



# **PALM BEACH COUNTY**

## **COMPREHENSIVE HIV NEEDS ASSESSMENT REPORT 2025-2026**

**RYAN WHITE PART A/MAI PROGRAM  
PALM BEACH COUNTY  
COMMUNITY SERVICES DEPARTMENT**

PREPARED BY:  
GENÈVE SIMEUS, MPH  
HEALTH PLANNER II



|   |           |
|---|-----------|
| <b>Introduction.....</b>  | <b>3</b>  |
| <b>Epidemiologic Profile.....</b>   | <b>4</b>  |
| Epidemiologic Summary.....  | 11        |
| <b>Estimate of Unmet Need and PLWH Who Are Unaware of their Status.....</b> | <b>11</b> |
| Estimate.....   | 12        |
| Characteristics of Persons Not in Care.....                                 | 12        |
| Estimate of PLWH Unaware of Their Status.....                               | 13        |
| Characteristics of Individuals Potentially Unaware of Their HIV Status..... | 13        |
| <b>HIV Client Survey.....</b>   | <b>14</b> |
| Demographic Characteristics.....  | 15        |
| Reasons for Not Taking HIV Medication (n = 6).....                          | 28        |
| Barriers to Accessing Needed Services.....                                  | 35        |
| Service Utilization Section Summary.....                                    | 36        |
| <b>Focus Group Findings.....</b>  | <b>52</b> |
| Initial Diagnosis and Entry into Care.....                                  | 53        |
| Barriers to Entering and Staying in Care.....                               | 53        |
| Stigma, Discrimination, and Confidentiality.....                            | 54        |
| Returning to Care.....  | 55        |
| Support Needs and Resources.....  | 55        |
| Misinformation and Community Awareness.....                                 | 56        |
| Recommendations for Improvement.....  | 56        |
| Summary of Key Themes.....  | 57        |
| <b>Resource Inventory.....</b>  | <b>58</b> |
| <b>Provider Capability and Capacity Assessment.....</b>                     | <b>64</b> |
| Survey Logic and Respondent Classification.....                             | 65        |
| <b>Assessment of Service Needs and Gap Analysis.....</b>                    | <b>78</b> |
| <b>Limitations.....</b>   | <b>81</b> |
| <b>Next Steps.....</b>  | <b>83</b> |

# Introduction

This report presents the findings of the Palm Beach County Comprehensive HIV Needs Assessment. The purpose of the assessment is to better understand the current needs of people living with HIV (PLWH) in Palm Beach County and to identify gaps within the local HIV prevention and care system.

The needs assessment was conducted to support planning activities for the Palm Beach County HIV CARE Council and to help inform priority setting, resource allocation, and service improvement efforts. The assessment incorporates multiple data sources to provide a comprehensive understanding of the local HIV service environment.

Data for this report were collected through several methods, including analysis of epidemiological surveillance data, estimates of unmet need and individuals unaware of their HIV status, a survey of people living with HIV receiving services in Palm Beach County, focus group discussions with clients, a resource inventory of HIV service providers, and a provider capacity and capability assessment.

Together, these data sources provide insight into the strengths of the current HIV service system as well as areas where additional resources, coordination, or service improvements may be needed to better meet the needs of individuals living with HIV in Palm Beach County.

## **Acknowledgements**

The Palm Beach County HIV CARE Council and Ryan White Part A Recipient office would like to acknowledge the contributions of the Planning Committee members, staff members and survey assistants who collected client data, community members, service providers, individuals living with HIV who participated in the development of assessment tools, and completed surveys and focus group discussions as part of this needs assessment. Their insights and experiences were essential in helping to better understand the needs of the community and strengthen the local HIV service system.

The CARE Council and Ryan White Part A recipient office also recognizes the ongoing collaboration of healthcare providers and agencies, community based organizations and public health partners who support HIV prevention, care, and treatment efforts throughout Palm Beach County.

# Epidemiologic Profile

## Purpose

The Epidemiologic Profile provides a comprehensive overview of the HIV epidemic in Palm Beach County and serves as a foundation for planning and service prioritization. This section summarizes the number of people living with HIV (PLWH), new diagnoses, demographic characteristics, geographic distribution, and key HIV Care Continuum indicators. Data presented in this section were obtained from the Florida Department of Health, Bureau of HIV/AIDS Surveillance, Integrated Epidemiological Profile (Area 9/Palm Beach County), 2024 data frozen as of June 30, 2025

## Overview of HIV in Palm Beach County

|                              | 2020      | 2021      | 2022      | 2023      | 2024      | Trend  |
|------------------------------|-----------|-----------|-----------|-----------|-----------|--------|
| Population                   | 1,469,904 | 1,487,272 | 1,519,461 | 1,538,719 | 1,554,160 | ▲ 1.0% |
| State of Florida             |           |           |           |           |           |        |
| People with HIV (Prevalence) | 125,010   | 126,478   | 128,049   | 130,074   | 132,444   | ▲ 1.8% |
| Palm Beach County            |           |           |           |           |           |        |
| People with HIV (Prevalence) | 8,716     | 8,799     | 8,894     | 8,968     | 9,175     | ▲ 2.3% |

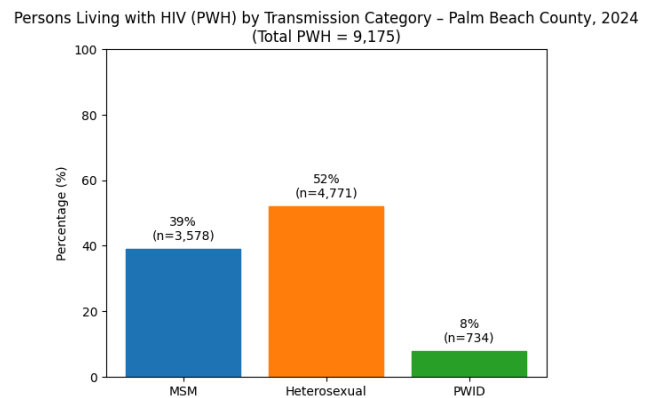
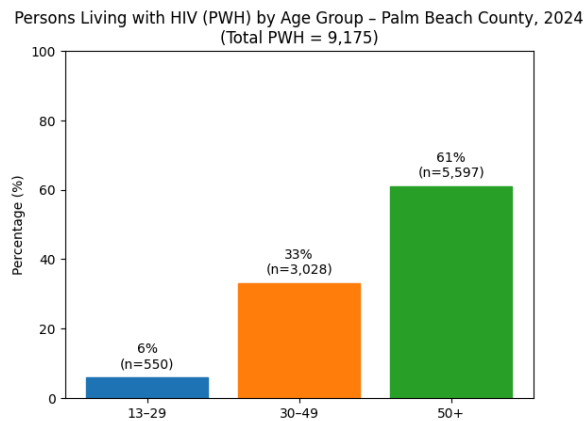
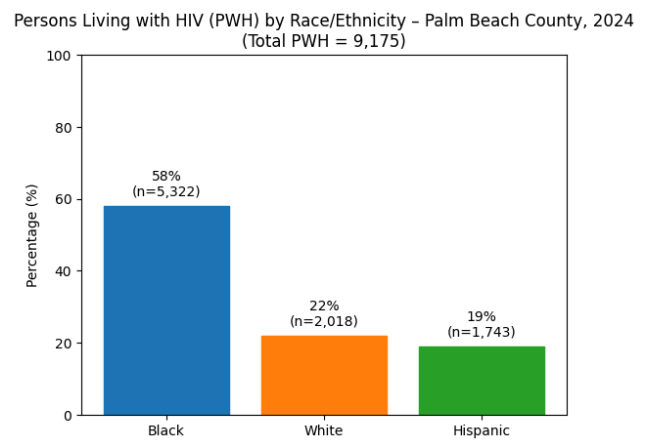
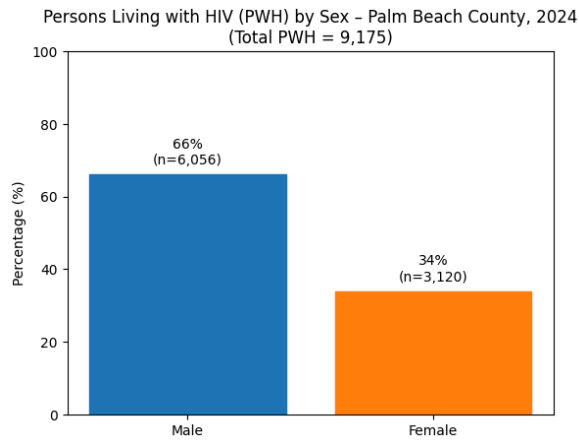
### HIV and AIDS, 2020-2024, Palm Beach County

|                              | 2020      | 2021      | 2022      | 2023      | 2024      | Trend   |
|------------------------------|-----------|-----------|-----------|-----------|-----------|---------|
| Population                   | 1,469,904 | 1,487,272 | 1,519,461 | 1,538,719 | 1,554,160 | ▲ 1.0%  |
| People with HIV (Prevalence) | 8,716     | 8,799     | 8,894     | 8,968     | 9,175     | ▲ 2.3%  |
| Diagnosed HIV cases          | 201       | 274       | 292       | 269       | 341       | ▲ 26.8% |
| Diagnosed AIDS cases         | 90        | 114       | 147       | 137       | 186       | ▲ 35.8% |
| HIV-related Deaths           | 49        | 39        | 40        | 28        | 49        | ▲ 75.0% |

*Source: Integrated Epidemiological Profile, Florida 2022, as of 6/30/25*

Palm Beach County is located along Florida’s Atlantic coast with an area of 1,970 miles. In 2024, Palm Beach County’s population was 1,554,160. As of 2024, there were 9,175 persons living with HIV (PWH) in Palm Beach County, representing a 2.3% increase from 2023 (8,968). In 2024, 341 new HIV diagnoses were reported in Palm Beach County, representing a 27% increase from 2023 (269) and a 17% increase from 2022 (292). Palm Beach County ranked among the top Florida counties for new HIV diagnoses in 2024.

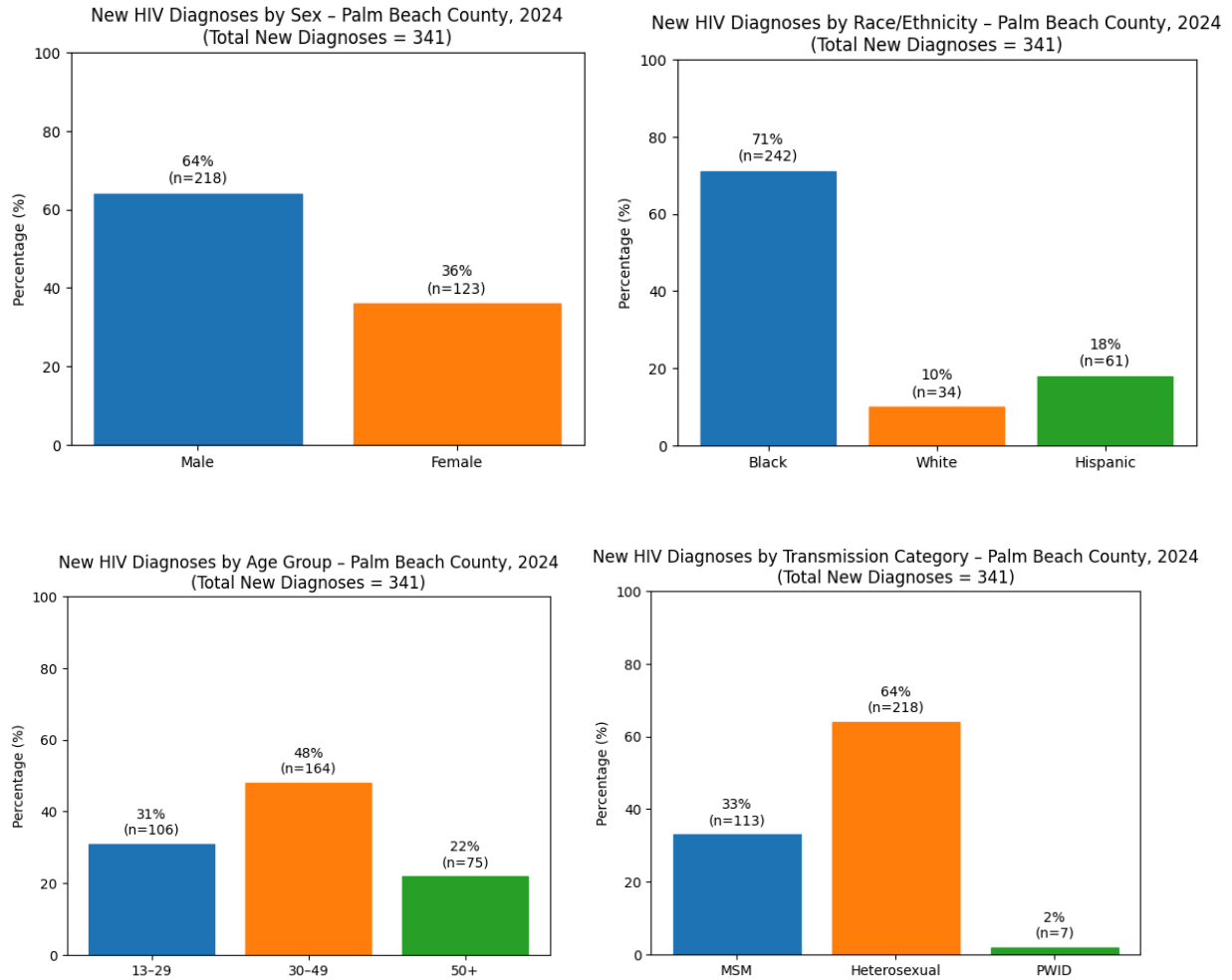
## Demographic Characteristics of PWH (2024)



**Source: Integrated Epidemiological Profile, Florida 2022, as of 6/30/25**

Among the 9,175 persons living with HIV in 2024, the following are the current demographic breakdowns. For gender demographics, 66% of persons with HIV were Male and 34% were Female. For race and ethnicity demographics, 58% were Black, 22% were White, and 19% were Hispanic. For age group demographics, 61% were aged 50 and older, 33% were aged 30-49 and 6% were aged 13-29. Transmission risk factors for persons living with HIV in 2024 were attributed to 52% heterosexual contact, 39% MSM contact, and 8% persons who injects drugs. The aging population of people with HIV is notable with a little over 60% aged 50 years or older.

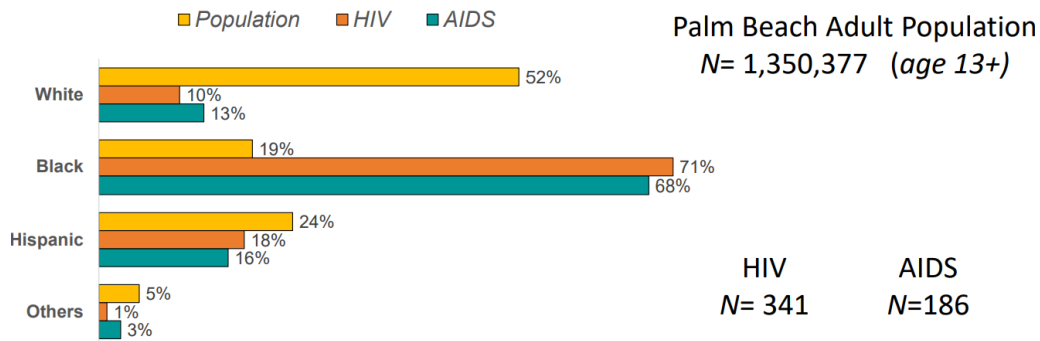
## Demographic Characteristics of New HIV Diagnoses (2024)



**Source: Integrated Epidemiological Profile, Florida 2022, as of 6/30/25**

Among the 341 individuals newly diagnosed with HIV in 2024, there were significant differences in new cases among genders, race/ethnicity, age, and transmission risk factors. Of the new diagnoses, 64% were male and 36% were female. 71% of new HIV diagnoses were Black, 10% were White, and 18% were Hispanic. 31% of new diagnoses came from individuals in the age group of 13-29, 48% of new diagnoses from the age group of 20-49, and 22% of new diagnoses were age 50 and above. New diagnoses were attributed from different transmission categories. 64% of new diagnoses were from heterosexual transmission, 33% were from men who have sex with men (MSM) transmission, 2% from Persons Who Inject Drugs. Significant racial disparities are evident, with Black residents disproportionately represented among new diagnoses relative to their share of the county population.

## New HIV&AIDS Diagnoses: Race vs Population 2024 Palm Beach

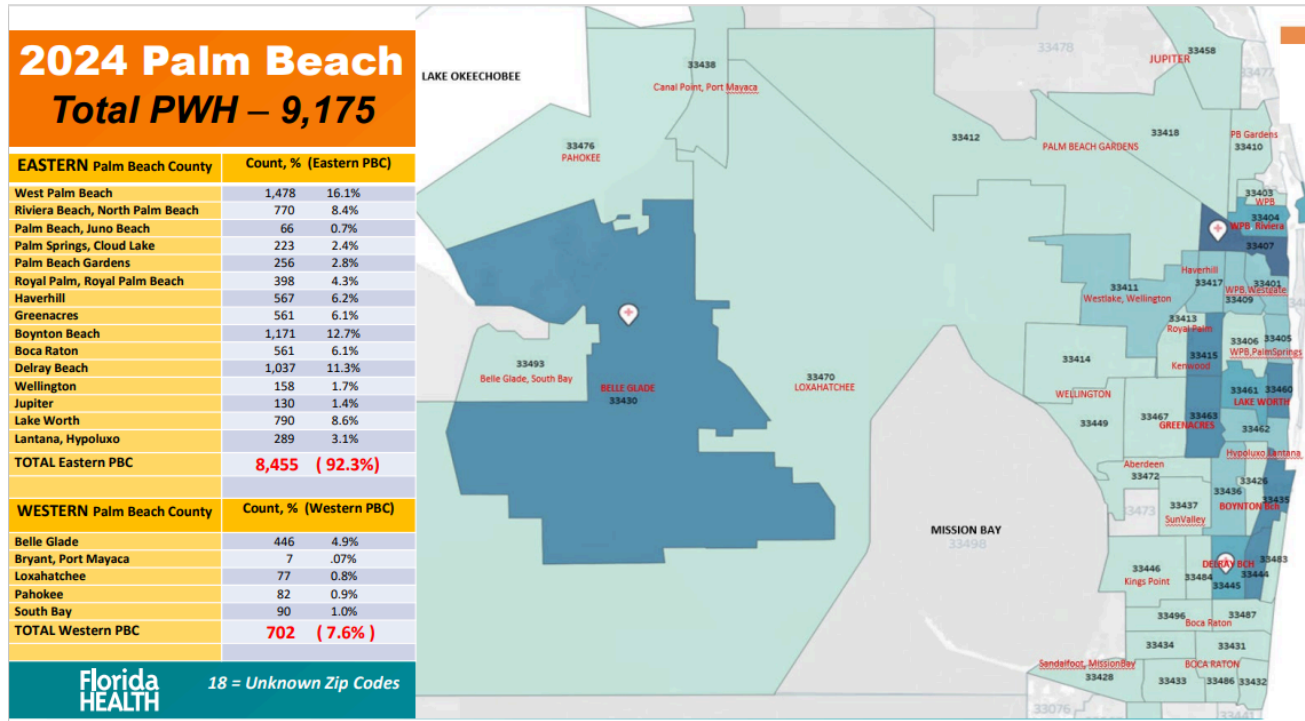


*Source: Integrated Epidemiological Profile, Florida 2022, as of 6/30/25*

This chart compares the racial/ethnic distribution of the adult population (age 13+) in Palm Beach County to the distribution of new HIV and AIDS diagnoses in 2024. While Black residents represent approximately 19% of the adult population, they accounted for 71% of new HIV diagnoses and 68% of new AIDS diagnoses. In contrast, White residents comprise 52% of the adult population but represented 10% of new HIV diagnoses and 13% of new AIDS diagnoses. Hispanic residents represent 24% of the adult population and accounted for 18% of new HIV diagnoses and 16% of new AIDS diagnoses.

These findings demonstrate a substantial racial disparity in new HIV and AIDS diagnoses, with Black residents disproportionately affected relative to their representation in the general population. This disparity underscores the continued need for targeted prevention, testing, linkage, and treatment strategies focused on communities most heavily impacted by HIV.

