%	Health Insurance	Retention in Care
HCSEF	72,913.00	1.05%	Medical Case Management	Retention in Care
HCSEF	27,888.00	0.40%	Medical Transportation	Retention in Care
HCSEF	25,212.00	0.36%	Non- Medical Case Management	Retention in Care
HCSEF	296,686.00	4.27%	Specialty Outpatient Medical Care	Diagnose, Retention/Viral Suppression
HCSEF	15,000.00	0.22%	Continuous Quality Management	Clinical Quality Management
Health Department	148,348.00	2.13%	Early Intervention Services	Linkage to Care
Health Department	311,039.00	4.47%	Oral Health Care	Retention in Care
Health Department	7,594.00	0.11%	Continuous Quality Management	Clinical Quality Management
Legal Aid	280,009.00	4.03%	Legal Aid	Retention in Care
Legal Aid	40,488.00	0.58%	Non-Medical Case Management	Retention in Care
Legal Aid	6,205.00	0.09%	Continuous Clinical Quality Management	Clinical Quality Management
Monarch	57,769.00	0.83%	Early Intervention Services	Linkage to care
Monarch	3,578.00	0.05%	Continuous Quality Management	Clinical Quality Management
Midway Specialty Care	25,538.00	0.37%	Laboratory Diagnostic testing	Diagnose
Midway Specialty Care	20,063.00	0.29%	Outpatient/Ambulatory Medical care	Diagnose/Retention/Viral Suppression
Midway Specialty Care	22,662.00	0.33%	Non-Medical Case Management	Retention in Care
Midway Specialty Care	3,683.00	0.05%	Continuous Clinical Quality Management	Clinical Quality Management
Poverello Center	101,413.00	1.46%	Food Bank/Home Delivery Meals	Retention in Care
Poverello Center	4,015.00	0.06%	Continuous Clinical Quality Management	Clinical Quality Management
HOPWA (HUD)	**3,203.00**	**100%**	**Housing assistance and related support services for low-income persons with HIV/AIDS and their families.**	**Retention in Care**

HIV Prevention Funded Agencies CDC High Impact prevention.	**1,055,000.00**	**100%**	**Comprehensive High Impact for Prevention, PrEP assessment, Social Media Marketing, Risk Reduction Counseling, Condom Distribution. Target populations at risk for HIV, priority populations.**	**Diagnose, Linkage to Care**
Treasure Coast Health Council dba HCSF	200,000	20%	HIV Testing and Linkage to services for priority populations	Diagnose/Linkage to Care
Compass	225,000	21%	HIV Testing, HIV Prevention Education	HIV, Testing, Linkage to Care, HIV Prevention
FoundCare	325,00	30%,	HIV Testing, Linkage to Care. Services target priority populations	Prevent: HIV Education, PrEP, Assessment, Social Media Marketing, Risk Reduction Counseling, Condom Distribution
ARTAS FoundCare	150,000	14%	HIV Testing, Linkage to Care. Services target priority populations	Prevent: HIV Education, PrEP, Assessment, Social Media Marketing, Risk Reduction Counseling, Condom Distribution
TOPWA Family First	155,000.	15%	HIV testing, linkage to Care for pregnant women	Prevent: HIV Education, PrEP, Assessment, Social Media Marketing, Risk Reduction Counseling, Condom Distribution
Ryan White Part B	731,137.00	100%	Healthcare and support services for PWH	Retention, viral load suppression
Ambulatory Outpatient Health Care Services	475,349.00	65%	Outpatient Medical services for PWH	Retention, viral load suppression
Medical Nutrition Therapy	196,602.00	27%	Medical Nutrition for PWH t	Retention, viral load suppression
Medical Transportation	10,000.00	1.%	Service to facilitate access to care	Retention, viral load suppression
Clinical Quality Management	37,500.00	5.%	Continuous Clinical Quality Management Program	Clinical Quality Management

Planning and Evaluation	12,500.00	2%	Planning and Evaluation	Planning and Evaluation
State General Revenue	730,96500	100%	Healthcare and support services for PWH	Retention, viral load suppression
Ambulatory Outpatient Health Care Services	84,500.00	11.56%	Outpatient Medical services for PWH	Retention, viral load suppression
Mental Health Services	94,848.00	12.97%	Outpatient Mental Health services for PWH	Retention, viral load suppression
Treatment Adherence Services	94,848.00	29.63%	Support services to promote adherence to treatment for PWH	Retention, viral load suppression
Referral for Health Care and support services	216,606.00	2.98%	Facilitates access to health care and support services	Retention, viral load suppression
Food Bank/home delivery meals	21,844.00	7.78%	Services for PWH with food insecurity	Retention, viral load suppression
Clinical Quality Management	56,887.00	7.7%	Continuous Clinical Quality Management Program	Clinical Quality Management
Oral health Services	161,432	22%	Oral Health Services for PWH	Retention, viral load suppression
Patient Care Network	570,403.00	100%	Healthcare and support services for PWH	Retention, viral load suppression
Ambulatory Outpatient Health Care Services	398,149.00	69.80%	Outpatient Medical services for PWH	Retention, viral load suppression
Referral for Health Care and support services	131,049.00	22.97%	Facilitates access to health care and support services	Retention, viral load suppression
Clinical Quality Management	41,205.00	7.22%	Continuous Clinical Quality Management Program	Clinical Quality Management
SAMHSA	445,987.00	100%	Services Integration	Linkage, retention, viral load suppression
CDC School Board of Palm Beach County	360,000.00	15%	HIV prevention, Health care services, referral	Diagnose, HIV Prevention education, referral for HIV testing

4 HIV Community Needs Assessment

In 2020-2021, Palm Beach County jurisdiction designed a survey to: (a) identify and assess existent services and needs across the HIV prevention and care continuum; (b) enhance the quality of services for persons at risk for HIV and PWH, and (c) identify barriers that hinder access to services. The survey was grouped into sections: Demographics, HIV prevention for persons at risk for HIV, HIV medical care and support services and COVID-19 impact on HIV services. A total of 397 surveys were completed by the end of the survey period.

Demographics

Survey participants were diverse. The sample was stratified by race and ethnicity using the Florida Department of Health epidemiological profile for the size of population for each demographic. Participants included those receiving services from both Ryan White-funded and not funded providers who ever received prevention or care services.

Figure 12

Percentage of Palm Beach County HIV Community Needs Assessment Survey Participants by Age, Race and Ethnicity, 2020-2021

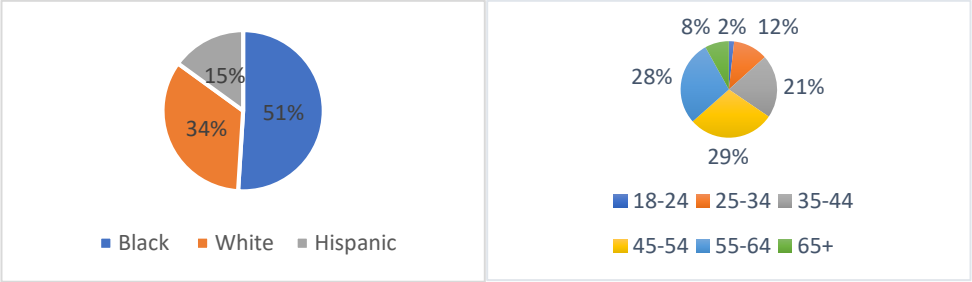
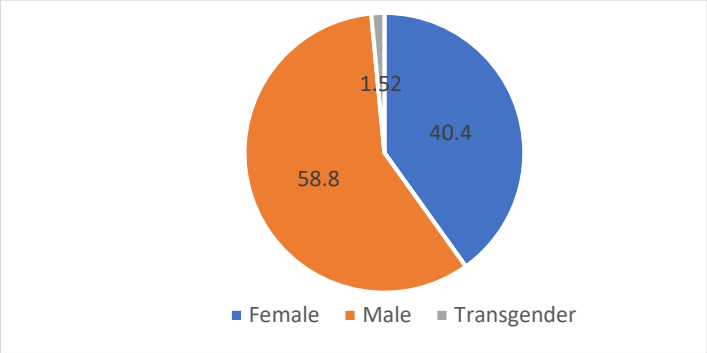


Figure 13

Percentage of Palm Beach County HIV Community Needs Assessment Survey Participants by Gender, 2020-2021



Survey participants also were diverse by sexual orientation. Sixteen percent identified themselves as bi-sexual, 24% percent as gay or lesbian and 60% as heterosexual. Of all participants (70%) spoke English, 19% French or Creole and 11% Spanish.

Services for Persons with HIV and for persons at risk for HIV

Survey participants were asked if they had received services listed on the table below within the last twelve months.

Table 17

Services for Persons at High Risk for HIV and PWH

Services Received	Response
STD Testing including Hepatitis	30.19%
Condom or safer sex kits	70.91%
Safer injection kits	9.97%
Information on syringe access programs	9.42%
Information on HIV counseling for pregnant women	9.70%
Partner services	11.08%
Information about disclosure of HIV	19.39%
Information about PrEP	18.56%
None of the above	14.40%
Does not apply	10.80%

Less than half (30%) of participants were tested for STDs and viral hepatitis. The majority of participants (71%) were offered condoms or safe sex kits. The percentage of participants receiving information about HIV counseling for pregnant women, and access to syringe programs was under 10%. Nearly twenty percent of participants reported receiving Information about PrEP and 19.39% information regarding disclosure of HIV status.

HIV Testing by Location

Sixty five percent (65%) of survey participants had an HIV test within the last 12 months. More than half (58%) of the participants had an HIV test at the doctor's office. The next most cited site for HIV testing (32%) took place at a public/community health center. HIV testing at hospital setting: 3% received an HIV test at an inpatient hospital unit and 1.79 percent at an emergency

department. Eighty-nine percent reported receiving an HIV positive test result, 10 % indicated they did not know the test result.

Table 18

Survey Responses to Where Participants Tested for HIV

Testing Site	Responses	N
Doctor's Office	58.06%	227
Public/community health center	31.97%	125
Emergency Department	1.79%	7
Inpatient at a hospital	2.81%	11
Health fair	0.77%	3
Testing Van	1.02%	4
Community Organization	0.51%	2
Pharmacy	0.00%	0
Prenatal care	0.00%	0
At labor and delivery in the hospital	0.00%	0
At home	0.00%	0
Jail or prison	0.51%	2
Another place listed (specify)	3.84%	15

Services Needed to Stay in HIV Care and Treatment and Achieve Viral Load Suppression

To ensure that services provided through the Ryan White HIV/AIDS Program (RWHAP) are appropriate and contribute to improving health outcomes for PWH, the survey assessed met and unmet service needs for PWH residing in Palm Beach County. Data collected from this survey was intended to help the Palm Beach County jurisdiction and planning stakeholders to determine the best ways to allocate funds and resources.

