Fort Lauderdale / Broward County EMA
Broward County HIV Health Services Planning Council
An Advisory Board of the Broward County Board of County Commissioners
200 Oakwood Lane, Suite 100, Hollywood, FL, 33020 - Tel: 954-561-9681 / www.BRHPC.org

MEETING AGENDA

Committee: Priority Setting & Resource Allocation (PSRA)
Date/Time: Thursday, April 19, 2018, 9:00 a.m.
Location: Governmental Center Room GC-430
Chair: Lorenzo Robertson **Vice Chair:** Marie Hayes

1. **CALL TO ORDER:** *Welcome, Ground Rules, Sunshine, Introductions, Moment of Silence, & Public Comment*
2. **APPROVALS:** 4/19/18 Agenda and 3/15/18 Meeting Minutes
3. **STANDARD COMMITTEE ITEMS**
   a. Monthly Expenditure/Utilization Report by Category of Service
4. **UNFINISHED BUSINESS**
5. **MEETING ACTIVITIES**

Goal/Work Plan Objective #:	*Accomplishments*
2016 Broward Epi Presentation (Handout A)	ACTION ITEM: Receive presentation on 2016 Broward EMA Epidemiology, discuss trends and impact on RW Part A Clients and services.
Ryan White Funder/Stakeholder Presentations (Handouts B-C)	ACTION ITEM: Receive presentations from Ryan White Funders/Stakeholders (RW Parts B and F/AETC), discuss trends and impact on RW Part A Clients and services.

6. **RECIPIENT REPORTS**
7. **PUBLIC COMMENT**
8. **AGENDA ITEMS/TASKS FOR NEXT MEETING:** May 17, 2018 **Time:** 9:00-1:00 p.m., **EXTENDED MEETING** **Venue:** Governmental Center Annex, Room A-337

Goal/Work Plan Objective #:	*Accomplishments*
Ryan White Funder/Stakeholder Presentations	ACTION ITEM: Receive presentations from Ryan White Funders/Stakeholders (RW Parts C, D, and HOPWA)
Needs Assessment/Community Forum Feedback	ACTION ITEM: Discussion of community needs and feedback from needs assessment activities.
Community Empowerment Committee Service Rankings	ACTION ITEM: Review CEC's ranking of FY2019 Part A Services
Data Presentation Wrap-Up and Final Discussion	ACTION ITEM: Final discussion on data presentations, key findings, service gaps and barriers, community needs, etc.
Priority Setting	ACTION ITEM: Rank Part A services based on community need, funder recommendations, and data presentations.

9. **ANNOUNCEMENTS**
10. **ADJOURNMENT**

PLEASE COMPLETE YOUR MEETING EVALUATIONS

THREE PRINCIPLES IDEAS OF THE BROWARD COUNTY HIV HEALTH SERVICES PLANNING COUNCIL

• Linkage to Care • Retention in Care • Viral Load Suppression •

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MEETING MINUTES

Committee: Priority Setting & Resource Allocation (PSRA)
Date/Time: Thursday, March 15, 2018 9:00 a.m.
Location: Government Center A-337
Chair: Will Spencer **Vice Chair:** Rick Siclari

ATTENDANCE					
#	**Members**	**Present**	**Absent**		**Guests**
1	Barrientos, Y.	**X**			
2	Barnes, B.		**A**		**HIVPC Staff**
3	Grant, C.	**X**			Ewart, L.
4	Hayes, M.	**X**			Oratien, V.
5	Katz, H. B.	**X**			Holloman, K.
6	Lopes, R.	**X**			
7	Schickowski, K.	**X**			**Grantee Staff**
8	Shamer, D.	**X**			Jones, L.
9	Siclari, R., *Vice Chair*		**A**		Anderson, T.
10	Spencer, W., *Chair*	**X**			Drummond, K.
					Meeks, A.
	Quorum = 8				

1. CALL TO ORDER:

The HIVPC Vice Chair called the meeting to order at 9:21 a.m. The HIVPC Vice Chair welcomed all present. Attendees were notified of information regarding the Government in the Sunshine Law and meeting reporting requirements, which includes the recording of minutes. Attendees were advised that the meeting ground rules are present, for reference. In addition, attendees were advised that the acknowledgement of HIV status is not required but is subject to public record if it is disclosed. Chairs, committee members, guests, Grantee staff and HIVPC staff self-introductions were made.

2. APPROVALS:

Motion #1: To approve 3/15/18 meeting agenda.
Proposed by: Grant, C. **Seconded by:** Hayes, M.
Action: Passed Unanimously

Motion #2: To approve meeting minutes of 1/18/18.
Proposed by: Shamer, D. **Seconded by:** Grant, C.
Action: Passed Unanimously

3. UNFINISHED BUSINESS

None.

4. STANDARD COMMITTEE ITEMS

Monthly Expenditure/Utilization Report: The Recipient presented the current FY2017 expenditures report. Not all provider invoices have been received, but the Recipient expects that utilization will be over 99%. There may be an estimated $1,000-$2,000 left over, but each service category is between 94% and 100% utilization. OAMC is the biggest outlier, because of its specialty billing and the need to reconcile services rejected by Medicaid. Once this takes place, OAMC is anticipated to have 100% utilization. Non-Medical Case Management is anticipated to have over 99% utilization. The Recipient reiterated that rebate dollars were received which supplemented funding for Dental, HICP, BSS, and Food Vouchers. The only money received so far has been for Oral Health because it was an easy transition of funds. The other service categories have not yet received their rebate funds but they should be coming. Billing was stopped for Food Vouchers in anticipation of the rebate dollars, and that service category's money was swept to fulfill expenditure requests. The Recipient has been in contact with the State Department of Health and anticipates the funds very soon, as well as word of available funding for FY18.

Some funds were offset in FY17, meaning that if the same utilization pattern emerges in FY18 there will be some difficult decisions to be made regarding service eligibility midyear unless the full grant award is received. One factor which may help is the expansion of the Part B ADAP Formulary. This change took effect on March 1, 2018 and may have a $200,000 impact. In addition to this, there is still no final grant award. The Recipient's Office was notified last week of another partial grant award, and may not know the full award until July or August.

FY18 may be the first fiscal year in some time in which there is no bulk purchase. In the last fiscal year, the State Department of Health had $88 million in rebate funds and was mandated to spend down $38 million of that amount, which had accumulated from previous years. The Recipient will know by the end of the month if the remaining funds will be available to Part As. There is also a need to consider whether anyone else can meet the needs of the funding continuum because, given the current funding situation, funding for services may have to be cut.

A member requested an update on the Peer Certification initiative. The Recipient stated that a grant was received from the Community Foundation of Broward, and the RFP closes on Friday, March 16, 2018. The program will have a consultant responsible for the curriculum and certification program. The RFP does not use Part A funds. The program is expected to start in August, and be designed as a 5 or 6-month process. Another RFP is also out for the MAI services, not including CIED. It is based on PSRA's previous suggestion to focus on Black men and women aged 18-38. The Peer Certification program comes from a goal of the Integrated Plan. Funding for the Peer Certification program can only come about one of two ways: either administrative dollars or an alternate funding source. In this case, the alternate funding source was provided by the Community Foundation of Broward. Another member mentioned the Health Foundation of South Florida as an option should there be a need for additional funding going forward.

5. MEETING ACTIVITIES

FY2017 PSRA Committee Evaluations (Handouts A-B): The Committee discussed its progress toward FY2017 Committee goals and completed an annual evaluation. Other than the Assessment of the Administrative Mechanism, PSRA completed all proposed items for the fiscal year. There was not a need for updated How Best to Meet the Need language. The Committee requested Technical Assistance for evaluating the PSRA process at the end of the fiscal year, however it was ultimately deemed unnecessary. When the Recipient attended the HRSA meeting on the PSRA process, it was clear that the Broward EMA's process was similar to other areas. Regarding targeting vulnerable populations, that activity was shifted to the System of Care Committee. PSRA can consider another population if the Committee is interested in completing this activity in FY2018. It is always a task of the PSRA Committee to review the Assessment of the Administrative Mechanism, so the Committee was asked to share any feedback regarding the surveys or the report.

A member asked if the Committee about the process for selecting target populations, and if the PSRA Committee had to wait for population recommendations from other committees. The HIVPC Manager stated that information is provided to PSRA through data presentations from funders and other Committees. The Chair added that the Committee should be vigilant regarding trends, but it needs data to support any recommendations. The member shared with the Committee that there is a trend of Transgender men becoming infected, and a recent study from California was released highlighting this trend. The Chair suggested that in the PSRA process, the Committee would pay attention to the population to determine if intervention was needed in Broward.

The Committee then evaluated its performance in FY2017. The evaluation used a Likert scale to ask questions about overall performance and short answer questions to dive deeper into member responses. Members said that there was room for improvement for over-the-phone attendees, as it can be difficult to hear what is going on in the room. Most often, members stated a need for new members to be brought onto PSRA. The Committee Chair encouraged members to bring someone to a meeting. Members also noted that not all meeting documents are available far enough in advance and that presenters often bring their documents to the meeting so there is no time for members to review beforehand. Members discussed issues with emails as well as suggested adding the Dropbox link to the reminder email in order to make meeting documents easier to access ahead of the meeting. A member also recommended training for new members as a way to improve the PSRA Committee, because it can take time for new members to understand what is going on.

The Committee discussed the upcoming PSRA process. The focus of presentations this year will be on recommendations from funders for the Part A process and population trends. The Recipient stated that PSRA is often expected to solve every problem, however Part A is the payer of last resort and has limited funding for increasing utilization. He asked

members to consider whether systems were operating at their maximum efficiency to serve clients' needs. Members emphasized the need for sharing information regarding resources between agencies so that case managers are made aware of which services are available and where.

The Committee took a consensus vote to approve Rachel Williams to join PSRA. Ms. Williams has taken the HOPWA seat on the HIVPC since Mr. DeSantis stepped down in January.

> **Motion #3**: To appoint Rachel Williams to the Priority Setting & Resource Allocation Committee.
> **Proposed by:** Spencer, W.
> **Action:** Passed Unanimously

FY2018 PSRA Committee Work Plan (Handout C): Members reviewed and approved the Work Plan for the current fiscal year (handout on file).

> **Motion #4**: To approve the FY2018 Priority Setting & Resource Allocation Committee Work Plan.
> **Proposed by:** Katz, H.B. **Seconded by:** Lopes, R.
> **Action:** Passed Unanimously

PSRA Process (Handouts D-E): The PSRA Committee reviewed and approved the proposed FY2019 PSRA process timeline. PSRA members signed a Member Agreement Form. The Committee reviewed the PSRA Manual and had no changes (handouts on file).

> **Motion #5**: To approve the FY2019 PSRA Process Timeline.
> **Proposed by:** Katz, H.B. **Seconded by:** Lopes, R.
> **Action:** Passed Unanimously

FY2016 Assessment of the Administrative Mechanism (Handout F): The HIVPC Manager reviewed the Assessment of the Administrative Mechanism (handout on file). One goal for this year's assessment is to ensure member responsiveness so that the needed information can be obtained in a timely manner. Overall, the Administrative Mechanism is functioning effectively and efficiently. There was a short-lived concern when the Recipient's Office got a new payments system.

6. RECIPIENT REPORT

In the coming months, new staff will be filling positions in the Ryan White Part A Recipient's Office which have been vacant for more than a year. One new staff member, Andrea Meeks, was introduced to the Committee.

The Broward Part A program was chosen by HRSA to participate in a national webinar to present on the implementation of Test and Treat. Broward County and Los Angeles County will each present for 20 minutes, followed by a Question & Answer period. This is going to be a larger initiative by HRSA, and falls under its Getting to Zero initiative.

A Committee member asked the Recipient about vaccines. The Recipient explained that the ADAP Formulary was updated on March 1, 2018 to include more pharmaceuticals that Part A covers, which makes it inefficient for Part A to continue covering them. The Recipient will facilitate conversations to ensure that the mechanism is there for the move to be effective.

7. PUBLIC COMMENT

None.

8. AGENDA ITEMS/TASKS FOR NEXT MEETING: April 19, 2018 **Time**: 9:00 a.m. **Venue:** A-337

Goal/Work Plan Objective #:	*Accomplishments*
2016 Broward Epi Presentation	ACTION ITEM: Receive presentation on 2016 Broward EMA Epidemiology
Ryan White Funder/Stakeholder Presentations	ACTION ITEM: Receive presentations from Ryan White Funders/Stakeholders

9. ANNOUNCEMENTS

a. Poverello is holding a lip sync event for the AIDS Walk this evening, March 15, 2018 at 8:00 p.m.
b. The AIDS Walk is on Sunday, March 18, 2018. The HIVPC is invited to table with the Ryan White Part A Office staff.
c. FLDOH-BC is holding a Broward Beach Blitz right now.

10. ADJOURNMENT

The meeting was adjourned at 11:13 a.m.

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PSRA Attendance CY2018

Consumer	PLWHA	Absences	Count	Meeting Month:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Attendance Letters
				Meeting Date:	18	C	15										
1	1	1	**1**	Barnes, B.	X		A										
1	0	0	**2**	Barrientos, Y.	X		X										
0	0	0	**3**	DeSantis, M.	X	Z-1/23											
0	0	0	**4**	Grant, C.	X		X										
0	0	1	**5**	Hayes, M.	A		X										
1	1	0	**6**	Katz, H.B.	X		X										
0	0	1	**7**	Lopes, R.	A		X										
0	0	0	**8**	Schickowski, K.	X		X										
1	1	0	**9**	Shamer, D.	X		X										
0	0	1	**10**	Siclari, R., *V. Chair*	X		A										
0	1	0	**11**	Spencer, W. *Chair*	X		X										
				Quorum = 7	9		8										

Legend:

- **X - present**
- **A - absent**
- **E - excused**
- **NQA - no quorum absent**
- **NQX - no quorum present**
- **NQE - no quorum excused**
- **N - newly appointed**
- **Z - resigned**
- **C - cancelled**
- **W - warning letter**
- **R - removal letter**

Ryan White Funders Presentation for PSRA

RYAN WHITE PART F/AETC

- 90% of PLWHA have a chronic oral condition
- 32-46 percent of PLWHA will have at least one major HIV-related oral health problem.
- 58-68 percent PLWHA do not receive regular health care.
- Barriers PLWHA face in receiving oral health care include lack of insurance, limited incomes, lack of providers, stigma, and limited awareness.
- Poor oral health can impede food intake and nutrition, leading to poor absorption of HIV medications and leaving PLWHA susceptible to progression of their disease.[4]
- HIV medications have side effects such as dry mouth, which predisposes PLWHA to dental decay, periodontal disease, and fungal infections.

- Bacterial infections (i.e., dental decay and periodontal disease) that begin in the mouth can escalate to systemic infections and harm the heart and other organs if not treated, particularly in PLWHA with severely compromised immune systems.

- A history of chronic periodontal disease can disrupt diabetic control and lead to a significant increase in the risk of delivering preterm low-birthweight babies.

- Poor oral health can adversely affect quality of life and limit career opportunities and social contact as result of facial appearance and odor.

Significance of Oral Manifestations

- First sign of clinical disease
- Signify disease progression
- Signify possible ART failure
- Effects on medication adherence and nutrition

The Ryan White Part F/AETC Program Overview

Part F: Dental Programs

Funds from all Ryan White HIV/AIDS Program Part recipients may support the provision of oral health services. However, two programs specifically focus on funding oral health care for people living with HIV: the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP). The key program elements are funding of services and funding of education and training for oral health providers.

Eligibility

Eligible applicants for both the DRP and the CBDPP are institutions that have dental or dental hygiene education programs accredited by the Commission on Dental Accreditation (for example, dental schools, hospitals with postdoctoral dental residency programs, and community colleges with dental hygiene programs).

Grant Recipients

Grant recipients are dental education programs seeking to improve their response to the HIV epidemic in their area.

The Ryan White Part F/AETC Program Overview

Community-Based Dental Partnership Program (CBDPP)

First funded in 2002, the Community-Based Dental Partnership Program increases access to oral health care services for people living with HIV while providing education and clinical training for dental care providers, especially those practicing in community-based settings.

To achieve its goals, CBDPP works through multi-partner collaborations between dental education and dental hygiene education programs and community-based dentists and dental clinics. Community-based program partners and consumers help design programs and assess their impact.

Community Partner is Broward Community and Family Health Center

Program Budget

- FY2017 Budget and Final Expenditures $219,000 fro five years/Expenditures $219,000
- Grant expires June 30,2018
- Any Other Funding Sources/Resources Medicaid/Private Insurance

Services Provided

Please list all of the services provided by your program, including:

- Comprehensive Oral Health Care including all specialty services
- Client Eligibility: HIV+
- Number of Unduplicated clients in 254

Male **136**

Female **115**

Transgender **3**

Unknown/unreported **0**

Total **254**

Services Provided

Hispanic or Latino/a **83**

Non-Hispanic or Latino/a **171**

Mexican, Mexican

American, Chicano/a

18

Puerto Rican **7**

Total **83**

Other Hispanic,

Latino/a or Spanish

Origin

41

Total **2**

Cuban

Services Provided

White **94**

Black or African

American

153

Asian **2**

Total **254**

Native Hawaiian or

Other Pacific Islander

0

American Indian or

Alaska Native

0

More than one race **5**

Services Provided

12 or younger **0**

13-24 **12**

25-44 **103**

45-64 **87**

Total **254**

65 or older **52**

Unknown/unreported **0**

Needs, Gaps, Barriers to Care

- Are there any service gaps? (services that clients needed but weren't available) No
- Are there waiting list for your services? No
- What are the primary barriers to care reported by your clients? Transportation

Notable Trends

On this slide please describe any notable trends occurring in your program, including:

- Newly diagnosed populations
- Young Adults (18-28) increased in numbers
- The elderly- stable
- Recently reengaged in care/ more patients with AIDS
- Clients with high viral loads vs. virally suppressed clients Large percentage of patients have suppressed viral loads
- Mental health or substance use issues/ A major barrier for care and retention

Recommendations

What are some of the successes of your program: Diagnosed of new clients with HIV and AIDS

What activities do you feel are contributing to the success of the program? Increased knowledge of providers in diagnosis

What are some of the challenges faced by your program: Retention/ failed appointments/racial cultural barriers

Based on the identified challenges, what are some activities or solutions that the Part A Program could potentially address through the PSRA process?