## Geographic Distribution



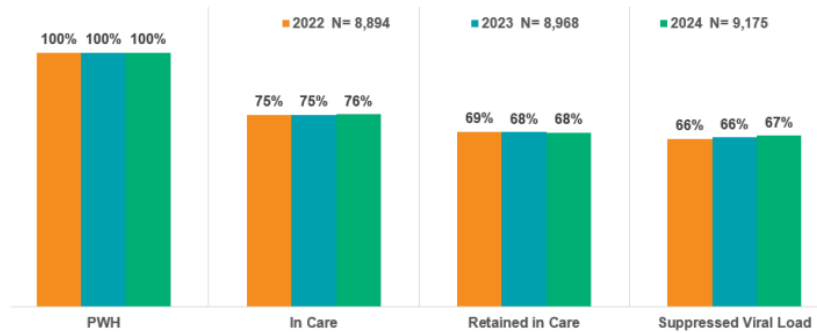
*Source: Integrated Epidemiological Profile, Florida 2022, as of 6/30/25*

In 2024, 92.3% of PWH resided in Eastern Palm Beach County, while 7.6% resided in Western Palm Beach County. Of the 92.3% of PWH residents in the eastern part of the county, municipalities and cities with the highest concentration of people with HIV are as follows: West Palm Beach (16.1%), Boynton Beach (12.7%), Delray Beach (11.3%), Lake Worth (8.6%), and Riviera Beach (8.4%).

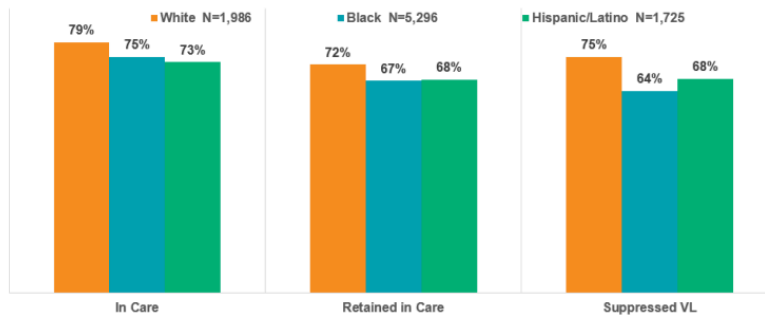
Of the 7.6% of PWH residents in the western communities the highest concentration of municipalities and cities is as follows: Belle Glade (4.9%), South Bay (1.0%), Pahokee (0.9%).

## HIV Care Continuum

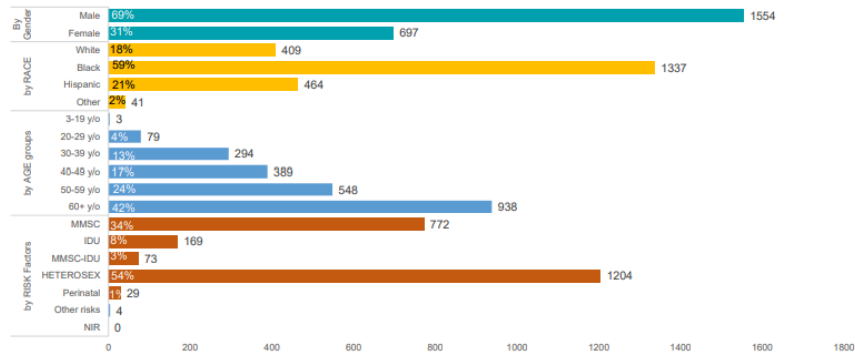
PWH along the HIV Care Continuum in 2022-2024, Palm Beach County



PWH by Race/Ethnicity along the HIV Care Continuum in 2024, Palm Beach County



PWH Not in Care = 2,251 (25%)



*Source: Integrated Epidemiological Profile, Florida 2022, as of 6/30/25*

### Care Continuum Definitions

**In Care:** PWH with at least one documented viral load or CD4 lab, medical visit, or prescription from 1/1/2024 to 3/31/2025.

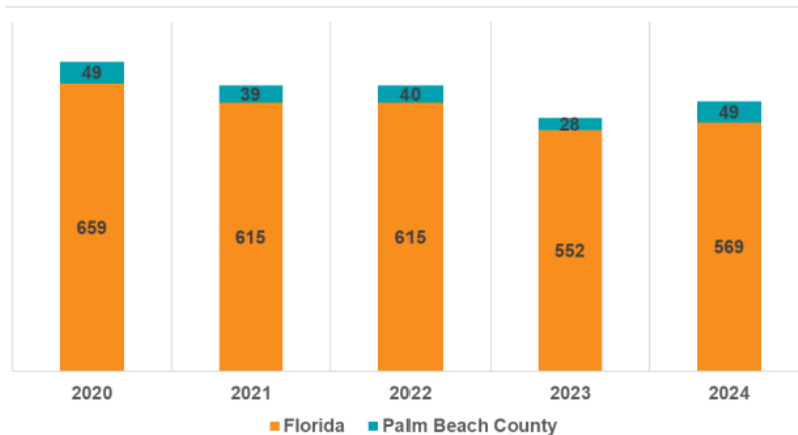
**Retained in Care:** PWH with two or more documented viral load or CD4 labs, medical visits, or prescriptions at least three months apart from 1/1/2024 to 3/31/2025.

**Suppressed Viral Load:** PWH with a suppressed viral load (<200 copies/mL) on the last viral load test from 1/1/2024 to 3/31/2025.

Among the 9,175 PWH in Palm Beach County in 2024, 76% were reported in care, 68% were retained in care and 67% were virally suppressed. The PWH Care continuum data between 2022-2024 were roughly the same. From 2023 to 2024, there was a 1% decrease of PWH in care, the percentage of PWH retained in care remained the same at 68%, and there was a 1% percentage increase of PWH that were virally suppressed from 66% to 67%. The amount of people with HIV between 2022-2024 increased from 8,894 in 2022 to 8,968 in 2023 to 9,175 in 2024.

Racial disparities in care engagement and viral suppression were reported in surveillance data. 79% of White PWH were in care compared to 75% of Black PWH and 73% Hispanic/Latino PWH. 72% of White PWH were retained in care compared to 67% Black PWH and 68% Hispanic/Latino PWH. 75% of White PWH were virally suppressed compared to 64% of Black PWH and 68% Hispanic/Latino PWH. Additionally, 25% (2,251) people with HIV were classified as not in care in 2024. Of those out of care (2,251), 69% were male and 59% were Black, and 42% were age 60 and older.

### Mortality



**Source: Integrated Epidemiological Profile, Florida 2022, as of 6/30/25**

In 2024, Palm Beach County reported HIV-related deaths consistent with recent trends. Death rates have fluctuated over time but reflect continued improvements in treatment access and viral suppression. From 2020 to 2024 HIV related deaths have averaged 41 deaths.

## **Epidemiologic Summary**

Overall, surveillance data indicate that Palm Beach County continues to experience a persistent HIV burden, with 9,175 persons living with HIV and 341 new diagnoses reported in 2024. While treatment advances have contributed to improved viral suppression outcomes, new diagnoses increased compared to the prior two years. Racial disparities remain pronounced, with Black residents disproportionately represented among both persons living with HIV and new diagnoses. Additionally, younger age groups represent a larger share of new diagnoses compared to the overall population of persons living with HIV, indicating ongoing transmission among younger residents.

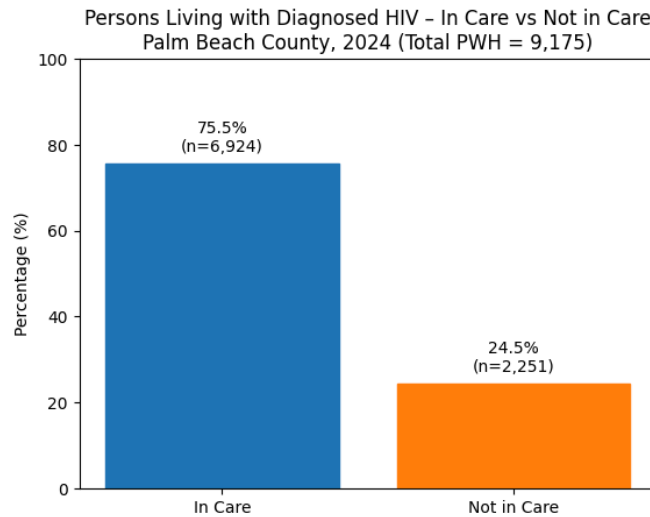
Care continuum data demonstrate substantial progress in viral suppression among those retained in care; however, approximately one-quarter of persons living with HIV were not in care during the measurement period. These epidemiologic trends underscore the continued need for targeted prevention, linkage, retention, and supportive service strategies within the service area.

## **Estimate of Unmet Need and PLWH Who Are Unaware of their Status**

### **Purpose and Methodology**

Unmet need refers to persons living with diagnosed HIV infection who are aware of their status but are not currently receiving HIV-related medical care. Estimates were developed using 2024 surveillance data provided by the Florida Department of Health, Bureau of HIV/AIDS Surveillance. Individuals were classified as “in care” based on documentation of at least one reported HIV-related laboratory test (CD4 count or viral load) within the 12-month measurement period. Individuals without laboratory evidence of care during that period were classified as having unmet need.

## Estimate



***Source: Integrated Epidemiological Profile, Florida 2022, as of 6/30/25***

In 2024, Palm Beach County had 9,175 persons living with diagnosed HIV infection. Of these individuals, 2,251 were not in care, representing 24.5% of diagnosed persons living with HIV. Approximately 76% were in care during the measurement period.

### **Characteristics of Persons Not in Care**

Surveillance data indicate that individuals not engaged in care are disproportionately represented among racial and ethnic minority populations, especially Black Americans, residents of high-prevalence eastern municipalities of West Palm Beach, Boynton Beach, Delray, Lake Worth and Riviera Beach. Persons not in care include younger individuals that are newly diagnosed alongside individuals with heterosexual transmission risk.

Unmet need includes individuals who were not linked to care following diagnosis (delayed entry) as well as individuals who were previously in care but subsequently dropped out.

Further assessment of barriers affecting these individuals is addressed in the Provider Capacity and Client Needs Assessment sections.

## **Estimate of PLWH Unaware of Their Status**

### **Overview**

At the time of this report, an updated jurisdiction-specific estimate of the number of people living with HIV who are unaware of their status in Palm Beach County was pending confirmation from the Florida Department of Health. These estimates are typically generated by the CDC state surveillance data. While the exact number of individuals currently unaware of their HIV status is not available, surveillance data on new HIV diagnoses indicate that targeted testing and outreach efforts should continue to focus on populations disproportionately affected by HIV. These include Black/African American residents, younger adults, individuals with heterosexual transmission risk, and communities with higher HIV prevalence such as Rivieria, Belle Glade, West Palm Beach, Lake Worth and Boynton Beach.

### **Characteristics of Individuals Potentially Unaware of Their HIV Status**

Individuals who are unaware of their HIV infection are not directly identifiable through routine surveillance data. However, analysis of new HIV diagnoses and testing patterns provides insight into populations most likely to include undiagnosed individuals.

In 2024, newly diagnosed HIV cases in Palm Beach County were disproportionately represented among specific demographic groups. Among the 341 individuals newly diagnosed, 71% were Black, 31% were aged 13–29, 64% reported heterosexual transmission risk and 64% were male.

These patterns suggest that individuals at highest likelihood of being undiagnosed may include Black residents, younger individuals particularly those under age 30, individuals with heterosexual exposure risk and residents of high-prevalence eastern municipalities of West Palm Beach, Boynton Beach, Delray, Lake Worth and Riviera Beach. Geographic data indicate that the majority of persons living with HIV reside in eastern Palm Beach County suggesting that testing, outreach, and prevention efforts should continue to prioritize these areas.

Although precise local estimates of undiagnosed infection require CDC modeling techniques, surveillance trends underscore the importance of targeted HIV testing, culturally responsive outreach strategies, and prevention initiatives focused on disproportionately affected populations.

### **Unmet Need and Unaware of Status Summary**

Together, the estimates of unmet need and potential undiagnosed infection highlight two critical priorities for the Palm Beach County EMA: (1) re-engagement of individuals who are aware of their HIV diagnosis but not currently in care, and (2) identification of individuals who remain

unaware of their infection. These findings inform planning, outreach, and resource allocation strategies aimed at improving linkage to care, retention in care, and viral suppression outcomes across the service area.

## HIV Client Survey

### **Survey Overview and Methodology**

The HIV Client Needs Assessment survey was conducted to assess the service needs, barriers to care, and experiences of people living with HIV in Palm Beach County. The survey was administered between November 2024 and February 2026 and was available in English, Spanish, and Haitian Creole to support participation among diverse client populations.

A total of 291 clients completed the survey. The survey intentionally included individuals who had recently re-engaged in care after being out of care in order to better understand barriers to sustained engagement in HIV medical services.

Most surveys were conducted over the phone (283 respondents), while 6 were completed in person and 2 were completed online. In-person surveys were conducted when clients were already present at service locations or interacting with staff, such as during visits to the Ryan White office, care re-engagement appointments, or meetings with case managers.

Respondents represented individuals at different stages of HIV care engagement and lived experience. The majority of respondents reported being currently engaged in HIV medical care (266 respondents), while 25 respondents reported being recently out of care at the time of the survey.

Respondents also reported a range of ages at the time of their HIV diagnosis. The largest proportion reported being diagnosed between 30–39 years old (88 respondents), followed by 20–29 years old (76 respondents) and 40–49 years old (70 respondents). Smaller proportions reported being diagnosed before the age of 20 (17 respondents) or at age 50 or older (40 respondents).

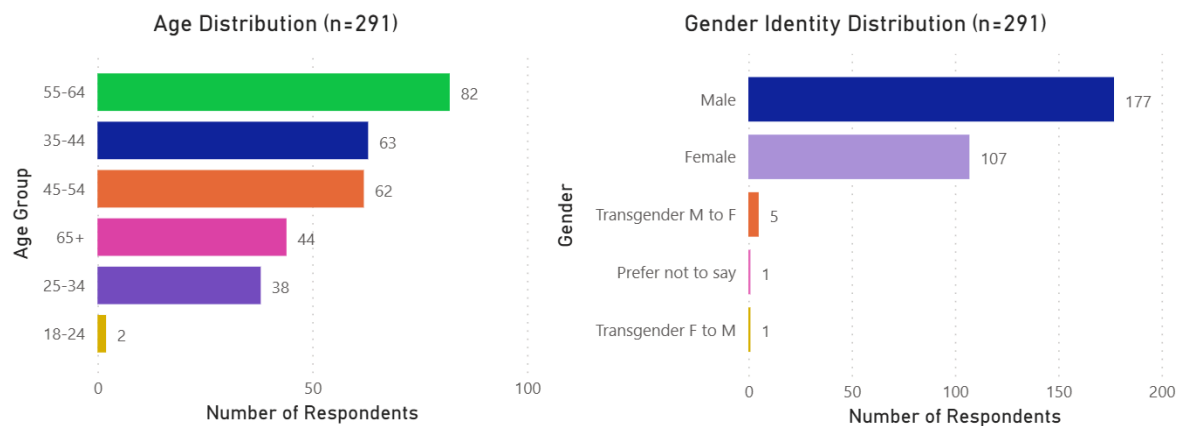
Respondents also reported varying lengths of time living with HIV. The largest proportion reported living with HIV for 11–20 years (123 respondents), followed by those living with HIV for more than 20 years (64 respondents). Additional respondents reported living with HIV for 6–10 years (55 respondents) or 1–5 years (47 respondents), while a small number reported being diagnosed within the past year (2 respondents).

## Demographic Characteristics

### Section Overview:

This section presents an overview of the demographic and socioeconomic characteristics of survey respondents. Questions examined age, gender identity, race and ethnicity, language, and cultural identity, as well as key socioeconomic indicators including education level, employment status, housing stability, household income, internet access, and number of individuals supported by household income. Together, these factors provide important context for understanding the lived experiences of people receiving HIV services in Palm Beach County and help inform service planning by identifying population trends and social determinants that may influence access to care and health outcomes.

### Age and Gender Distribution

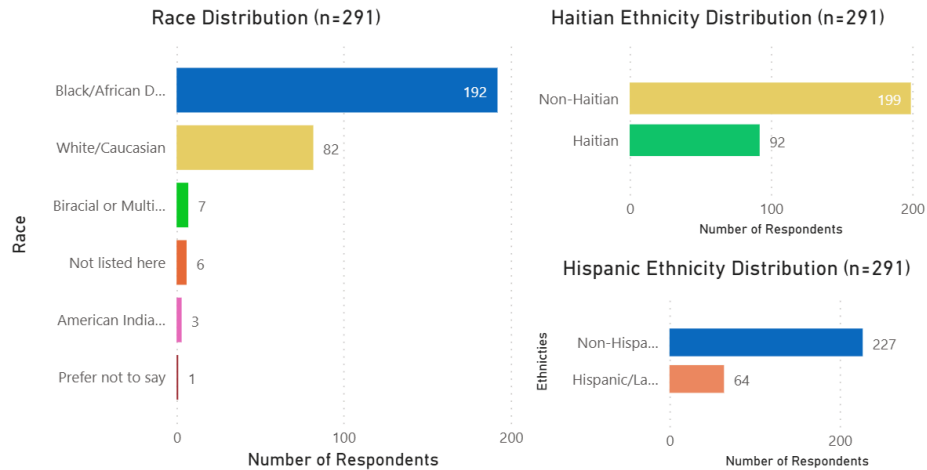


Survey respondents represented a wide range of ages. The largest proportion of respondents were 55–64 years old (82 respondents), followed by those aged 35–44 (63 respondents) and 45–54 (62 respondents). Additional respondents were aged 65 years and older (44 respondents) and 25–34 (38 respondents). A very small number of respondents were 18–24 years old (2 respondents). Overall, the age distribution indicates that most survey participants were middle-aged or older adults, reflecting the aging population of people living with HIV.

In terms of gender identity, the majority of respondents identified as male (177 respondents), followed by female (107 respondents). A small number of respondents identified as transgender male to female (5 respondents), while one respondent identified as transgender female to male and one respondent preferred not to disclose their gender identity. These findings reflect the

gender composition of survey participants and highlight the importance of ensuring HIV services remain responsive to individuals of diverse gender identities.

### Race and Ethnicity Distribution



Survey respondents represented a racially diverse population of people living with HIV in Palm Beach County. The majority of respondents identified as Black or African American (192 respondents), followed by those who identified as White or Caucasian (82 respondents). Smaller numbers of respondents identified as Biracial or Multiracial (7 respondents), another race not listed in the survey options (6 respondents), or American Indian or Alaska Native (3 respondents). One respondent preferred not to disclose their race.

Respondents also represented diverse ethnic backgrounds. Most respondents identified as non-Hispanic/Latino (227 respondents), while 64 respondents identified as Hispanic/Latino. Additionally, 92 respondents identified as Haitian, while 199 respondents identified as non-Haitian. These findings reflect the ethnic diversity of the population served and highlight the importance of ensuring HIV services remain culturally and linguistically responsive to the needs of Hispanic/Latino and Haitian communities within Palm Beach County.

### Demographic Summary:

A total of 291 individuals completed the survey. Clients who responded and completed the survey were selected from a racially, ethnically, and gender-stratified client sample designed to reflect the population of clients within the local system of care.

Respondents represented a broad age distribution. The largest proportion of respondents were aged 55–64 (n = 82, 28.2%), followed by individuals aged 35–44 (n = 63, 21.6%) and 45–54 (n = 62, 21.3%). Individuals aged 65 years and older accounted for 44 respondents (15.1%), while 38 respondents (13.1%) were between the ages of 25–34. Younger adults aged 18–24 were minimally represented (n = 2, 0.7%).

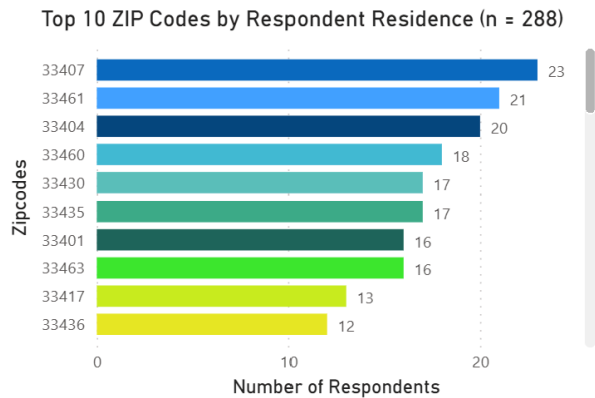
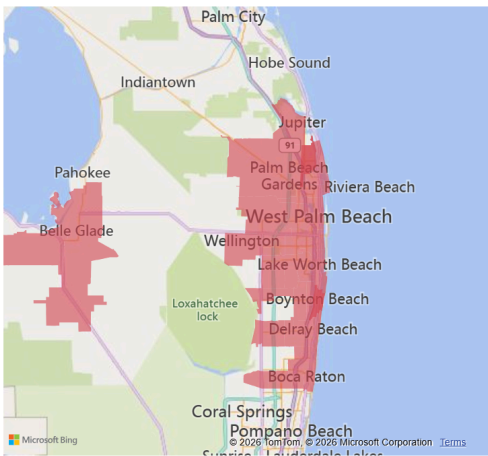
The majority of respondents identified as male (n = 177, 60.8%), followed by female (n = 107, 36.8%). A small number of respondents identified as transgender male-to-female (n = 5, 1.7%), transgender female-to-male (n = 1, 0.3%), or preferred not to disclose their gender identity (n = 1, 0.3%).