Most of survey participants (81%) reported having 2-5 visits with their medical provider while 2% did not have any visits. Ninety-eight percent (98%) reported taking antiretroviral medication at the time of the survey (2020-2021). See Table 17

Table 19

HIV Services Used, Needed and not Needed by PWH

Services	I have used this service in the last 12 months	I need this service but I did not get it	I do not use this service or I did not need this service	N	Weighted Average

Oral Health (Dental Services)	24.32%	45.41%	30.27%	370	2.06
	90	168	112		
Housing Services	7.61%	12.77%	79.62%	368	2.72
	28	47	293		
SNAP Benefits	37.84%	11.62%	50.54%	370	2.13
	140	43	187		
Emergency Financial Assistance	5.41%	11.35%	83.24%	370	2.78
	20	42	308		
Specialty Medical Care (Oncology, Dermatology, Cardiology)	29.19%	10.27%	60.54%	370	2.31
	108	38	224		
Medical Case Management	66.12%	8.94%	24.93%	369	1.59
	244	33	92		
Food Bank/Home Delivery Meals	21.08%	8.42%	70.00%	370	2.49
	78	31	259		
Social Security (SSI Benefits)	23.72%	7.82%	68.46%	371	2.45
	88	29	254		
Medical Transportation	14.32%	7.57%	78.11%	370	2.64
	53	28	289		
Mental Health Therapy Counseling	8.65%	7.57%	81.08%	370	2.75
	32	28	310		
Medical Nutrition Therapy (Nutritional Supplements, Nutritionist)	11.89%	7.03%	81.08%	370	2.69
	44	26	300		
Legal services	0.04	6.56%	89.34%	366	2.85
	15	24	327		

Eleven percent indicated that in the last twelve months needed medical care but did not get it. The most reported needed service but unable to get it was oral health (45%) while 30 percent of respondents reported not needing and not using oral health care services.

Over 10 percent of participants indicated that the following services were needed but they were unable to get it: housing, services, SNAP benefits, emergency financial assistance and specialty medical care (oncology, dermatology and cardiology).

Assessment of Barriers

Most (86%) of survey respondents indicated they had received services needed. Not receiving services needed was primarily due to the COVID-19 pandemic. Some of the services that had limited access was oral health and specialty care.

Table 20

Barriers to access HIV Services

Barrier	Responses	N
I get the services I need	86.11%	310
Can't afford them	5.83%	21
Don’t know where to go	3.33%	12
I don’t have insurance	1.94%	7
I don't know where to go where they speak my language	0.28%	1
I have responsibilities that prevent me from going (caring for children or family members, work, etc.	0.28%	1
I don’t want to go	0.28%	1
I do not have transportation to get there	2.22%	8
Depression	0.56%	2
Denial	0.56%	2
Another reason not listed	4.44%	16

The survey assessed barriers to HIV testing, linkage to care and HIV treatment. Common barriers cited in the literature include: mental health illness, substance use, HIV-related stigma, access to health insurance, ability to pay co-pays and deductibles, and lack of transportation.

Mental Health and Substance Use

Among survey participants 18% had experienced depression, 15% anxiety and 5% had been diagnosed with bi-polar disorder. However, 83% of participants indicated they did not need mental health services. Ten percent (10.4%) reported needing mental health services and receiving them. Less than 10% reported needing services and being unable to get them.

The majority (92.9%) of participants indicated that they did not need substance use (including drug and alcohol use) services. Four percent needed and received substance use services and 3 percent needed the services but they did not get it.

HIV Related Stigma

HIV-related stigma is a challenge for PWH. Among those who participated in the survey, 77% of respondents indicated experiencing HIV-related stigma. Using a Likert scale, participants graded their fears of rejection upon other people finding out they had HIV. Seventy-seven percent (77%) expressed having some degree of fear associated with others finding out their HIV status. The Likert scale stigma range extended from: no fear (23%), slightly (26%), moderately (32%), very (10%) to extremely (9%).

Transportation

Some of the barriers associated with transportation include living too far from a bus line, or having to schedule transportation needs within a specific time in advance. The majority (90%) of survey participants claimed that they did not miss a medical appointment due to a transportation related problem.

Access to Health Insurance

Most respondents reported having access to health insurance. The percentage of uninsured was 4%. Furthermore, when participants were asked if they were unable to get medical care because they could not afford co-pays and deductibles, 89% responded not having that issue while 8% reported they were unable to receive medical care due to not being able to afford co-pays and insurance deductibles.

Services for PWH upon Release from Jail or Correctional Institutions

Planning for health care needs prior to being released contributes to rapid linkage to care. Five percent of survey participants indicated they had served a jail or prison sentence. Among them (n=33) only 24% stated they received assistance with their health care needs upon release while the majority (76%) indicated that they did not receive any assistance.

a. Priorities Arising from HIV Community Needs Assessment

The HIV Community Needs Assessment findings suggest prioritizing the following areas:

1. Increase need for information regarding: PrEP, disclosure of HIV, syringe access programs, HIV counseling for pregnant women.
2. Increased utilization of HIV testing at testing van and community organizations
3. Increased access to emergency financial assistance
4. Increased access to housing opportunities
5. Health care planning for PWH upon their release from jail or correctional facility
6. Increased access to oral health and specialty medical care

b. Actions Taken

The EHE program has been addressing the needs for information regarding PrEP, IDU programs and Jail Release/Re-Entry.

Expansion of HIV testing also has resumed after the most disruptive period of the COVID-19 pandemic. At the time when PWH identified barriers in accessing oral health care and specialty medical care, there were limitations to getting those services due to the COVID-19 pandemic.

c. Approach Used to Complete the HIV Community Needs Assessment.

The Needs Assessment used a representative and randomized sampling plan. Persons in Ryan White care were randomly selected to complete survey from stratified sampling plan via data pull from Provide Enterprise (database). Hired staff administered most surveys via phone, completed paper entry for tracking, and then entered the data into SurveyMonkey. All persons out of care were asked to complete survey upon re-entry into care through Early Intervention Services (EIS). Providers outside Ryan White were contacted to provide masked lists of client IDs. Distribution of surveys for the non-Ryan White clients was facilitated by health care

providers. The survey was made available in three languages: English, Haitian-Creole, and Spanish. Paper surveys were collected locally and mailed to the RWHAP office for data entry and analysis. A total of 398 surveys were completed. The sample was stratified to represent Black, Hispanic/Latinx, White and other race/ethnicities using the Florida Department of Health Epidemiological Profile. The CARE Planning Council participated in the review of Needs Assessment tool. The Clinical Quality Manager presented findings to the CARE council. Care Council meetings were open to the public.

SECTION IV: SITUATIONAL ANALYSIS

Palm Beach County, has thirty-nine different and distinct municipalities. These cities represent a diverse population made up of people from different races, ethnicities, gender identities, sexual orientations, religions and socio-economic statuses. The county is also home to a large number of immigrants, particularly from Cuba, Haiti, Colombia, Venezuela, and Mexico. According to the U.S. Census Bureau, 26% percent of the Palm Beach County population are foreign born[28], 24% of those are Hispanic/Latinx and 20% Black.

Priority Populations

Priority populations for prevention and care align with those of the HIV National Strategy Plan and the Ending of the HIV Epidemic Plan. Overall, Black/African-American and Hispanic/Latinx populations are disproportionately affected by HIV compared to other racial ethnic groups. By country or territory of birth Haitians born persons make up 20% of persons living with HIV. MMSC is the predominant mode of transmission for White and Hispanic/Latinx males.

The Palm Beach County jurisdiction has identified and adopted evidence-based interventions to prevent and decrease the incidence of HIV among racial/ethnic minorities and other underserved groups. For those who are already diagnosed and living with HIV in Palm Beach County, activities centering around rapid access to HIV care, retention in HIV care, including ART, and viral suppression focus on priority populations.

[28] https://www.census.gov/quickfacts/fact/table/palmbeachcountyfloridOP645220

To implement integrated HIV prevention and care services, Palm Beach County will continue to employ strategies and carry out activities that align with the NHAS Plan and the Ending the HIV Epidemic Plan.

Pillar 1: Diagnose all People with HIV as Early as Possible.

Access to Routine HIV Testing

Knowledge of one's status is critical to linkage in care, and achieving viral suppression. The most recent data (2017-2019) data showed that only 45% of adults living in Palm Beach County had ever been tested for HIV. However, that percentage varied by racial ethnic groups. Sixty-nine percent (69%) of Blacks, 53% of Hispanics and 36% of Whites had ever been tested for HIV. This finding suggests a positive trend in targeting HIV screening among priority populations. Nevertheless, testing efforts must be expanded to communities at facilities accessible to target populations. The HIV Community Needs Assessment data showed that most participants were tested at a medical facility or at a Federally Qualified Health Center. Additional testing facilities may include mobile units that can reach target populations during non-traditional hours including weekends. Priority populations for HIV testing and PrEP include MSMC of all racial/ethnic backgrounds, Black and Hispanic persons.

Access to Routine STD and Viral Hepatitis Testing

Most recent data showed an increase in STIs rates for syphilis, gonorrhea and chlamydia. Therefore, enhancing routine testing for STIs is necessary. Thirty percent (30%) of those participating in the needs assessment indicated they had been tested at their doctor's office. This finding further supports the need to increase routine testing efforts at public and private medical care facilities. The strategy of "no wrong door approach" can result in the expansion of point of care testing sites that include routine HIV, STD and viral hepatitis and referral to medical, and behavioral services.

Access to PrEP, nPEP

The CDC recommends PrEP as an HIV prevention strategy for persons at increased risk for HIV. Per FDOH, current challenges to PrEP delivery throughout FDOH CHDs include clinician/staffing shortages. However, the FDOH publicly funded PrEP drug assistance program

only accounts for a small portion of all PrEP services statewide. In Palm Beach County, there are private physicians, FQHCs, community health centers, who have the capacity for screening, prescribing, and maintaining people on PrEP.

According to the latest data available in AHEAD, Palm Beach County has seen an increase in the percentage of persons prescribed PrEP since 2017 from 5.1% to 30.1% in 2021. AIDSvu data for Palm Beach County showed disparities in the number of PrEP used by sex at birth. In 2021, the number of males using PrEP was 2,449 compared to females (267).

Our most recent HIV Community Needs Assessment showed that of 361 survey participants, only 20% received PrEP information at their doctor's office. These findings suggest the need for expansion of current initiatives. Interventions should aim at increasing public/private partnerships to fill gaps in access to PrEP services. Access to nPEP is needed within 72 hours after exposure to HIV to prevent seroconversion. Clients requesting nPEP tend to do so more often during evening hours and weekends. Partnerships with retail pharmacies, rape crisis centers, and sexual assault nursing teams in hospital EDs is required in order to expand access points to nPEP.

Pillar 2. Treat people with HIV rapidly and effectively to reach sustained viral suppression.

NHAS Goal: Improve HIV-related health outcomes of persons with HIV (PWH).

Access and adherence to HIV treatment is important to promote optimal health outcomes for PWH. In 2021, 82% of people who tested positive for HIV were linked to care within 30 days of testing. The Palm Beach County jurisdiction aims to increase the percentage of people linked to care within 30 days or less by at least 10 percentage points from the 2021 baseline. Starting antiretroviral therapy (ART) as soon as possible will require new strategies in addition to current efforts to re-engage PWH in care as well as quickly engaging those who receive positive test result.

Test and Treat (T &T)

Decreasing HIV transmission in Pam Beach County, ensuring adherence to ART and improving health outcomes of PWH begins with using strategies such as Test and Treat (T&T). The T&T program is designed for clients newly diagnosed with HIV, and those who are re-engaging in

care. This approach creates the opportunity for clients to obtain expedited medical visits, labs, and ART, combined with a support system of retention-in-care specialists. However, the implementation of this approach requires additional accessible Test and Treat sites located in geographical location already identified as vulnerable for people at risk for HIV and for PWH. This gap represents a need for expanded access points and hours of operation (to include non-traditional hours and locations) as well as telehealth capabilities to facilitate engagement or reengagement of people to care.