Increase funding for mental health and or patient eligibility specialists in oral health care site

Questions?

Discussion

Created: 12/15/15

Revision: 12/05/2017

HIV Epidemiology Broward County

(Excluding Department of Corrections)

Presented By:
Florida Department of Health
HIV/AIDS Section
Data as of 6/30/2017

Division of Disease Control and Health Protection

Technical Notes

- HIV cases by year of diagnosis represent HIV cases diagnosed in that year, regardless of AIDS status at time of diagnosis
- AIDS and HIV cases by year of diagnosis are **not** mutually exclusive and **cannot** be added together
- HIV prevalence data represent persons who were living with a diagnosis of HIV in the reporting area through the end of the calendar year (regardless of where they were diagnosed)

Technical Notes, Continued

- Adult cases represent ages 13 and older; pediatric cases are those under the age of 13. For data by year, the age is by age at diagnosis. For living data, the age is by current age at the end of the most recent calendar year, regardless of age at diagnosis
- Unless otherwise noted, Whites are non-Hispanic, Blacks are non-Hispanic and Other (which may be omitted in some graphs due to small numbers) represents Asian, American Indian, or mixed races
- Unless otherwise noted, area and county data will exclude Department of Corrections cases

Florida's Plan to Eliminate HIV Transmission and Reduce HIV-related Deaths

Four Key Components

- Implement routine HIV and Sexually Transmitted Disease (STD) screening in health care settings and priority testing in non-health care settings
- Test and Treat (T & T): provide rapid access to treatment and ensure retention in care
- Improve access to antiretroviral pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP)
- Increase HIV awareness and community response through outreach, engagement, and messaging

Florida HEALTH

Definitions of Mode of Exposure Categories

- **MSM:** Men who have sex with men or male-to-male sexual contact
- **IDU:** Injection Drug User
- **MSM/IDU:** Men who have sex with men or male-to-male sexual contact & injection drug user
- **Heterosexual:** Heterosexual contact with person with HIV or known HIV risk
- **Other**: includes hemophilia, transfusion, perinatal and other pediatric risks and other confirmed risks

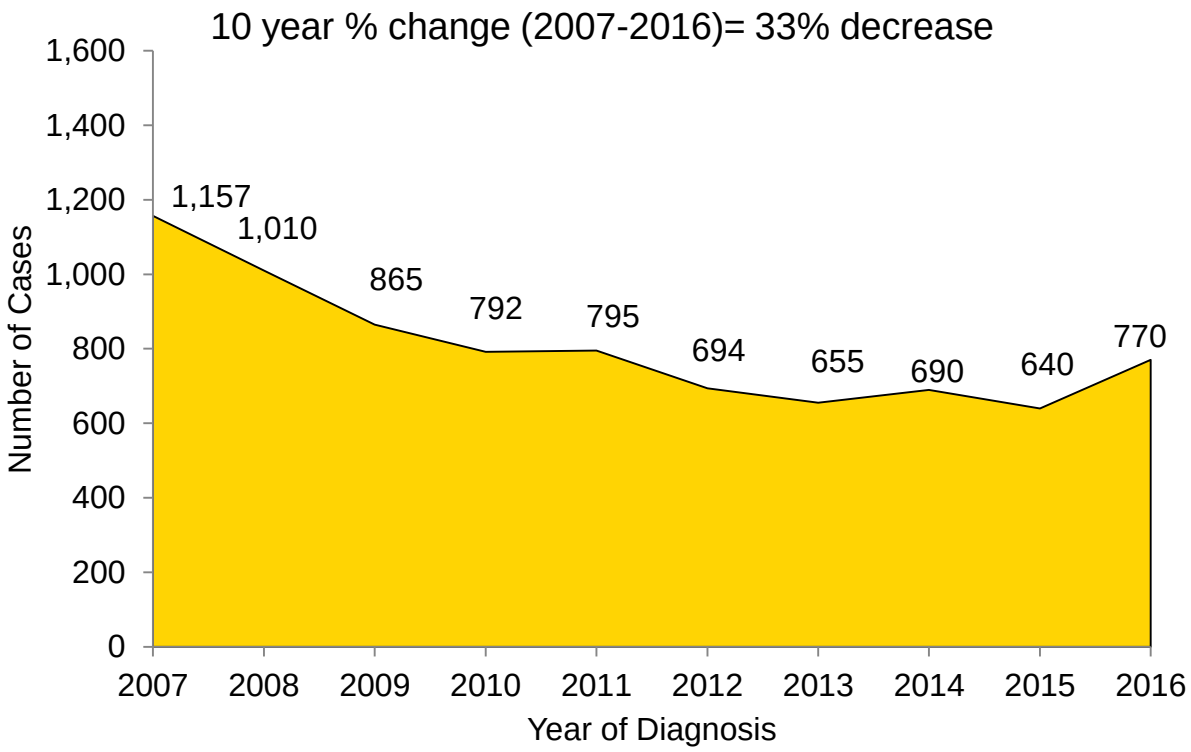
The Epidemic in Broward County

	2015	2016	Trend
Population	1,821,974 (41% White, 27% Black, 27% Hispanic, 5% Other)	1,853,380 (37% White, 27% Black, 32% Hispanic, 4% Other)	1.7% increase
Newly diagnosed HIV cases	640	770	20.3% increase
Newly diagnosed AIDS cases	277	252	9.0% decrease
Pediatric AIDS cases diagnosed	0	0	
Perinatal HIV cases born in Florida	1	0	
People diagnosed & living with HIV (Prevalence)	19,595 (35% White, 46% Black, 17% Hispanic, 2% Other)	20,041 (34% White, 46% Black, 17% Hispanic, 3% Other)	2.3% increase
HIV - related deaths	113	126	11.5% increase

Cases by Year of Diagnosis

HIV Cases by Year of Diagnosis, Broward County, 2007–2016

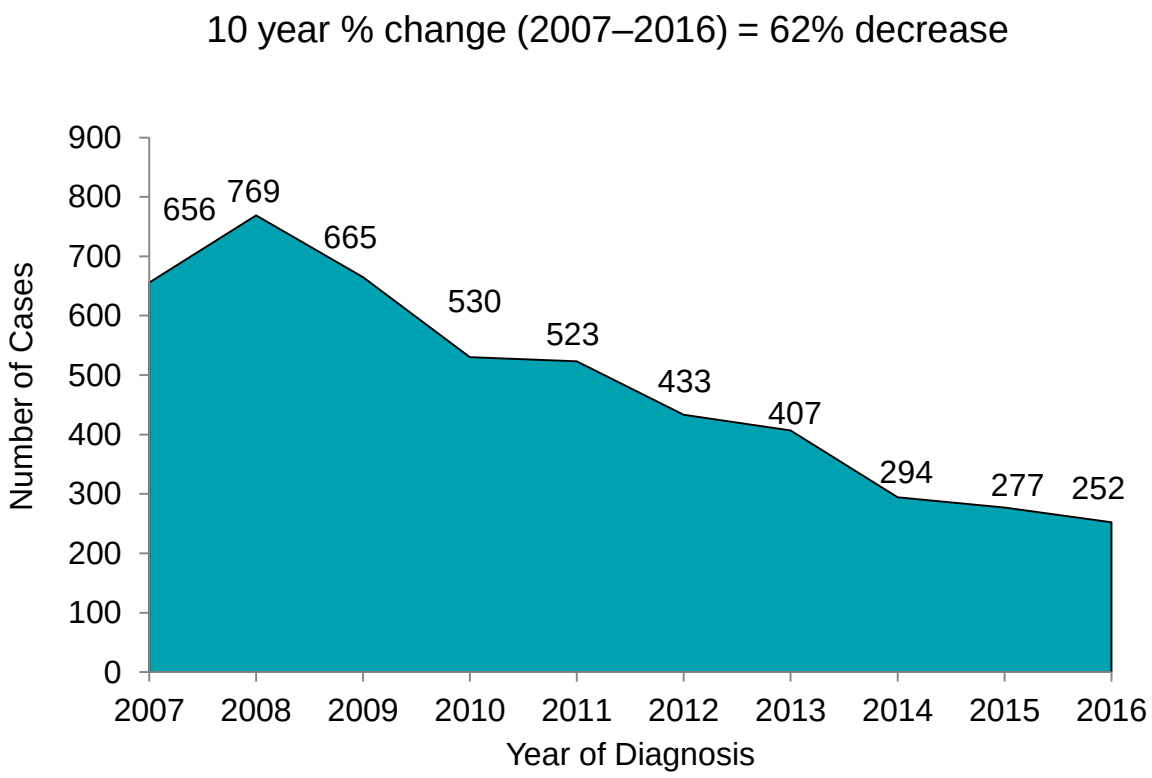
HIV Cases Diagnosed in 2016 by Selected Demographics and Risk Factors in Broward County and Florida[1]	Broward County	Florida
N=	770	4,972
Sex		
Male	78%	78%
Female	22%	22%
Race/Ethnicity		
White	24%	24%
Black	48%	42%
Hispanic	26%	32%
Other[2]	2%	2%
Age at Diagnosis		
Age <13	0%	<1%
Age 13–29	32%	34%
Age 30–49	47%	45%
Age 50+	21%	21%
Mode of Exposure		
MSM	58%	60%
IDU	4%	4%
MSM/IDU	2%	2%
Heterosexual	36%	33%
Other[3]	<1%	<1%



[1] Source: Florida data: FL Department of Health, HIV/AIDS Section, alive and diagnosed Year-end 2016, as of 6/30/2017.
[2] Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial individuals.
[3] Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.

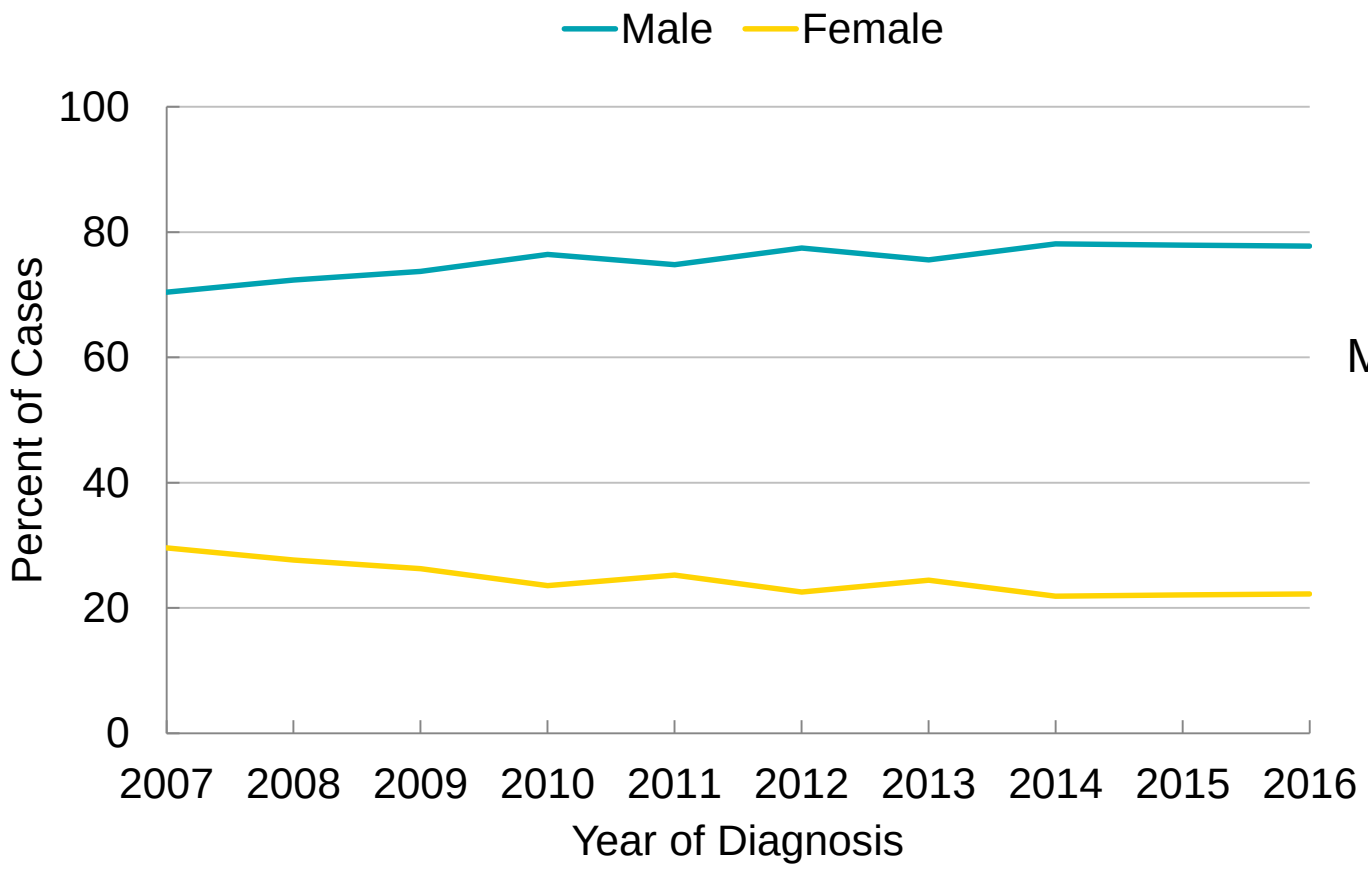
AIDS Cases by Year of Diagnosis, Broward County, 2007–2016

AIDS Cases Diagnosed in 2016 by Selected Demographics and Risk Factors in Broward County and Florida[1]	Broward County	Florida
N=	252	2,119
Sex		
Male	70%	70%
Female	30%	30%
Race/Ethnicity		
White	19%	24%
Black	59%	51%
Hispanic	17%	22%
Other[2]	4%	3%
Age at Diagnosis		
Age <13	0%	<1%
Age 13–29	19%	18%
Age 30–49	49%	50%
Age 50+	32%	32%
Mode of Exposure		
MSM	43%	45%
IDU	6%	7%
MSM/IDU	<1%	3%
Heterosexual	49%	44%
Other[3]	1%	1%



[1] Source: Florida data: FL Department of Health, HIV/AIDS Section, alive and diagnosed Year-end 2016, as of 6/30/2017.
[2] Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial individuals.
[3] Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.

Adult (Age 13+) HIV Cases, by Sex and Year of Diagnosis, Broward County, 2007–2016

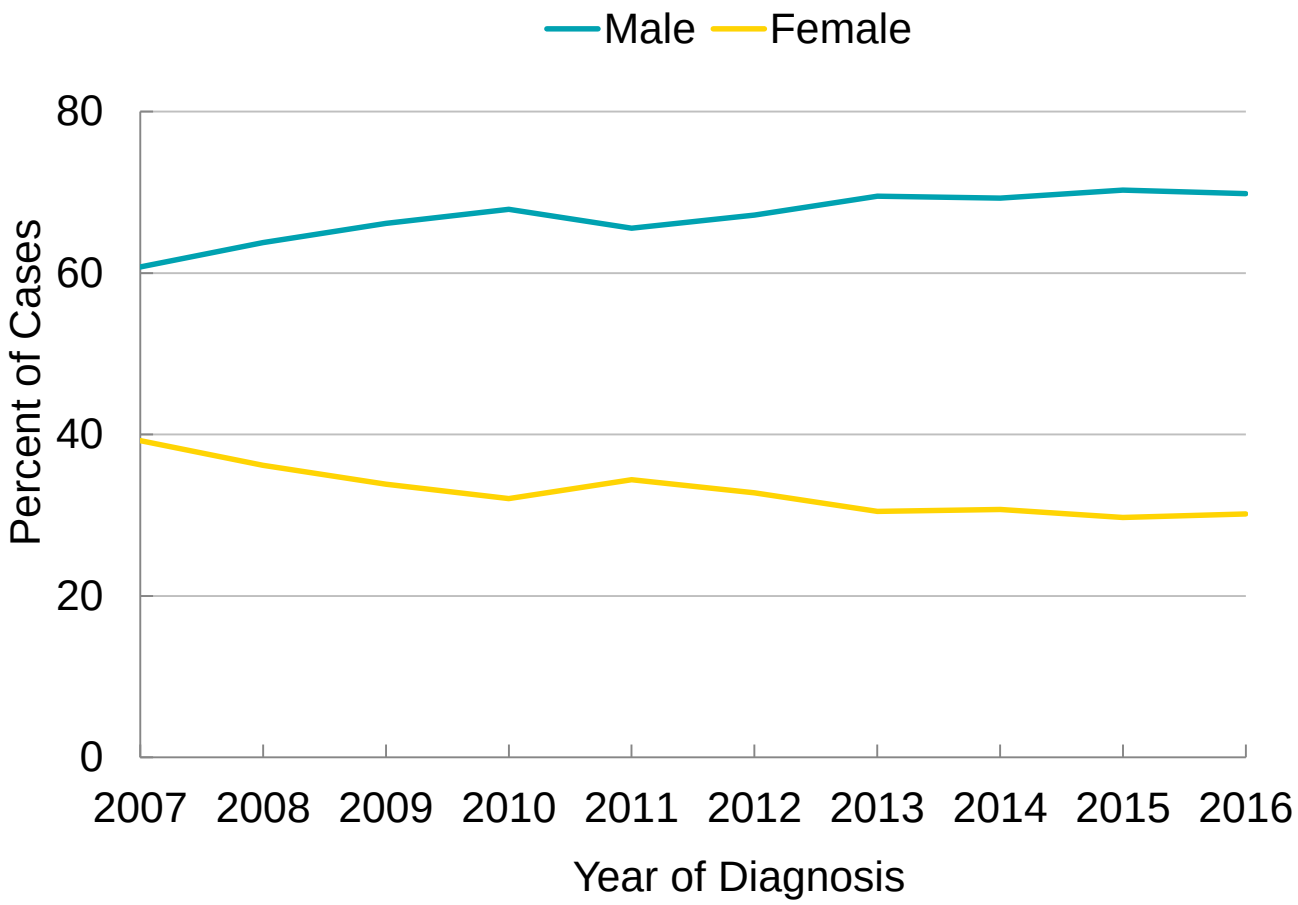


Male to Female Ratio

2007= 2.4 to 1

2016= 3.5 to 1

Adult (Age 13+) AIDS Cases, by Sex and Year of Diagnosis, Broward County, 2007–2016