Racially, the respondent population was predominantly Black or African American (n = 192, 66.0%), followed by White or Caucasian (n = 82, 28.2%). Smaller proportions identified as biracial or multiracial (n = 7, 2.4%), another race not listed in the survey options (n = 6, 2.1%), American Indian or Alaska Native (n = 3, 1.0%), or preferred not to respond (n = 1, 0.3%).

With respect to ethnicity, 64 respondents (22.0%) identified as Hispanic/Latinx, while 227 respondents (78.0%) identified as non-Hispanic/Latinx. Additionally, 92 respondents (31.6%) identified as Haitian, representing nearly one-third of the survey population

**Zipcode:**

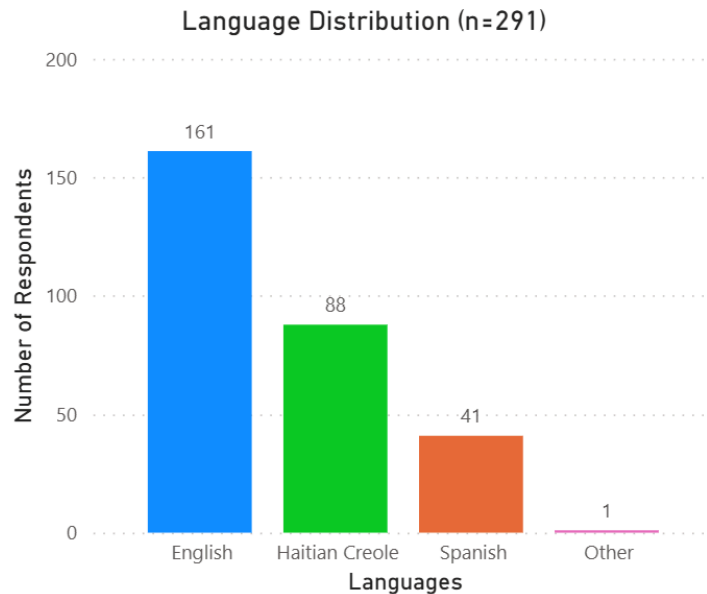
Geographic Distribution of Respondents (n = 288 mappable ZIP codes)



A total of 291 respondents responded to this question. Of these, 288 provided valid ZIP codes and were included in the geographic analysis. Three respondents reported ZIP code “00000,” reflecting housing instability, and were excluded from mapping.

Respondents were geographically concentrated within central and eastern Palm Beach County, with the highest representation from ZIP code 33407 (n = 23), followed by 33461 (n = 21) and 33404 (n = 20). Additional high-concentration ZIP codes included 33460 (n = 18), 33430 (n = 17), and 33435 (n = 17). The distribution demonstrates clustering of clients within urban and coastal areas of the county, particularly in and around West Palm Beach, Riviera Beach, Lake Worth Beach, and surrounding communities. These findings suggest that service demand remains concentrated in historically high-burden areas and population-dense corridors.

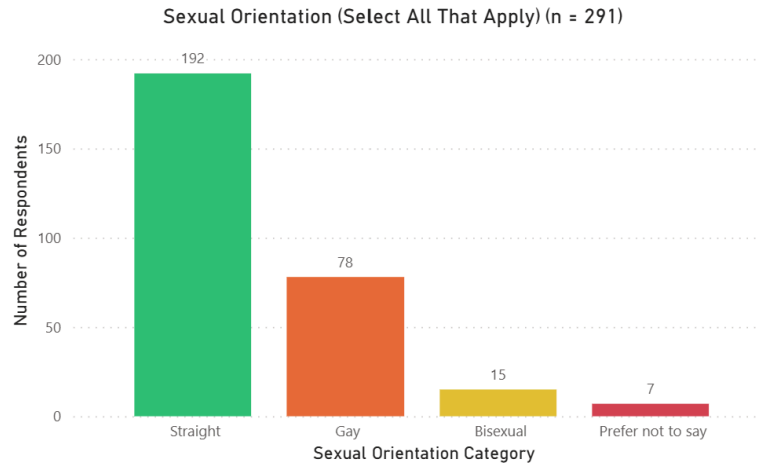
## Language



English was the primary language reported by 161 respondents (55.3%). A substantial proportion of respondents reported Haitian Creole as their primary language (n = 88, 30.2%), followed by Spanish (n = 41, 14.1%). One respondent (0.3%) reported another language.

The distribution of primary languages reflects the linguistic diversity of the service population and underscores the continued importance of multilingual service delivery capacity, particularly for Haitian Creole and Spanish-speaking clients.

## Sexual Orientation (Select All That Apply)



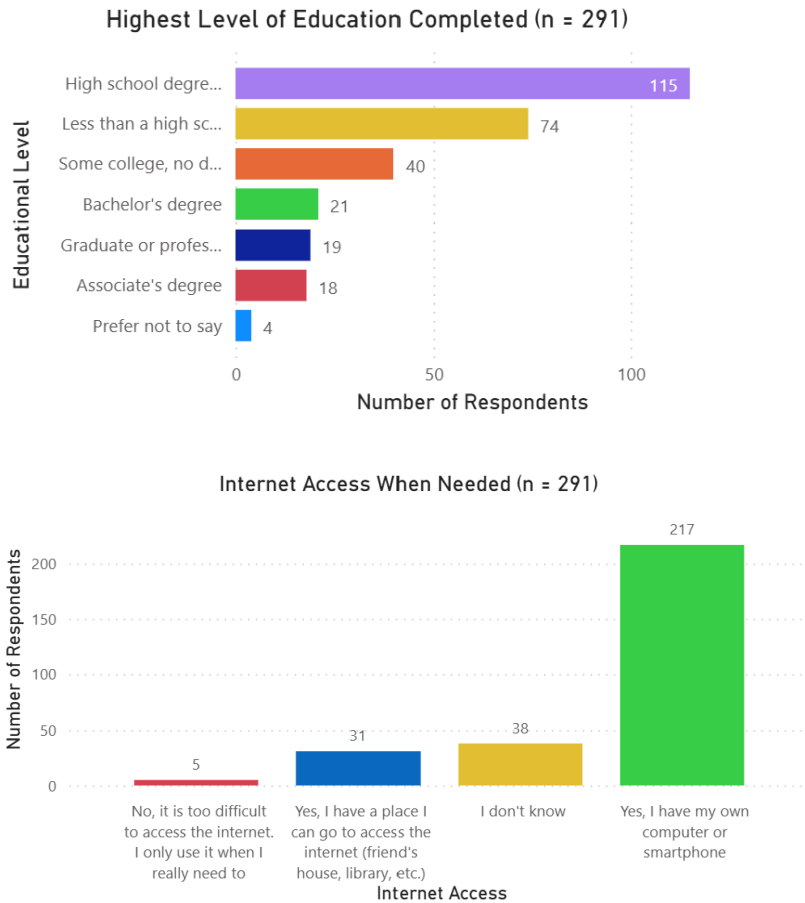
Respondents were asked to identify their sexual orientation, with the option to select all that apply. A total of 192 respondents (66.0%) identified as straight, 78 (26.8%) identified as gay, and 15 (5.2%) identified as bisexual. Seven respondents (2.4%) preferred not to disclose their sexual orientation. Because this question allowed multiple responses, totals may exceed 291.

The distribution reflects a predominantly heterosexual-identifying population, with more than one-quarter of respondents identifying as gay, highlighting the continued need for culturally responsive services tailored to diverse sexual identities.

### Socioeconomic Demographics

This next sub-section of socioeconomic demographics focuses on educational level, internet access, housing, income level, and employment status.

## Educational and Internet Access



## Educational Attainment

Among respondents, the majority reported a high school diploma or GED as their highest level of education (n = 115, 39.5%). A substantial proportion reported less than a high school diploma (n = 74, 25.4%). Forty respondents (13.7%) reported some college but no degree.

Eighteen respondents (6.2%) reported completing an associate's degree, 21 (7.2%) reported a bachelor's degree, and 19 (6.5%) reported a graduate or professional degree. Four respondents (1.4%) preferred not to disclose their educational attainment.

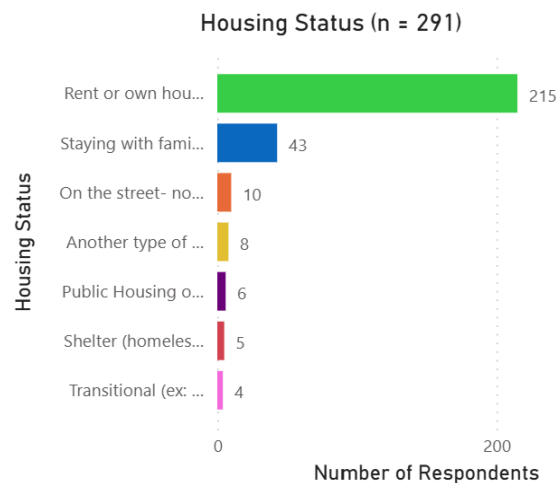
Overall, nearly two-thirds of respondents (64.9%) reported a high school diploma or less, highlighting the importance of accessible communication strategies and service models that account for varying levels of educational attainment.

## Internet Access

Most respondents (n = 217, 74.6%) reported having personal access to the internet through their own computer or smartphone. However, 31 respondents (10.7%) indicated they rely on accessing the internet at another location, such as a public space or community setting. Thirty-eight respondents (13.1%) reported that they did not know whether they have internet access when needed, and five respondents (1.7%) indicated that it is too difficult to access the internet.

Overall, approximately one-quarter of respondents do not report consistent personal internet access. This has implications for telehealth utilization, electronic communication, and online service navigation within the system of care.

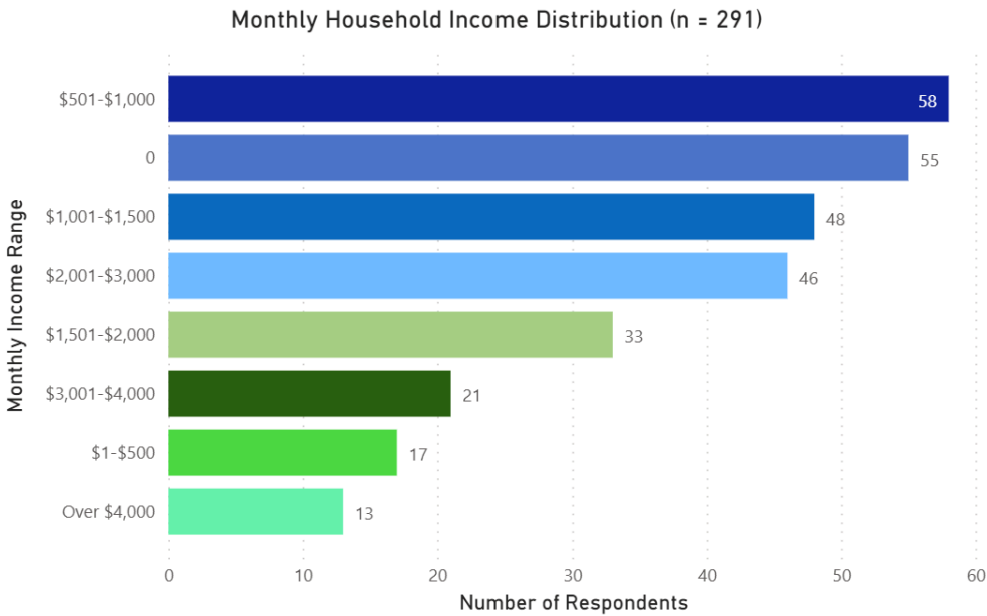
## Housing Status



Most respondents (n = 215, 73.9%) reported renting or owning their housing. However, 43 respondents (14.8%) indicated they were staying with family or friends. Smaller proportions reported experiencing housing instability, including 10 respondents (3.4%) who reported being on the street or without stable housing, five (1.7%) residing in a shelter, and four (1.4%) in transitional housing. An additional six respondents (2.1%) reported living in public housing, and eight (2.7%) reported another type of housing arrangement.

Overall, more than one-quarter of respondents (26.1%) reported living situations that may reflect housing instability or non-independent housing arrangements. Housing stability remains a critical structural factor influencing health outcomes, access to care, and continuity of services within the system of care.

## Gross Monthly Income

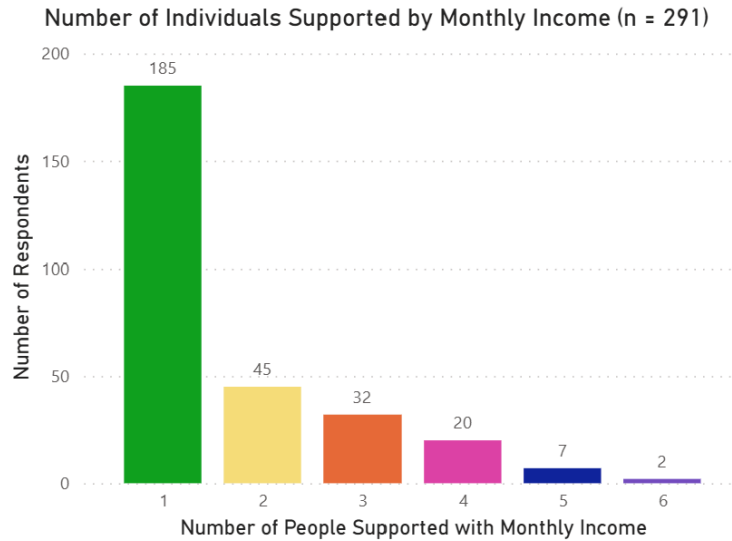


Respondents reported a wide range of monthly household income levels, with a substantial proportion indicating low-income status. The largest income bracket was \$501–\$1,000 per month (n = 58, 19.9%), closely followed by respondents reporting \$0 monthly income (n = 55, 18.9%). Together, these findings indicate that nearly two in five respondents reported earning \$1,000 or less per month.

An additional 48 respondents (16.5%) reported earning \$1,001–\$1,500 monthly, and 46 (15.8%) reported \$2,001–\$3,000 per month. Smaller proportions reported incomes between \$1,501–\$2,000 (n = 33, 11.3%) and \$3,001–\$4,000 (n = 21, 7.2%). Only 13 respondents (4.5%) reported earning over \$4,000 per month.

Overall, the income distribution reflects a predominantly low-income population, with the majority of respondents reporting monthly household incomes below \$2,000. These findings underscore the continued importance of publicly funded services and financial assistance programs in supporting access to HIV care and related services.

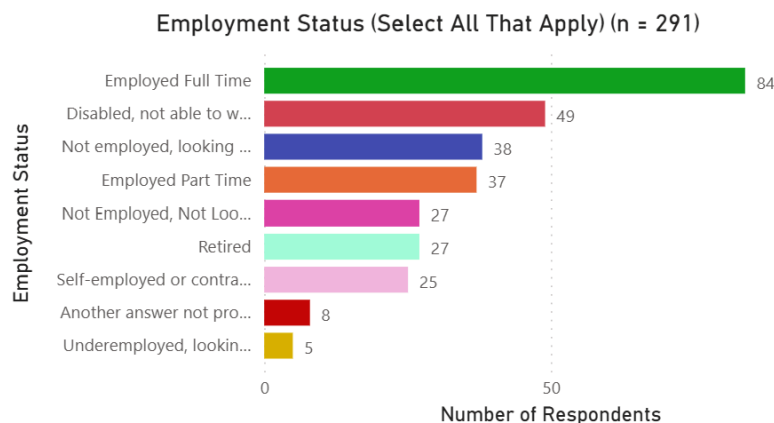
## Number of Individuals Supported by Monthly Income



Most respondents (n = 185, 63.6%) reported supporting only themselves with their monthly income. However, 45 respondents (15.5%) reported supporting two individuals, and 32 (11.0%) reported supporting three individuals. Smaller proportions reported supporting four (6.9%), five (2.4%), or six (0.7%) individuals.

Overall, more than one-third of respondents (36.4%) reported financial responsibility for at least one additional person. These findings highlight varying levels of household financial burden within the survey population, particularly when considered alongside reported income and housing stability.

## Employment Status



Employment status was assessed as a “select all that apply” question; therefore, totals may exceed the overall number of respondents (n = 291).

Among respondents, 84 individuals (28.9%) reported being employed full time, and 37 (12.7%) reported being employed part time. An additional 25 respondents (8.6%) identified as self-employed or contract workers.

A notable proportion of respondents reported not being employed. Thirty-eight individuals (13.1%) indicated they were not employed and actively looking for work, while 27 (9.3%) reported not being employed and not currently looking for work. Forty-nine respondents (16.8%) reported being disabled and not able to work, and 27 (9.3%) indicated they were retired. Five respondents (1.7%) reported being underemployed and seeking additional work, and 8 (2.7%) selected another employment category not listed.

Overall, the findings reflect a diverse employment profile within the sample, including a substantial proportion of respondents who are employed, alongside a significant segment experiencing unemployment, disability-related work limitations, or retirement.

## **Summary of Core Demographic and Socioeconomic Section**

The survey sample reflects a diverse population of individuals living with HIV in Palm Beach County, with varied demographic and socioeconomic characteristics. While respondents represent a range of ages, racial and ethnic backgrounds, and gender identities, socioeconomic indicators reveal significant financial vulnerability within the population. A substantial proportion reported low monthly income, reliance on public assistance, and employment instability. Although many respondents reported stable housing and access to technology, income distribution patterns suggest that a large segment of the population lives at or near poverty levels.

Together, these findings underscore the importance of integrated HIV care models that address both medical needs and the broader social determinants of health that influence access, engagement, and long-term outcomes.

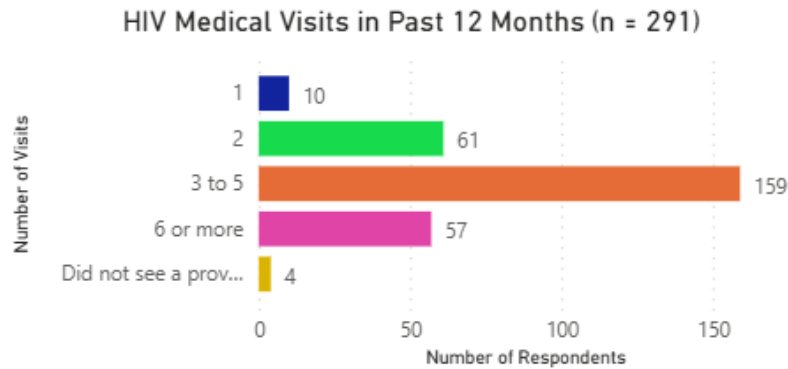
## **Health and Medical Access Questions**

### **Section Overview**

This section examines respondents’ engagement in HIV medical care, access to needed services, medication utilization, and continuity of care experiences. Questions focused on frequency of medical visits, communication with providers, ability to obtain care when needed, medication access and payment sources, and healthcare transitions following incarceration. Together, these

findings provide insight into the overall functioning of the local HIV care continuum and identify areas of strength and opportunity within the system.

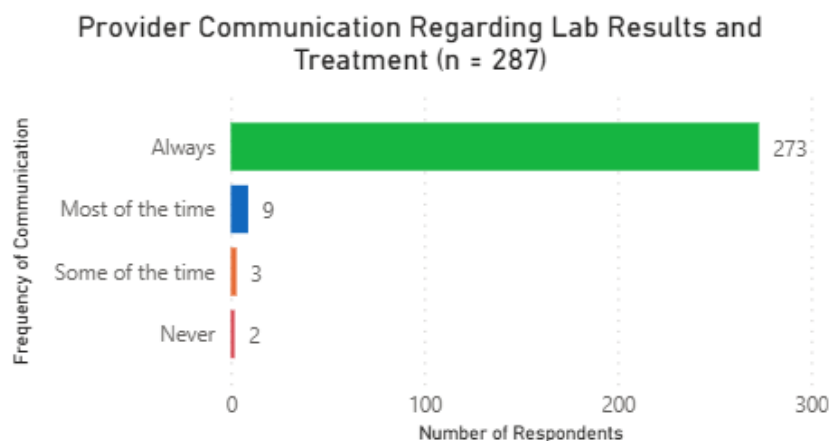
### HIV Medical Visits



Respondents were asked how many times they saw their HIV medical provider in the past 12 months (n = 291). The majority of respondents (n = 159, 54.6%) reported attending between three and five medical visits during the year, while 57 individuals (19.6%) reported six or more visits. Sixty-one respondents (21.0%) reported attending two visits, and 10 respondents (3.4%) reported only one visit. A small proportion of respondents (n = 4, 1.4%) indicated that they did not see a provider during the past year.