Linkage to Care

To overcome the challenges related to rapid linkage to care for newly diagnosed and those who are returning to care the Palm Beach County jurisdiction has a team of dedicated linkage staff responsible for linking persons who are newly diagnosed with HIV and re-engaging PWH who drop out of HIV care and treatment. Collaboration and data sharing with the FDOH facilitates the identification of PWH participating in the Ryan White system of care who fell out of care under a Data to Care (D2C) Model.

The implementation of Community Outreach, Response, and Engagement (CORE) Teams work in the field, conducting home visits to locate individuals and re-engage them back to care is a cornerstone activity of Ending the HIV Epidemic Initiatives in Palm Beach County. Rapid Entry to Care sites are also being supported by EHE funding to ensure re-engagements and linkage to care occurs quickly, within 72 hours of locating an individual or positive test result.

Coordination of Prevention and Care Activities

In order to improve and enhance the coordination of prevention and care services requires enhancing the level of knowledge about the RWHAP system of care among non-RW funded network health care providers. The data shows the need to expand the existent prevention and care network of health care providers including mental health, substance use and reproductive treatment centers. These community partners can serve as an additional source of information and referral for PrEP services for persons at high risk for HIV. Partnerships with non-Ryan White funded medical providers will expand the current capacity for routine HIV testing, STD and viral hepatitis. The jurisdiction will have to employ strategies such as educating new partners about existent support services for persons at risk for HIV and those who test positive for HIV.

These strategies include Tele-Adherence Counseling (TAC) using the PositiveLinks smartphone platform so those out of care can be linked back to care using EHE's Community Outreach, Response and Engagement (CORE) Teams and Rapid Entry to Care (REC) sites. Expansion of the PositiveLinks (smartphone app for adherence) intervention among providers will enhance efforts to improve retention in care and increase viral load suppression. The Ending the HIV Epidemic is conducting a transportation needs assessment to better understand and then address the transportation needs across Palm Beach County for PWH. In addition, a mobile unit is being purchased and outfitted so that activities of testing, lab draws, provider visits, and medication dispensing can take place in the community.

Inequities and Health Disparities

Racial and ethnic minorities (Blacks and Hispanic/Latinx), sexual and gender minority groups (LGBTQ+), and low-income populations have historically experienced poorer health outcomes and poorer social conditions (social determinants of health) than nonminority populations who live across the country. In 2021 in Palm Beach County, 52.2% of new HIV diagnoses were among Black/African-Americans, 27.0% among Hispanic/Latinx while 18.3% were among Whites. Health disparities were observed among those who were out of care. Blacks (26.2%) and Hispanic/Latinx (27.1%) populations were disproportionately out of care when compared to Whites (18.8%). Retention in care among Blacks (66.9%) and Hispanic/Latinx populations (67.4%) was lower than the retention percentage for White populations (73.2%). Health disparities also were noted in the number of Blacks achieving viral load suppression when compared to Whites and Hispanic/Latinx. Blacks (60.9%) had achieved the lowest percentage of viral load suppression followed by Hispanic/Latinx (65.8%). Whites (75.1%) represented the highest percentage of achieving viral load suppression. Differences were also observed when comparing the percentage of those who were retained in care and achieved viral load suppression by race and ethnicity. Nearly ninety-five percent of Whites achieved the desired health outcome (viral suppression) compared to 86% of Blacks.

To address and ultimately eliminate health inequities and health disparities, the Palm Beach County jurisdiction needs to identify an approach aiming to understand the multiple ways the virus impacts targeted priority populations. The multidisciplinary approach needs to focus on

addressing inequities in the social determinants of health and tailored to the specific needs of the population. For subpopulations such as those who are foreign-born, the removal of cultural and linguistic barriers to participation in testing and treatment activities is necessary. Furthermore, the approach requires the engagement and support of communities most affected by HIV and for persons at risk for HIV. Strategies are also needed to develop and increase the capacity of providers, and involvement of persons at risk for, and PWH in the HIV labor force. PBC RWHAP has hired a new Health Equity Coordinator to focus on health disparities and to develop interventions to address them, along with the support of two Quality Management Clinicians and a Health Planner. A system-wide Health Equity Quality Improvement Project will start in GY 2023.

Minority AIDS Initiative (MAI)

MAI seeks to address the gaps in medical care capacity and increase the accessibility and availability of HIV medical care and related HIV services in minority communities through outreach and education. The Palm Beach RWHAP Part A receives MAI funds designed to improve the linkage and re-engagement to comprehensive care for PWH of targeted racial/ethnic backgrounds.

Injectable ART

In 2021, Florida's AIDS Drug Assistance Program (ADAP) added Cabenuva, long-acting injectable antiretroviral to the formulary. Insured and uninsured clients are able to access this medication in coordination between the health care provider's office and the specialty pharmacy. The expansion of this program will require both increased awareness of Palm Beach County providers with prescription privileges on how to access medication and increased capacity to administer injection (scheduling, tracking and reminder systems and injection administration training).

Jail and Correctional Resources

Persons with HIV in prisons and jails are disproportionately represented compared to the general population. The Florida Department of Health addresses the need for health care planning prior to being released through: the Pre-Release Planning Program and Peer Education. The

Department maintains two interagency agreements with the Florida Department of Corrections (FDC) to provide the Pre-Release Planning Program (PRPP) and Peer Education Program (Peer-Ed). The Palm Beach County HIV Community Needs Assessment suggests the need to ensure that all inmates released to Palm Beach County have received those supportive services. This will require close collaboration with FDC, local jail facilities and FDOH. The Ending the HIV Epidemic in Palm Beach County is receiving technical assistance to better understand the jail linkage system and address opportunities for improvement in re-linking PWH who are justice-involved back into care in the community

Access to Health Insurance

The Palm Beach jurisdiction has dedicated resources to ensure access to health insurance as well as assistance with co-pays, insurance premiums and deductibles for those who receive care in the Ryan White care network. There is a need to expand awareness and education for PWH regarding insurance resources and support efforts to reach out to those persons who are uninsured and are at high risk for HIV.

Housing

The average Housing Fair Market Rent prices for Palm Beach County are in the $2,000/month range. Annual rent increases have surpassed the usual rate of 3-5% in 2021 to 7.5 percent. PWH are at greater risk of homelessness due to high medical costs and rising housing costs. Stable housing is closely linked with and is often one of the main determinants affecting HIV health outcomes. The Palm Beach County Housing Opportunities for Persons with AIDS (HOPWA), has partnered with the Palm Beach Housing Authority and coordinate activities with Social Security, Medicaid, Medicare, US HUD, State of Florida, Palm Beach County, and private insurance companies to meet client needs for housing, transportation, food, alcohol and drug abuse programs, mental health services, and vocational programs. Through supportive services, clients are referred to additional Ryan White services. Ending the HIV Epidemic has stepped in to create housing assistance with dedicated housing case managers. In addition, EHE is funding vocational training opportunities through the Community Action Program specifically to increase income among PWH who are having trouble affording housing. PBC RWHAP is also committed to finding solutions to the housing crisis, from participating in a 100 Day Challenge for Housing

and Healthcare with the goal of linking 60 PWH to stable housing and healthcare within 100 days by working with Coordinated Entry partners, to participating in NASTAD's Housing Learning Collaborative and supporting an ad-hoc Housing Committee in the HIV CARE Council.

Pillar 3: Prevent new HIV transmission by using proven interventions, including PrEP and syringe services programs

NHAS Goal: Reduce HIV related disparities and health inequities

HIV Related Stigma and Discrimination

Barriers to health care include HIV related stigma and discrimination, as well as medical mistrust. HIV internalized stigma can prevent people from getting tested or treated for HIV. Additionally, HIV related stigma and discrimination can result in feelings of isolation and fear of disclosure. Barriers caused by stigma and discrimination can be removed by using interventions directed to improve knowledge about HIV, reduce discriminatory attitudes, and negative perception of PWH. Given the long history of mistreatment experiences in health care (e.g. Tuskegee research) Black are more likely to distrust health care providers. HIV-related stigma, discrimination and medical mistrust must be corrected. The majority of PWH participating in the HIV Community Needs Assessment indicated they have fears about people rejecting them due to their HIV status.

The Palm Beach County jurisdiction is focusing on reviewing and improving the current media messaging about HIV, and ensuring that non-stigmatizing language is used. Strengthening relationships with faith-based leaders and faith-based organizations (FBOs) is required. Partnerships with FBOs and messaging to faith-based communities is needed to reduce and eliminate HIV related stigma and discrimination as well as to address misinformation and medical mistrust.

The state of Florida laws criminalizes the transmission of HIV. The laws undermine prevention and care efforts by punishing PWH for transmission of HIV to others. Furthermore, these laws not only further stigmatize PWH but impact communities most affected by HIV, including racial and ethnic groups such as Black and Hispanic/Latinx communities.

In addition, new laws in Florida now are putting LGBTQ+ and women at risk of losing access to health care and supportive environments in school and the workplace. Currently, the LGBTQ+ Community Center in Palm Beach County (Compass Community Center) offers a safe space to convene, support one another and build community, particularly for LGBTQ+ youth and PWH. However, more safe spaces where PWH can address the impact of HIV-related stigma, discrimination and state laws are needed. Information can increase awareness and lead to repeal current laws and eliminate stigmatizing practices. RWHAP in PBC is planning to apply for ESCALATE Learning Collaborative for 2023 and form a stigma reduction team for this 18-month opportunity to address the discrimination and stigma that PWH in PBC face.

Peer Health Navigation, Peer Support

To decrease disparities in health care strategies such as using a Peer Health Navigation and Community Health Worker models can have positive impact on the health and well-being of targeted populations. Peer health navigation programs are a valuable resource to of support to combat HIV related stigma. Peers can provide support and education for persons newly diagnosed with HIV, persons with substance issues or for those previously diagnosed and returning to care. Expanding the current peer health navigation and community health worker model is necessary to support target populations at risk for or with HIV, and address the needs of those with concurrent co-morbidities including mental health and SUD. Expansion of peer navigation and community health care model requires recruitment and training of peers. In the Ending the HIV Epidemic initiatives, peers will be a part of the Community Outreach, Response and Engagement (CORE) teams through a sub-contract with the Florida Department of Health.

Outreach, Education and Engagement

Outreach efforts driven by the Data to Care (D2C) model can effectively find PWH who need to be linked or re-engaged. The expansion requires education of providers in using data available to identify PWH who are not virally suppressed and direct outreach to PWH identified as being out of care. Clients who are not virally suppressed can be referred to EHE's Tele-Adherence Counseling.

Data to Care (D2C)

The D2C model is currently used to identify PWH who are out of care according to HIV surveillance data from the Florida Department of Health (FDOH), conduct field/home visits to locate individuals and re-engage them back to care. There is need to share D2C outcomes with all PWH, persons at risk for HIV, stakeholders and community partners.

Services for persons at high risk for HIV and PWH

PWH with active substance use disorders (SUDs) often delay the initiation of HIV treatment. Those who are in HIV treatment and actively using alcohol or drugs have difficulty in adhering to ART. Often, stigma associated with SUD or mental health issues prevents people from disclosing the need for services. Most participants (83%) of needs assessment survey indicated they did not have the need for mental health or substance use services. Although 17% indicated of respondents indicated they had issues with depression, and anxiety only 9% reported needing and using mental health services, and 7.57% indicated needing the services but they could not get it. To increase the capacity and availability of mental health disorders and SUD services requires expanding the opportunities for screening of mental health and SUD. Such screening should take place during the first contact with a person at risk for or with PWH who are reengaging to care. As it is currently, PWH who are case managed are screened using the PHQ and SAMISS screening tools every six months when case management assessments are (re)done, which is in alignment with when action plans are reviewed. Increased partnership with SUD and mental health providers, education of clients and accessible services such as telehealth can assist in removing barriers to care as clients who are screened can quickly access appointments and link

HIV Prevention and Care Across the Life Span and Sub-Populations

HIV prevention strategies have had a positive impact in lowering transmission of HIV among youth and pediatric populations. Diagnoses of youth (13-24) in Palm Beach County has steadily decreased as well as the rates of perinatal transmission. However, there is a need to attend the growing number of PWH over 50 (59% of all PWH) and to maintain low rates of HIV infection among youth will need to continue to focus on prevention and care efforts. To support the needs

of PWH over 50 years of age there is the need to plan and address health care challenges associated with growing older.