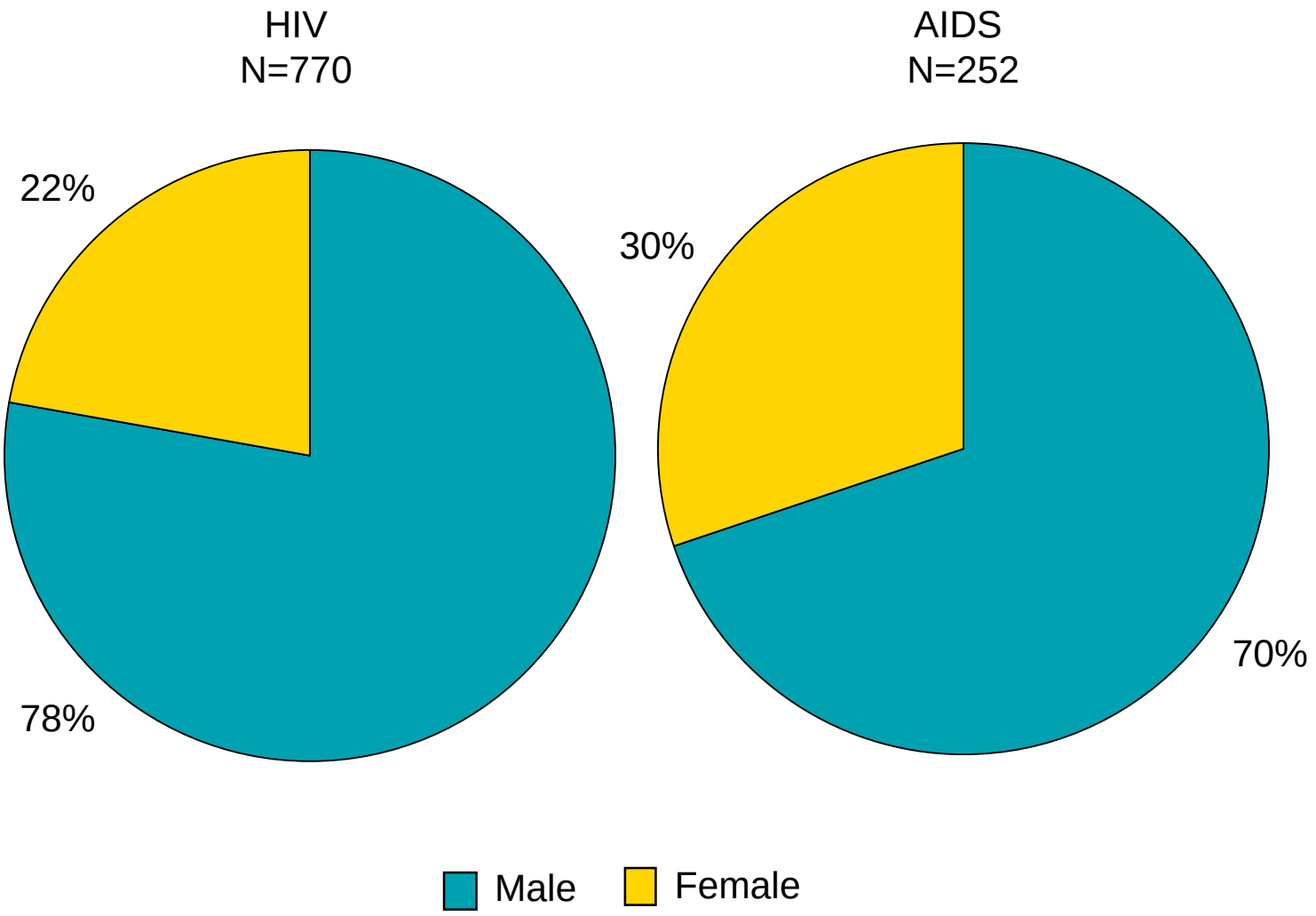


Male to Female Ratio

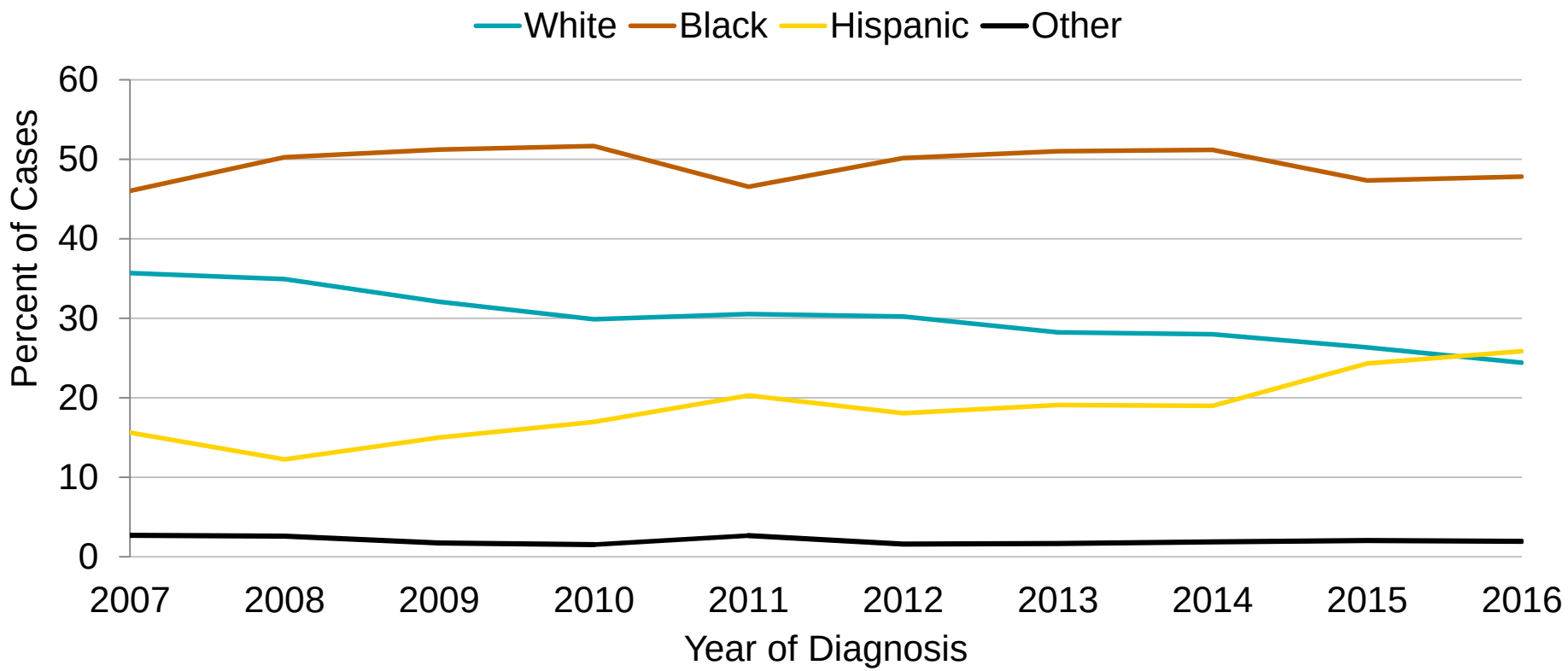
2007= 1.5 to 1

2016= 2.3 to 1

Adult (Age 13+) HIV and AIDS Cases by Sex, Broward County, Diagnosed in 2016

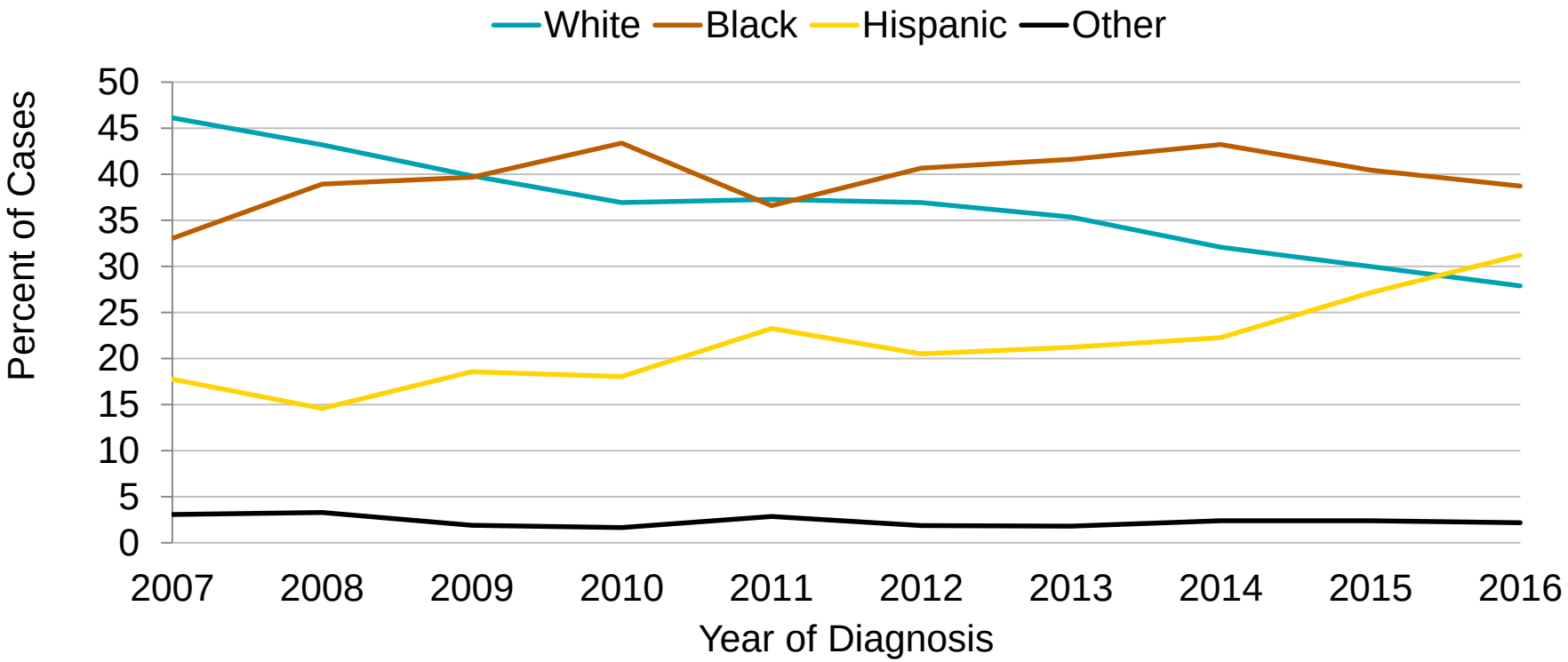


Adult (Age 13+) HIV Cases by Race/Ethnicity and Year of Diagnosis, Broward County, 2007–2016



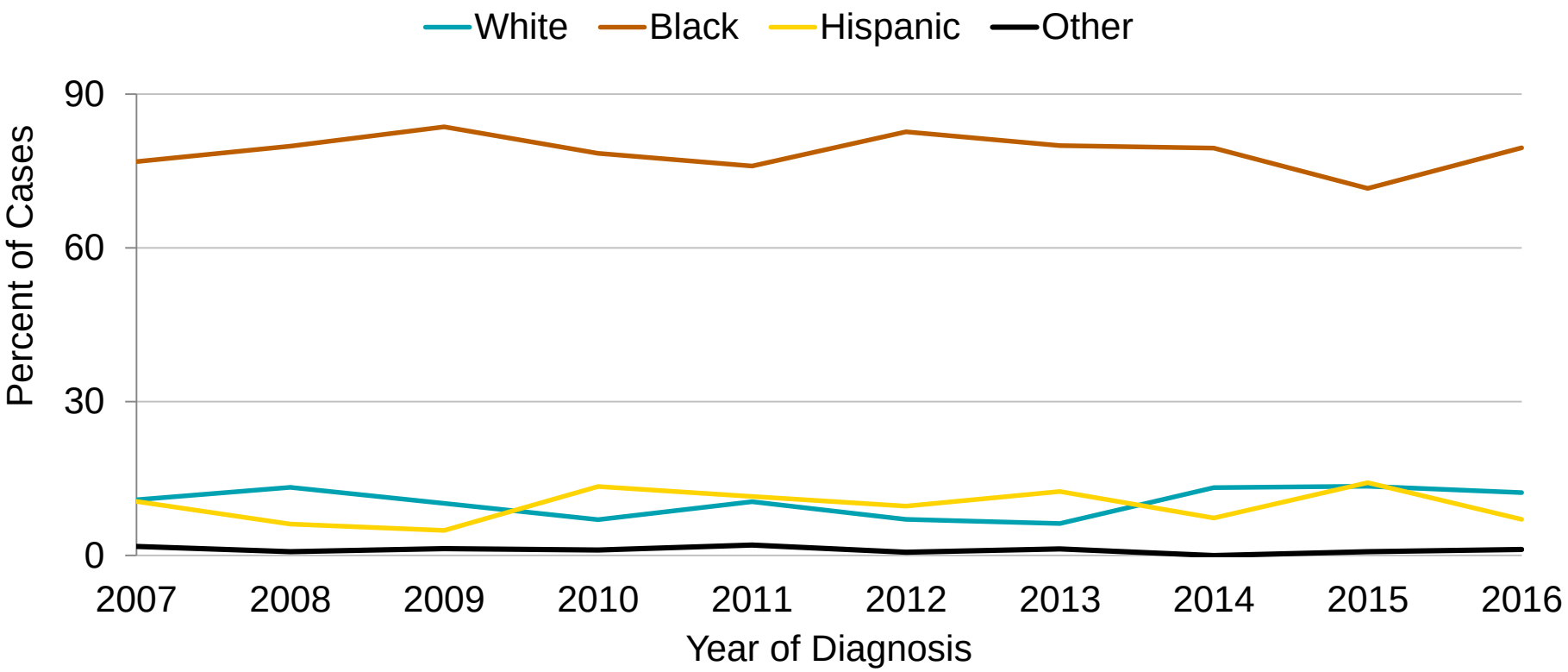
[1]Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial.

Adult (Age 13+) Male HIV Cases by Race/Ethnicity and Year of Diagnosis, Broward County, 2007–2016



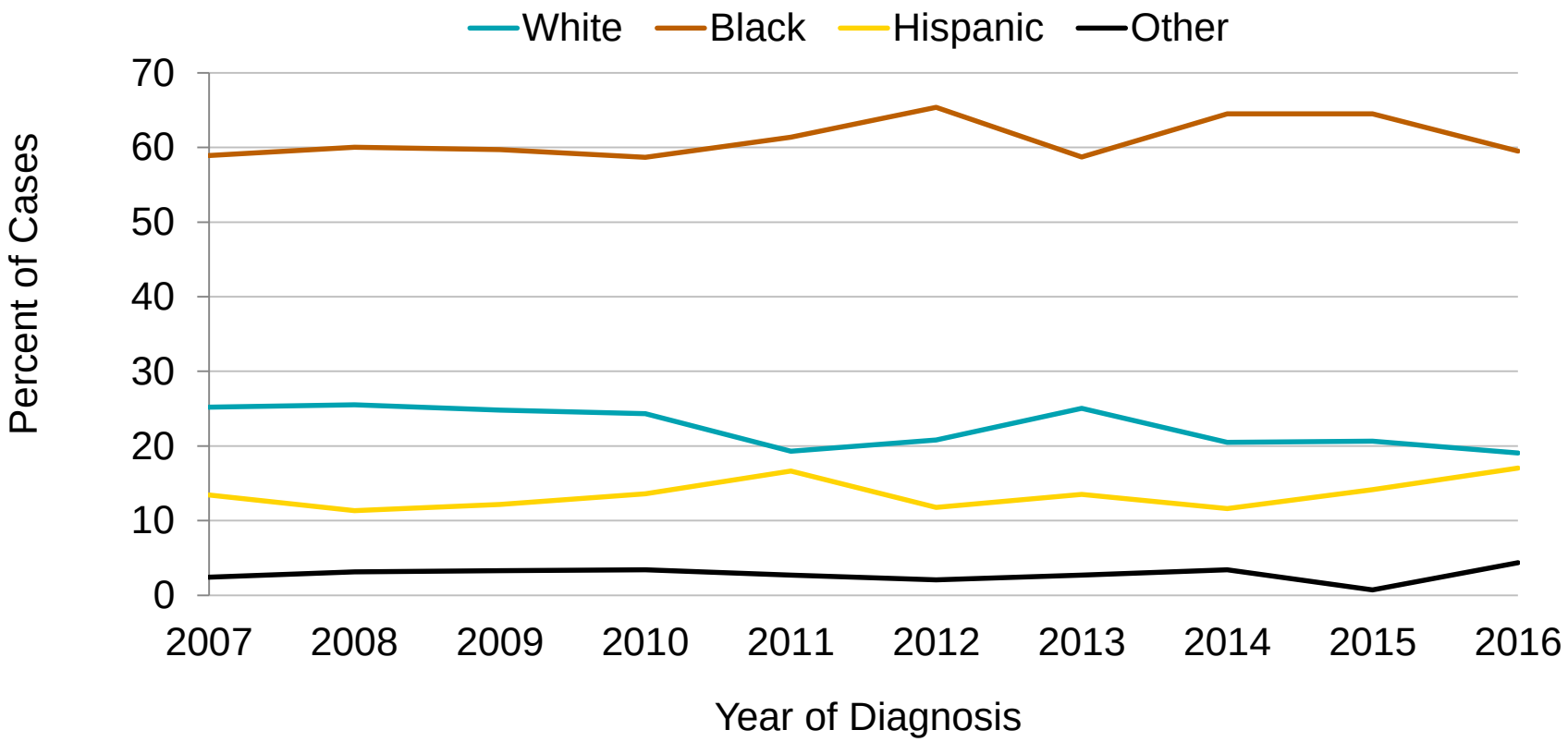
[1]Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial.

Adult (Age 13+) Female HIV Cases by Race/Ethnicity and Year of Diagnosis, Broward County, 2007–2016



[1]Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial.