Overall, the findings suggest strong engagement in HIV medical care among survey participants, with nearly three-quarters reporting three or more medical visits in the previous 12 months.

### Provider Communication on Lab Results and Treatment Plans

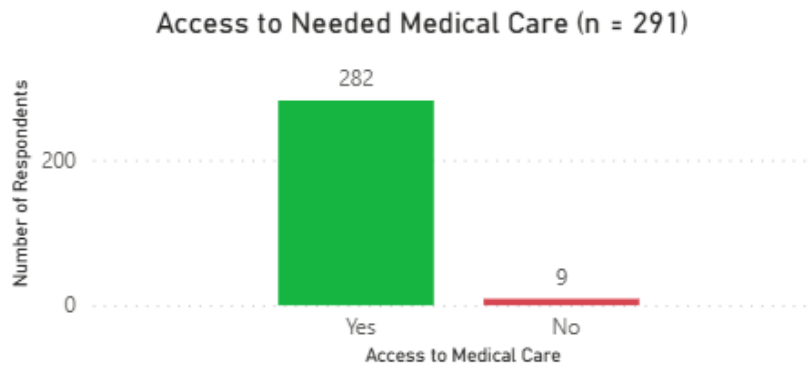


Respondents who reported seeing an HIV medical provider in the past 12 months (n = 287) were asked whether their provider took the time to explain lab results, diagnoses, treatment plans, and

answer questions. The vast majority of respondents (n = 273, 95.1%) indicated that their provider *always* took the time to explain their medical information clearly. An additional 9 respondents (3.1%) reported this occurred *most of the time*. Only a small proportion indicated that providers explained information *some of the time* (n = 3, 1.0%) or *never* (n = 2, 0.7%).

Overall, findings reflect very high levels of perceived provider communication and patient-provider engagement among respondents who accessed care. Respondents who reported not seeing a provider in the past 12 months were not asked this question due to survey branching logic.

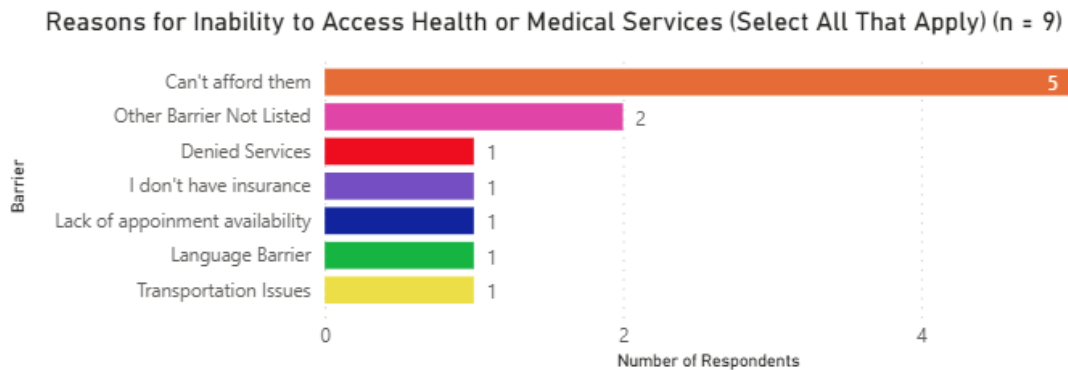
### Access to Needed Medical Care in the Past 12 Months (n=291)



Respondents were asked whether they were able to access medical care when needed in the past 12 months. The vast majority (n = 282, 96.9%) reported that they were able to access care when needed. A small proportion of respondents (n = 9, 3.1%) indicated that they were unable to access medical care during this period.

Overall, findings indicate strong reported access to HIV-related medical services among survey participants. However, the small subset of respondents who experienced access challenges highlights the continued importance of identifying and addressing barriers to care.

## Barriers to Health and Medical Services (n = 9)

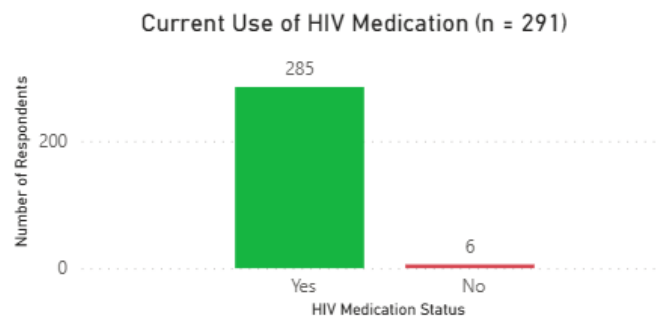


Nine respondents reported being unable to access needed medical care in the past 12 months and were asked to identify reasons. Among this subgroup, the most frequently reported barrier was cost-related, with five respondents (55.6%) indicating they could not afford services. Two respondents (22.2%) selected another reason not listed.

Additional barriers reported by one respondent each (11.1%) included lack of insurance, denied services, lack of appointment availability, language barriers, and transportation challenges.

Although the number of respondents reporting access difficulties was small, findings suggest that financial barriers, including affordability and insurance coverage, remain primary contributors to challenges in accessing care.

## Current Use of HIV Medication



Respondents were asked whether they are currently taking medication to treat their HIV. The vast majority (n = 285, 97.9%) reported that they are currently taking HIV medication. A small proportion of respondents (n = 6, 2.1%) indicated that they are not currently taking medication.

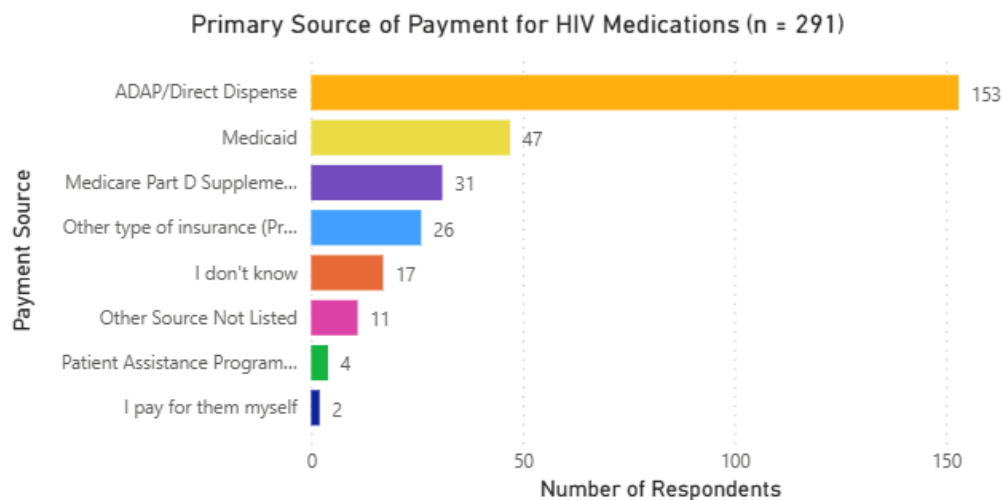
These findings suggest high levels of reported antiretroviral therapy (ART) utilization among survey participants, consistent with the strong engagement in medical care observed in previous measures.

### Reasons for Not Taking HIV Medication (n = 6)

Among the six respondents who reported not currently taking HIV medication, written responses reflected several primary themes. The most frequently cited issue involved insurance-related barriers, including lack of insurance, complications with marketplace coverage, and challenges related to co-pays and transportation. One respondent reported running out of medication, suggesting a temporary interruption in access. Another respondent indicated that recent incarceration disrupted their care and required assistance to re-engage in services. One respondent reported choosing not to take medication.

Although the number of respondents not on medication was small, these responses highlight the continued importance of insurance coverage stability, re-entry support for individuals leaving incarceration, and assistance with medication access.

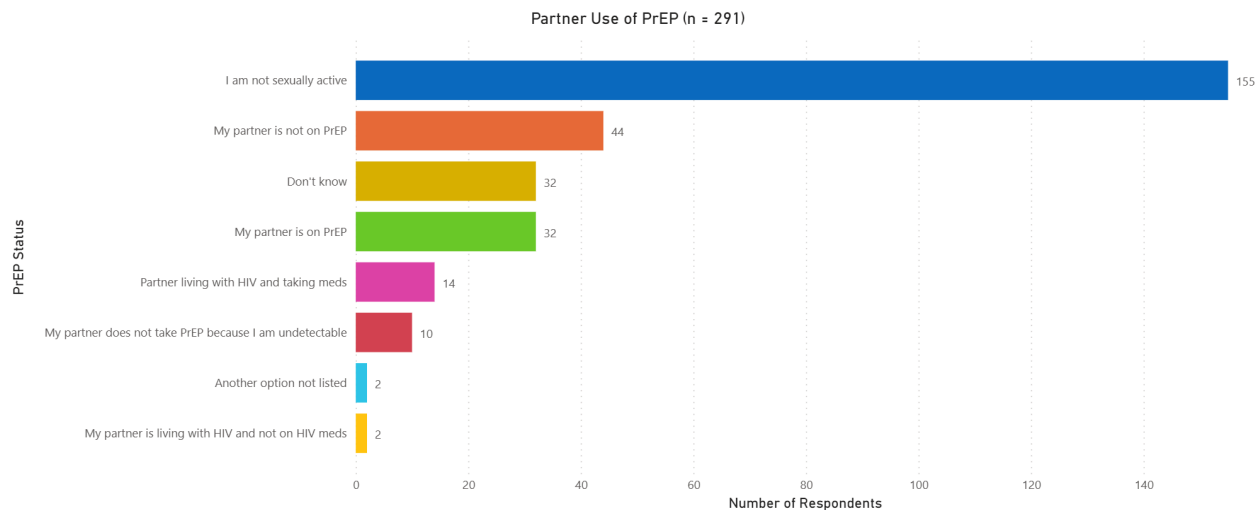
### Payment Source for HIV Medication



Among all respondents (n = 291), the majority reported receiving HIV medications through ADAP/Direct Dispense (n = 153, 52.6%), reflecting substantial reliance on Ryan White Part B–funded medication assistance programs administered at the state level. Public insurance programs also play a significant role, with 47 respondents (16.2%) covered through Medicaid and 31 (10.7%) through Medicare Part D supplemental coverage. An additional 26 respondents (8.9%) reported coverage through private or other insurance.

Seventeen respondents (5.8%) indicated that they did not know how their medications were paid for, while 11 respondents (3.8%) reported another source not listed among the survey options. Very few individuals reported paying for medications out of pocket (n = 2, 0.7%). These findings highlight the critical role of publicly funded insurance and medication assistance programs in ensuring sustained access to HIV treatment.

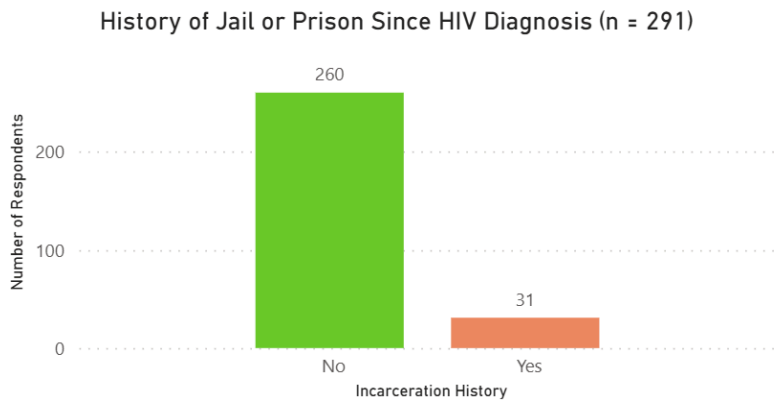
### PrEP Use and HIV Status of Sexual Partners



Among all respondents (n = 291), 155 individuals (53.3%) reported that they were not sexually active. Among respondents who reported having sexual partners (n = 136), prevention engagement varied. Forty-four respondents (32.4% of sexually active respondents) reported that their partner was not taking PrEP, while 32 respondents (23.5%) indicated that their partner was taking PrEP. An additional 32 respondents (23.5%) reported that they did not know whether their partner was taking PrEP.

Fourteen respondents (10.3%) reported having a partner living with HIV who is on HIV medication, and two respondents (1.5%) reported a partner living with HIV who is not on medication. Ten respondents (7.4%) indicated that their partner does not take PrEP because they themselves are undetectable, reflecting awareness of the Undetectable = Untransmittable (U=U) prevention strategy. These findings demonstrate variability in prevention engagement among sexual partners and highlight opportunities for continued PrEP education, partner communication support, and prevention counseling within the community.

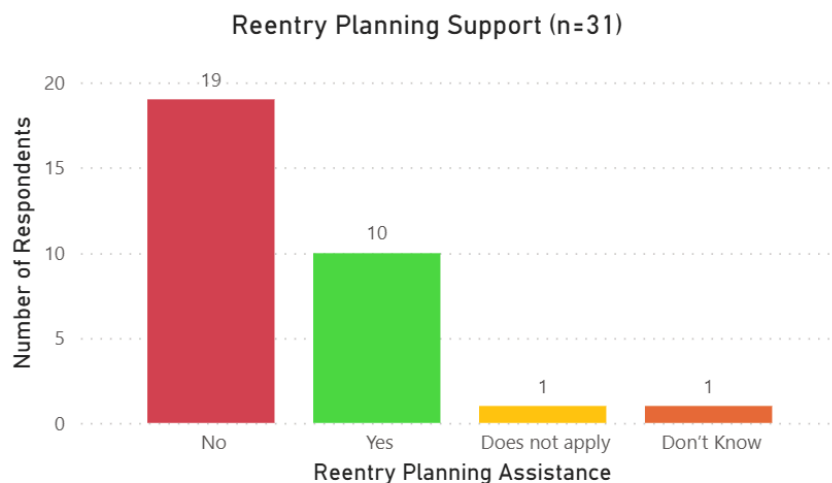
## Incarceration History



Among the 291 respondents, 31 individuals (10.7%) reported having served a jail or prison sentence since their HIV diagnosis, while the majority (n = 260, 89.3%) reported no history of incarceration during that time period.

Although most respondents have not experienced incarceration since diagnosis, approximately one in ten individuals reported justice system involvement. This finding is significant, as incarceration can disrupt continuity of HIV care, medication adherence, and linkage to supportive services. Individuals transitioning from correctional settings may require coordinated reentry planning and targeted support to ensure uninterrupted access to HIV treatment and related services.

## Reentry Planning Assistance Following Incarceration



Among the 31 respondents who reported a history of incarceration since their HIV diagnosis, 19 individuals (61.3%) indicated they were not offered assistance with healthcare or other needs planning upon release. Ten respondents (32.3%) reported receiving reentry planning support, while one respondent (3.2%) indicated the question did not apply and one (3.2%) did not know.

These findings suggest that while some individuals receive transitional support upon release from correctional settings, a majority do not report receiving structured assistance with healthcare reengagement or service coordination. Given the known risks of treatment interruption during incarceration transitions, strengthening formal reentry linkage processes may represent an important opportunity to improve continuity of HIV care and overall health outcomes within the community.

### **Summary of Health and Medical Access Findings**

Overall, findings indicate strong engagement in HIV medical care among survey respondents. The majority reported attending multiple HIV medical visits in the past 12 months, and nearly all respondents indicated that providers consistently communicated laboratory results and treatment information. Access to needed medical care was also reported as high, with most respondents indicating they were able to obtain care when needed.

Medication adherence and coverage appear similarly strong. Nearly all respondents reported currently taking HIV medications, and the majority receive medication support through ADAP/Direct Dispense, reflecting the critical role of Ryan White Part B and publicly funded programs in sustaining treatment access. Public insurance programs, including Medicaid and Medicare, also contribute significantly to medication coverage.

Despite these strengths, several areas warrant attention. A small but meaningful proportion of respondents reported barriers to care, most commonly affordability-related concerns. Additionally, approximately one in ten respondents reported a history of incarceration since HIV diagnosis. Among those individuals, most did not report receiving structured reentry planning assistance, indicating a potential gap in continuity-of-care coordination during justice system transitions.

Collectively, these findings suggest a largely functional HIV medical care system with high levels of engagement and medication coverage, while also highlighting targeted opportunities to strengthen reentry support and address residual access barriers.

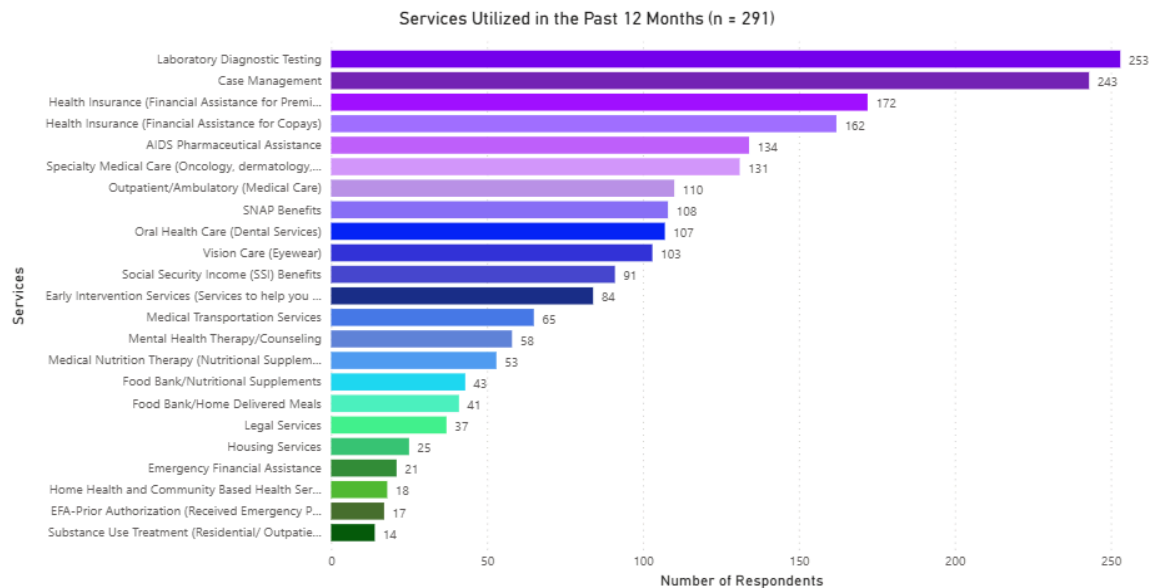
### **Service Utilization Section**

#### **Overview**

This section examines the types of HIV-related medical and supportive services respondents reported using in the past 12 months, as well as services they needed but were unable to obtain. Understanding both service utilization and unmet need provides important insight into how

effectively the local HIV service system is meeting the needs of people living with HIV in Palm Beach County. In addition to quantitative responses regarding service access, respondents were also asked to describe barriers preventing them from obtaining needed services. Together, these findings provide a more comprehensive understanding of service access and system gaps.

## Service Utilization



Among survey respondents (n = 291), utilization of core medical and supportive services was high. Laboratory Diagnostic Testing was the most commonly utilized service (n = 253), followed closely by Case Management (n = 243), indicating high levels of engagement in core HIV medical services and care coordination.

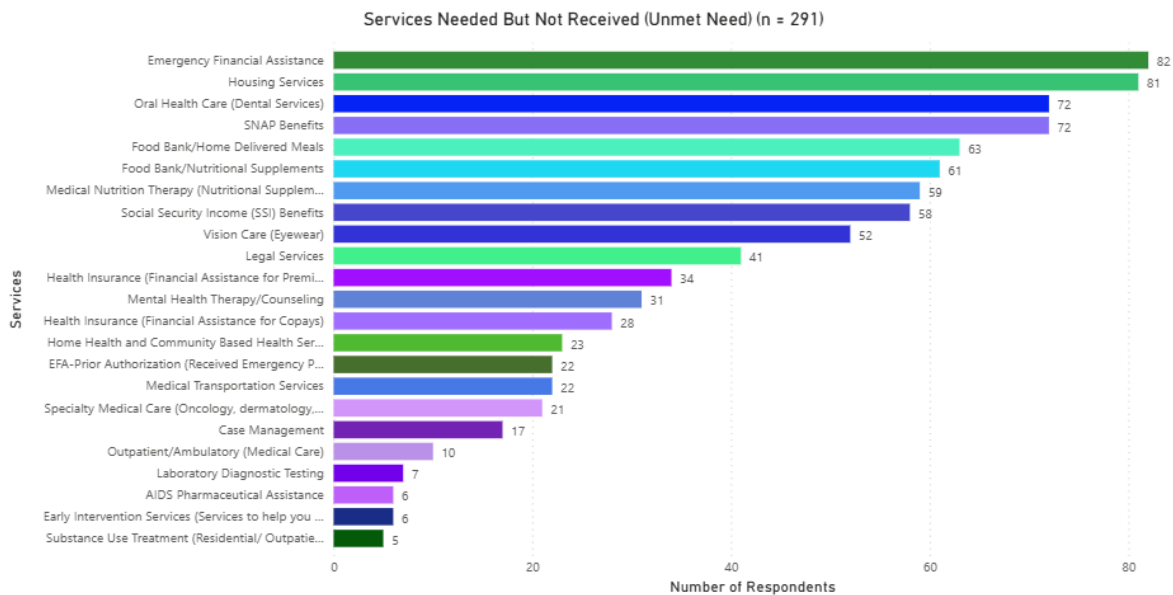
Health insurance assistance services were also widely used, with 172 respondents receiving premium assistance and 162 receiving copay assistance. A substantial number of respondents reported utilizing AIDS Pharmaceutical Assistance (n = 134), Specialty Medical Care (n = 131), and Outpatient/Ambulatory Medical Care (n = 110), further reflecting strong engagement in comprehensive HIV treatment services.