Health challenges across the HIV continuum for LGBTQ+ communities need to be addressed. Strategies include enhancing the capacity and knowledge of health care providers.

Response to the Opioid Epidemic

Palm Beach County has diligently been involved in efforts to reduce the opioid epidemic. Part of these efforts include being the first County in Florida to authorize a mobile syringe services program and having a dedicated office of Substance Use and Behavioral Health in Palm Beach County to coordinate efforts. The success of these programs relies on the collaboration and partnering with entities that contribute to enhance the provision of patient-centered recovery services. The Palm Beach jurisdiction recognizes the need for training of providers including naloxone training as well as building a strong partnership with SUD providers.

Pillar 4: Respond quickly to potential HIV Outbreaks to get needed prevention and treatment services to people who need them.

NHAS Goal: Achieve integrated coordinated efforts that address the HIV epidemic among all partners and stakeholders.

Cluster Detection and Response

FDOH is responsible for conducting surveillance and investigation for HIV clusters. Additionally, a state level cluster review committee is convened monthly to review cluster data, discuss challenges, and brainstorm strategies to improve the statewide response. The Palm Beach County Florida Department of Health (FDOH) is responsible for communicating to partners if clusters have been detected as well as for coordinating and guiding local responses.

Integration of services

The Palm Beach County jurisdiction has a coordinated system of care that has strengthened the response to the HIV, STI, and viral hepatitis syndemic at the local and state level. However, the current network of health care and social support providers would benefit from partnering with non-RW services providers. In addition, there is a need for expanding the integration, availability and access to substance use and mental health services. Enhancing partnerships will require

developing strategies to educate partners on the benefits of integrating HIV, STIs, viral hepatitis testing, and HIV care and treatment. The execution of models of care such as the “no wrong door” approach is needed to effectively respond to the HIV syndemic.

Data Systems

Palm Beach County jurisdiction uses data-driven models to inform program activities and resource allocation. However, there is need to evaluate current data systems to ensure timely, standard and uniform access to providers who need the data to inform and improve their programs. Training for providers is required to ensure uniformity on standards that protect client’s confidentiality.

Health literacy and understanding of personal record data also affect PWH. PWH would also benefit from learning how to access patient portals, medical and lab records and overall use of available digital technology.

SECTION V: INTEGRATED PREVENTION AND CARE PLAN

Table 21
2022-2026 Goals and Objectives

Pillar 1: Diagnose (D)					
NHAS Goal: Prevent New Infections					
Goal D1: By 2026, Increase the percentage of individuals who know their HIV serostatus in Palm Beach County from 87% to 95%					
Strategy: Develop and expand status neutral interventions specific to the needs of priority populations in Palm Beach County					
Objective D1.1: Increase availability and accessibility to HIV testing in traditional and non-traditional venues.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
D1.1a	Increase the use of digital media resources to include messaging on dating apps (e.g., Grindr) and social media apps (e.g., TikTok) (increase funding opportunities)	PBC priority populations	Years 1-5	PBC DOH Prevention Program Prevention community partners	Number of rapid HIV tests completed Number of community awareness campaigns about U=U
D1.1b	Culturally competent sexual health and awareness sessions at local teen centers throughout Palm Beach County	PBC priority populations	Years 1-5	PBC DOH Prevention Program Prevention community partners	Number of education opportunities for sexual health delivered at local teen centers
D1.1c	Increase collaborative efforts between community-based organizations to bring awareness of HIV to communities in geographic disproportionately affected area (meet people where they are)	PBC priority populations	Years 1-5	PBC DOH Prevention Program Prevention community partners	Number of private entities who provide referrals to prevention services. Number of BRTA/FRTA initiatives implemented each year

D1.1d	Increase awareness and collaboration with existing SSP to incorporate Hepatitis, STIs, mental health and substance use messaging in campaigns.	PBC priority populations	Years 1-5	PBC DOH Prevention Program Prevention community partners	Number of collaboratives and messaging in media campaigns that incorporates Hepatitis, STIs, mental health and substance use
Objective D1.2: Increase Knowledge of HIV status					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
D1.2a	Increase opportunities for HIV testing outside M-F (8-5pm) unconventional hours	PBC priority populations	Years 1-5	PBC DOH Prevention Program/Partners Private healthcare providers (i.e. physicians, nurse practitioners,	Number of providers who offer unconventional hours for rapid HIV testing
D1.2b	Implementing provider detailing to increase awareness for routine opt out HIV testing (private clinics, professional organizations, partner with Gilead/ViiV)	PBC priority populations	Years 1-5	PBC DOH Prevention Program/Partners	Number of rapid HIV tests completed. Number of educational sessions for private providers
D1.2c	In addition to in person testing, make at home testing more accessible (paying for it, ordering it, finding out any additional barriers)	PBC priority populations	Years 1-5	PBC DOH Prevention Program/Partners	Number of home test kits provided to Palm Beach County community members
D1.2d	Offer routine HIV testing as part of standard of care during an annual physical as well as during episodic visits to urgent care and emergency rooms	PBC priority populations	Years 1-5	Palm Beach Medical Society, Nurse Practitioner Council of Palm Beach County & Palm Beach Society of Health-System Pharmacists	Number of HIV testing performed during annual physical exams

D1.2e	Ensure strong linkage between outreach teams (completing rapid HIV testing) and access to PrEP/nPEP providers/organizations.	PBC priority populations Private providers	Years 1-5	PBC DOH Prevention Program/Partners Palm Beach Medical Society, Nurse Practitioner Council of Palm Beach County & Palm Beach Society of Health-System Pharmacists	Evidence of collaborative work between outreach teams and Organizations providing access to PrEP/nPEP.
D1.2f	Educate private providers about status neutral HIV prevention and care services.	Private providers	Years 1-5	PBC DOH Prevention Program/Partners Private healthcare providers (i.e. physicians, nurse practitioners, physician assistants and pharmacists)	Number of educational sessions for private providers on status neutral HIV prevention and care services.
D1.2g	Support informational campaigns and social media messaging around HIV/STI testing, PrEP and linkage to care	Persons at risk of HIV	Years 1-5	PBC DOH Prevention Program/Partners	Number of informational campaigns and social messaging centered on HIV/STI testing, PrEP and linkage to care.
D1.2h	Use partner services to provide negative partners access to PrEP, educational materials, and other preventative resources and services during non-traditional hours and via telehealth to reduce barriers	PBC priority populations	Years 1-5	PBC DOH Prevention Program Prevention community partners	Expand scope of partner services to facilitate access to PrEP educational materials and preventative resources and services. Expand partner services during non-traditional hours.

D1.2i	Increase collaboration with SSP/harm reduction programs.	Persons who inject drugs	Years 1-5	PBC DOH Prevention Program Prevention community partners	Collaborative agreements with SSPs

Objective D1.3: Expand and Improve Implementation of Effective Prevention Intervention					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
D1.3a	Increase academic detailing to Primary Care, Urgent Care, and Emergency Department settings about prevention interventions/rapid HIV testing opportunities	PBC priority populations. Health care providers	Years 1-5	PBC DOH Prevention Program	Number of educational sessions on rapid HIV testing for Primary care, Urgent Care, and Emergency Department staff.
D1.3b	Partner with social service organizations, (i. e. domestic violence, human trafficking, YMCA, Boys and Girls club, etc.) to expand HIV testing, prevention and care services.	Social Service Organizations	Years 1-5	PBC DOH Prevention Program	Partnerships with social organizations are in place.
D1.3c	Implement community awareness campaigns about U=U (include peers in messaging).	PBC priority populations	Years 1-5	PBC DOH Prevention Program	Number of U=U campaigns in place
D1.3d	Promote use of PrEP hotlines (i.e. provider/organization specific phone numbers and websites such as pleaseprepme.org and PrEP locator)	Persons at risk for HIV	Years 1-5	PBC DOH Prevention Program	Evidence of promotional PrEP hotlines in place.
D1.3e	Assess additional needs of SSP.	Persons who inject drugs	Years 1-5	PBC DOH Prevention Program PBC RW Recipient's Office	Assessment of SSP needs completed
D1.3f	Embrace the adoption of assessing quality of life instead of focusing only on health outcomes.	PBC Priority populations	Years 1-5	PBC DOH Prevention Program	Incorporate quality of life metrics with health outcomes reports

D1.3g	Increase HIV prevention messaging in multiple languages (English, Spanish, Creole, etc.)	PBC Priority populations	Years 1-5	PBC DOH Prevention Program	Prevention messaging delivered in multiple languages.
D1.3h	Engage with local and state civic, political, community, and spiritual leaders to increase awareness of HIV and populations affected by HIV	Social services, State and local leaders, Faith based leaders	Years 1-5	PBC DOH Prevention Program	Expansion of community engagement to include local and state civic, political, community, and spiritual leaders
D1.3i	Partner with organizations performing research to disseminate research opportunities to Palm Beach County community, providers and community organizations	Research organizations	Years 1-5	PBC DOH Prevention Program	Partnerships with research organizations in place
D1.3j	Engage with organizations performing research to encourage inclusivity of all communities (including the transgender community)	Research organizations	Years 1-5	Professional organizations Palm Beach Medical Society, Nurse Practitioner Council of Palm Beach County & Palm Beach Society	Engagements with research organizations to promote inclusivity
D1.3k	Conduct listening sessions/town halls with those currently implementing interventions and those participating in interventions to uncover best practices and lessons learned	PBC priority populations	Years 1-5	PBC DOH Prevention Program	Engagements with organizations via town hall meetings, listening sessions to share and adopt best practices

Objective D1.4: Increase capacity of healthcare delivery systems, public health and health workforce to prevent and diagnose HIV					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
D1.4a	Provide HIV prevention and treatment toolkits to academic institutions for or inclusion in healthcare focused programs (i.e. nursing, pharmacy, physical therapy, medicine)	Academic Institutions	Years 1-5	PBC DOH Prevention Program	Partnerships with academic institutions to facilitate access for them to use HIV prevention and treatment toolkits.

D1.4b	Increase the number of peers who provide supportive services, including but not limited to linkage to care, case management and retention efforts	Peers PBC Priority populations	Years 1-5	PBC DOH Prevention Program	Number of peers
D1.4c	Assess and foster additional partnerships with private entities to enhance access to prevention services.	Private entities	Years 1-5	PBC DOH Prevention Program	Assessment of partnership with private entities completed
D1.4d	Enhance job descriptions of certified medical assistants to include additional skillsets like phlebotomy, case management, substance use support, mental health first aid and HIV 500/501	Medical Assistants	Years 1-5	PBC DOH Prevention Program	Updated job descriptions
D1.4e	Increase the number of inclusive sexual health services being offered by increasing training opportunities on sexual orientation and gender identity (i.e. assessment of need and offering of 3 site testing for gonorrhea/chlamydia)	Sexual health service providers	Years 1-5	PBC DOH Prevention Program	Number of inclusive health service providers Number of trainings on sexual orientation and gender identity

Key Partners: Medical providers, hospitals, ER. Community based organizations, Academic Institutions, Youth Organizations, Faith Based Organizations, state and local leaders.