Adult (Age 13+) AIDS Cases by Race/Ethnicity and Year of Diagnosis, Broward County, 2007–2016

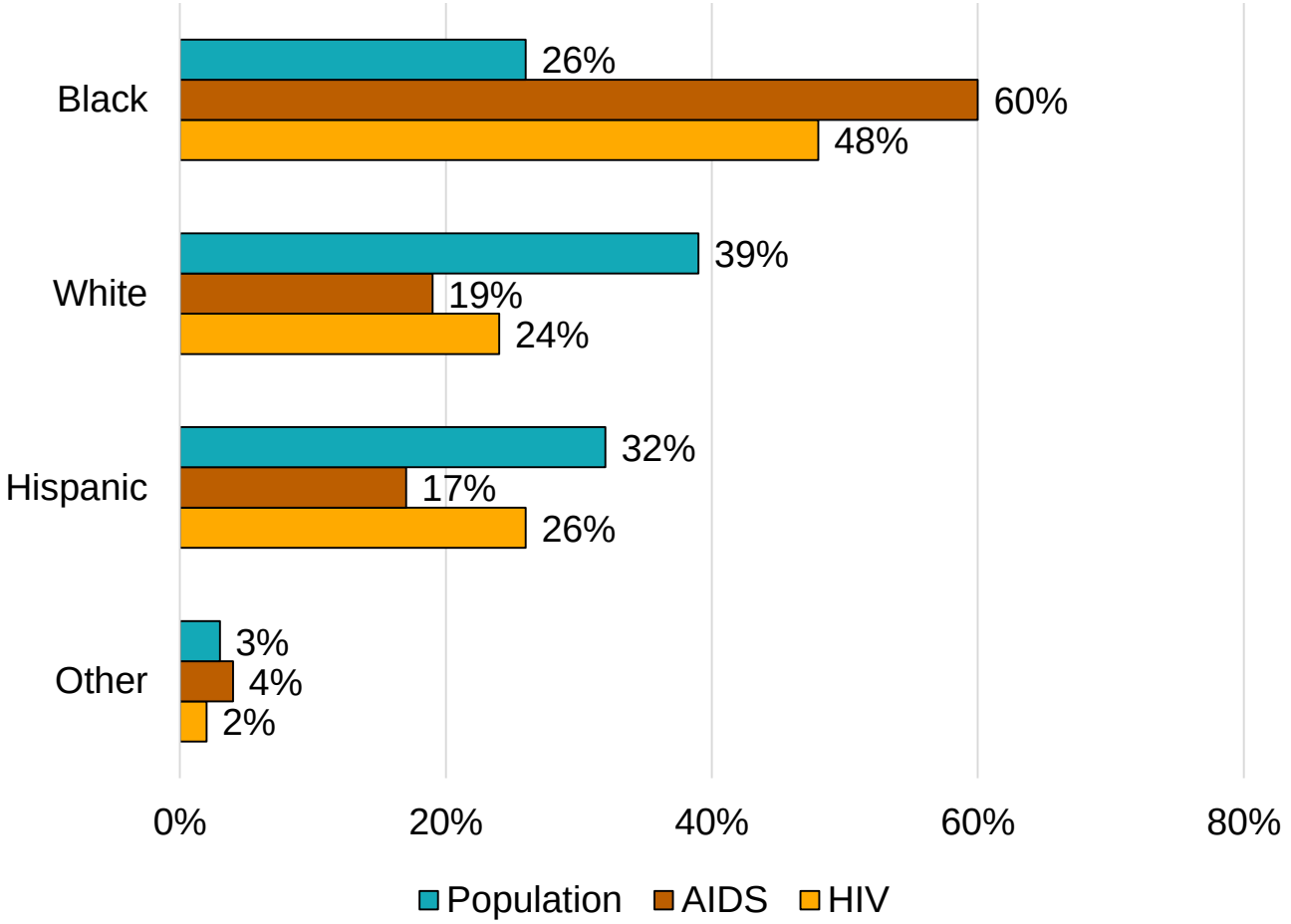


[1]Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial.

Factors Affecting Disparities

- Late diagnosis of HIV
- Access to/acceptance of care
- Delayed prevention messages
- Stigma
- Prevalence of HIV and Non-HIV STDs in the community
- Prevalence of injection drug use
- Complex matrix of factors related to socioeconomic status
- Immigrants from outside of the United States

Percentage of Adult (Age 13+) HIV and AIDS Cases Diagnosed in 2016 and Population, by Race/Ethnicity, Broward County



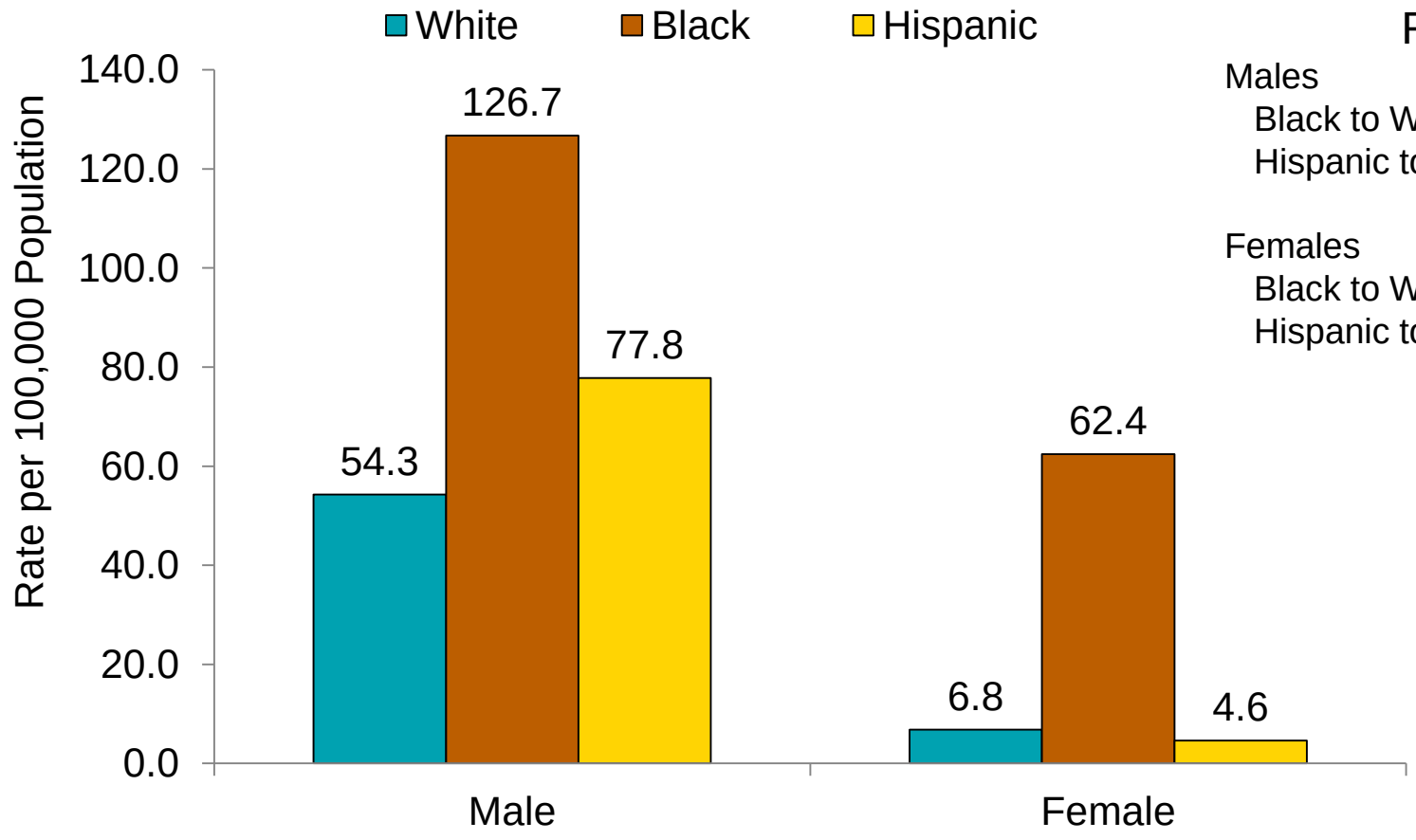
HIV
N=770

Broward Adult Population Estimates
N=1,570,283

AIDS
N=252

[1]Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial.

Adult (Age 13+) HIV Case Rates[1] by Sex and Race/Ethnicity, Broward County, Diagnosed in 2016



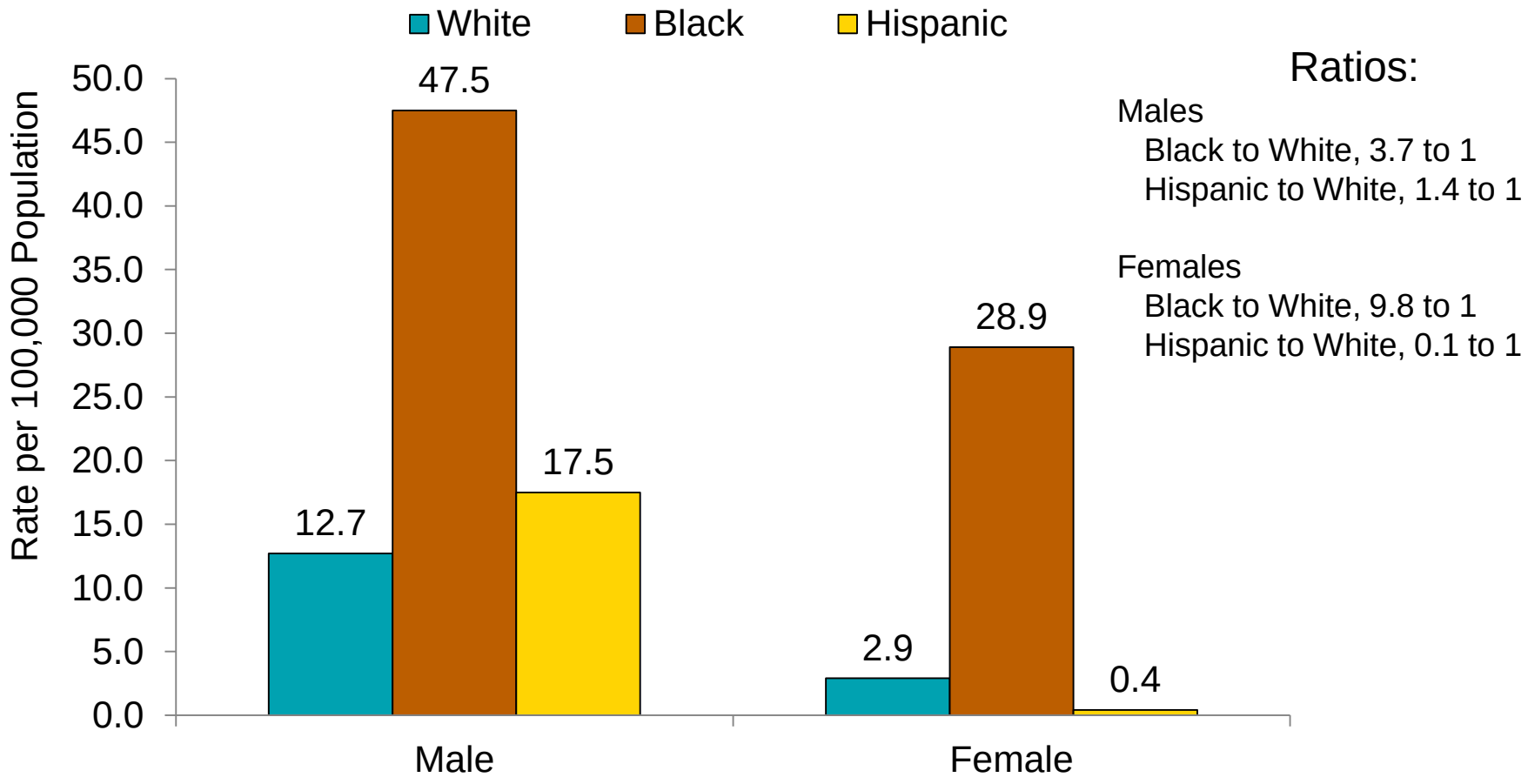
Ratios:

Males
- Black to White, 2.3 to 1
- Hispanic to White, 1.4 to 1

Females
- Black to White, 9.2 to 1
- Hispanic to White, 0.7 to 1

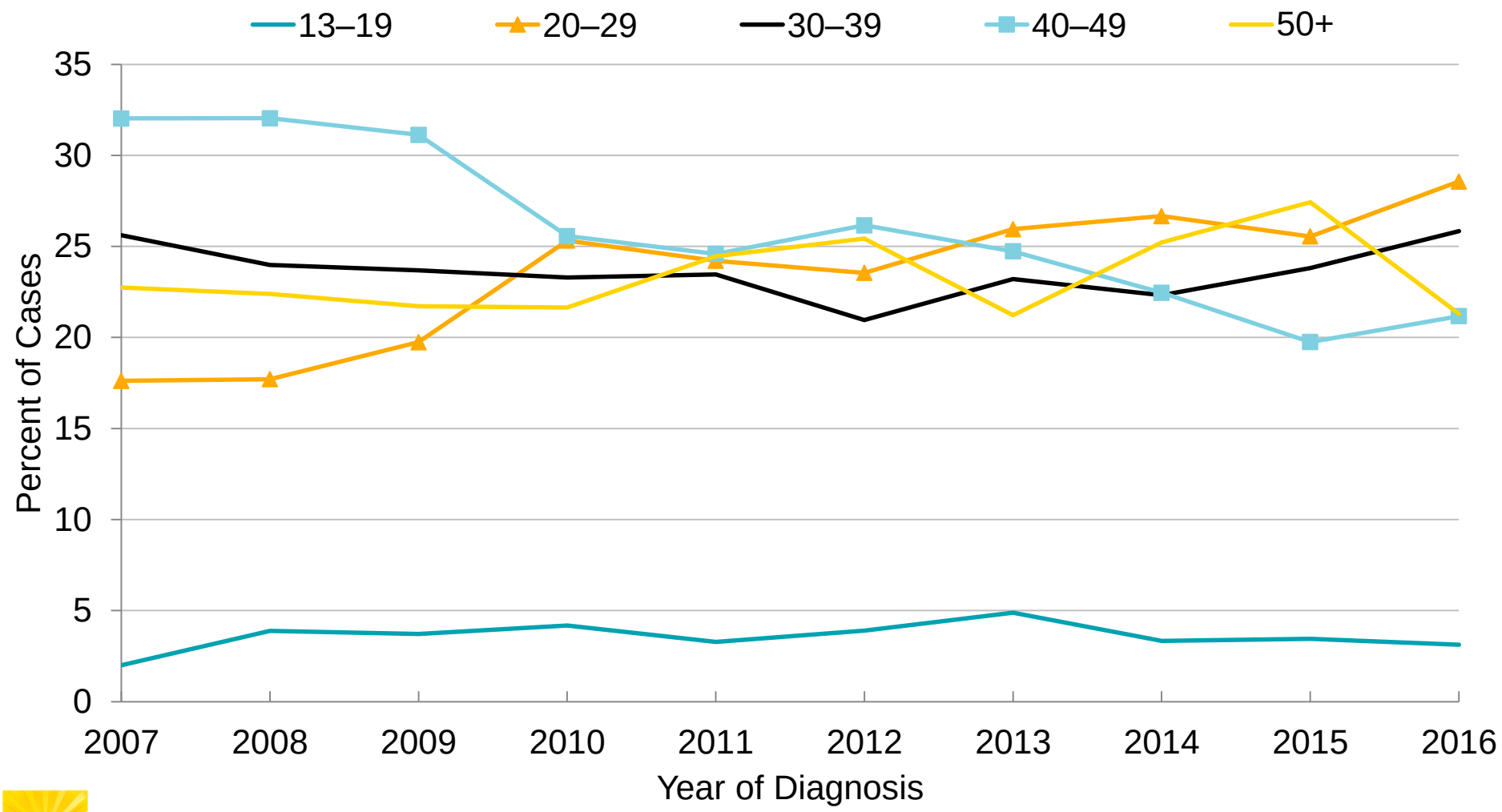
[1]Source: Population estimates are provided by Florida CHARTS as of 6/20/2017.

Adult (Age 13+) AIDS Case Rates[1] by Sex and Race/Ethnicity, Broward County, Diagnosed in 2016

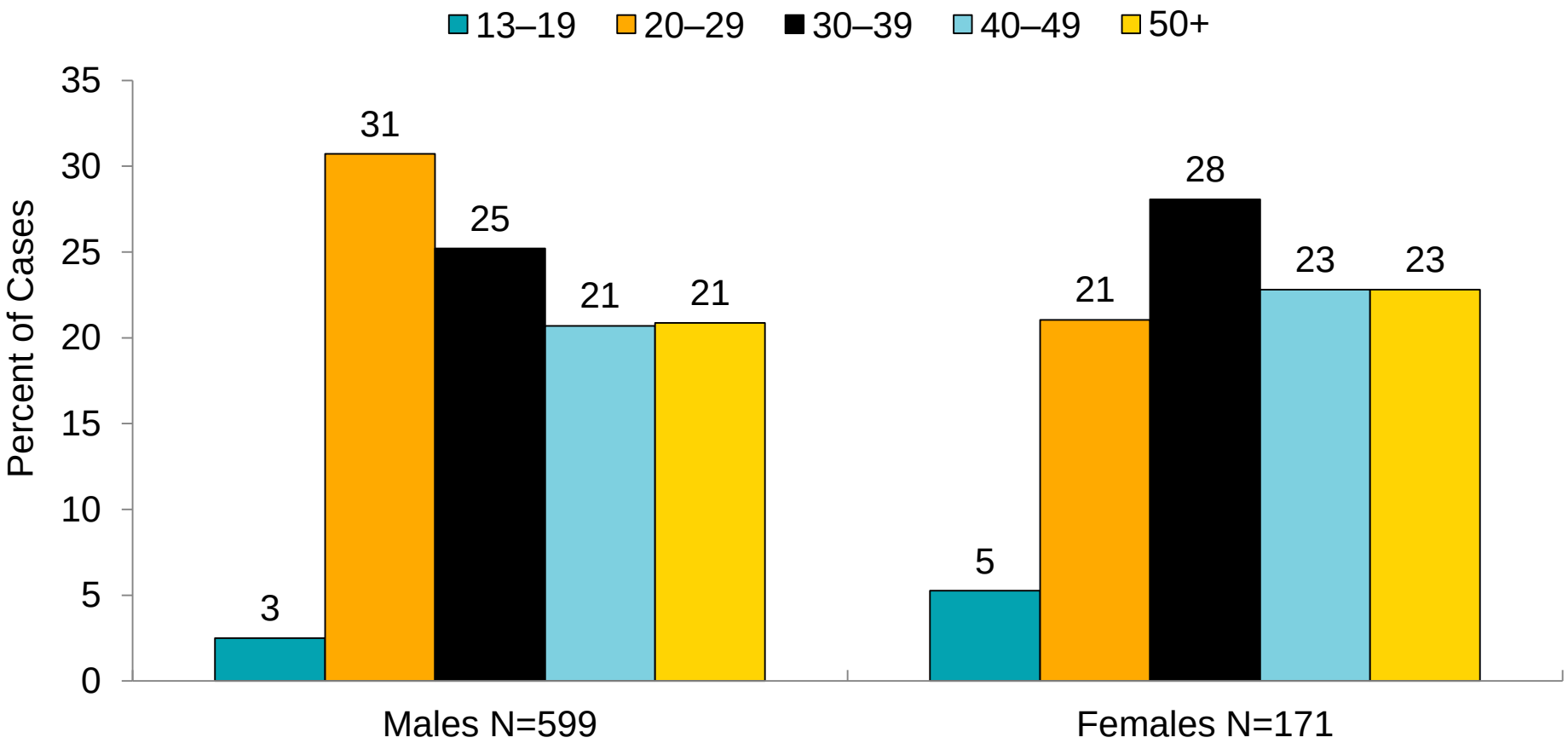


[1]Source: Population estimates are provided by Florida CHARTS as of 6/20/2017.