In addition to medical care, respondents accessed a range of supportive services, including SNAP benefits (n = 108), Oral Health Care (n = 107), Vision Care (n = 103), and Social Security Income (SSI) benefits (n = 91). Utilization of services such as Medical Transportation (n = 65), Mental Health Therapy/Counseling (n = 58), and Medical Nutrition Therapy (n = 53) suggests that supportive services addressing broader health and social needs are also being accessed.

Lower levels of utilization were observed for services such as Housing Services (n = 25), Emergency Financial Assistance (n = 21), and Substance Use Treatment (n = 14). These patterns may reflect differences in eligibility, service capacity, or varying levels of need among respondents.

Overall, findings suggest strong engagement in core HIV medical services and case management, alongside meaningful utilization of insurance assistance and supportive service programs.

## Unmet Service Needs

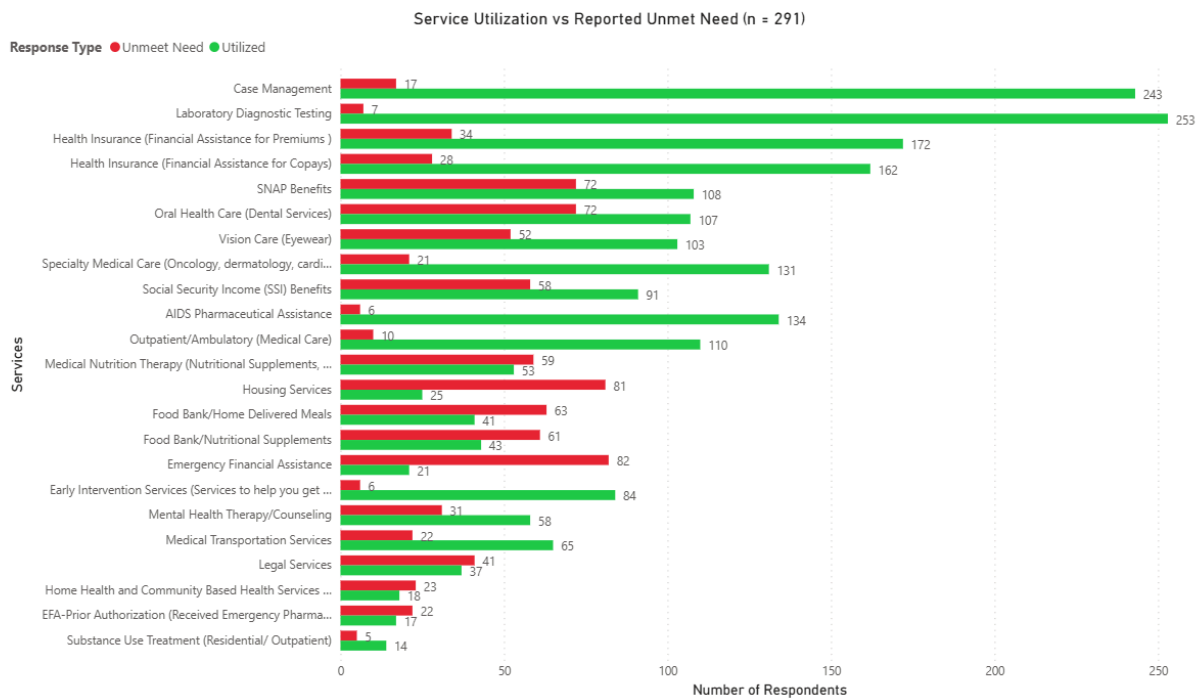


Among all respondents (n = 291), the highest levels of unmet need were concentrated in financial and basic support services rather than core HIV medical care. The most frequently reported unmet needs included Emergency Financial Assistance (n = 82), Housing Services (n = 81), and Oral Health Care (Dental Services) (n = 72). Comparable levels of unmet need were also reported for SNAP Benefits (n = 72), Food Bank/Home Delivered Meals (n = 63), and Food Bank/Nutritional Supplements (n = 61).

In contrast, unmet need for core HIV-related medical services such as laboratory diagnostic testing, outpatient medical care, AIDS pharmaceutical assistance, and early intervention services was substantially lower. These findings suggest that while the HIV clinical care system demonstrates strong accessibility and utilization, significant gaps remain in addressing social determinants of health — particularly housing stability, food security, and financial assistance.

The concentration of unmet need within essential support services underscores the importance of strengthening wraparound and stabilization resources to promote sustained health outcomes and treatment adherence among people living with HIV.

### Service Utilization vs Reported Unmet Need



The comparison of service utilization and reported unmet need highlights important differences in access across service categories. Core medical services such as case management, laboratory diagnostic testing, outpatient medical care, and AIDS Pharmaceutical Assistance showed high utilization and relatively low levels of unmet need, suggesting that the core HIV medical care system is functioning effectively for most respondents.

In contrast, several support services demonstrated higher levels of unmet need relative to utilization, including emergency financial assistance, housing services, food assistance programs, oral health care, and vision care. For several support services, the number of respondents reporting unmet need exceeded those reporting service utilization, particularly for emergency financial assistance, housing services, and food assistance programs, indicating substantial gaps in access to these services.

These patterns are consistent with themes identified in the open-ended responses, where respondents frequently cited financial constraints, housing instability, and difficulty navigating available services as barriers to accessing needed support services.

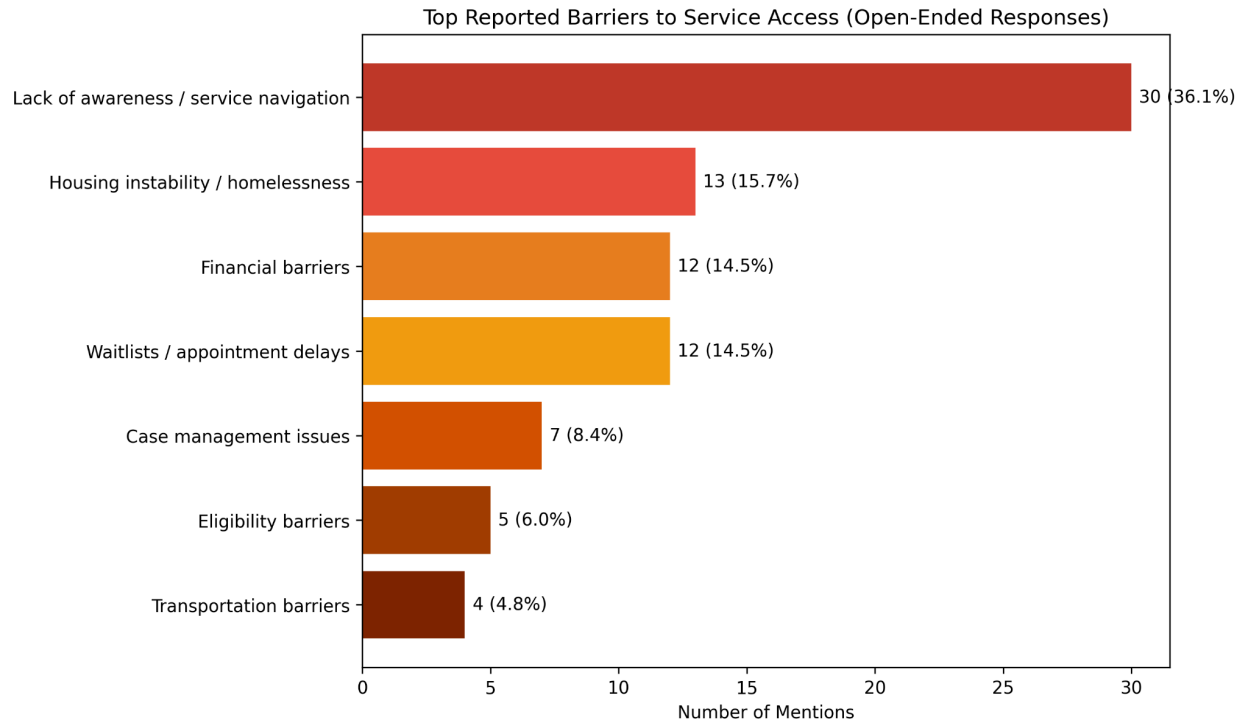
## **Barriers to Accessing Needed Services**

Survey respondents who indicated that they needed services but were unable to obtain them were asked to describe the specific service and the reason it was not accessed. Analysis of open-ended responses revealed several recurring barriers to service access. The most frequently reported barrier was lack of awareness or knowledge about available services, with many respondents indicating that they did not know where to go, how to apply, or that certain services were available. Financial constraints were also commonly reported, particularly related to dental care, vision services, and health insurance premiums or copay assistance. Several respondents described housing instability or homelessness, which often coincided with multiple unmet service needs.

Additional barriers included delays in service availability, appointment scheduling challenges, and waitlists, particularly for housing and specialty care services. A smaller number of respondents described difficulties related to case management or system navigation, including inconsistent communication, lack of referral support, or uncertainty about eligibility for services. These findings suggest that, in addition to financial barriers, improved service navigation, outreach, and coordination may help increase access to available services for people living with HIV in Palm Beach County.

## **Top Reported Barriers to Service Access (Open-Ended Responses)**

Open-ended responses were reviewed and coded into common themes to identify the most frequently reported barriers preventing clients from accessing needed services. A total of 83 barrier mentions were identified across respondent comments, reflecting a range of challenges related to service awareness, financial constraints, housing instability, and appointment availability.



**Top Reported Barriers to Service Access Identified from Open-Ended Survey Responses (n = 83 coded mentions).**

Lack of awareness or difficulty navigating available services was the most frequently reported barrier, accounting for more than one-third of coded responses. Housing instability, financial barriers, and appointment delays or waitlists were also commonly reported. Smaller numbers of respondents described challenges related to case management coordination, eligibility requirements, and transportation access.

Many responses specifically referenced challenges accessing dental services, housing assistance, financial support programs, and SNAP benefits, suggesting these areas may warrant additional outreach and service coordination efforts.

**Service Utilization Section Summary**

Overall, survey findings suggest that respondents are successfully accessing many core HIV medical services, including case management, laboratory diagnostic testing, outpatient medical care, and medication assistance programs. However, several supportive services showed higher levels of unmet need, particularly those related to financial assistance, housing support, food assistance, and oral health services.

Open-ended responses further highlighted barriers that may prevent clients from accessing needed services. The most commonly reported barriers included lack of awareness about available services, financial constraints, housing instability, and delays related to appointments or waitlists. These findings suggest that while the HIV medical care system is largely functioning as intended, additional efforts to improve service navigation, outreach, and access to supportive services may help address persistent gaps in care.

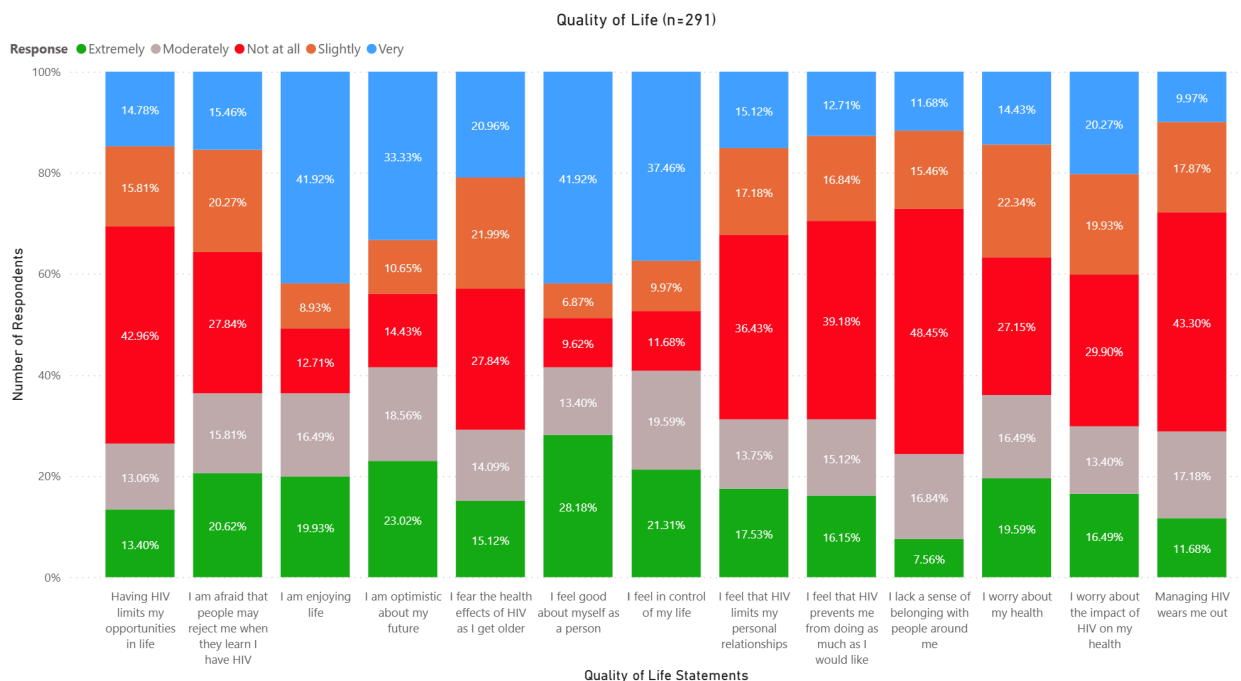
## Quality of Life Section

### Section Overview

The Quality of Life section explores respondents’ emotional wellbeing, perceived stigma, and the overall impact of living with HIV across multiple personal and social domains. Participants were asked to indicate the extent to which they agreed with a series of statements reflecting life satisfaction, self-perception, social connectedness, and HIV-related burden. Responses ranged from “Not at all” to “Extremely,” allowing for a nuanced understanding of both positive wellbeing and areas of emotional strain.

Findings highlight the complex and often dual experience of living with HIV—where resilience and positive self-concept coexist alongside ongoing concerns related to stigma, health, and social belonging.

### Overall Quality of Life



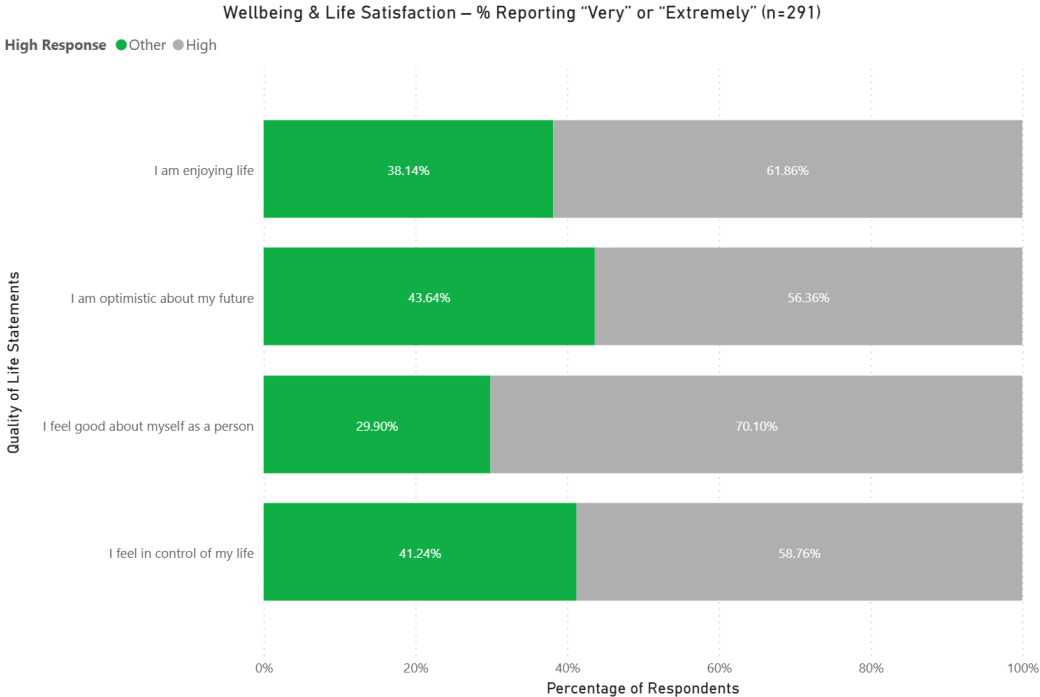
The overall distribution of responses reveals substantial variation across domains of wellbeing and HIV-related burden. Positive self-perception and life satisfaction indicators—such as enjoying life, feeling optimistic about the future, feeling in control of one’s life, and feeling good about oneself—demonstrate relatively higher proportions of “Very” and “Extremely” responses compared to stigma-related statements.

At the same time, several burden-oriented statements reflect elevated levels of concern and emotional strain. Statements related to stigma, social belonging, health-related worry, and perceived life limitations show larger proportions of respondents reporting “Very” or “Extremely” in those areas, suggesting that while many individuals maintain resilience, HIV-related stressors remain significant.

The distribution underscores that quality of life among respondents is not uniform; rather, it reflects a dynamic balance between positive coping and ongoing psychosocial challenges.

This chart provides the full context for the more focused domain analyses that follow.

**Wellbeing and Life Satisfaction**



Findings indicate that a majority of respondents report strong overall wellbeing across multiple life satisfaction indicators. Approximately 70% of participants reported feeling “very” or

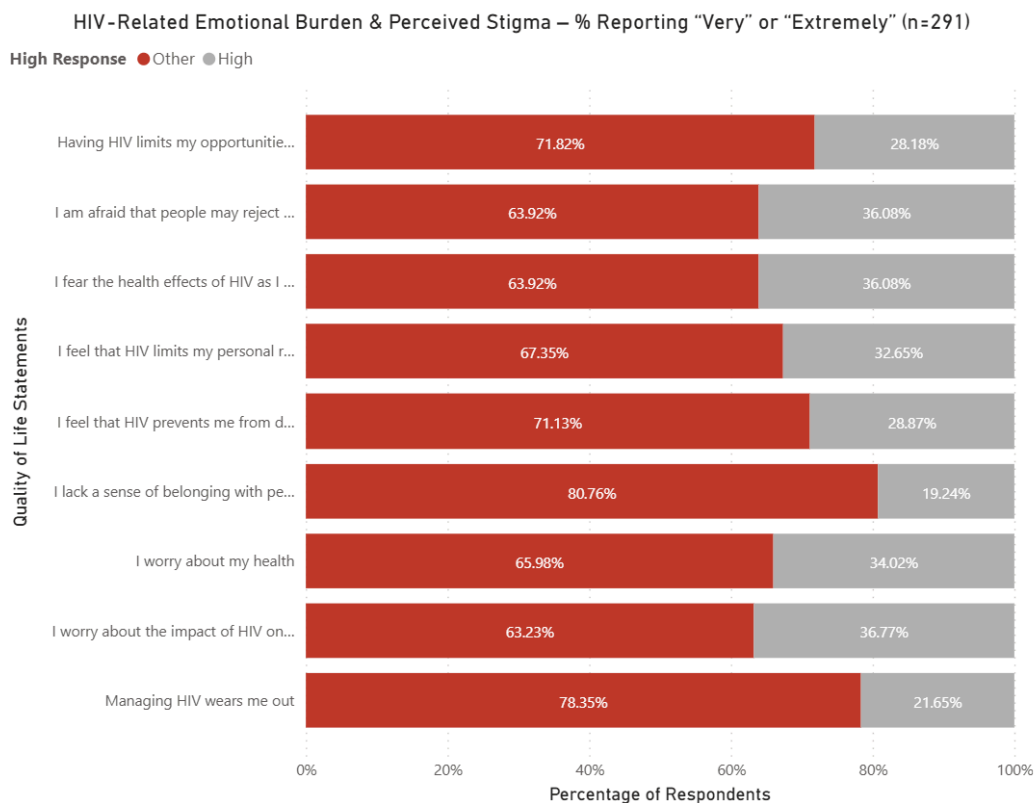
“extremely” good about themselves as a person, representing the highest level of positive endorsement among the wellbeing statements.