Potential Funding Sources: CDC, SAMSHA, State funding

Estimated Funding Allocation: $1,055,000

Outcomes Reported (reported annually, monitored quarterly): % of individuals who know their serostatus

Monitoring data sources: FDOH Epi Surveillance for Palm Beach Area, CAREWare database

Expected Impact on the HIV Care Continuum: Increased knowledge of HIV status. Reduced new HIV diagnoses. Increased PrEP coverage.

Pillar 2: Treat people with HIV rapidly and effectively to reach sustained viral load					
NHAS Goal 2: Improve HIV-related outcomes of PWH					
Goal T1: By 2026, engage 2,069 out-of-care PWH residing in Palm Beach County in ongoing HIV care.					
Strategy: Provide the same day or rapid (within 7 days) start of ART for persons who are able to take it.					
Objective T1.1 Increase the percentage of newly diagnosed PWH linked to care within 30 days from 83% to 95%					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
T1.1a	Expand access to onsite phlebotomy services at testing sites	PBC priority populations	Year 1	PBC RW Part A Recipient Office	Number of Phlebotomy services at testing/outreach sites
T1.1b	Offer integrated services at 4 mobile units located at East, West, North, South geographical areas. Services to be included: Test and Treat, rapid entry /linkage to care, phlebotomy and direct access to mental health and social support services.	Persons at risk for HIV Newly diagnosed PWH PWH out of care	Years 1-5	PBC DOH Prevention Program RW Part A Recipient's Office Service providers	Number of Test and Treat events Number of services offered at mobile units Number of clients receiving services at mobile units Number of clients linked to care within 30 days
T1.1c	Expand and maintain the number of providers with reserve capacity for same day appointments or walk-ins for PWH who are newly diagnosed or re-engaging in care.	Persons at risk for HIV Newly diagnosed PWH PWH out of care	Years 1-5	PBC DOH Prevention Program RW Part A Recipient's Office Service providers	Number of providers with enhanced services capacity
T1.1d	Create on demand telehealth medical services for rapid entry to care including after hours or on weekends.	Newly diagnosed PWH PWH out of care	Years 1-5	PBC DOH Prevention Program RW Part A Recipient's Office	Number of clients receiving on-demand telehealth services

				Service providers	
T1.1e	Create a pediatric specific HIV medical care clinic with mental health and peer support services	Children and youth (0-24) diagnosed with HIV	Years 2-5	PBC RW Part A Recipient Office. PBC medical providers, mental health providers and peers	Number of children and youth receiving pediatric medical care and having access to mental health and peer support at the pediatric clinic

Goal T2: By 2026, increased the number of PWH who are virally suppressed from 5,480 to 7,575 (38.2% increase)					
Strategy: Expand uptake of data to care model using data sharing agreement, integration and use of surveillance and other sources to identify people who are not in care or virally suppressed.					
Objective T2.1 By 2026, reduce the percentage of PWH who are not in care from 24% to 10%					
Strategies	Activities	Target Population	Time Frame	Responsible	Indicators
T2.1a	Review contracts to ensure data sharing agreements.	RW Part A, MAI services providers	Years 1-5	PBC RW Part A, MAI Recipient Office EHE Programs: REC, CORE	Number of funded providers with data sharing agreements
T2.1b	Identify potential contributing entities such as subrecipient providers, pharmacies, social/support services to funnel data to outreach teams.	RW Part A, MAI pharmacy services providers	Years 1-5	PBC RW Part A, MAI Recipient Office Service providers	Number of entities able to funnel data to outreach teams.

T2.1c	Support data sharing by engaging and educating providers on data to care models.	RW Part A, MAI services providers	Years 1-5	PBC RW Part A, MAI Recipient Office. Service providers	Number of providers engaging in training to become proficient in using data to care model.
T2.1d	Conduct front end analysis to identify client barriers and develop acuity scale system to identify client risk of falling out of care.	RW Part A, MAI services providers	Years 1-5	PBC RW Part A, MAI Recipient Office Service providers	Acuity scale in place. Number of clients deemed in the acuity scale as high or low risk of falling out of care
T2.1e	Expand the availability of supportive and behavioral health services at the time of client engagement (mental health, Case management, Peer support).	PWH out of care Newly Diagnosed PWH	Years 1-5	PBC RW Part A, MAI Recipient Office Service providers	Number of clients receiving supportive and behavioral health services at the time of engagement or reengagement in care.
T2.1f	Increase the number and engagement of Peer Mentors by creating a training program	Peer Mentors	Years 1-5	PBC RW Part A, MAI Recipient Office Service providers AETC	Number of PWH attending Peer Mentor trainings
T2.1g	Provide training to RW funded and Non-RW funded providers regarding availability of safety net programs.	RW and Non-RW funded service providers	Years 1-5	PBC RW Part A, MAI Recipient Office	Number of RW and Non-RW providers attending safety net trainings
T2.1h	Create a phone/text hotline for clients who may be experiencing a crisis	PWH	Years 1-5	PBC RW Part A, MAI Recipient Office	Phone/text hotline in place

Goal T3: By 2026, increased the number of PWH who are retained in care from 5,139 to 6,558 (27.6% increase).
Strategy: Support the transition of health care systems, promote health literacy
Objective T3.1 By 2026, increase support for treatment initiation, adherence and retention services for PWH residing in Palm Beach County

Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
T3.1a	Create solution and experience-based educational programs for clients and community members focused on navigating HIV prevention and care continuum and overcoming barriers to care.	PBC priority populations at risk of disengagement	Year 1-5	PBC RW Part A Recipient Office Service providers	Number of experience-based educational programs provided
T3.1b	Provide training for traditional and non-traditional health care providers, including PWH, related to HIV prevention and care continuum.	Service providers PWH	Year 1-5	PBC RW Part A Recipient Office. Service providers	Number of trainings provided
T3.1c	Support the involvement of Peers in assisting with linkage, engagement, reengagement and retention in care.	PWH Peer Mentors	Year 1-5	PBC RW Part A Recipient Office	Number of clients receiving assistance from Peers.
T3.1d	Focus on Test and Treat programs, increasing rapid entry-to-care programs, and getting clients linked to care within a 72 hour time frame.	Persons at risk for HIV Newly diagnosed PWH	Year 1-5	Test and Treat programs	Increased number of Test & Treat sites
T3.1e	Use Medical Monitoring Project (MMP) data to guide policy, funding decisions aimed at increasing engagement and improving medical care for PWH.	PWH	Year 1-5	RW service providers	MMP data reviewed and presented to the public annually
T3.1f	Identify and integrate best practice or evidence informed interventions in Peers Programs.	PWH	Year 1-5	RW services providers, Peer Mentor programs	Use of evidence-based interventions in Peer programs in place.
T3.1g	Provide education to people at risk of HIV and health care providers on PrEP services.	Persons at risk for HIV. PWH with HIV negative partners	Year 1-5	FDOH Health Care providers	Number of Persons at risk for HIV receiving PrEP information Number of Providers trained on PrEP

T3.1h	Adopt a virtual/telehealth approach to assist clients virtually rather than in-person whenever possible.	PWH	Year 1-5	RW Part A Health care providers	Number of telehealth services available Number of clients receiving telehealth services.
T3.1i	Provide Patient Navigation training to Peers.	PWH	Year 1-5	Peer Programs, AETC	Number of peers receiving training.
T3.1j	Deploy community health workers in the field to provide in-person visits at key access points in PBC through Community Based Organizations and AIDS Services Organizations.	PWH	Year 1-5	Community health programs	Number of home visits made by community health care workers
T3.1k	Hold stakeholder meetings with Infectious Disease (ID) providers as well as pharmaceutical representatives to ensure that everyone has the most up-to-date information.	ID providers Pharmaceutical Reps	Year 1-5	RW Recipient Office Health Care providers PBC Prevention Programs	Number of continuing education meetings with stakeholders
T3.1l	Collaborate with AETC to assist with training needs.	Health care providers	Year1-5	Recipient Office. Health Care providers PBC Prevention Programs	Increased capacity of health care providers and delivery of services

Goal T4 By 2026, increase the capacity of health care delivery systems and health care work force					
Strategy: Provide value- based resources, incentives, training and technical support to expand capacity of health care workforce.					
Objective T4.1 Develop and implement training needed to improve capacity of services providers.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
T4.1a	Provide training to all health care providers, including case managers on ho	PWH	Year 1-5	RW Part A, MAI DOH	Improved capacity and education of providers regarding services and

	to apply for all services or to make referrals across the HIV continuum of prevention, care and treatment.			AETC	application processes to access public or private benefits for clients. Increased client retention in care.
T4.1b	Create a place for providers to engage and In venues such as forums, hotline, website.	Services Providers	Year 2-5	RW Part A, MAI DOH	Provider avenues in place
T4.1c	Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) into primary care.	PWH over 50 years. Local Partners	Year 2-5	RW Part A, MAI DOH	Collaborative work with local partners in place. Decreased barriers for PWH who are engaging in care or at risk of falling out of care.
T4.1d	Conduct a reflectiveness survey to assess diversity and inclusion of the workforce in our current health care system.	Health Care providers	Year 2-5	RW Part A, MAI	Administration of reflectiveness survey Diversity assessment completed
T4.1e	Train prescribing medical providers in HIV, LBTQ+ care, MMSC/WWSC throughout the year (quarterly). Offer CME for completion of training.	Prescribing medical providers LGBTQ+ PWH	Year 2-5	RW Part A, MAI	Improved capacity of prescribing medical providers to serve LGBTQ+.
T4.1f	Hold training events focusing on building the diversity of workforce of providers at least annually.	Health Care Providers	Year 1-5	RW Part A, MAI Recipient's office AETC	Improved capacity to build diversity of workforce. Number of providers attending trainings
T4.1g	Enhance the participation of paraprofessionals in health care teams across the HIV continuum of prevention, care and treatment.	Paraprofessional Staff	Year 2-5	RW Part A, MAI Recipient's office AETC	Number of paraprofessionals who are part of health care teams.

T4.1h	Hold annual training for paraprofessionals and their supervisors.		Year 1-5	RW Part A, MAI Recipient's office AETC	Improved performance of paraprofessionals and supervision guidance.

Goal T5: By 2026, increase the capacity to serve PWH who are 50 years old and over from 5,102 to 6,122					
Strategy: identify, implement, and evaluate models of care models of care that meets the needs of aging PWH					
Objective T5.1 Expand the capacity of PBC providers to serve older adults with HIV and long- term survivors.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
T5.1a	Collaborate with local partners and educate them on HIV syndemics and aging	Medical Providers. PWH aged 50+.	Year 1-5	RW Part A Recipient Office.	Number of providers receiving training focused on serving older PWH (50+) and number of collaborative meetings
T5.1b	Training for providers serving older adults including gay and transgender PWH.	PWH aged 50+ Gay and Transgender	Year 1-5	RW Part A Recipient Office. AETC	Number of trainings focused on older PWH including gay and transgender.
T5.1c	Identify and develop a services model that best meet the needs of aging PWH.	Medical Providers. Older PWH	Year 2-5	RW Part A recipient Office.	Development and implementation of best practice model for older PWH.
T5.1d	Ensure provision of behavioral health care in mobile units.	PWH 50+	Year 1-5	RW Recipient Office.	Number of older PWH 50+ receiving behavioral health care in mobile units.
T5.1e	Train providers serving older PWH on the effects of dementia.	Services Providers	Year 1-5	RW Part A Recipient Office.	Number of providers receiving training focused on dementia. Implementation of Best Practice model for aging PWH 50+ populations
T5.1f	Identify and deliver clinical, community and homebased interventions tailored to aging PWH populations	PWH ages 50+	Year 2-5	RW Part A Recipient Office.	