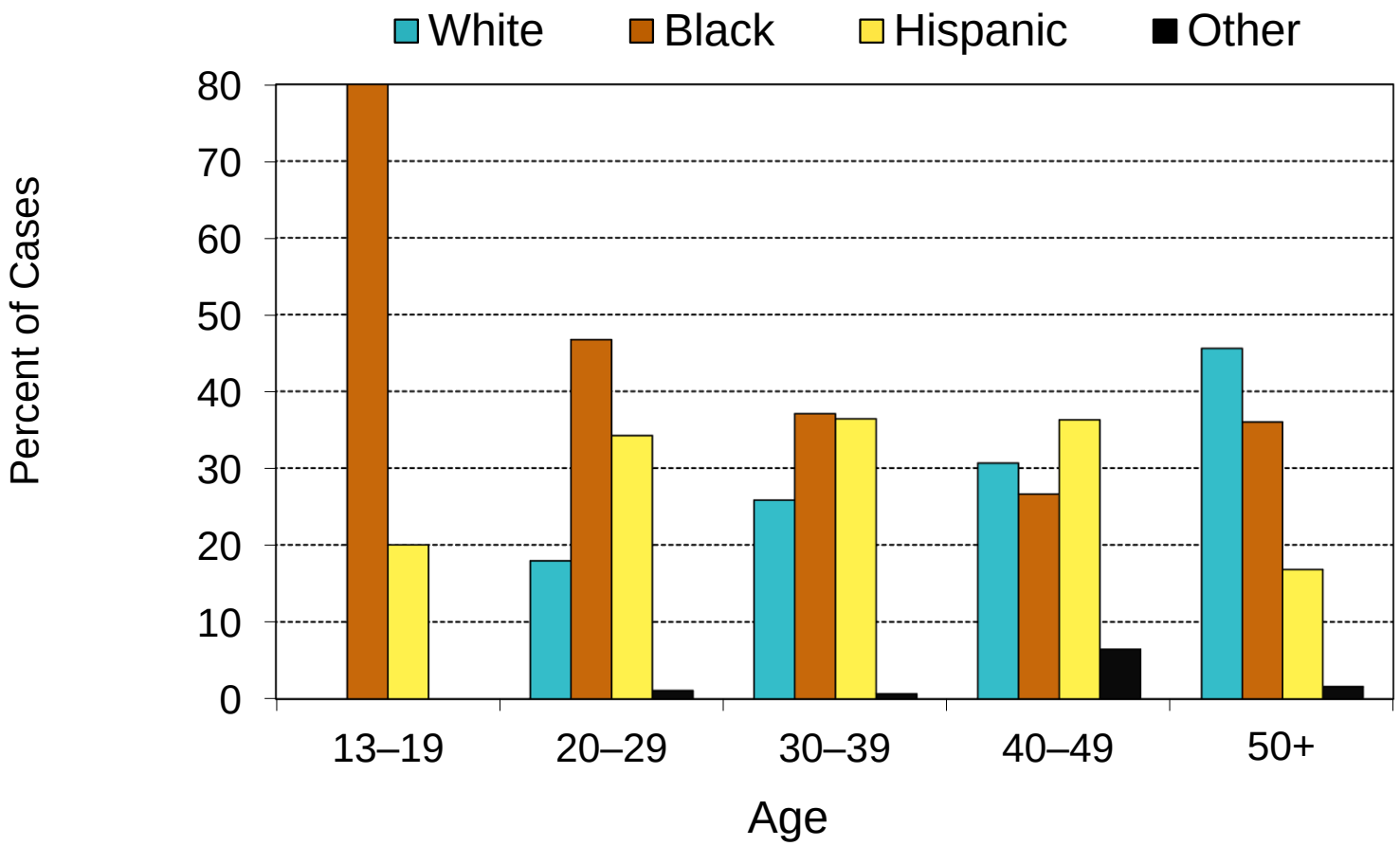
Adult (Age 13+) HIV Cases, by Age Group a Diagnosis, and Year of Diagnosis, Broward County, 2007–2016



Adult (Age 13+) HIV Cases, by Sex and Age Group at Diagnosis, Broward County, Diagnosed in 2016

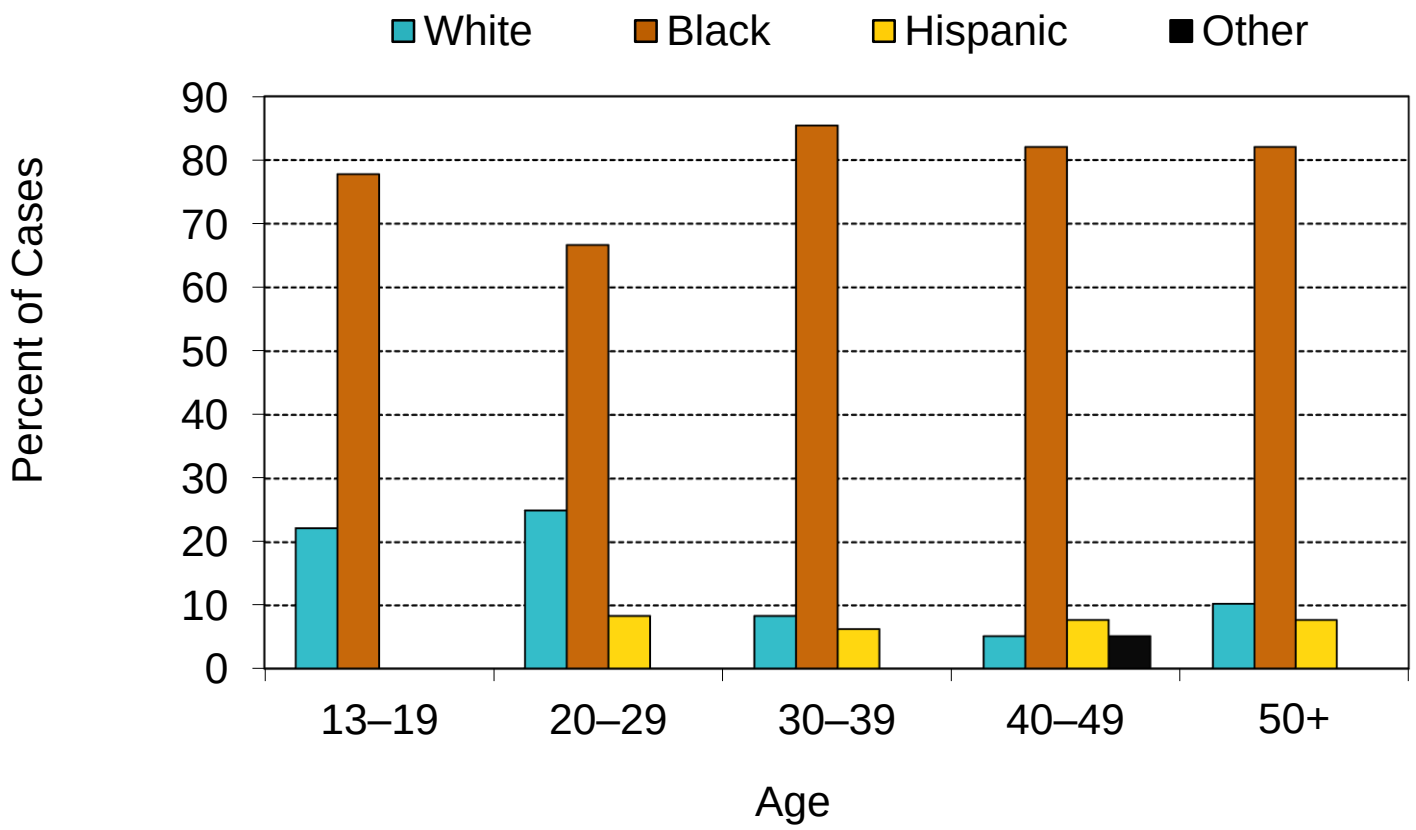


Adult (Age 13+) Male HIV Cases by Race/Ethnicity and Age at Diagnosis, Diagnosed in 2016, Broward County



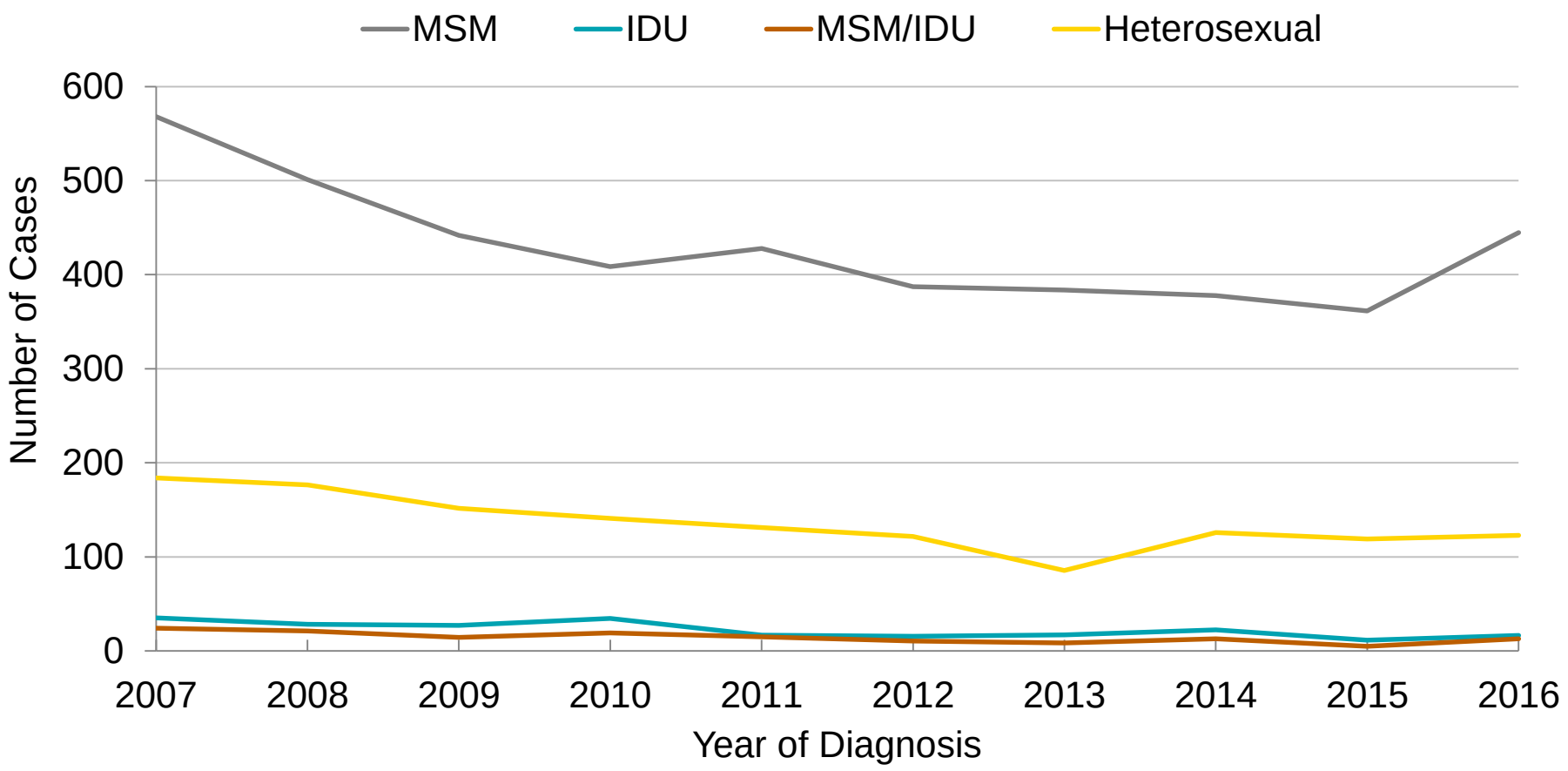
[1]Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial.

Adult (Age 13+) Female HIV Cases by Race/Ethnicity and Age at Diagnosis, Diagnosed in 2016, Broward County

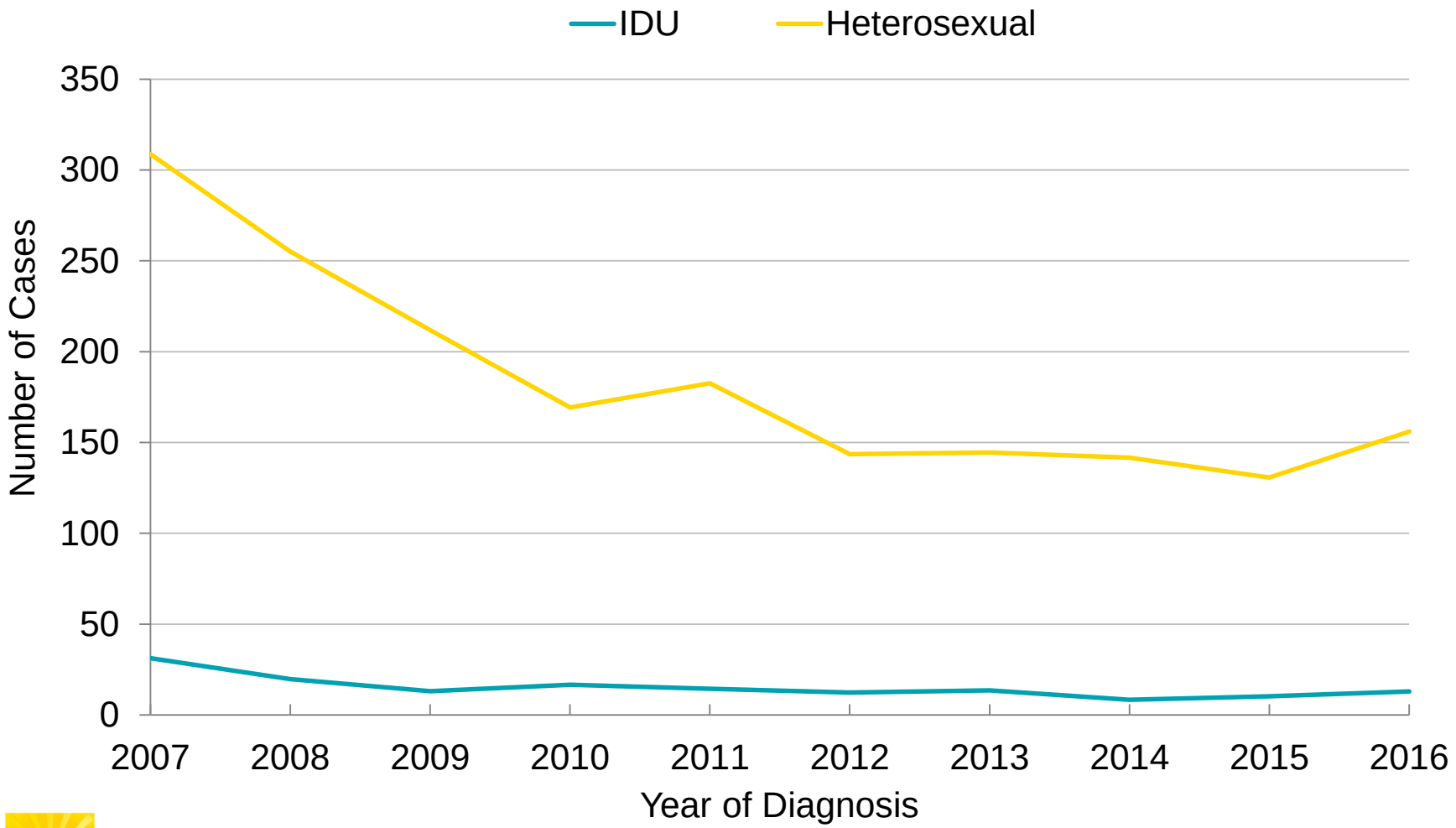


[1]Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial.