Similarly, 62% reported enjoying life at a high level, and 59% indicated that they feel in control of their lives. More than half (56%) also reported feeling very or extremely optimistic about their future.

These findings suggest a notable degree of resilience among respondents living with HIV. While participants may experience ongoing health and social challenges, many continue to report strong self-perception, life satisfaction, and a sense of personal agency.

However, the fact that approximately 30–44% of respondents did not endorse high levels of wellbeing across these domains indicates that a substantial portion of the population may benefit from continued psychosocial support, mental health services, and empowerment-based interventions.

### HIV-Related Emotional Burden & Perceived Stigma



Despite strong levels of reported wellbeing in certain domains, respondents also reported substantial levels of HIV-related emotional burden and perceived stigma.

More than three-quarters of respondents indicated high levels of distress in several areas. Approximately 81% reported lacking a sense of belonging with people around them, representing the highest level of reported burden. Similarly, 78% indicated that managing HIV wears them out, and 71% reported that HIV prevents them from doing as much as they would like. A comparable proportion (72%) indicated that having HIV limits their opportunities in life.

Fear-based concerns were also prevalent. Nearly two-thirds of respondents reported high levels of fear regarding the long-term health effects of HIV (64%), fear of rejection when others learn of their status (64%), and worry about the impact of HIV on their health (63%). Additionally, 66% reported worrying about their health overall.

Collectively, these findings suggest that while many respondents report resilience and positive self-perception, substantial emotional strain, stigma, and perceived life limitations remain significant challenges. The coexistence of resilience and burden underscores the importance of integrated service approaches that address both clinical care and psychosocial support, including mental health services, stigma reduction efforts, peer support, and interventions that promote social connectedness.

### **Quality of Life Summary**

Findings from the Quality of Life assessment reveal a dual narrative. Many respondents report strong personal resilience, including high levels of self-worth, life enjoyment, and optimism about the future. These indicators suggest meaningful strengths within the community and highlight the importance of maintaining supportive services that reinforce empowerment and self-efficacy.

However, the data also reveal persistent emotional burden and perceived stigma. High proportions of respondents report feeling limited by HIV, fearing rejection, worrying about their health, lacking a sense of belonging, and feeling emotionally fatigued by the ongoing management of their condition. These findings indicate that psychosocial stressors remain prevalent and may influence long-term health outcomes, engagement in care, and overall wellbeing.

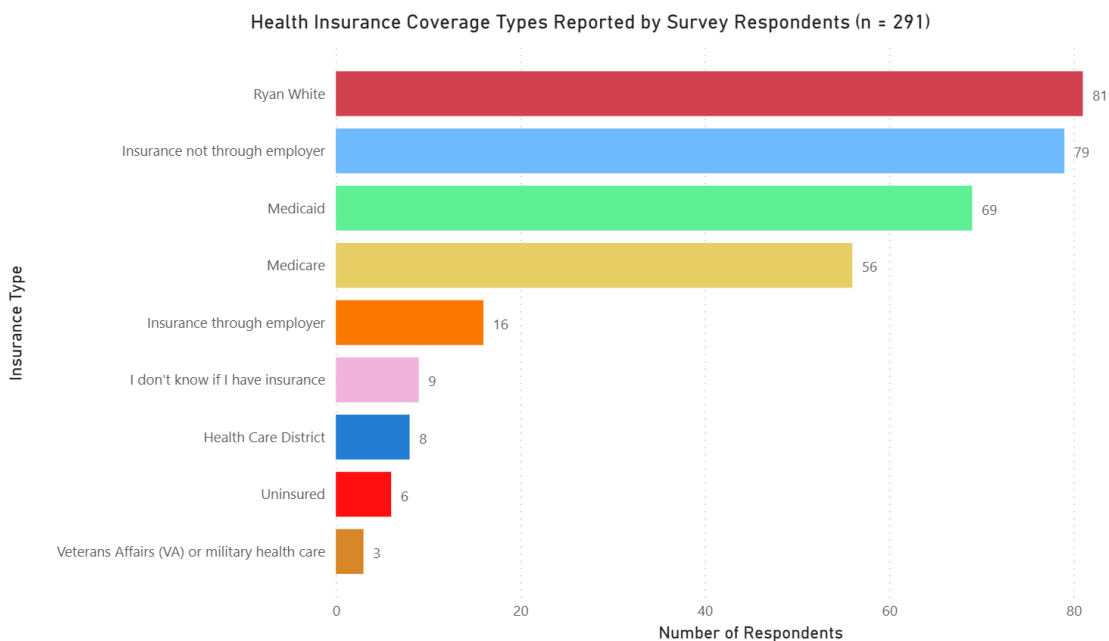
Taken together, the results emphasize the need for a comprehensive approach to HIV care that integrates medical treatment with mental health services, stigma reduction initiatives, peer support, and interventions that strengthen social connectedness. Addressing both resilience and burden is essential to improving overall quality of life outcomes for individuals living with HIV.

### **Insurance and Co-Occurring Condition**

#### **Section Overview**

This section examines respondents’ health insurance coverage and the presence of additional health conditions that may affect overall health and engagement in care. Understanding insurance coverage provides insight into how clients access medical services and medications, while information on co-occurring conditions helps identify additional health and behavioral health needs among people living with HIV. These findings help inform service planning and coordination within the local HIV system of care.

## Health Insurance Coverage



Note: Respondents could select more than one type of health insurance coverage; therefore totals may exceed the total number of survey respondents.

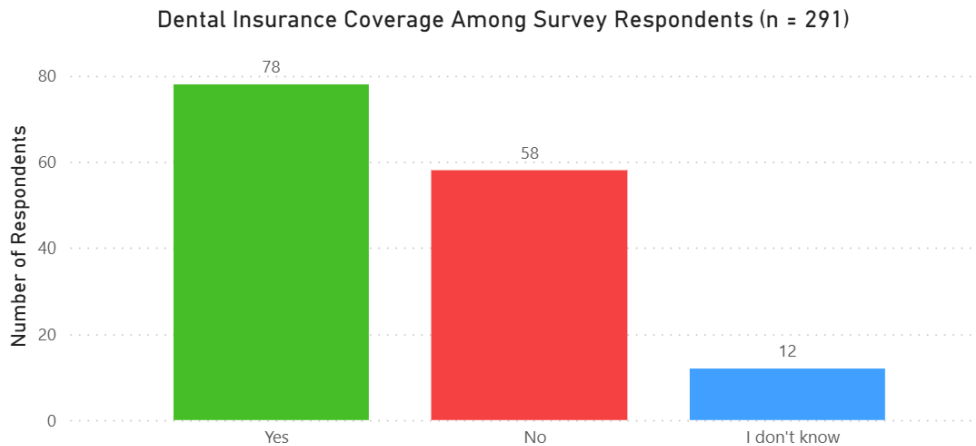
Survey respondents reported a range of health insurance coverage types. Ryan White program coverage and insurance obtained outside of an employer were the most frequently reported sources of coverage, followed by Medicaid and Medicare. A smaller number of respondents reported employer-sponsored insurance.

A limited number of respondents indicated that they were uninsured or unsure of their insurance status. These findings highlight the important role of Ryan White services and public insurance programs in supporting access to HIV medical care and treatment for people living with HIV in Palm Beach County.

A small number of respondents who reported being uninsured provided additional information about how they access medical care. Responses indicated reliance on public health programs and safety-net providers, including the Health District, the Department of Health, the Ryan White

Program, and the AIDS Drug Assistance Program (ADAP). One respondent reported paying for care out-of-pocket, while another indicated that they were not currently receiving medical care due to financial barriers. These responses further underscore the importance of publicly funded HIV programs in ensuring access to care for uninsured individuals.

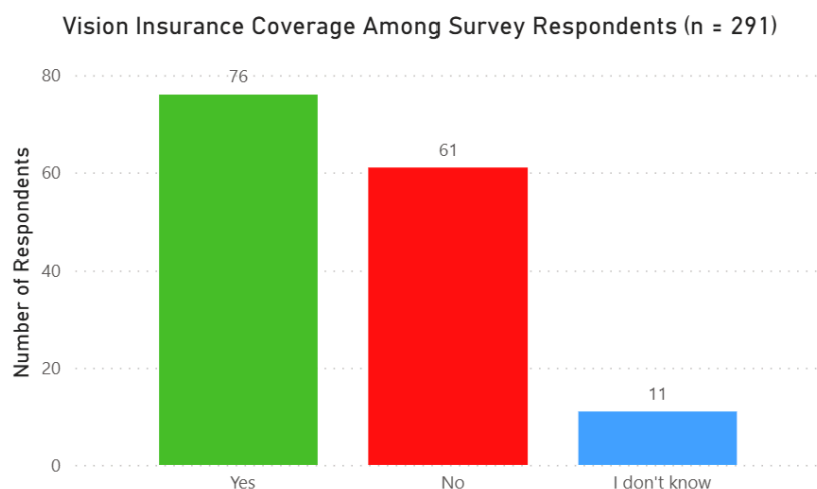
### Dental Insurance Coverage



Survey respondents were asked whether they currently have dental insurance coverage. Most respondents reported having dental insurance (78 respondents), while a substantial number reported having no dental coverage (58 respondents). A small number of respondents indicated that they were unsure whether they had dental insurance coverage.

These findings suggest that although many respondents have some level of dental coverage, a significant portion of clients may still face challenges accessing dental care, highlighting the continued importance of dental services within the Ryan White HIV/AIDS Program.

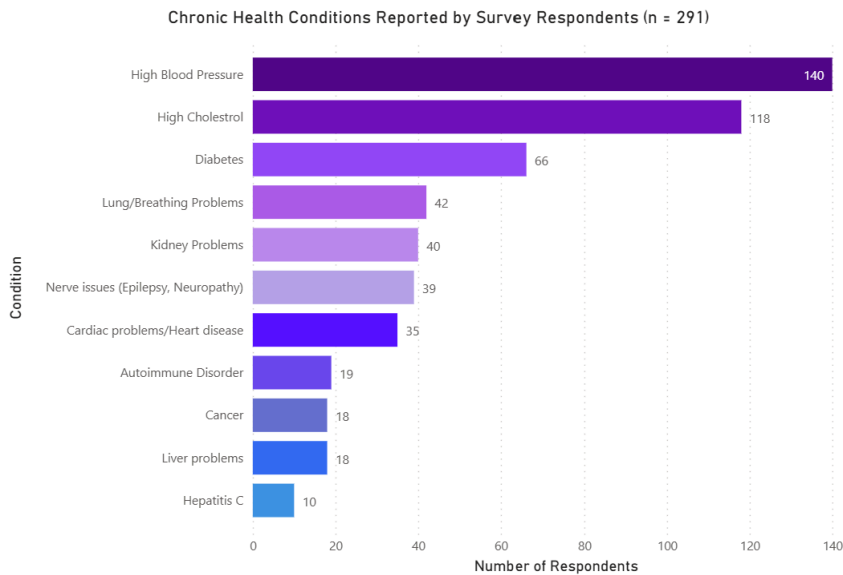
### Vision Insurance Coverage



Survey respondents were asked whether they currently have vision insurance coverage. Most respondents reported having vision insurance (76 respondents), while a substantial number reported having no vision coverage (61 respondents). A smaller number of respondents indicated that they were unsure whether they had vision insurance coverage.

These findings suggest that although many respondents report having vision coverage, a considerable portion may lack access to vision insurance, which may affect access to vision care services such as eye exams and corrective eyewear.

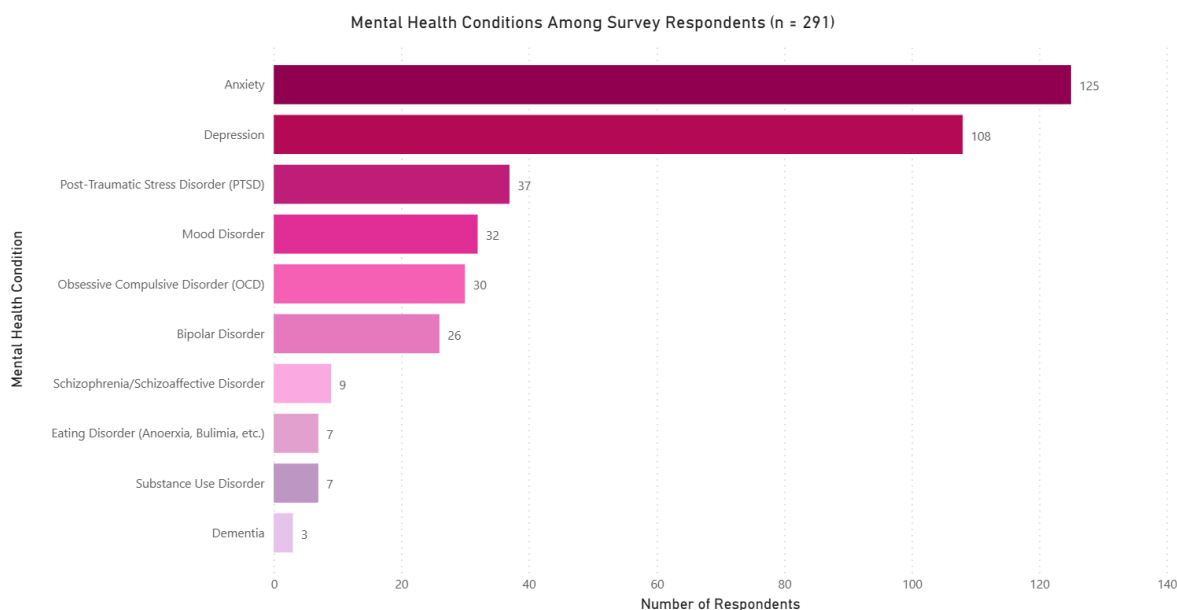
### **Chronic Co-Occurring Health Conditions**



Survey respondents were asked whether a healthcare provider had ever diagnosed them with selected chronic health conditions. The most commonly reported conditions were high blood pressure (140 respondents) and high cholesterol (118 respondents), followed by diabetes (66 respondents). Other frequently reported conditions included lung or breathing problems (42 respondents), kidney disease (40 respondents), nerve-related conditions such as epilepsy or neuropathy (39 respondents), and cardiac disease (35 respondents). Smaller numbers of respondents reported autoimmune disorders (19 respondents), cancer (18 respondents), liver disease (18 respondents), and Hepatitis C (10 respondents).

Seventy-seven respondents indicated that none of the listed conditions applied to them, while eight respondents reported that they did not remember whether they had been diagnosed with any of the listed conditions. These findings highlight the presence of multiple chronic health conditions among people living with HIV in Palm Beach County and underscore the importance of integrated care that addresses both HIV treatment and the management of chronic comorbidities.

### **Mental Health Co-Occuring Conditions**

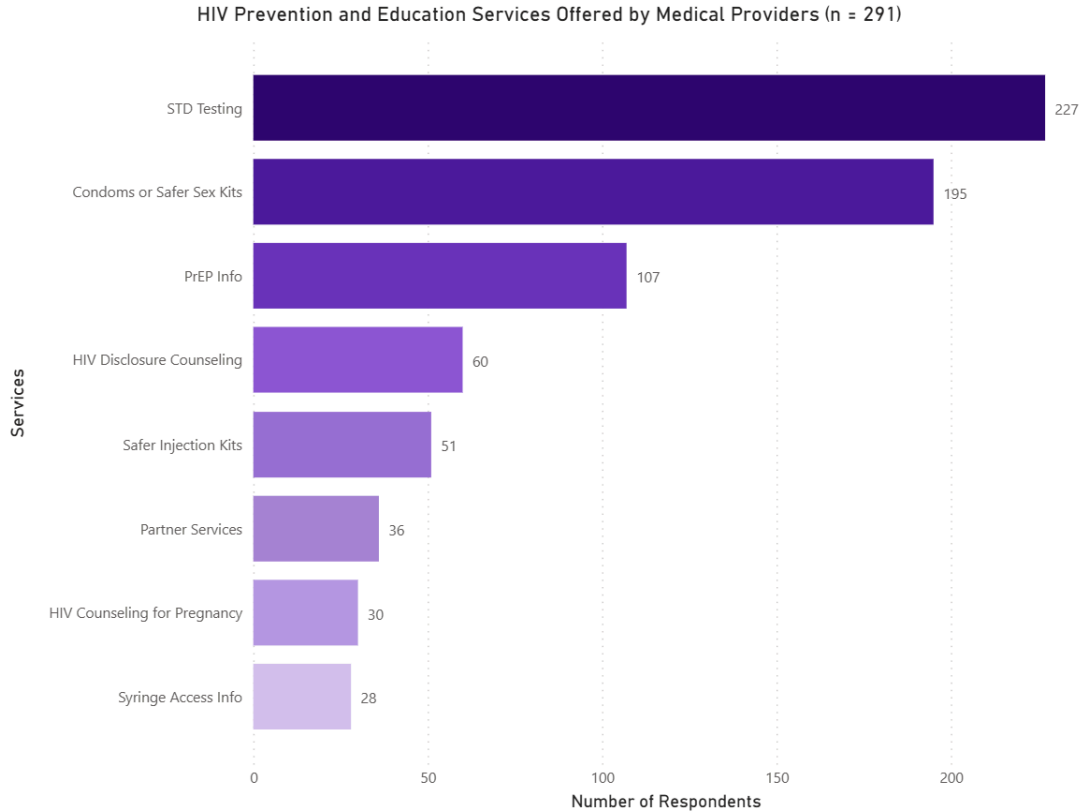


Anxiety and depression were the most frequently reported mental health conditions among survey respondents. A total of 125 respondents reported anxiety, while 108 respondents reported depression. Other conditions reported included post-traumatic stress disorder (37 respondents), mood disorders (32 respondents), and obsessive-compulsive disorder (30 respondents). Less frequently reported conditions included bipolar disorder (26 respondents), schizophrenia or schizoaffective disorder (9 respondents), eating disorders (7 respondents), substance use disorder (7 respondents), and dementia (3 respondents).

In addition, 139 respondents reported none of the listed mental health conditions, while 5 respondents indicated that they did not remember whether they had been diagnosed with any of the listed conditions.

These findings highlight the importance of behavioral health services for people living with HIV, as mental health conditions can significantly affect treatment adherence, overall health outcomes, and quality of life.

## **HIV Prevention and Education Services Offered by Medical Providers**



Survey respondents reported receiving a range of HIV prevention and education services from their medical providers in the past 12 months. The most commonly reported services were STD testing (227 respondents) and condoms or safer sex kits (195 respondents). Over one-third of respondents also reported receiving information about pre-exposure prophylaxis (PrEP) (107 respondents).

Other prevention-related services reported by respondents included HIV disclosure counseling (60 respondents) and safer injection kits (51 respondents). Less frequently reported services included partner services (36 respondents), HIV counseling for pregnancy (30 respondents), and syringe access information (28 respondents).

A total of 32 respondents indicated that their medical provider had not offered any of the listed prevention or education services in the past 12 months. These responses were excluded from the chart to allow clearer visualization of the services reported by respondents who indicated receiving at least one prevention service.

## **Insurance and Co-Occuring Condition Section Summary**

Findings from the survey indicate that respondents experience a range of co-occurring health conditions and rely on multiple sources of insurance coverage and prevention services to support their overall health and well-being. Chronic conditions such as high blood pressure, high cholesterol, and diabetes were commonly reported, while mental health conditions including anxiety and depression were also frequently identified among respondents. These findings highlight the importance of integrated medical and behavioral health services for people living with HIV.

Most respondents reported having some form of health coverage, with Ryan White program support, individual insurance plans, Medicaid, and Medicare representing the most frequently reported sources of coverage. The limited number of respondents who reported being uninsured indicated reliance on publicly funded HIV service programs and safety-net providers, including the Health District, the Department of Health, Ryan White services, and ADAP, to access medical care.