T5.1g	Create a marketing campaign to improve awareness of services for aging PWH residing in PBC.	PWH ages 50+	Year 1-5	RW Part A Recipient Office.	Marketing campaigns in place
T5.1h	Create a local channel to advertise services available.	PWH ages 50+	Year 2-5	RW Part A Recipient Office.	Local Chanel advertisement in place
T5.1i	Collaborate with non RW funded local providers of services targeting older populations.	PWH ages 50+	Year 1-5	RW Part A Recipient Office.	Number of collaborative meetings
T5.1j	Provide education about HIV and aging to local partners and services organizations	PWH ages 50+	Year 2-5	RW Part A Recipient Office. AETC	Educational events took place
T5.1k	Create a quarterly multi agency collaboration update (virtually) on research innovations.	Services Providers	Year 1-5	RW Part A Recipient Office.	Quarterly meetings in effect
T5.1l	Hold an annual summit that brings together multi-sectoral agencies to share challenges and strategies to support quality of life of PWH.	Services Providers	Year 1-5	RW Part A Recipient Office.	Annual summit took place
T5.1m	Increase awareness among local providers to incorporate messaging on Test and treat, HIV stigma and aging HIV population.	Services Providers	Year 1-5	RW Part A Recipient Office.	Number of Providers who are incorporating messaging on T&T

Goal T6: By 2026, identify and increase formal collaboration with HIV related research entities and academic institutions
Strategy: Promote research and private and public partnerships to accelerate new therapies

Objective T6.1: By 2026, increase the number of private and public partnerships, and participation in advancing the development of next generation HIV therapies and accelerating research for HIV cure.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
T6.1a	Establish relationships with local, regional and national research entities to provide opportunities for PWH to participate in clinical trials	RW Providers Academic Institutions HIV related Research entities PWH	Year 2-5	RW Part A Recipient Office. 3DOH	Number of partnerships with HIV research related and academic institutions.
T6.1b	Create a local directory for known research studies and make it available to providers and PWH	RW Part A recipient Office. PWH	Year 2-5	RW Part A Recipient Office. DOH	HIV related research directory.
T6.1c	Support research initiatives and clinical trials recruitment and advertise vial list serv or web portals.	RW Part A recipient Office. RW HIV Planning Council.	Year 2-5	RW Part A Recipient Office. DOH	Number of clinical trials identified annually Number of PWH participating in clinical trial or other HIV related research initiatives.
T6.1d	Establish relationships with local, regional, national research entities to provide avenues for interested clients to participle in studies exploring new therapies or care models designed to improve health outcomes for PWH.	Research entities PWH	Year 1-5	RW Part A Recipient Office.	Number of PWH participating in research studies.
T6.1e	Increase access to ART injection medications through ADAP and other payer sources	PWH ADAP Prescribing health care providers	Year 2-5	RW Part A Recipient Office. ADAP	Number of health care facilities administering ART injections in place.

T6.1f	Collaborate with academic partners on clinical research and ART clinical trials	Academic partners	Year2-5	RW Part A Recipient Office.	Number of collaboratives with academic partners

Key Partners: FQHCs, medical providers, hospitals, community- based organizations, ADAP, Academic institutions, Florida Department for Elder Affairs
Potential Funding Sources: RW Part A, MAI, RW Part B, State General Revenue, State Patient Care Network, local funding, other public, private funding
Estimated Funding Allocation: **$**9,230.030
Outcomes Reported: Viral suppression rates in Palm Beach County
Monitoring Data Sources: FDOH Surveillance data, RW program data, DOH program data
Expected Outcomes in the HIV Care Continuum: Increased number of PWH linked to care within 30 days; Increased number of PWH who are in care and virally suppressed. Decreased number of PWH who are out of care.

Pillar 3: Prevent					
Goal P1: By 2026, reduce HIV-related health disparities among PWH through intentional and targeted interventions					
Strategy: Promote compliance with civil rights, promote reform state criminalization laws, assists with protecting PWH from discrimination and violence					
Objective P1.1: Reduce HIV-related stigma and discrimination from baseline					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
P1.1a	Identify and select stigma scale to assess baseline of HIV related stigma experienced by PWH.	PWH	Year 1-5	PBC RW Part A Recipient Office PBC DOH Prevention Program.	HIV stigma related scale Baseline established.
P1.1b	Create drop- in centers for clients to receive and ask questions regarding their civil rights.	PWH	Year 1-5	PBC RW Part A Recipient Office	Number of Drop-in centers. Number of clients using drop-in centers.
P1.1c	Support education and skill building for PWH to promote engagement and understanding of civil rights and policy making	PWH	Year 1-5	PBC RW Part A Recipient Office HIV CARE Council.	Number of educational events for PWH.

P1.1d	Annual mandatory training for providers on HIV related stigma and discrimination.	HIV Service Providers	Year 1-5	PBC RW Part A Recipient Office	Annual training on HIV-related and stigma discrimination.
P1.1e	Identify and disseminate continuing education opportunities for health care professionals on eliminating HIV stigma including working with AETC	HIV Service Providers	Year 2-5	PBC RW Part A Recipient Office	Dissemination of continuing education opportunities among providers Training calendar in place.
P1.1f	Invite community and faith-based leaders to participate in addressing HIV misconceptions and reducing HIV related stigma and discrimination.	PWH Faith-Based Community Leaders	Year 2-5	PBC RW Part A Recipient Office DOH	Number of meetings with Faith Based Organizations and Community leaders.
P1.1g	Provide outreach, HIV and STI testing and education in places and zip codes frequented by priority populations.	PWH Persons at risk of HIV	Year 1-5	PBC RW Part A, MAI, Recipient Office DOH	Number of Outreach, testing and education events at venues frequented by High-risk priority populations.
P1.1h	Use HIV, STI data to target education and outreach efforts in high priority populations, and zip codes	HIV Service Providers	Year 1-5	PBC RW Part A, MAI, Recipient Office FDOH	Number of providers using data to inform outreach to priority populations Outreach events taking place in high-risk geographic areas
P1.1i	Hold fund raising activities, perform grant search for alternative resources for special programs addressing priority populations.	HIV Service Providers	Year 2-5	PBC RW Part A, MAI, Recipient Office FDOH	Number of fund-raising activities and grants for priority populations.
P1.1j	Develop mini-grants and create other opportunities to support outreach efforts to priority populations.	Priority Populations of PWH		PBC RW Part A, MAI, Recipient Office FDOH	Number of mini-grants awarded

Goal P2: By 2026, increase the number of Black\African Americans and Hispanic/Latinx achieving viral load suppression from 2,967 to 4316 for Blacks, and from 958 to 1,324 for Hispanic/Latinx.					
Strategy: Increase awareness of HIV related disparities					
Objective P2.1 increase the percentage of Black/African Americans and Hispanic/Latinx who are in care and have viral suppression					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
P2.1a	Hold annual integrated Planning Summit to disseminate data driven reports and highlight progress towards decreasing disparities and health inequities for priority populations and MMSC of all racial background.	HIV Service providers Community stakeholders. PWH	Year 2-5	PBC RW Part A Recipient Office HIV CARE Council FDOH	Annual Summit data reports and number of participants.
P2.1b	Utilize regularly community forums as means to share data and identify health outcomes for priority populations.	HIV Service providers Community stakeholders.	Year 1-5	PBC RW Part A Recipient Office FDOH	Number of community forums held where data and information is exchanged
P2.1c	Develop and expand the use of easy-to read materials (e.g. infographics, one pagers) to help various types. Materials in English, Spanish, Creole.	PWH	Year 2-5	PBC RW Part A Recipient Office FDOH	Materials in various formats and languages are in place
P2.1d	Collaborate with academic institutions and other partners to identify and or develop interventions focusing on priority populations	Academic Institutions Substance Use Disorder providers Mental Health Providers Youth Organizations	Year 2-5	PBC RW Part A Recipient Office FDOH	Number of meetings with academic institutions and other research related partners. Number of interventions implemented

Goal P3: By 2026, increase capacity to facilitate employment and leadership positions for PWH					
Strategy: Create and promote public leadership opportunities for PWH and persons at risk of HIV					
Objective P3.1: By 2026, engage, employ and provide public leadership opportunities at all levels for PWH and persons at risk for HIV.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
P3.1a	Develop and support opportunities for employment including vocational training and leadership at the local and state level.	PWH Persons at risk of HIV	Year 2-5	RW Part A recipient FDOH	Number of opportunities available to facilitate employment and leadership positions for PWH and persons at risk of HIV.
P3.1b	Create a training program for leadership development and program management for PWH.	PWH	Year 2-5	RW Part A recipient FDOH	Number of PWH who attend leadership development training.
P3.1c	Engage and employ PWH at all levels and provide public leadership opportunities for PWH or persons at risk of HIV	PWH Persons at risk of HIV	Year 2-5	RW Part A recipient FDOH	Number of PWH who gained employment or leadership positions at the local or state level
P3.1d	Create a community HIV Advocacy Day	PWH	Year 1-5	RW Part A recipient FDOH HIV CARE Council	Recognition of HIV Advocacy Day
P3.1e	Ensure intentional use of people first language in all HIV services activities and messaging	PWH	Year 1-5	RW Part A recipient FDOH	Media Campaigns, evidence of educational materials using people first language.

Goal P4 By 2026, increase social services support to reduce food and housing insecurity for priority populations					
Strategy: Develop whole-person systems of care and wellness that address co-occurring conditions					
Objective P4.1 By 2026, reduce the impact of social determinants of health (SDOH) and co-occurring conditions such as substance use and mental health disorders.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
P4.1a	Pilot Medical Mall or One stop Shop model to offer multiple services co-located in a specific geographical area.	PWH Medical providers including specialty care.	Year 1-5	RW Part A recipient FDOH	Co-located services for primary and specialty care.
P4.1b	Require medical providers to sign MOUs to facilitate referrals to other services.	RW Providers	Year 1-5	RW Part A recipient	Number of MOUs stipulating referral procedures.
P4.1c	Improve client education regarding their right to choose their providers	PWH	Year 1-5	RW Part A recipient HIV CARE Council	Number of trainings including clients right to choose service providers
P4.1d	Implement comprehensive range of prevention and care services provided at 4 mobile units.	PWH	Year 2-5	RW Part A recipient.	Number of PWH or persons at risk for HIV receiving services at mobile units.
P4.1e	Training of Providers specializing in co-occurring conditions regarding linkage services	Health care providers	Year 2-5	RW Part A recipient. AETC	Number of providers receiving training on co-occurring conditions linkage services
P4.1f	Use of mobile units and telehealth to provide Test and Treat rapid entry /linkage to care referrals	PWH Services providers	Year 1-5	RW Part A and B recipient.	Telehealth system at mobile units in place Number of clients receiving T&T/Rapid Entry intervention
P4.1g	Provide information and training for PWH on client rights, grievances, customer feedback and health literacy.	PWH	Year 1-5	RW Part A and B recipient.	Number of trainings provided for PWH

				HIV CARE Council	
P4.1h	Create opportunities for providers to implement evidence- based interventions to address trauma and violence	RW Part A recipient office	Year 1-5	RW Part A AETC	Number of HIV providers adopting Trauma-Informed Care service models
P4.1i	Identify and incorporate best practice in Peer Programs.	PWH	Year 2-5	RW Part A, MAI recipient.	Number of Peer Programs implementing best practice interventions.
P4.1j	Create additional safe spaces for LGBTQ+ youth off campus, but near support centers.	LGBTQ+ Youth Providers	Year 1-5	RW Part A, MAI recipient.	Number of safe spaces created for LGBTQ+ youth.
P4.1k	Identify and disseminate trainings on Trauma Informed Care.	RW Part A recipient. HIV Service Providers	Year 1-5	RW Part A, MAI recipient.	Number of providers receiving information on Trauma Informed Care.