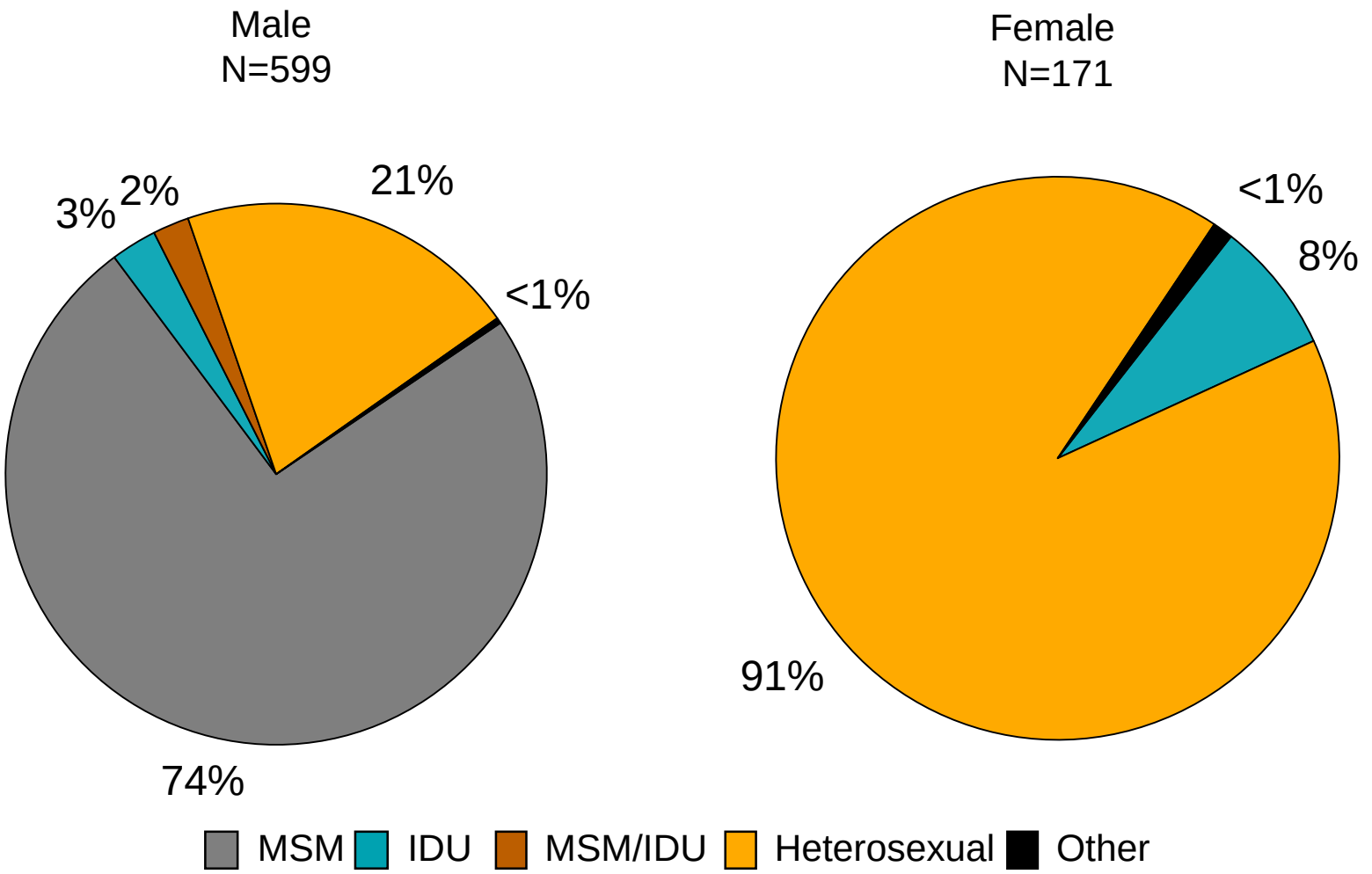
Adult (Age 13+) Male HIV Cases, by Mode of Exposure and Year of Diagnosis, Broward County, 2007–2016



Adult (Age 13+) Female HIV Cases by Exposure Category and Year of Diagnosis, Broward County, 2007–2016

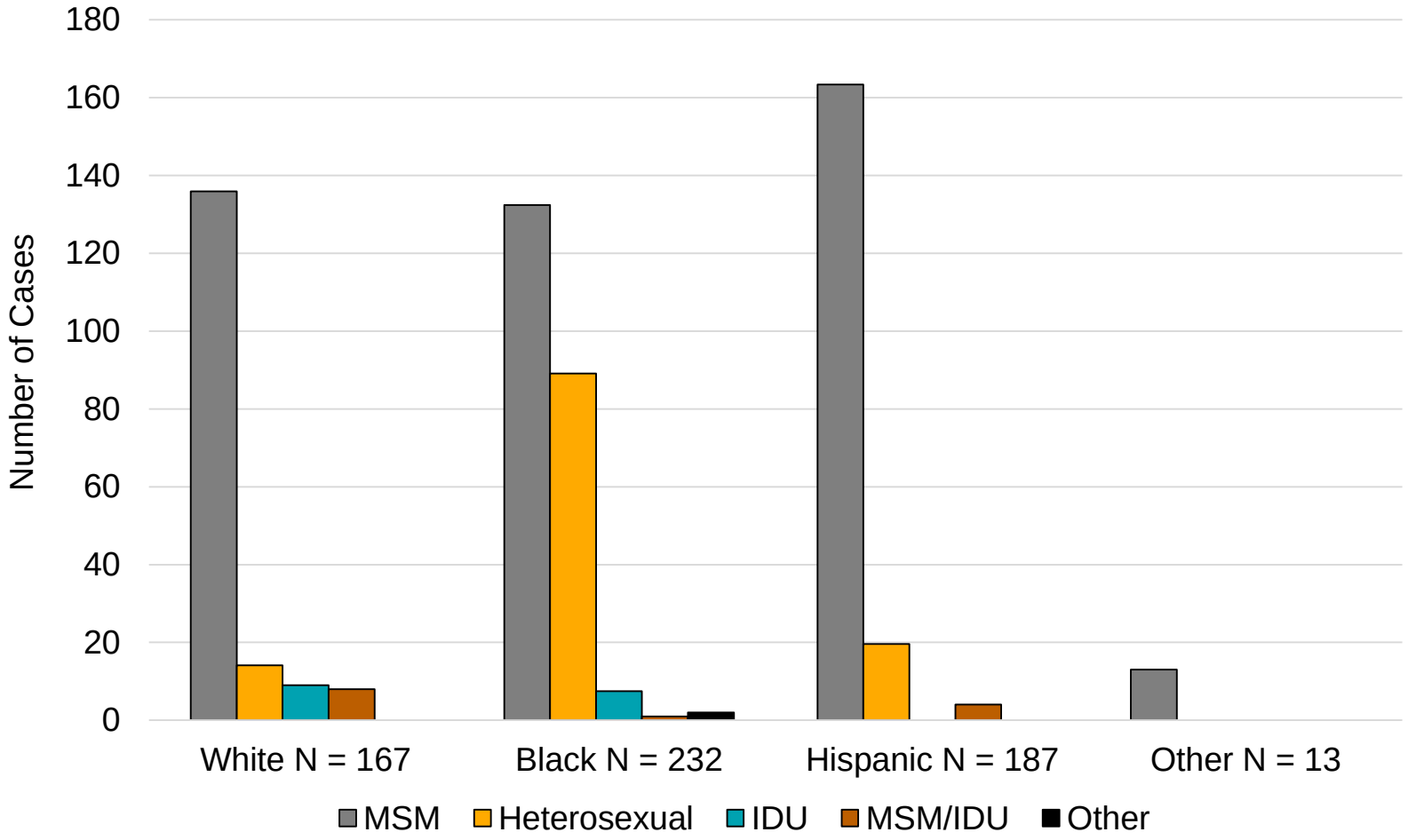


Adult (Age 13+) HIV Cases for Males and Females, by Mode of Exposure, Broward County, 2016



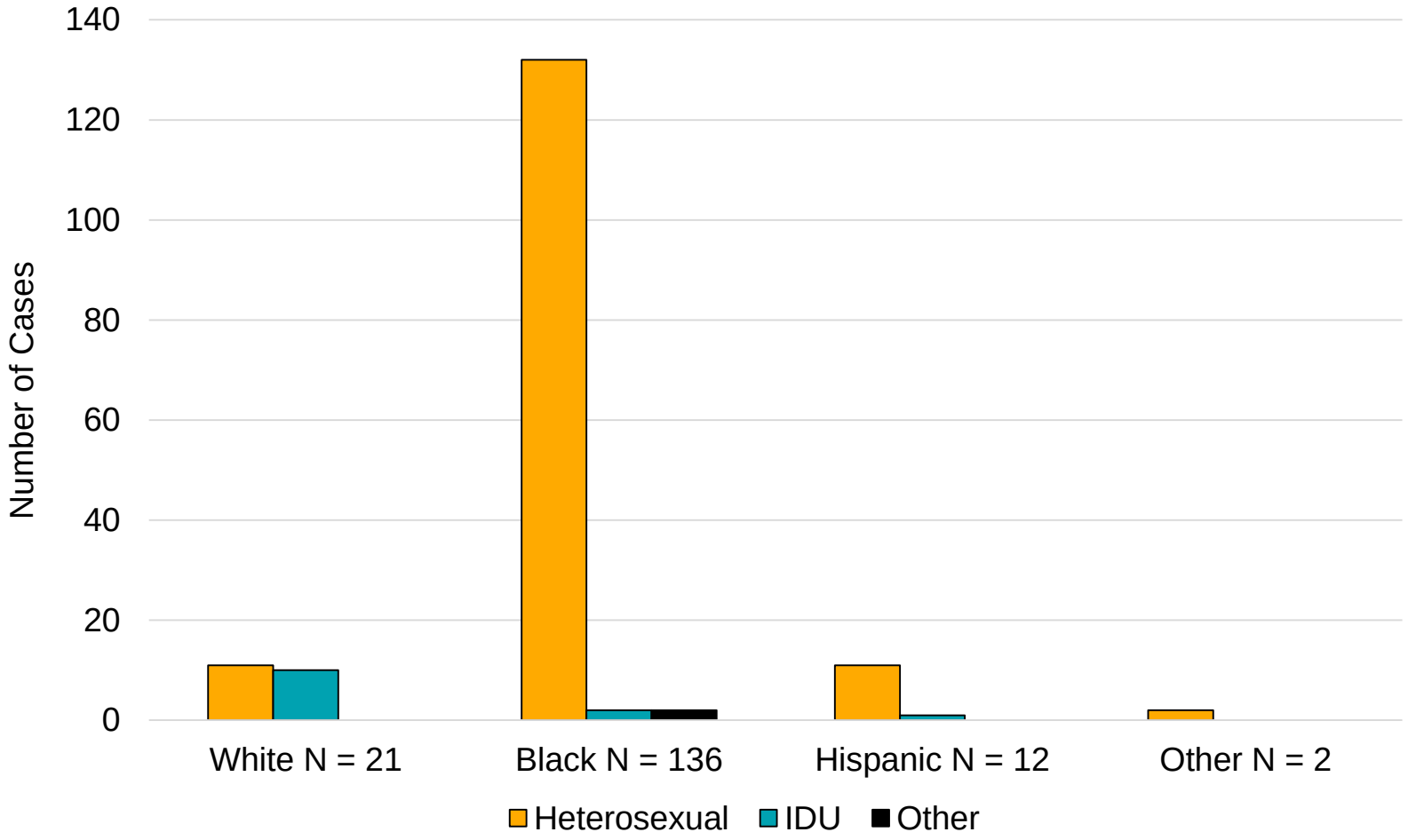
[1]Other Risk includes hemophilia, transfusion, perinatal and other pediatric risks as well as other confirmed risks.

Adult (Age 13+) Male HIV Cases by Race/Ethnicity and Mode of Exposure, Diagnosed in 2016, Broward County



[1]Other includes Asian/Pacific Islander, Native Alaskan/American Indian and Multi-racial individuals.
[2] Other Risk includes hemophilia, transfusion, perinatal and other pediatric risks as well as other confirmed risks.

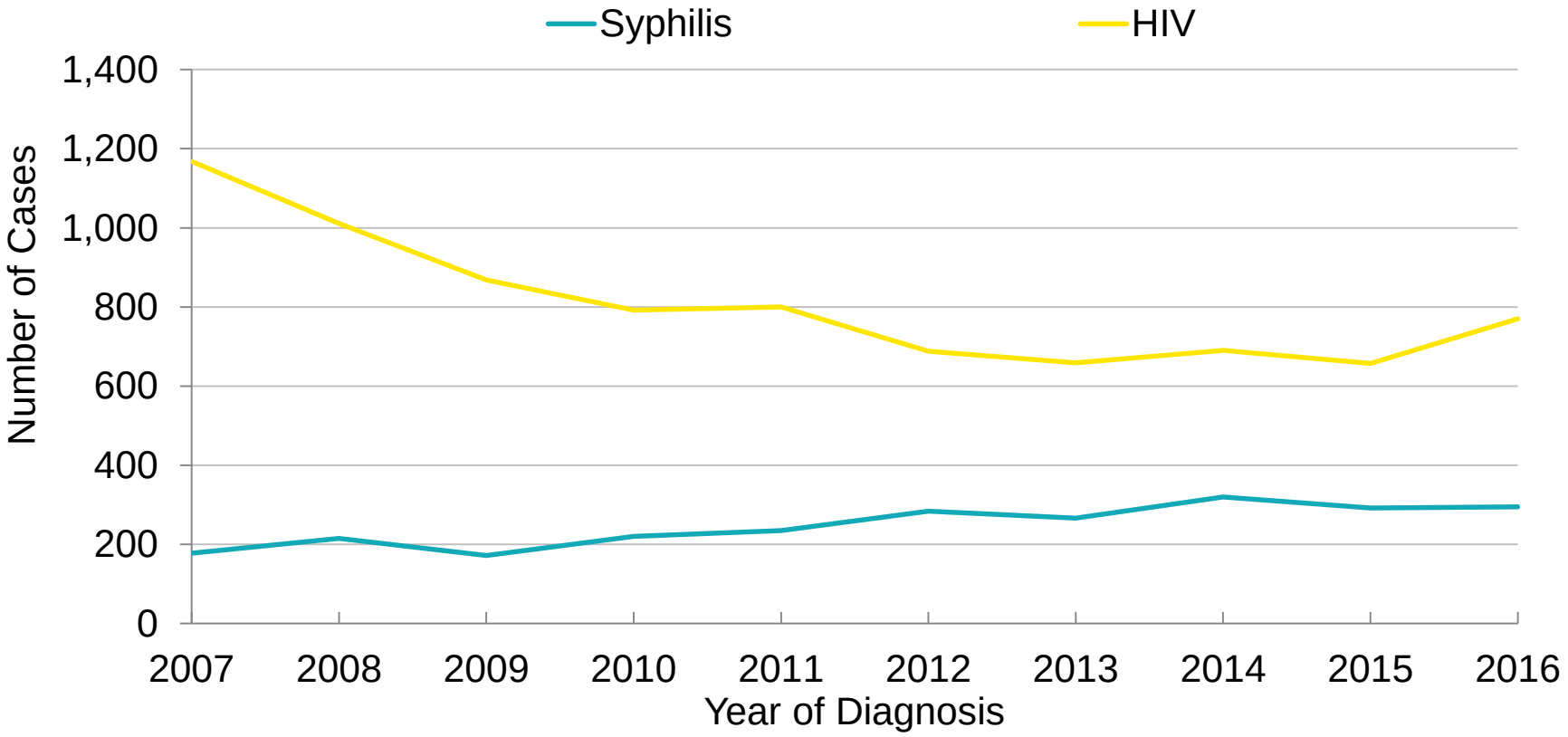
Adult (Age 13+) Female HIV Cases by Race/Ethnicity and Mode of Exposure, Diagnosed in 2016, Broward County



[1]Other includes Asian/Pacific Islander, Native Alaskan/American Indian and Multi-racial individuals.
[2] Other Risk includes hemophilia, transfusion, perinatal and other pediatric risks as well as other confirmed risks.