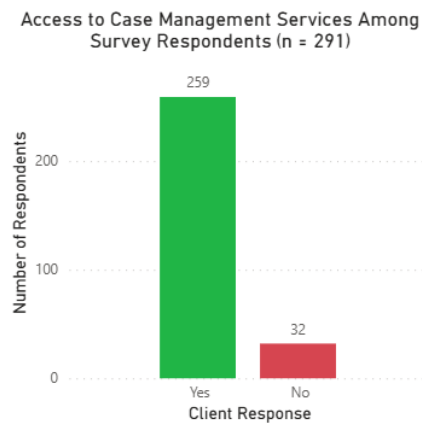
Respondents also reported receiving a variety of HIV prevention and education services from their medical providers. STD testing and condom or safer sex kit distribution were the most frequently reported services, followed by information about pre-exposure prophylaxis (PrEP). Other services such as HIV disclosure counseling, partner services, and safer injection resources were reported less frequently. Together, these findings suggest that while core prevention services are widely available, opportunities remain to strengthen access to additional prevention education and supportive services.

## **Case Management Section**

## Overview

Case management services play a critical role in supporting people living with HIV by helping clients navigate the healthcare system, access medical and supportive services, and address barriers that may affect engagement in care. The HIV Client Needs Assessment survey included several questions related to clients' access to case management services, communication with case managers, and overall satisfaction with the support they receive. These questions were designed to better understand clients' experiences with case management services and identify potential opportunities to strengthen service delivery within the Ryan White system of care in Palm Beach County.

## Access to Case Management Services

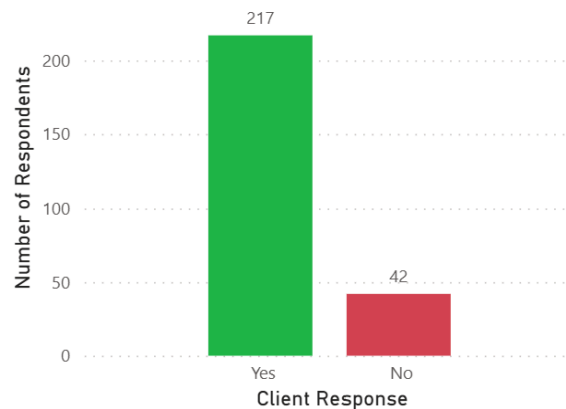


The majority of survey respondents reported having access to case management services. A total of 259 respondents indicated that they currently have a case manager, while 32 respondents reported that they do not have a case manager. Case management services play an important role in supporting people living with HIV by helping clients navigate medical care, access supportive services, and address barriers that may affect engagement in treatment and care.

Respondents who reported having a case manager indicated receiving services from several agencies throughout Palm Beach County, including FoundCare, AIDS Healthcare Foundation (AHF), Compass Community Center, Midway Specialty Care Center, and the Florida Department of Health, among others.

## Access to Case Manager within 2-3 Business Days

Access to Case Manager Within 2–3 Business Days  
(n = 259)

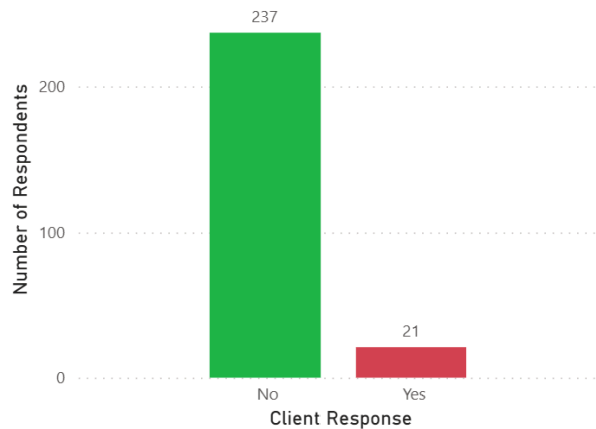


Among respondents who reported having a case manager, the majority indicated that they are able to access their case manager within 2–3 business days. A total of 217 respondents reported that they can reach their case manager within this timeframe, while 42 respondents reported that they are not able to access their case manager within 2–3 business days. These findings suggest that most clients experience timely communication with their case managers, although a smaller portion of respondents may experience delays in accessing support.

Survey respondents reported varying levels of communication with their case managers. Many respondents indicated that they communicate with their case manager on a monthly basis, with approximately 70 respondents reporting contact once per month. An additional group of respondents reported more frequent communication, including multiple contacts per month or weekly contact when needed. Other respondents indicated communicating with their case manager every few months or as needed depending on their circumstances. A smaller number of respondents reported infrequent communication, including contact once or twice per year, difficulty reaching their case manager, or rarely communicating with their case manager. Overall, responses suggest that most clients maintain periodic communication with their case managers, though the frequency of contact varies based on individual needs and engagement in services.

## Case Management Agency Changes

History of Changing Case Management Agencies (n = 258)



Most respondents reported that they have not changed case management agencies. A total of 237 respondents indicated that they have not changed agencies, while 21 respondents reported that they have changed their case management agency at some point. These findings suggest that the majority of clients maintain continuity with their case management provider. Among respondents who reported changing agencies, the most commonly cited reason was relocation, with several respondents indicating that they moved to a different city or county. Other respondents reported dissatisfaction with services received, including concerns about service quality or their experience with the agency. A smaller number of respondents cited agency-related factors, such as frequent case manager turnover or changes in assigned case managers, as well as other circumstances including incarceration, homelessness, distance from the provider, or having their case closed.

When asked how many times their case manager had changed in the past five years, most respondents indicated that their case manager had changed between one and three times, while a smaller number reported four or more changes during that period. A few respondents indicated that their case manager had not changed or that they did not recall how many times changes had occurred.

### **Client Satisfaction with Case Manager**

Client Satisfaction with Case Manager (n = 259)



The majority of respondents reported being satisfied with their case manager. A total of 235 respondents indicated that they are satisfied with their case manager, while 24 respondents reported that they are not satisfied. These findings suggest that most clients report positive experiences with their case management services. Among respondents who reported dissatisfaction, the most commonly cited concern was lack of communication, including difficulty reaching their case manager, calls or emails not being returned, or uncertainty about who their assigned case manager was. Some respondents also reported frequent case manager turnover, which contributed to communication challenges. Other concerns included lack of assistance or follow-up on requested services, as well as structural barriers such as high caseloads among case managers or language barriers requiring translation services.

### **Case Management Section Summary**

Overall, survey findings suggest that most respondents have access to case management services and report positive experiences with their case managers. The majority of respondents indicated that they currently have a case manager and are able to reach their case manager within a few business days when needed. Most respondents also reported being satisfied with their case management services.

While responses generally reflect positive experiences, some respondents identified areas for improvement. Concerns most commonly related to communication challenges, difficulty reaching case managers, and frequent case manager turnover. A small number of respondents also reported changing case management agencies due to relocation or dissatisfaction with

services. These findings highlight the importance of maintaining strong communication, continuity of care, and adequate staffing to support effective case management services.

### **Additional Feedback**

When asked if there was anything else they would like service providers to know to better serve them, many respondents indicated that they did not have additional comments.

Among those who provided feedback, several themes emerged. Some respondents requested additional assistance with housing, including support for individuals experiencing homelessness or needing rental assistance. Others highlighted the need for improved communication and responsiveness from case managers, including timely follow-up and easier access to staff. Respondents also noted a need for additional support services, such as dental care, legal assistance, transportation, financial assistance, and help accessing benefits such as SNAP. A few respondents suggested improving coordination between agencies and providing clearer information about available services. Some respondents also expressed positive feedback and appreciation for the services they currently receive.

## **Focus Group Findings**

### **Overview**

To better understand the experiences, service needs, and barriers faced by people living with HIV in Palm Beach County, three focus groups were conducted as part of the Comprehensive Needs Assessment. The focus groups included a Hispanic/Latino client group (n=7), a Black/African American client group (n=12), and a multicultural group representing individuals from diverse racial and ethnic backgrounds (n=10). Participants discussed their experiences with HIV diagnosis, engagement in care, barriers to accessing services, stigma and discrimination, and recommendations for improving HIV-related services in the county. These discussions provided valuable qualitative insights that complement findings from the client survey and provider assessments, highlighting both shared challenges and unique perspectives across communities.

While many themes were consistent across all three focus groups, some concerns were emphasized more strongly within particular communities. Hispanic/Latino participants more frequently discussed immigration-related fears, language accessibility, family rejection, and the importance of discretion in healthcare settings. Black/African American participants highlighted

the role of faith-based support systems, stigma within families and communities, historical mistrust of healthcare institutions, and the needs of individuals reentering care after incarceration or housing instability. Participants in the multicultural focus group more frequently emphasized financial barriers, communication challenges with providers, and the importance of culturally and linguistically responsive services.

### **Initial Diagnosis and Entry into Care**

Across all focus groups, participants described receiving an HIV diagnosis as a deeply emotional and often traumatic experience. Many individuals recalled feelings of shock, fear, sadness, denial, confusion, and uncertainty about the future. Several participants described struggling to accept the diagnosis initially, particularly when they felt physically healthy or had limited prior knowledge about HIV.

Others reported receiving their diagnosis during already challenging life circumstances, including pregnancy, substance use, mental health struggles, or unstable housing, which intensified the emotional impact of the news. Participants also reflected on how misinformation about HIV shaped their early reactions. For some individuals diagnosed during earlier stages of the epidemic, HIV was widely perceived as a death sentence, contributing to fear and hopelessness.

Despite these difficult experiences, many participants described developing resilience over time. Support from healthcare providers, community organizations, and peer networks helped individuals begin treatment, access resources, and adapt to living with HIV.

### **Barriers to Entering and Staying in Care**

Participants identified several structural and social barriers that make it difficult to enter and remain engaged in HIV care. Transportation was one of the most frequently cited challenges, particularly for individuals without reliable transportation or with limited financial resources. Difficulty traveling to medical appointments, pharmacies, and service providers often delayed care or interrupted treatment.

Housing instability and homelessness were also significant barriers. Participants explained that when individuals are focused on meeting basic needs such as finding shelter, food, or safety, healthcare becomes more difficult to prioritize. Unstable housing disrupted medication adherence, appointment attendance, and continuity of care.

As one participant explained:

“When you’re trying to figure out where you’re sleeping that night, going to a doctor’s appointment becomes the last thing on your mind.”

Financial barriers were another recurring theme. Participants described concerns about medical costs, lack of insurance coverage, and fear of accumulating healthcare-related debt. These challenges were particularly significant for individuals already experiencing economic hardship.

Language access and communication barriers also emerged, particularly among Spanish-speaking and Creole-speaking participants. Individuals emphasized the importance of services that are linguistically accessible and easier to navigate. Participants also described system-level challenges such as delays in provider communication, limited follow-up, and confusion related to eligibility requirements, pharmacy practices, or case management processes.

In some cases, immigration-related fears further complicated access to care. One participant described avoiding healthcare services because the clinic was located near immigration offices, creating concern about potential exposure to immigration authorities. Others described family rejection, domestic violence, or reentry after incarceration as factors that disrupted their ability to remain consistently engaged in care.

### **Stigma, Discrimination, and Confidentiality**

Stigma emerged as one of the most significant and consistent themes across all focus groups. Participants described HIV-related stigma within families, communities, housing environments, and healthcare settings. Many individuals reported encountering misconceptions about HIV transmission, including fears that HIV could be spread through casual contact such as sharing utensils, towels, or sitting near someone living with HIV.

These misunderstandings often contributed to social isolation, discrimination, and fear of disclosure.

One participant described the experience this way:

“When people hear HIV, they think they can catch it just by sitting next to you.”

Participants also described institutional stigma and concerns about confidentiality within healthcare settings. Some individuals felt that HIV services were too visibly separated from general healthcare services, making it easy for others to infer why someone was seeking care. This lack of discretion sometimes discouraged individuals from accessing services or remaining engaged in treatment.

Participants also described experiences of stigma in shelters, employment settings, and insurance systems, where their HIV status resulted in unfair treatment or exclusion. In addition to external stigma, several individuals described internalized stigma, including feelings of shame or fear that led them to hide medications, avoid disclosing their status, or disengage from care altogether.

Participants emphasized that HIV-related stigma continues to affect not only individuals living with HIV but also their families, including children who may face discrimination or bullying after a parent's diagnosis becomes known.

### **Returning to Care**

Participants described several factors that contributed to interruptions in HIV care, as well as the circumstances that eventually motivated them to return to treatment. Housing instability, homelessness, domestic violence, relocation, emotional distress, and other life disruptions were commonly cited reasons individuals fell out of care.

For many participants, worsening physical health ultimately prompted re-engagement with healthcare services. Experiencing illness, complications, or a noticeable decline in health often served as a turning point that encouraged individuals to seek medical attention and reconnect with treatment.

Participants also emphasized the important role of supportive organizations in facilitating their return to care. Community-based providers that offer multiple services in one location—including medical care, counseling, medication assistance, and case management—were described as particularly helpful. These programs created supportive environments where individuals felt respected, understood, and better equipped to navigate the healthcare system.

### **Support Needs and Resources**

Participants consistently emphasized that effective HIV care requires more than medical treatment alone. Mental health services were repeatedly identified as a critical component of care. Participants described the importance of counseling, therapy, and emotional support in addressing the psychological challenges associated with living with HIV, including stigma, trauma, stress, and isolation.

Community-based organizations were also described as essential sources of support. Participants valued programs that provide medical care, medication access, case management, counseling, and practical assistance in one location.

As one participant noted:

“When everything is in one place—medical care, counseling, help with medications—it makes it much easier to stay on track.”

Transportation assistance, housing support, childcare services, mentoring programs, and peer support networks were also identified as important resources that help individuals remain connected to care.

Some participants highlighted the importance of faith-based support systems, particularly within Black/African American communities. Churches and spiritual communities were described as providing emotional encouragement, a sense of belonging, and a supportive environment for individuals living with HIV.

Participants also emphasized the importance of services that support individuals reentering the community after incarceration, as well as job training and workforce development programs for individuals who have experienced long-term illness, poverty, or housing instability.

### **Misinformation and Community Awareness**

Misinformation about HIV remains a significant concern across communities. Participants described persistent myths about HIV transmission, including the false belief that HIV can be spread through casual contact. These misconceptions contribute to ongoing stigma, fear, and discrimination.

Participants also noted that outdated perceptions about HIV continue to influence attitudes toward testing and treatment. In some communities, HIV is still viewed as a fatal condition despite significant advances in treatment that allow people living with HIV to lead long and healthy lives.

In the Black/African American focus group, participants also discussed conspiracy theories and mistrust of public institutions, which can discourage some individuals from participating in testing programs or engaging with healthcare providers.

Participants emphasized the need for stronger community education efforts that provide accurate, culturally relevant information about HIV transmission, prevention, and treatment. Expanding education in schools, community settings, and public health campaigns was widely seen as an important strategy for reducing stigma and increasing awareness.

### **Recommendations for Improvement**

Participants offered several recommendations for strengthening HIV services in Palm Beach County. One commonly suggested improvement was increasing privacy and discretion by integrating HIV services more fully into general healthcare settings rather than maintaining visibly separate programs. Participants believed this approach could reduce stigma and encourage greater utilization of services.

Participants also recommended expanding public education and awareness efforts, particularly for youth and community members who may still hold outdated beliefs about HIV. Providing accurate information about transmission, prevention, and treatment was viewed as essential for reducing stigma and improving community understanding.

Additional recommendations included strengthening mental health services, improving transportation assistance, expanding housing support programs, enhancing case management and provider follow-up, improving pharmacy coordination, and increasing funding for supportive services.

Some participants supported the development of a “one-stop shop” service model in which medical care, mental health support, case management, and social services are provided in a single location. Others emphasized the importance of job training and workforce development programs to support individuals seeking greater financial stability and independence. Participants also highlighted the need for stronger support systems for individuals reentering the community after incarceration.

### **Summary of Key Themes**

Overall, the focus groups highlighted that barriers to HIV care are not solely medical but are strongly influenced by social, economic, and structural factors. Across all three groups, participants described the impact of stigma, housing instability, transportation barriers, financial hardship, misinformation, and limited support systems on their ability to access and remain engaged in care.

At the same time, participants identified several opportunities to strengthen HIV services in Palm Beach County. These include expanding mental health services, improving confidentiality protections, increasing access to housing and transportation assistance, strengthening culturally and linguistically responsive services, and developing more coordinated, patient-centered systems of care.

# Resource Inventory

## Purpose

The Resource Inventory provides an overview of HIV-related core medical and support services available within Palm Beach County. This section identifies major funding streams, the types of services delivered, and the general system infrastructure supporting prevention, care, and treatment.

## Overview

Palm Beach County maintains a comprehensive HIV prevention and care network supported by federal, state, and local funding streams. Major federal investments include HRSA Ryan White Part A, Part B, Part C, Minority AIDS Initiative (MAI), Ending the HIV Epidemic (EHE), CDC High Impact Prevention, HOPWA (HUD), and other federal sources such as Veterans Affairs and Federally Qualified Health Centers. State and local funding further supplement the service delivery system. This comprehensive system works to serve people with HIV, high risk individuals and the general community.

## Funding Streams and HIV Care Continuum Alignment

The following Table summarizes major HIV funding streams in Palm Beach County, associated service categories, and their alignment with stages of the HIV Care Continuum.

In addition to Ryan White-funded providers, Palm Beach County’s HIV service system includes Federally Qualified Health Centers, hospital-based infectious disease clinics, Veterans Affairs facilities, and private medical providers delivering HIV primary care. Table 9.X provides a summary of HIV-related core medical and support service providers across the service area, inclusive of both Ryan White and non-Ryan White-funded entities.

| Funding Source                   | Services Delivered/Priority Population Served  | Impact on HIV Care Continuum           |
|----------------------------------|--|--|
| HRSA Ryan White Part A providers | Health care and support services to facilitate retention in care and viral suppression for PWH | Retention in Care<br>Viral Suppression |
| HRSA Ryan White Part A/EHE       | Linkage services for PWH who are either newly diagnosed, or are diagnosed                      | Linkage to Care                        |

|                                       |  |  |
|---------------------------------------|--|--|
|                                       | but currently not in care, to essential HIV care and treatment and support services.   |  |
| HRSA Ryan White Part A/MAI providers  | Support Services for racial/ethnic minorities who are either newly diagnosed, or are currently not in care, to essential HIV care and treatment and support services.                        | Linked to Care In Care Retention Viral Suppression           |
| HOPWA (HUD)                           | Housing assistance and related support services for low-income persons with HIV/AIDS and their families.   | Retention in care  |
| CDC High Impact Prevention            | 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                                    |
| HRSA EHE Primary Care HIV Prevention  | Expand access to medication to prevent HIV including PrEP related services, link people to care and ensure coordination of services.   | Diagnose, Linkage to Care                                    |
| Ryan White Part B                     | Healthcare and support services for PWH  | Retention, viral load suppression                            |
| CDC School Board of Palm Beach County | HIV prevention education   | Diagnose, HIV Prevention education, referral for HIV testing |

**Major Funded Service Providers**

Ryan White Part A-funded providers form the backbone of the HIV care delivery system in Palm Beach County. Major contracted providers include organizations such as FoundCare, Compass

Community Center, CAN Community Center, Health Council of SouthEast Florida (HCSEF), AHF, Legal Aid Society, Midway Specialty Care, Monarch Health Services, Poverello Center, Rebel Recovery and the Palm Beach County Health Department.

These providers deliver a range of core medical and support services including outpatient/ambulatory medical care, medical case management, non-medical case management, mental health services, oral health services, early intervention services, food assistance, medical transportation, health insurance premium assistance, psychosocial support services, and continuous quality management activities.

Ending the HIV Epidemic (EHE) and Primary Care HIV Prevention funding further expands linkage to care and PrEP-related services within Federally Qualified Health Centers and other clinical partners, strengthening rapid linkage and prevention capacity across the county. Ryan White Minority AIDS Initiative (MAI) funding supports targeted services for racial and ethnic minority populations disproportionately impacted by HIV, with a focus on improving linkage, retention, and viral suppression outcomes.

Together, these agencies operate clinic and service locations throughout high-prevalence municipalities including West Palm Beach, Riviera Beach, Lake Worth, Boynton Beach, Belle Glade, and surrounding communities. Many of the Ryan White agencies have multiple clinics in different cities throughout the county. The following is a list of agencies and city and zipcode locations.