Goal P5: By 2026, expand the HIV related capacity and diversify of PBC providers and diversify the workforce.					
Strategy: Promote the expansion of existent programs and initiatives designed to increase numbers of non-White researchers.					
Objective P5.1 By 2026, increase training opportunities and expand the diversity of HIV-related workforce in Palm Beach County.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
P5.1a	Establish relations between local, regional and national research entities and create opportunities for HIV research related internships for non- White individuals.	PWH RW Part A recipient office.	Year 2-5	RW Part A recipient office.	Number of partnerships with local, state and national research entities. Number of internships for non-white individuals
P5.1b	Identify and support mentorship programs for individuals from diverse backgrounds.	RW Part A recipient.	Year 2-5	RW Part A recipient office.	Number of internships for individuals of diverse backgrounds.

P5.1c	Encourage the implementation of effective recruitment of community partners through community based participatory research and social networking approaches.	RW Part A recipient.	Year 2-5	RW Part A recipient office.	Development and implementation of community based participatory research.
P5.1d	Provide information on and encourage participation on research and grants related research.	RW Part A recipient.	Year 2-5	RW Part A recipient office.	Number of applications for research grants

Goal P6: By 2026, Reduce misinformation and healthcare mistrust by improving the delivery of HIV related communication					
Strategy: Develop and test strategies to promote uptake of information to counter associated misinformation					
Objective P6.1: By 2026, Improve HIV related communication and uptake of information.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
P6.1a	Create a media support portal and an application with bite size educational programs.	RW Part A recipient. FDOH	Year 2-5	RW Part A recipient. FDOH	Media portal an application in place
P6.1b	Utilize social media (Tik Tok, Facebook) to create messaging in short form.	Health and Social Services providers PWH	Year 1-5	RW Part A recipient. FDOH	Use of Social-Media by type in place
P6.1c	Develop messaging targeted to specific populations and depicting real world situations	Health and Social Services providers PWH	Year 1	RW Part A recipient. FDOH	Number of messages tailored to specific populations issued annually.
P6.1d	Seek collaborations in designing messaging from people with lived experience and who are willing to share their stories.	Health and Social Services providers PWH	Year 1	RW Part A recipient. FDOH	Number of people with lived experience collaborating in the designing of messages
P6.1e	Identify ways to create messaging targeting people from a diverse cultural, racial/ethnic, gender and socioeconomic background.	Health and Social Services providers PWH	Year 1-3	RW Part A recipient. FDOH	Evidence of messaging targeting diverse populations.

P6.1f	Increase community engagement in health communication initiatives at Town Hall meetings	Health and Social Services providers PWH	Year1-5	RW Part A recipient. FDOH	Community engagement of health communication initiatives.
P6.1g	Provide health literacy training by staff who understand the RW system of care.	PWH RW Part A recipient.	Year 1-5	RW Part A recipient. FDOH	Literacy training. Number of providers trained.
P6.1h	Provide training to case managers geared to educate and support clients to advocate for themselves.	Case Managers	Year 1-5	RW Part A recipient. FDOH	Case Manager's training. Number of case managers trained.
P6.1i	Hold meetings with various stakeholders and community representatives who are not part of the traditional system of care to optimize collaborative work.	Non- RW funded providers	Year 2-5	RW Part A recipient. FDOH	Number of meetings held with non RW funded programs.
P6.1j	Identify best practices for effective communication strategies between providers, consumers and to address medical mistrust.	RW Part A recipient. DOH	Year 1-5	RW Part A recipient. FDOH	Implementation of best practice for health communication.

Key Partners: FDOH, FQHC, medical providers, academic institutions, FBOs, community social services providers, social media platform providers
Potential Funding Sources: HRSA, CDC, State, SAMSHA, local funding, other public and private funding
Estimated Funding Allocations: $1,941.817
Outcomes Reported: HIV-related disparities among sub-populations disproportionately burdened by HIV.
Monitoring Data Source: HIV surveillance, RW and DOH program data
Expected Outcomes in the HIV Care Continuum: Decreased health disparities among Blacks and Hispanics across the continuum of prevention and care. Improved linkage to care, retention and viral suppression among Blacks, Hispanics and MMSC of all racial and ethnic backgrounds.

Pillar 4: By 2026, develop and integrated a coordinated approach in response to HIV, STI, substance use and mental health disorders.
Strategy: Integrate HIV awareness and services into outreach services for issues that intersect with partner violence, homelessness, STI and behavioral health issues
Objective P1.1 By 2026, develop and implement an integrated and coordinated response to HIV, STI, Viral Hepatitis, Substance use and mental health disorders.

Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
R1.1a	Collaborate with drug treatment centers and increase awareness of HIV syndemic.	RW Part A recipient.	Year 2-5	RW Part A recipient.	Collaborative Meetings with drug treatment centers.
R1.1b	Engage and educate clients on substance use and its side effects.	PWH	Year 2-5	RW Part A recipient.	Number of clients receiving education on substance use and its effects.
R1.1c	Increase outreach and engagement of FBOs and community partners to address the HIV syndemic.	Service Providers FBOs	Year 1-5	RW Part A recipient. DOH	Number of outreach events to FBOs and community partners and engagement in addressing HIV.
R1.1d	Start-up program for mothers and fathers to promote independence and address housing instability issues.	PWH	Year 1-5	RW Part A recipient.	Program in place
R1.1e	Educate providers and PWH on overcoming the barriers and society attitudes towards persons who are homeless, substance user or have a mental disorder.	Services Providers PWH	Year 2-5	RW Part A recipient.	Number of providers attending educational focusing on homelessness, substance use, mental disorder.
R1.1f	Create a program for youth attending schools to inform them how to reach for help in cases of parental substance use or family violence.	RW Part A recipient. DOH	Year 2-5	RW Part A recipient. DOH	Information resources focusing on parental substance use and family violence available for youth.
R1.1g	Collaborate with family planning organizations like Planned Parenthood to bring awareness and education on the HIV syndemic as well as empower women in the community to fight against domestic violence.	RW Part A recipient.	Year 2-5	RW Part A recipient.	Community partnership meetings with family planning agencies.

R1.1h	Adopt a client-centered approach and streamline referral processes and linkage to care	RW Part A recipient.	Year 1-5	RW Part A recipient.	Streamlined referral process and client centered services in place
R1.1i	Conduct local information sessions with stakeholders to analyze data and identify problematic areas as they relate to services delivery.	RW White Part A recipient.	Year 1-5	RW Part A	Number of informational sessions with stakeholders focusing on data analysis
R1.1j	Invite non- Ryan white funded local health care providers to collaborate in local needs assessment and planning efforts.	Community partners.	Year 1-5	RW Part A recipient.	Evidence of participation on local needs assessment.
R1.1k	Implement CDC naloxone training course and training program	Health Care and Social services providers	Year 2-5	RW Part A recipient. AETC	Training took place. Number of providers attending training

Goal R2: By 2026, achieve integration to the meet the needs of PWH and persons at risk of HIV.					
Strategy: Focus resources including evidence-based informed interventions in geographic areas where priority populations are most impacted by HIV.					
Objective R2.1: By 2026 increase coordination of services providers and sharing of best practices across the continuum of HIV prevention and care throughout of all levels of government (federal, state and local).					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
R2.1a	Identify best practice implemented in other similar jurisdictions with similar populations.	PWH Ryan White Part A	Year 2-5	Ryan White Part A Recipient's Office	Number of best practices adopted in PBC.
R2.1b	Expand community forums and use them to educate, receive input and share information regarding integrated plan strategies, activities and outcomes	PWH Ryan White Part A	Year 2-5	Ryan White Part A Recipient's Office DOH	Number of annual community forums.

R2.1c	Coordinate with PBC DOH to respond to active HIV transmission clusters and address consent, privacy, and data use concerns.	Ryan White Part A	Year 1-5	Ryan White Part A Recipient's Office DOH	Evidence of Coordination with DOH.
R2.1d	Increase engagement and capacity of FBOs and health care providers in cases of emerging HIV outbreaks	FBOs Health care providers Ryan White Part A	Year2-5	Ryan White Part A Recipient's Office DOH	Evidence of community engagement in cases of emerging HIV outbreaks
R2.1e	Review MOUs to ensure agreements with prevention, care and social support services providers.	Ryan White Part A Prevention Programs	Year 1-5	Ryan White Part A Recipient's Office	MOUs include agreement with prevention, care and social support providers.

Goal R3: By 2026, achieve integration of services to meet the needs of PWH and persons at risk for HIV					
Strategy*: Develop and optimize collaboratives to address emergent and evolving challenges facing PWH*					
Objective R3.1: By 2026, enhance the quality, accessibility, sharing and uses of data between DOH, HIV medical providers and essential support services.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
R3.1a	Coordinate efforts of electronic data sharing between the DOH and medical and social services providers.	DOH Ryan White Part A HIV Providers	Year 2-5	Ryan White Part A Recipient's Office	Increased Data sharing opportunities.
R3.1b	Create a data base that can be interfaced with internal and external Registries	Ryan White Part A	Year 2-5	Ryan White Part A Recipient's Office	Database in place

R3.1c	Promote the use of EMR Portals and other electronic health systems.	PWH	Year 1-5	Ryan White Part A Recipient's Office	Number of PWH having access to Patient Portals
R3.1d	Develop fundamental interoperability to send data to other systems.	Ryan White Part A	Year 2-3	Ryan White Part A Recipient's Office	Evidence of interoperability in data base
R3.1e	Develop structural interoperability. A recipient system to intercept information at the data field level allowing providers to exchange patient summary information.	Ryan White Part A	Year 2-3	Ryan White Part A Recipient's Office	Evidence of structural interoperability in data base
R3.1f	Semantic Interoperability-Health IT system to exchange patient patient's summary information	Ryan White Part A	Year 2-3	Ryan White Part A Recipient's Office	Evidence of semantic interoperability in data base
R3.1g	Organizational Interoperability. Governance, policy, social, legal organization. Consideration to facilitate secure, timeless communication and use of data both between entities organizations, and individuals.	Ryan White Part A	Year 2-3	Ryan White Part A Recipient's Office	Evidence of organizational interoperability
R3.1h	Develop an electronic system that can spot unauthorized access to health records and data exfiltration to protect PHI and build users' trust	Ryan White Part A	Year 2-3	Ryan White Part A Recipient's Office	Evidence of a system that protect PHI

Goal R4: By 2026, develop the mechanisms for timely dissemination of HIV related research and best practices.					
Strategy: Adopt approaches that incentivize the scale up of effective interventions among providers, academic institutions, PWH and other Partners					
Objective R4.1: By 2026, foster private public community partnerships to identify and scale up best practices and accelerate HIV advances.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators

R4.1a	Create a partnership workshop designed specifically to create a sense of urgency and rally support for creating change. Participants will determine a clear goal and vision for the partnership.	Community partners.	Year 2	Ryan White Part A recipient's office.	Community workshop. Number of partners attending workshop.
R4.1b	Promote the understanding of the role of partnerships on how health promotions are designed, delivered and maintained.	Ryan White Part A recipient's office.	Year 2	Ryan White Part A recipient's office.	Evidence of increased understanding of role of partnerships.
R4.1c	Make seed money available to assist people to put their ideas to practice and give "quick wins" to keep the partnership's involvement.	Ryan White Part A recipient's office.	Year 2	Ryan White Part A recipient's office.	Number of providers receiving seed money who are implementing an innovative program.
R4.1d	Create incentives to collaborate and determine how work/product/information can be shared and benefit each other.	RW Part A recipient's office.	Year 2-3	Ryan White Part A recipient's office.	Number of providers receiving incentive to increase collaboration and sharing of
R4.1e	Create workshops for partners to create a sense of urgency and rally to support emergent and evolving challenges.	Ryan White Part A recipient's office. HIV Providers	Year 2-3	Ryan White Part A recipient's office.	Number of workshops

Goal R5: By 2026, reduce the burden of reporting data by collection standards and data quality.					
Strategy*: Streamline reporting and data systems to reduce burden of using Data*					
Objective R5.1: By 2026, create methods, to measure, monitor, and evaluate data systems.					
Strategies	Activities	Target Populations	Time Frame	Responsible	Data Indicators
R5.1a	Develop statewide data standards where all subrecipients have timely access to the same information	Ryan White Part A Recipient Office. FDOH.	Year 2-5	Ryan White Part A Recipient Office. FDOH.	Data Standards established.