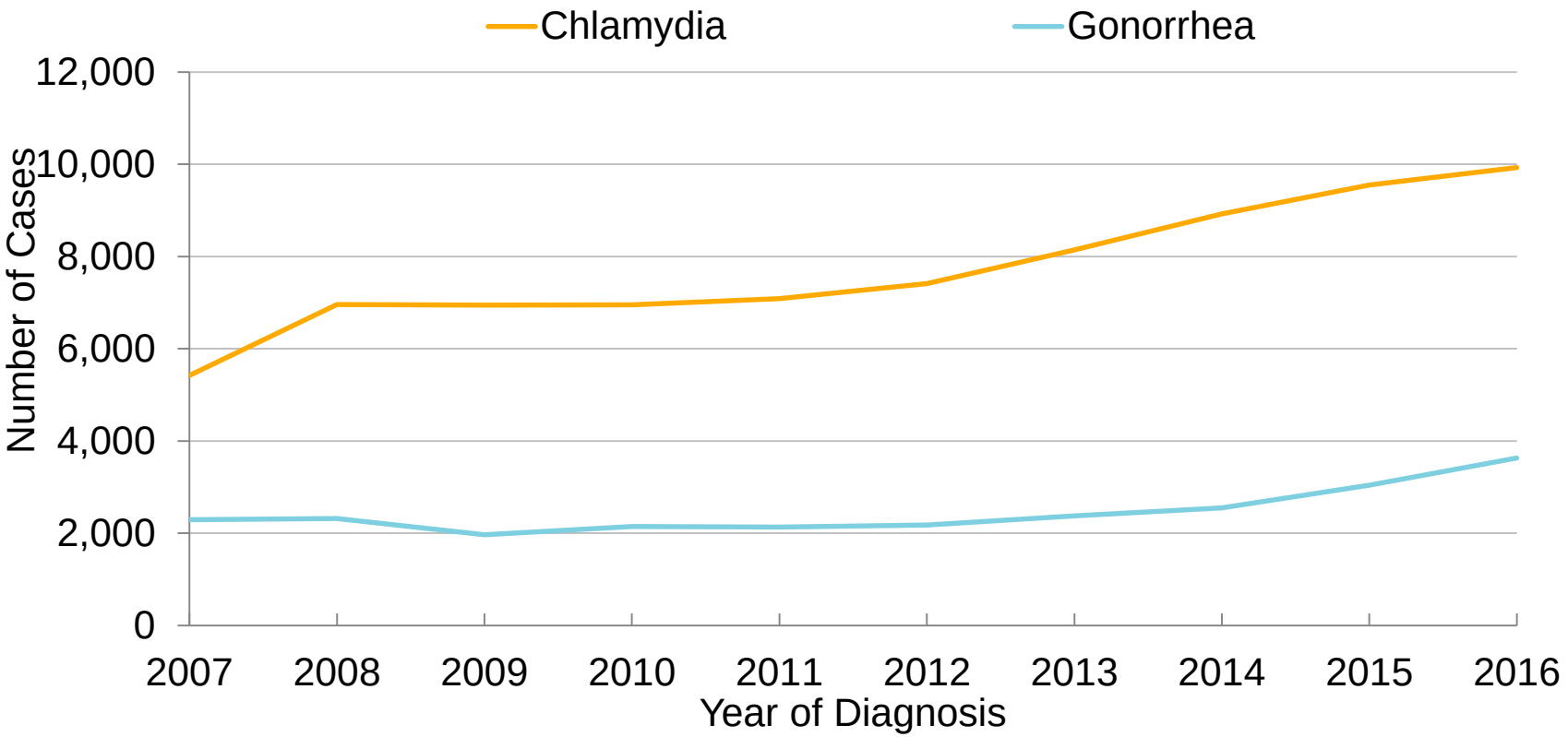
Other Morbidity Data

Adult (Age 13+) Syphilis[1] and HIV Cases, Broward County, Diagnosed 2007–2016



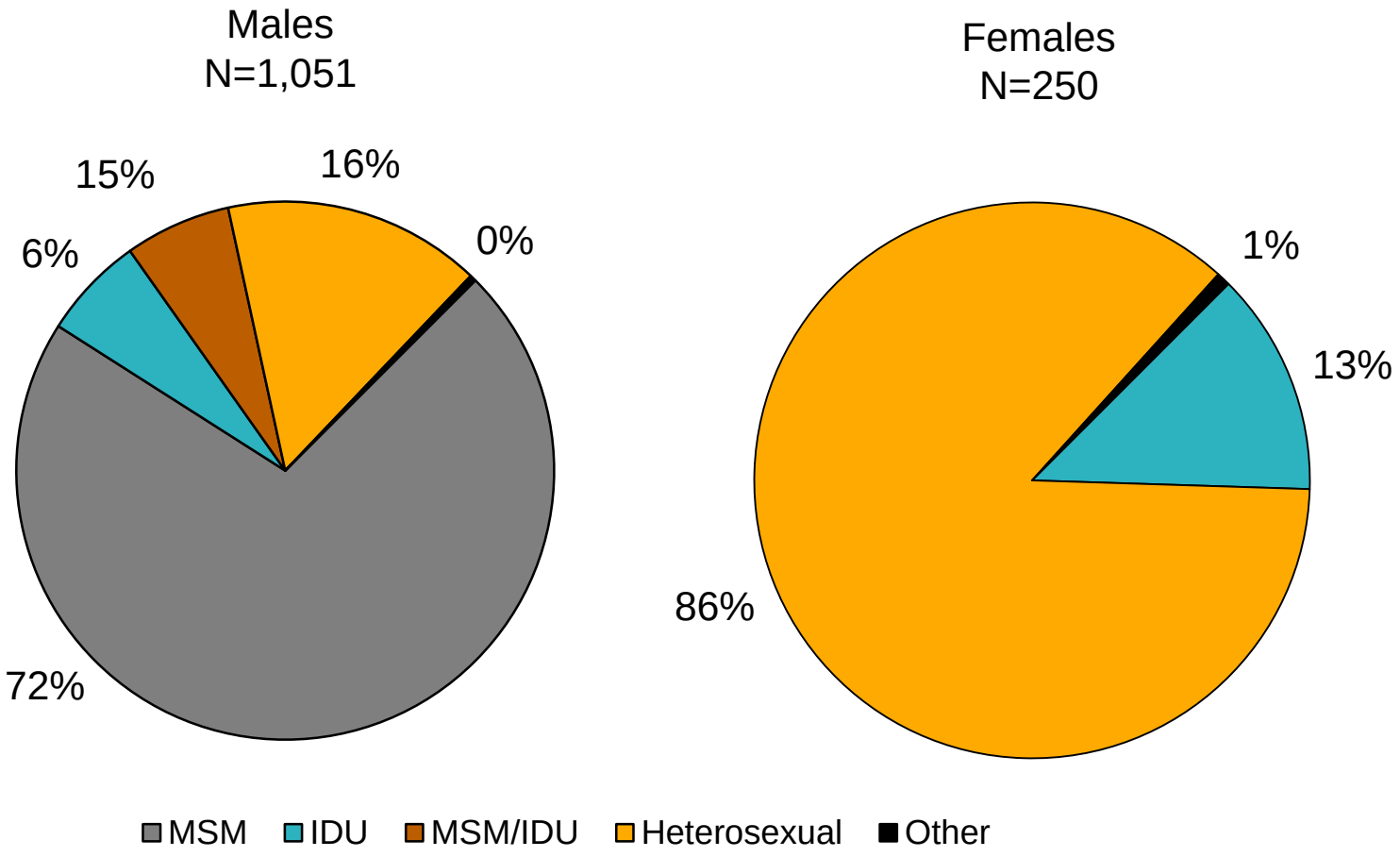
[1]Source: STD data provided by the Sexually Transmitted Disease & Viral Hepatitis Section.

Adult (Age 13+) Chlamydia and Gonorrhea[1] Cases, Broward County, Diagnosed 2007–2016



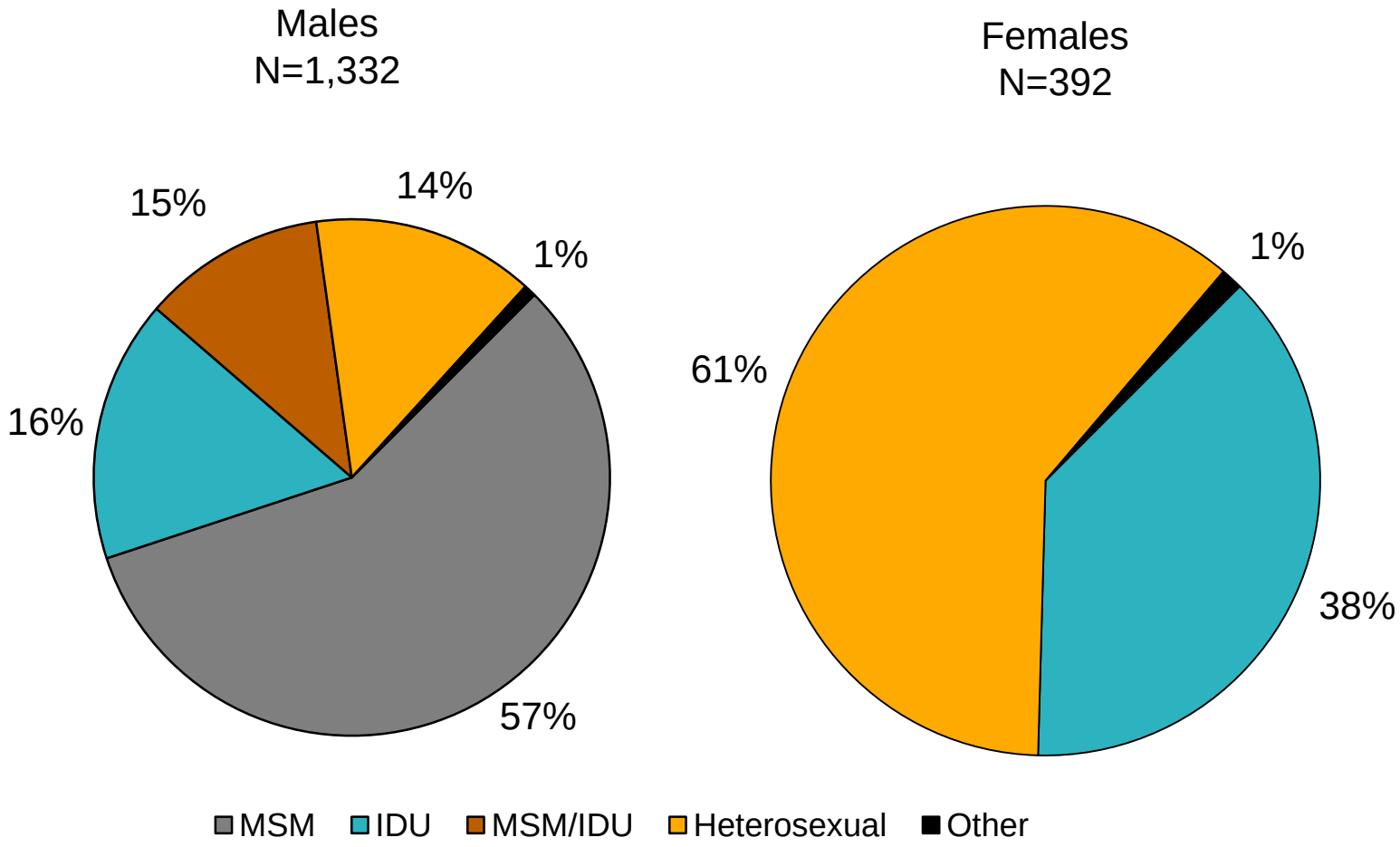
[1]Source: STD data provided by the Sexually Transmitted Disease & Viral Hepatitis Section.

Living HIV/HBV Co-infected Adult (Age 13+) Cases by Sex and Mode of Exposure, Year-end 2016, Area 10



[1]Source: Hepatitis B (HBV) data, which includes both acute and chronic cases were generated from MERLIN as of 6/30/2017.
[2] Other Risk includes hemophilia, transfusion, perinatal and other pediatric risks as well as other confirmed risks.

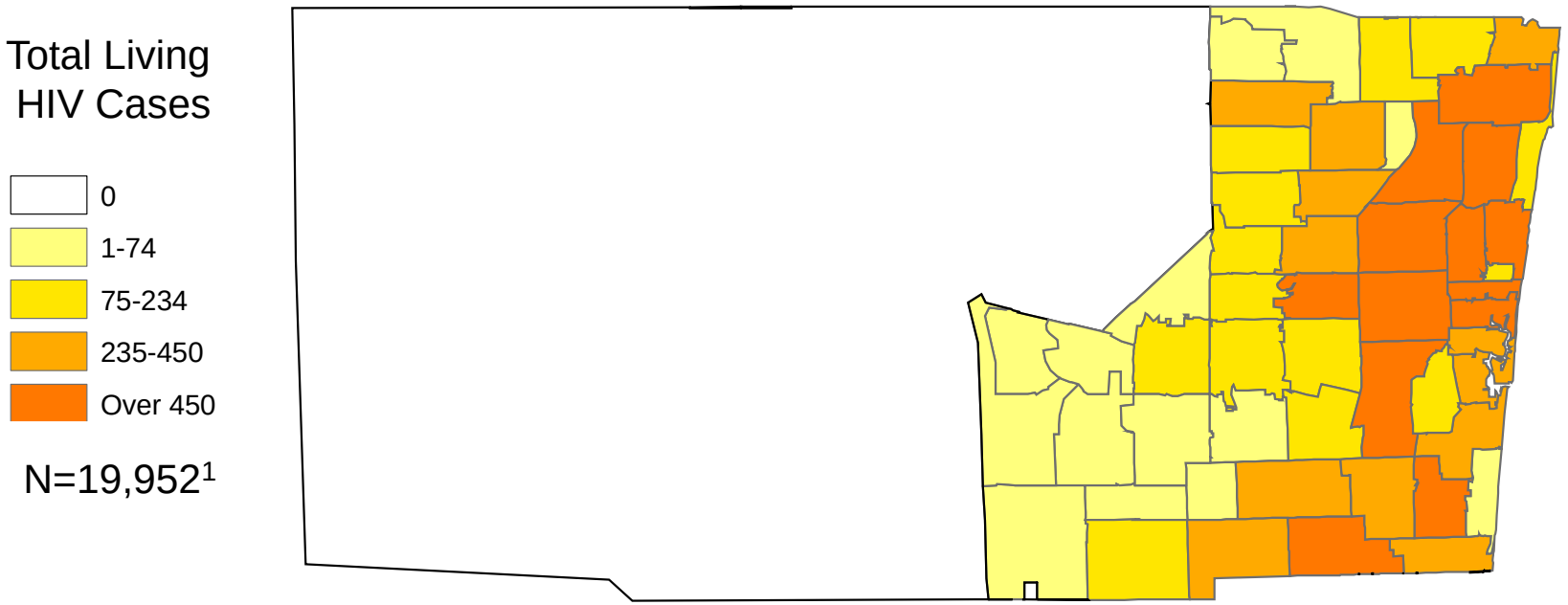
Living HIV/HCV Co-infected Adult (Age 13+) Cases by Sex and Mode of Exposure, Year-end 2016, Area 10



[1]Source: Hepatitis C (HCV) data, which includes both acute and chronic cases were generated from MERLIN as of 6/30/2017.
[2] Other Risk includes hemophilia, transfusion, perinatal and other pediatric risks as well as other confirmed risks.

Cases Living with HIV

Adults (Age 13+) Living with HIV By ZIP, Broward County, Year-end 2016



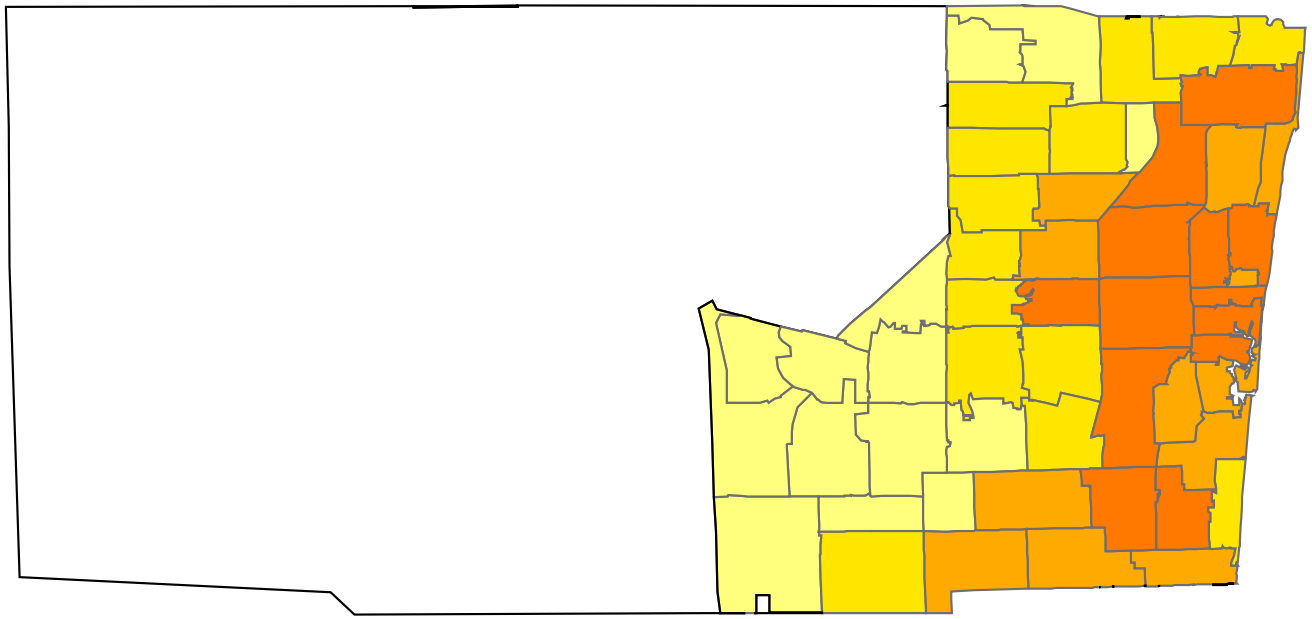
[1]Excludes DOC, homeless, and cases with unknown zips. Data as of 6/30/2017

MSM[1] Living with HIV By ZIP, Broward County, Year-end 2016

Presumed Living MSM HIV Cases

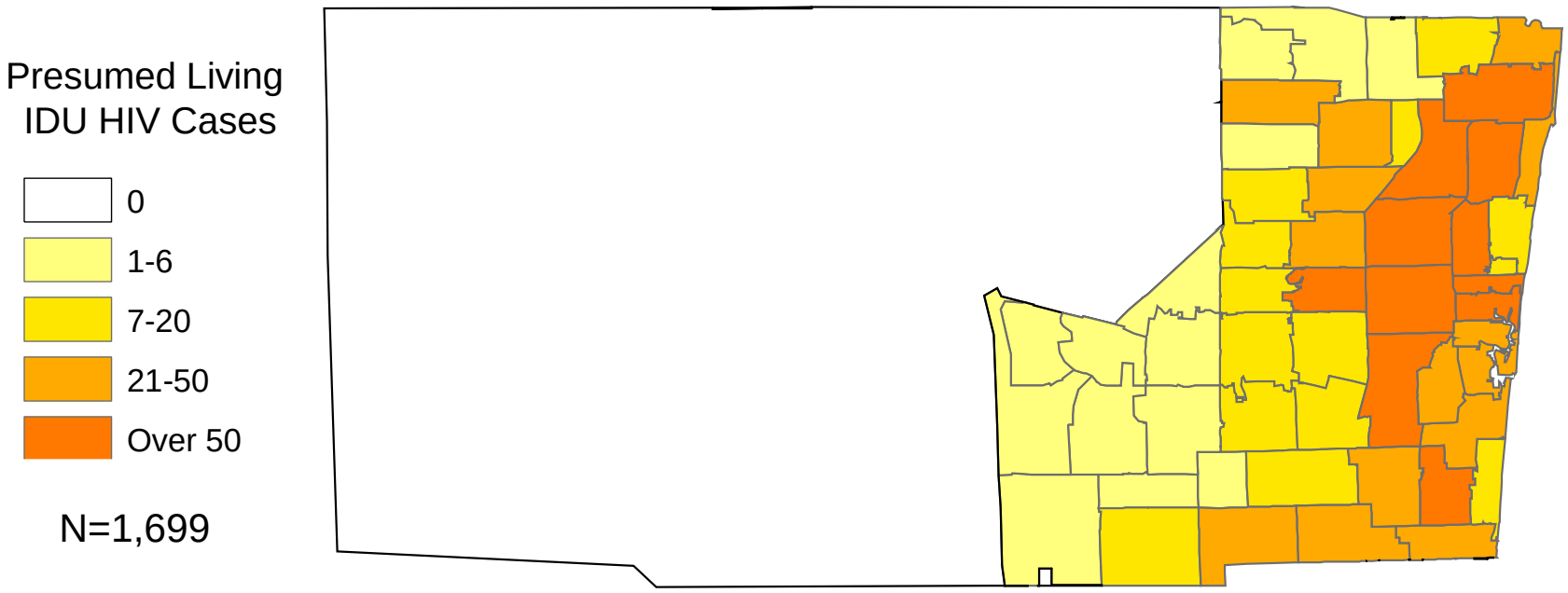
- 0
- 1-47
- 48-105
- 106-200
- Over 200

N=11,134



[1]Includes MSM/IDU cases. Excludes DOC, homeless, and cases with unknown zips. Data as of 6/30/2017

IDUs[1] Living with HIV By ZIP, Broward County, Year-end 2016



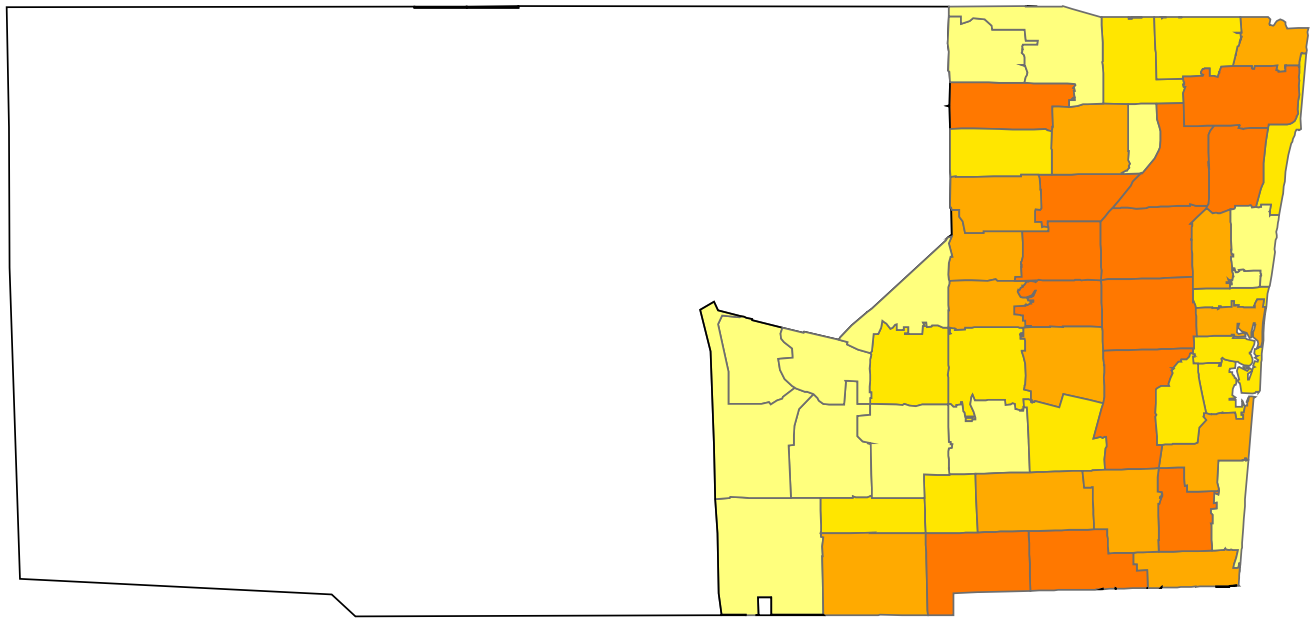
[1]Includes MSM/IDU cases. Excludes DOC, homeless, and cases with unknown zips. Data as of 6/30/2017

Adult (Age 13+) Heterosexuals Living with HIV By ZIP, Broward County, Year-end 2016

Presumed Living Heterosexual HIV Cases

- 0
- 1-24
- 25-75
- 76-200
- Over 200

N=7,455



Excludes DOC, homeless, and cases with unknown zips. Data as of 6/30/2017

One-In-Statements for Adults (Age 13+) Living with HIV in Broward County, Year-end 2016

- One in 78 adults in Broward County were known to be living with HIV
  - One in 90 Whites were living with HIV
  - One in 43 Blacks were living with HIV
  - One in 145 Hispanics were living with HIV

Adults (Age 13+) Living with HIV, Broward County, Year-end 2016, N=20,020

	Males		Females	
Race/Ethnicity	**No.**	**Percent**	**No.**	**Percent**
White	6,343	43%	487	9%
Black	5,083	34%	4,183	79%
Hispanic	2,961	20%	492	9%
Other	358	2%	113	2%
Age Group				
13–19	39	0%	46	1%
20–29	1,063	7%	344	7%
30–39	1,933	13%	981	19%
40–49	3,371	23%	1,451	28%
50+	8,339	57%	2,453	47%
Mode of Exposure				
MSM	10,556	72%	---	---
IDU	609	4%	506	10%
MSM/IDU	605	4%	---	---
Heterosexual	2,868	19%	4,613	87%
Other	107	1%	157	3%
TOTAL	14,745	100%	5,275	100%

Broward County's Top-Nine Priority Populations[1] for Primary[2] HIV Prevention

1. Black heterosexual men and women
2. White MSM
3. Hispanic MSM
4. Black MSM
5. Hispanic heterosexual men and women
6. White IDU
7. White heterosexual men and women
8. Black IDU
9. Hispanic IDU

[1]MSM=(MSM and MSM/IDU cases) and IDU=(IDU and MSM/IDU cases), therefore the data are not mutually exclusive.
[2]Priorities are based on the average on HIV cases diagnosed 2014–2016 (as of 6/30/2017). These priorities are used to target those not infected with HIV to reduce transmission among those with high risk for HIV.

Broward County's Top-Nine Priority Populations[1] Prevention for Positives

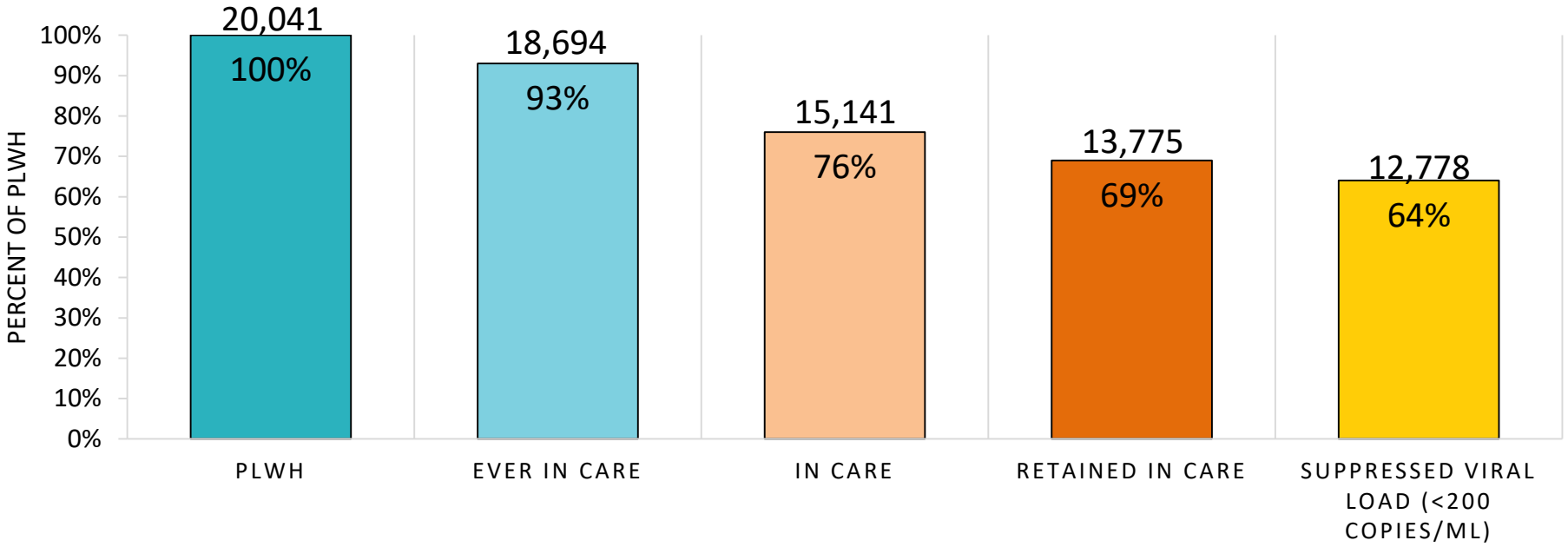
1. Black heterosexual men and women
2. White MSM
3. Hispanic MSM
4. Black MSM
5. Black IDU
6. Hispanic heterosexual men and women
7. White IDU
8. White heterosexual men and women
9. Hispanic IDU

[1]MSM=(MSM and MSM/IDU cases) and IDU=(IDU and MSM/IDU cases), therefore the data are not mutually exclusive.
[2]Priorities are based on the number of cases living with HIV in Florida, year-end 2016 (as of 6/30/2017). These priorities are used to intervene and reduce progression of the disease among those known to be HIV-infected to prevent further infection in the community.

HIV Care Continuum Definitions

- **HIV Diagnosed**: The number of persons known to be diagnosed and living in Florida with HIV (PLWH) at the end of 2016, from data as of 6/30/2017
- **Ever in Care**: PLWH with at least one documented Viral Load (VL) or CD4 lab, medical visit, or prescription from HIV diagnosis through 3/31/2017
- **Currently in Care:** PLWH with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2016 through 3/31/2017
- **Retained in Care:** PLWH with two or more documented VL or CD4 labs, medical visits, or prescriptions at least three months apart from 1/1/2016 through 6/30/2017
- **Suppressed Viral Load**: PLWH with a suppressed VL (<200 copies/mL) on the last VL from 1/1/2016 through 3/31/2017

Persons Living with HIV (PLWH) in Broward County along the HIV Care Continuum in 2016

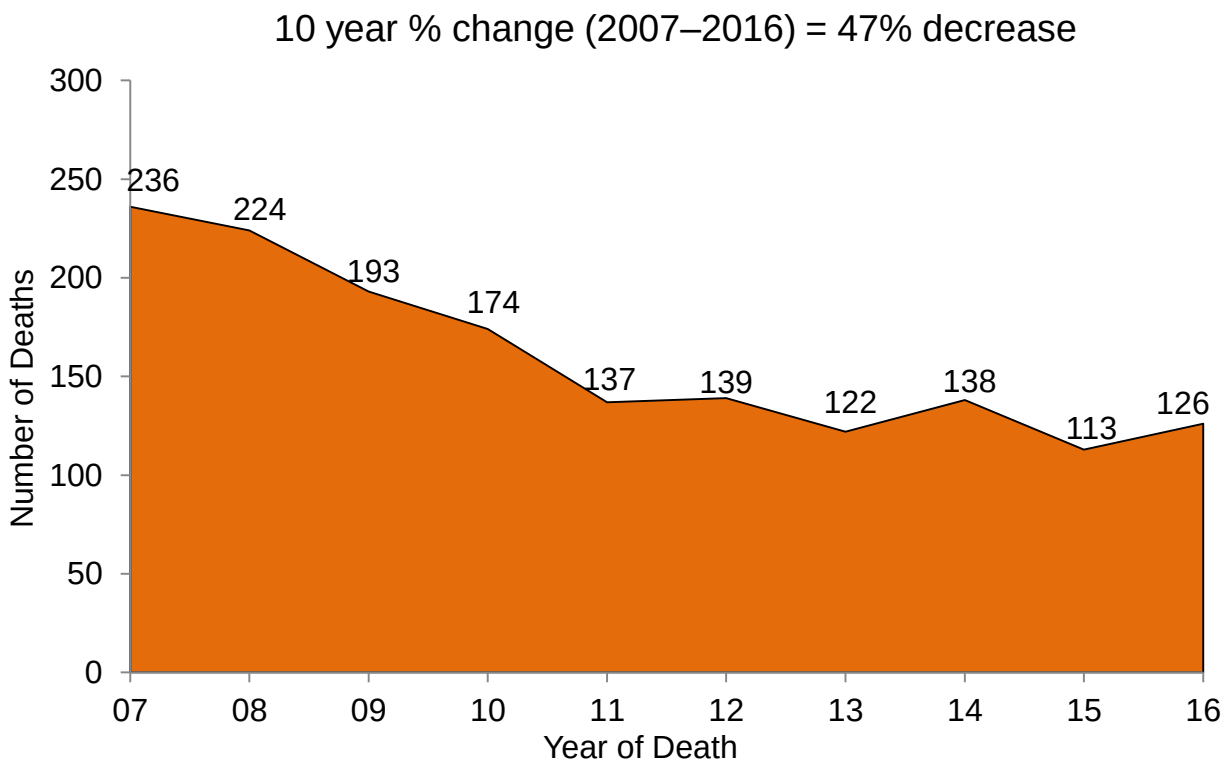


- 86% of the 770 diagnosed with HIV in 2016 had documented HIV-related care within 3 months of diagnosis.
- 84% of PLWH in care had a suppressed viral load.
- 88% of PLWH retained in care had a suppressed viral load.
- 24% of PLWH were not in care.

Cases by Year of Death

Resident Deaths Due to HIV by Year of Death, Broward County, 2007–2016

Resident Deaths Due to HIV in 2016, Broward County[1]		
Race/Ethnicity	**No.**	**Rate[2]**
White Male	25	7.2
White Female	0	0.0
Black Male	48	20.6
Black Female	36	13.5
Hispanic Male	9	3.1
Hispanic Female	2	0.6
Other[3]	6	9.1
Total	126	6.8



[1] Source: Florida Department of Health, Bureau of Vital Statistics, Death Certificates (as of 6/20/2017).
[2]Source: Population data are provided by Florida CHARTS as of 6/20/2017.
[3]Other includes American Indian/Alaska Native, Asian/Pacific Islander, and multi-racial individuals.

Some Useful Links

Department. of Health, HIV Section Website
http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html

CDC HIV Surveillance Reports (State and Metro Data):
http://www.cdc.gov/hiv/stats/hasrlink.htm

MMWR (Special Articles on Diseases, Including HIV):
http://www.cdc.gov/mmwr/

U.S. Census Data (Available by State, County):
http://www.census.gov

Surveillance Contacts:
Department of Health, Broward County

Martha Duarte
Phone: 954-467-4700 ext. 5560
Email: Martha.Duarte@flhealth.gov

Joshua Rodriguez, HIV Program Coordinator
Phone: 954-467-4700 ext. 5611
Email: Joshua.Rodriguez@flhealth.gov

Florida HIV/AIDS Surveillance Data Contacts:

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Florida Department of Health
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Emma Spencer, MPH, PhD, Surveillance Program Manager
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Danielle Curatolo, Data Analyst
Florida Department of Health
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Email: Danielle.Curatolo@flhealth.gov

HIV/AIDS surveillance data is frozen on June 30, following the end of each calendar year.

These are the same data used for Florida CHARTS and all grant-related data.

http://www.floridacharts.com/charts/CommunicableDiseases/default.aspx

Ryan White Funders Presentation for PSRA

RYAN WHITE PART B

Ryan White Part B Program Overview

Ryan White Part B Program is a Federal program that provides HIV-cognate support services to Broward County clients. The program avails those that do not have adequate health care coverage and/or financial resources needed for managing HIV disease or AIDS. To be eligible for the program one must be HIV positive, a Broward County resident, and meet the income requisite of (400%) below the federal poverty level.

Program Budget

- FY2017 Budget and Final Expenditures 1,161,929.00
- FY2018 Budget: Level Funding.

Services Provided

Ryan White Part B assists clients with the following services:

- Emergency Financial Assistance (Medications from the Part B Formulary)
- Home and Community-Based Health Services
- Health Insurance Premium/Cost Sharing
- Medical Transportation Services (Bus Pass)
- Substance Abuse Services – Detox & Residential
- Home Delivered Meals/Nutritional Supplements

Emergency Financial Assistance

- Temporary assistance with medications, services are capped at $2,000 per year per client.
- Client must be Ryan White Part B(RWPB) eligible.
- Service Components:
  - ✓Medications when client ADAP eligibility has expired, awaiting to enroll, or Insurance concerns.

Home and Community-Based Health Services

- Assist homebound client's based on a plan of care by the client's Case Manager and doctor.
- Client must be Ryan White Part B(RWPB) eligible.
- Referrals are approved by the RWPB Program Manager.
- Service Components :
  - ✓Home health aide/personal care/home maker: Assist with daily cleaning and bathing as needed.
  - ✓Wound care nurse: Chronic ulcer care.
  - ✓Nutritional supplement shakes: 4 cases delivered monthly of Walgreens Brand unless specified on the prescription.
  - ✓Durable medical equipment: Catheters, surgical lube, diapers, shower chairs, and canes.
  - ✓Home delivered meals: Alternative breakfast, lunch, and dinner.
    - Microwavable meals based on client and/or doctor's diet request.

Medication Co-Payment

- The Medication Co-Payment Program provides monthly co-payments assistance for FDA-approved medications to insured clients who are **not** eligible for ADAP. It can also cover insurance premiums on a case per case basis.

- Client must be Ryan White Part B(RWPB) eligible.

- Service Components
  - ✓Client's choose one of the (41) participating pharmacies
  - ✓Client's pick up meds monthly (RWPB Approved Formulary)
  - ✓After applying co-pay cards; pharmacy submits bills to RWPB for clients portion.
  - ✓RWPB submits invoices for payment within 5-business days

Medical Transportation Services

- Ryan White Part B staff issues bus passes to Part A case managers for monthly distribution.
- Client must be Part B eligible.
- Client's income cannot exceed 150% of the Federal Poverty Level.
- Client's must Case Manager provide proof of medical appointments.
- Service Components:
  - ✓Monthly Bus Pass: Clients who exceeds 7 medical appointments per month
  - ✓Daily Bus Pass: clients with 3 or fewer medical appointments per month

Substance Abuse Services

- Provides Detoxification and Residential Substance Abuse Treatment Services to clients needing assistance to address substance abuse issues.
- Client must be Ryan White Part B(RWPB) eligible.
- Client's must be a Broward County resident age 18 or older.
- Service Components:
  - ✓Detoxification (Detox): Medically supervised inpatient detoxification 7-days per episode of care.
  - ✓Residential Treatment Services (RTS): Residential substance abuse treatment 60-day per episode of care.
  - ✓BARC's top three priorities during intake are Alcoholism, IV-Drug Use, and HIV in that order.

Unduplicated Clients 2017-18

Category Name	# Unduplicated Clients	Units of Service Provided
Health Insurance Premium/Cost Sharing	201	1195
Home & Community-based Health Services	17	235
Emergency Financial Assistance	1243	5956
Food Bank/Home Delivered Meals /Nutritional Suppl	281	2314
Medical Transportation Services	480	2665
Referral for Healthcare/Supportive Services	5275	5275
Substance Abuse Services - Residential	40	803

****Referral for Healthcare/support Services are Patient Assistance Specialists completing RWPB Eligibility*

Notable Trends

- High volume of clients needing assistance with copayments and deductibles for private insurance.
- The need for Emergency Financial Assistance to cover meds for clients who's ADAP eligibility has expired or pending premium payments.

Questions?

Discussion