R5.1a	Develop consistent and synchronized methods to communicate progress towards goals, objectives and activities	Ryan White Part A Recipient Office. FDOH.	Year 2-5	Ryan White Part A Recipient Office. FDOH.	System to monitor the implementation of integrated plan is in place.
R5.1a	Ensure availability of federal funding to Implement integrated plan goals and objectives.	Ryan White Part A Recipient Office. FDOH.	Year 2-5	Ryan White Part A Recipient Office. FDOH.	Federal funding allocation
R5.1a	Monitor progress towards goals and objectives of the integrated prevention and care plan on a quarterly basis.	Ryan White Part A Recipient Office. FDOH.	Year 2-5	Ryan White Part A Recipient Office. FDOH.	Monitoring process in place. Data presented on a quarterly basis.
R5.1a	Identify barriers and offer technical support to partners who are experiencing difficulties in achieving goals.	Ryan White Part A Recipient Office. FDOH.	Year 1-5	Ryan White Part A Recipient Office. FDOH.	Evidence of providing technical support

Key Partners: RW Part A and B providers, MAI providers, Health Care providers. FQHC, DOH, AETC, Academic Institutions
Potential Funding Sources: RW Part A, B, MAI, DOH, local private and public funding, CDC local funding
Estimated Funding Allocations: $2,307.00
Outcomes Reported: HIV-related syndemic data on STI, viral hepatitis, substance use, mental health and other co-occurring disorders
Monitoring Data Sources: FDOH HIV Surveillance data, RW program data.
Expected Outcomes in the HIV Care Continuum: Increased timeliness of data to identify PWH who need rapid linkage to care, who are out of care, retained in care, and virally suppressed.

SECTION VI: INTEGRATED PLANNING IMPLEMENTATION, MONITORING AND FOLLOW UP

Planning Infrastructure

The RWAP Part A HIV CARE Council is as a federally required planning body works in coordination with the RWHAP Part A Recipient to address and support the five key phases of the integrated planning. The Planning Council work is directed to: (a) ensure that the planning goals and objectives are met; (b) monitor and evaluate the plan implementation; (c) make sure that improvement activities are done as warranted; (d) report and disseminate integrated planning reports, and (e) prioritize and allocate needed funding resources.

Furthermore, the HIV CARE Council through its various committees will share and seek input and feedback from stakeholders including PWH regarding progress, challenges and any improvement efforts encountered during the implementation of the plan.

The RWHAP Part A and HIV CARE Council is committed to: (a) accountability and reporting of data on quarterly basis regarding the progress achieved towards implementation of the Integrated Plan, (b) highlight challenges encountered and (c) report any changes or modifications to the plan.

a. Implementation Approach

The Ryan White HIV CARE Council in coordination with the RWHAP Part A and FDOH Prevention Program will provide leadership to the coordination of strategies and associated program activities outlined in the Integrated Plan. These entities will agree on a collaborative structure and define membership's roles. PWH and persons at risk for HIV will be included in the collaborative structure. RWHAP Part A staff will provide support for coordination efforts.

Coordination of shared activities

The coordination process has as a primary goal to maximize collaborative effectiveness and enhance communication among entities involved in the Integrated Plan. Meetings will take place at regular structured meetings. These meetings will be held on a quarterly basis. The meetings will address information regarding progress towards achieving outcomes and challenges encountered. Planning Partners will review data analysis. At the end of each year progress and challenges will be shared with all the partners.

Additional coordination efforts will reach to Ryan White funded providers, as well as administrators from different funding streams (Prevention and Care). These meetings will take place on a quarterly basis. These meetings will serve as a forum to discuss progress in achieving outcomes outlined in the Integrated Plan including progress achieved towards increasing collaboration with health care and behavioral providers.

The process for coordinating with partners will include PWH, and people with high risk for HIV. The process leading to the coordination with new partners will be led by the Part A Ryan White HIV CARE Council in coordination with the RWHAP Part A Recipient and CPP and representatives of FDOH.

Coordination with identified new prospective partners such as drug treatment centers, Planned Parenthood, local health providers targeting older populations, academic and research institutions, faith-based leaders and Youth organizations will take place virtually or in person. Representatives of those organizations will be invited to discuss HIV-related goals and reciprocal contributions that can be made by working in partnership.

Leverage and coordination of funding streams

The Integrated Plan will leverage and coordinate funding streams by identifying diverse funding streams among key partners and avoiding the duplication of delivery of services. The coordination of funding streams also will maximize the identification of third-party reimbursement sources available.

b. Monitoring

The monitoring of the Integrated HIV Prevention and Care Plan is designed to provide the HIV CARE Council and Community Prevention Partnership (CPP) information needed to measure progress toward the goals and objectives set forth in the Integrated Plan, and to inform decision-making geared to improve HIV prevention, care, and treatment efforts within the Palm Beach County jurisdiction. Monitoring of the implementation of the Integrated Plan and its implementation strategies, will include periodic review of data associated with identified indicators and metrics. As described in the implementation of plan the RW HIV CARE Council in coordination with the RWHAP Recipient's office and CPP will coordinate efforts to

incorporate different stakeholders, funding streams and new partners in the implementation of the Integrated Plan.

To avoid duplication of efforts and potential gaps in services, representatives from the RW HIV CARE Council will continue to participate and collaborate in the coordination of the monitoring processes of State of Florida Integrated Plan. The health planner will facilitate the coordination of monitoring activities timeline includes quarterly updates and annual reviews on the progress achieved in meeting the Integrated Plan goals, objectives and strategies. Relevant data will be examined to determine progress. Any barriers encountered during the implementation of the plan will be subject to further discussion geared to removal of obstacles. Annual review will identify relevant data analysis on performance measures and outline the mechanisms used to evaluate the planning process.

c. Evaluation

Methodology and Performance Measures

The goals and objectives of the Integrated Plan align with the NHAS and EHE pillars. The evaluation process will consist of a data driven structured interpretation of the plan's proposed strategies, goals and objectives.

Outcomes Evaluation

The outcomes evaluation will focus on whether the expected changes occurred. The following indicators of progress in achieving health outcomes will be used: (a) Increased linkage to care within one month of diagnoses from a 2021 baseline (b) Decreased number of PWH who are out of care from 2021 baseline; (c) Increased viral load suppression for heterosexual Blacks (men and women) from 2021 baseline (d) Increased viral load suppression for heterosexual Hispanic/Latinx (men and women) from 2021 baseline (e) Increased viral load for MMSC of all race/ethnic backgrounds, and (f) Decreased HIV related stigma scores from a 10-item stigma scale from 2022 baseline.

Process Evaluation

The process evaluation will assess whether the Integrated HIV Prevention and Care Plan is implemented as originally intended. The process evaluation will focus on activities as indicators of progress: (a) Number of Ryan White staff trained; (b) Number of educational sessions held;

(c) Number of new partnerships and services integration with non RW funded services organizations; (d) Number of meetings held with planning bodies and partners to assess progress; (e) Number of mobile units implementing integrated services; (d) Number of PWH employed by Ryan White funded providers, and (e) Number of PWH in leadership positions.

Data Collection

Program evaluation will perform a data collection on a quarterly basis from existent data sources. The data review process and analysis will be presented by the RWHAP staff to the HIV CARE Council, the CPP, and other stakeholders. HIV Surveillance and program data from various sources will be used to assess health outcomes, health disparities and health inequities. Process outcomes data will be incorporated into the overall assessment to measure its impact on the health status of PWH and the quality of HIV services delivery.

Data Analysis

Data analysis will take place on a quarterly basis. The analysis will focus on answering the question: Are Integrated Plan goals, objectives and strategies being achieved? Performance indicators will be used to gauge progress. Data analysis will be prepared and presented by the RWHAP Part A staff to the HIV CARE Council and other stakeholders.

Evaluation Reports

Reports will be generated by the RWHAP Part A and FDOH Prevention Program and presented to the Ryan White Council and CPP on a quarterly basis. The quarterly evaluation report will document the level of success in achieving plan goals and objectives, and identify areas of improvement. The annual report will integrate quarterly reports into one document.

d. Improvement

The Palm Beach County jurisdiction Ryan White HIV CARE Council in coordination with the RWHAP Part A, are committed to use a systematic approach to analyzing performance and identifying opportunities for improvement across the HIV continuum of prevention and care. The jurisdiction will use performance outcomes and process indicators to evaluate progress. The Quality Management and Evaluation committee will take the lead in the development of quality project initiatives when performance outcome indicators are not met. Both, the RW HIV CARE Council and Planning Committee will review performance data, and will seek input from the community as needed.

The Planning bodies, with input from affected communities and PWH, will make the decisions on pursuing corrective actions.

e. Reporting and Dissemination

To ensure that the planning results are known, the jurisdiction will design a communication plan. Basically, the plan will specify the *Why*- as to the purpose of dissemination of information, the *What*- as to the message to be disseminated, the *Whom*- as to the audience, *How*- as to the method, and *When*- as to timing. Once the objective of communication plan and audiences are identified, information will be disseminated in a wide variety of manners. The information dissemination strategy will be based on the understanding of stakeholders and their information needs and preferences.

The HIV CARE Council and the CPP will require the approval of the dissemination plan. External stakeholders will benefit from knowing the outcomes of the project. Therefore, the community partners, health care providers, social services providers, faith-based organizations, and academic institutions will all be appraised of planning progress through newsletter articles, community forums, and Town Hall meetings, and partners meetings. The communication plan will consider broader communication to be shared via social media, websites, and listserv that can connect providers across different organizations.

SECTION VII: LETTERS OF CONCURRENCE

Letters of concurrence for the Palm Beach County Integrated HIV Prevention and Care Plan 2022-2026 were provided by the PBC HIV Care Council and the PBC Community Prevention Partnership, which along with Palm Beach County Community Services Department and the Florida Department of Health in Palm Beach County will serve as the Integrated Planning Body for Palm Beach County.