The following table summarizes major funded HIV care and prevention providers in Palm Beach County, including agencies offering clinical services, prevention programs, and supportive services for people living with HIV and individuals at risk for HIV infection.

| Agency/Organization              | Services   | Locations                               |
|----------------------------------|--|---|
| AIDS Healthcare Foundation (AHF) | PrEP and nPEP, AIDS Pharmaceutical Assistance, Early Intervention Services, Medical Case Management, Outpatient / Ambulatory Health Services | Delray (33445), West Palm Beach (33401) |
| CAN Community Health             | PrEP and nPEP, AIDS Pharmaceutical Assistance, Outpatient / Ambulatory Health Services   | Lake Worth (33460)                      |

|                                     |   |  |
|-------------------------------------|---|--|
| Caring Hearts Medical Center        | PrEP and nPEP   | Palm Springs (33406)   |
| Campbell Health Solutions           | PrEP and nPEP   | West Palm Beach (33409)  |
| Compass                             | PrEP and nPEP, Early Intervention Services, Medical Case Management   | Lake Worth (33460)   |
| CVS Minute Clinics                  | PrEP and nPEP   | Delray Beach (33483), Lake Worth (33460), Lantana (33467)  |
| Dr. G's Urgent Care                 | PrEP and nPEP   | Delray (33445)   |
| Florida Department of Health        | PrEP and nPEP, Early Intervention Services, Medical Case Management, Rapid Entry to Care (REC)  | West Palm Beach (33407, 33401), Belle Glade (33430), Delray Beach (33445), Greenacres (33463), Jupiter (33458), Lantana (33462), Riviera Beach (33404) |
| FoundCare Health Center             | PrEP and nPEP, Early Intervention Services, Medical Case Management, Outpatient / Ambulatory Health Services, Rapid Entry to Care (REC) | West Palm Beach (33417), Palm Springs (33406), Belle Glade (33430), Boynton Beach (33426), North Palm Beach (33408)                                    |
| Genesis Community Health            | PrEP and nPEP   | Boca Raton (33432), Boynton Beach (33435)  |
| Health Council of Southeast Florida | PrEP and nPEP, Early Intervention Services, Medical Case Management   | Palm Beach Gardens (33432)   |
| HOPWA                               | Housing services for people with HIV  | West Palm Beach (33406)  |
| Legal Aid                           | PrEP and nPEP   | West Palm Beach (33401)  |
| Life Resources LLC                  | PrEP and nPEP   | Wellington (33414)   |
| Medical Essentials Clinic           | PrEP and nPEP   | Lantana (33462)  |

|                               |  |                                   |
|-------------------------------|--|-----------------------------------|
|                               |  |                                   |
| Midway Speciality Care        | PrEP and nPEP, Medical Case Management, Outpatient / Ambulatory Health Services, Rapid Entry to Care (REC)   | West Palm Beach (33409), Atlantis |
| Monarch Health Services       | PrEP and nPEP, Early Intervention Services, Medical Case Management, Outpatient / Ambulatory Health Services | Delray Beach (33484)              |
| Oceana Community Health       | PrEP and nPEP, Rapid Entry to Care (REC)   | Boynton Beach (33435)             |
| Palm Beach Infectious Disease | PrEP and nPEP  | Delray Beach (33445)              |
| Poverello                     | PrEP and nPEP  | Delray Beach (33445)              |
| Palm Beach School District    | STD, STI and HIV prevention education for appropriate aged students  | West Palm Beach (33406)           |
| Rebel Recovery                | PrEP and nPEP  | West Palm Beach (33401)           |
| Triple O Medical Services     | PrEP and nPEP  | West Palm Beach (33407)           |
| Wheat Community Health        | PrEP and nPEP  | Greenacres (33463)                |

**Geographic Distribution of Services**

HIV-related services are available throughout Palm Beach County, with concentrations in high-prevalence areas including West Palm Beach, Riviera Beach, Lake Worth, Boynton Beach, Belle Glade and surrounding municipalities. The Florida Department of Health Redbook provides a directory of agencies offering HIV-related services, including prevention, clinical care, behavioral health, housing assistance, and supportive services. Together, these resources create a countywide service network spanning prevention, diagnosis, linkage, retention, and viral suppression.

## **Core Medical Service Infrastructure**

Core medical services in Palm Beach County are supported by a combination of Ryan White Parts A, B, and C funding, as well as federal, state, and local revenue streams. Core services include outpatient/ambulatory health services, medical case management, early intervention services, oral health care, mental health services, substance use outpatient treatment, and health insurance premium and cost-sharing assistance.

These services collectively support retention in care and viral suppression among people with HIV. Integration across funding streams allows for coordinated delivery of medical care, laboratory monitoring, treatment adherence support, and ancillary services necessary to achieve optimal health outcomes.

## **Supportive Service Infrastructure**

Support services play a critical role in addressing social determinants of health that impact engagement in care. Ryan White Part A, MAI, HOPWA, state, and local funding streams support non-medical case management, emergency financial assistance, food bank and home-delivered meals programs, tenant-based rental assistance, transportation services, legal services, outreach and HIV prevention education, psychosocial support, and linguistic services. Housing assistance through HOPWA (HUD) provides rental and supportive housing services for low-income individuals with HIV/AIDS and their families, directly supporting retention in care and viral suppression.

The integration of supportive services with core medical care strengthens the overall service delivery system and reduces barriers to sustained engagement in care.

## **Service System Coordination**

Palm Beach County's HIV service system reflects coordination across multiple funding streams and provider types. Ryan White-funded agencies collaborate with prevention programs, Federally Qualified Health Centers, behavioral health providers, housing agencies, and community-based organizations to ensure continuity of care. Cross-referral relationships and integrated service delivery models support individuals across prevention, diagnosis, linkage, retention, and viral suppression stages of the HIV Care Continuum.

## **Summary Statement**

Collectively, the HIV service infrastructure in Palm Beach County reflects a coordinated, multi-funded system designed to support individuals across all stages of the HIV Care Continuum. The Resource Inventory confirms the availability of core medical and support

services necessary to promote linkage to care, retention in care, and viral suppression. Subsequent sections of this Needs Assessment examine system capacity and service gaps within this infrastructure for Ryan White and EHE funded providers

## Provider Capability and Capacity Assessment

### Overview

As part of the 2025 Comprehensive Needs Assessment for the Ryan White HIV/AIDS Program (RWHAP) Part A in Palm Beach County, a Provider Capacity and Capability Survey was administered to funded Ryan White Part A, Part B and Part C, MAI and EHE service providers. A total of 72 provider representatives responded to the survey.

The purpose of this assessment was to assess the current capacity of the local HIV system of care to meet the needs of people with HIV (PWH), including workforce capacity and capability, operational challenges impacting quality of care, service accessibility, availability of essential services, and appropriateness of services provided in Palm Beach County. Findings are summarized below.

### Methodology

A structured electronic survey was developed to assess provider capacity, workforce characteristics, service accessibility, waitlists, linkage challenges, and perceived barriers to care. The HIV CARE Council Planning Committee utilized previous Provider Capability and Capacity survey questions that were modified and tailored for this assessment. Questions from other Ryan White Part A Eligible Metropolitan Area (EMA)s Provider Capability and Capacity surveys were also utilized. The survey totaled twenty five questions and included a combination of yes or no questions, multiple response selections, likert scale questions and open-ended qualitative questions. No identifying information was collected to encourage respondents to honestly respond to all survey questions.

The survey assessed the following domains: workforce characteristic, case management caseload and documentation burnout, service availability and waitlists, barriers to care, access to certified peers, telehealth implementation, language capacity and inclusivity practices, and linkage to mental health and dental services.

The survey administration began in August 2025 and was closed in February 2026. The survey was distributed in several different methods including email blasts with an invitation to complete the survey with the survey link, in person QR codes on little postcards that led to the survey

questions and targeted outreach to agency staff to complete the survey. The survey was distributed to a little over 100 providers in our system of care via email. A total of 72 respondents completed the survey. Respondents represented multiple roles include case managers, supervisors, administrative staff, quality management staff, certified peers, and other provider roles. Quantitative data were analyzed using descriptive statistics. Qualitative responses were reviewed and coded into thematic categories to identify system level patterns. Findings from this assessment are brought to the HIV CARE Council.

### **Survey Logic and Respondent Classification**

The survey included both role identification questions and function-specific branching questions.

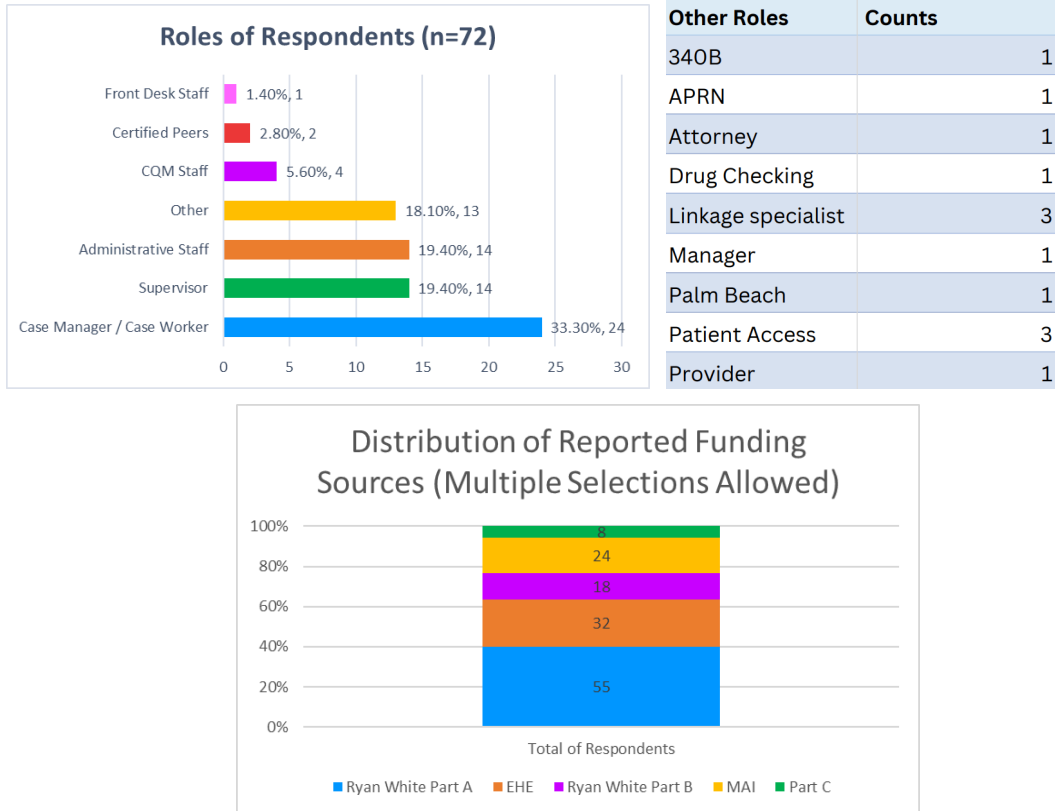
In the workforce characteristics section, 33 respondents selected “Case Manager/Case Worker” when identifying their role within their agency. However, in a subsequent section of the survey, respondents were asked to confirm whether they actively provide case management services. Twenty-one respondents (n=21) confirmed active case management responsibilities.

Case management-specific questions, including those related to caseload size, documentation burden, and dental wait times, were directed only to respondents who confirmed active case management responsibilities (n=21).

This distinction reflects the presence of multi-role staff and supervisory personnel who may identify as case managers organizationally but do not currently carry active caseloads. All subgroup analyses were conducted using the appropriate denominator for each question.

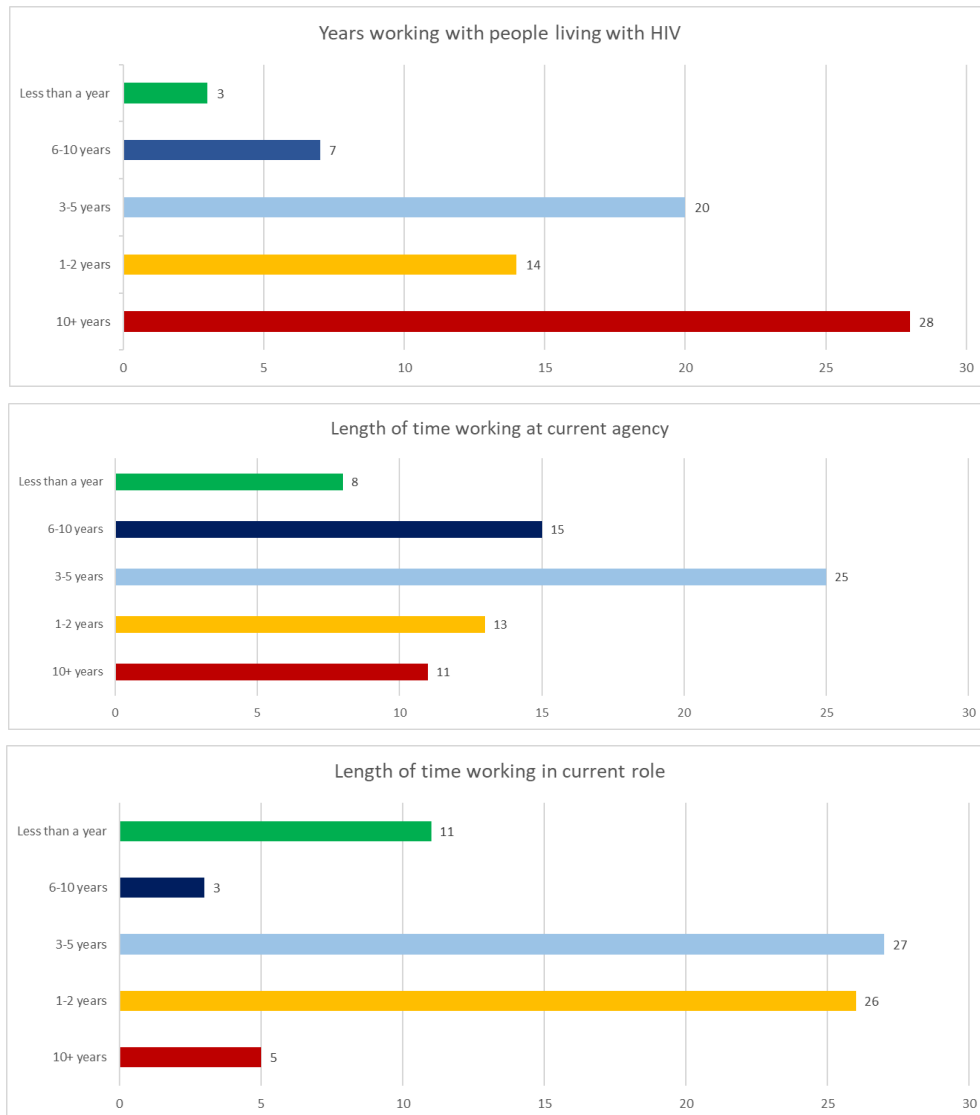
## Results

### Provider Profile



A total of N=72 providers participated in the Provider Capacity and Capability Assessment. Respondents represented a range of roles, including case managers, supervisors, administrative staff, clinical personnel, and program leadership. Participants reported funding from multiple sources, including Ryan White Part A and other Ryan White Parts and HIV funding streams. Providers were permitted to select multiple funding sources; therefore, funding totals exceed the number of respondents. This diverse representation provides a comprehensive perspective on service delivery capacity, workforce dynamics, and structural barriers within the Palm Beach County HIV care system.

## Workforce Experience and Organizational Tenure



Respondents reflect a highly experienced HIV workforce with many reporting more than 10 years of experience working with people living with HIV. While overall experience in the HIV field is substantial, tenure within current agencies and roles varies, suggesting some workforce movements across organizations and potential workforce mobility. The presence of an experienced workforce reflects institutional knowledge within the system.

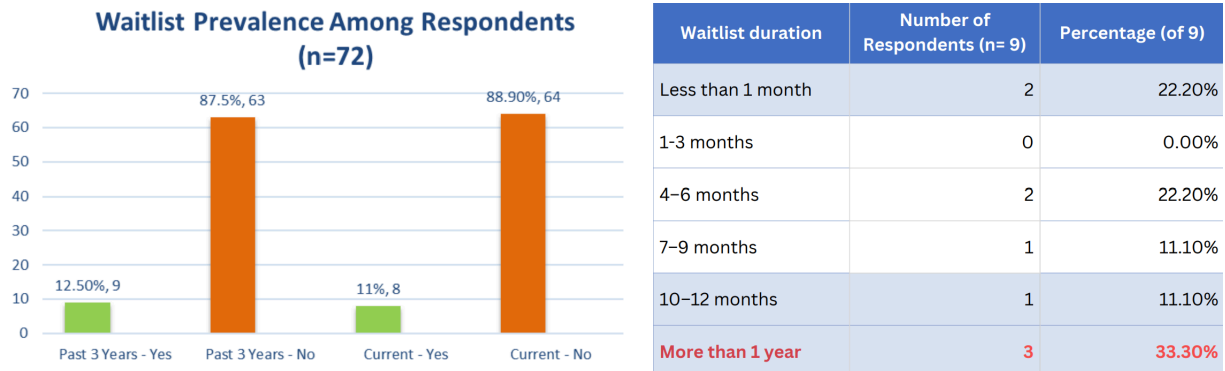
### Advancement Opportunities and Workforce Sustainability

Common themes on workforce advancement and commitment to work in the HIV field were identified by survey findings through written responses. Nearly half of respondents (47%)

reported limited or no formal advancement opportunities within their organizations. Advancement was frequently described as contingent upon leadership vacancies or funding availability rather than structured career pathways. Many respondents indicated that professional growth often occurs through role expansion rather than formal promotion.

Despite these limitations, respondents expressed strong commitment to the HIV mission (67%). However, sustained engagement in the field was closely tied to competitive compensation (57%), manageable caseloads (50%), supportive organizational culture (40%), and opportunities for continued professional development (36%). These findings suggest that while workforce dedication remains high, structural factors such as compensation, advancement pathways, and workload management are critical to long-term system sustainability.

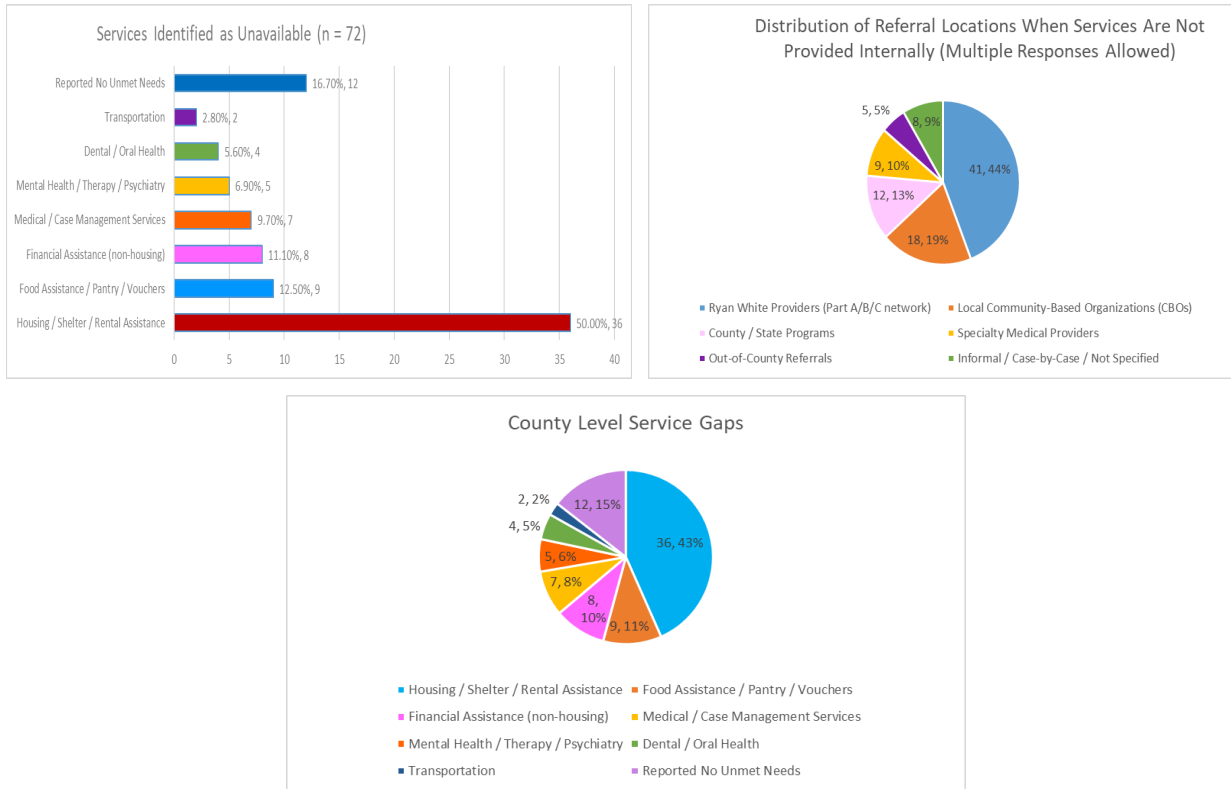
### Service Capacity and Waitlist Prevalence



The majority of providers reported adequate service capacity. However, 12.5% indicated experiencing a waitlist within the past three years, and 11.1% reported a current waitlist at the time of survey administration.

Among providers reporting waitlists (n = 9), the most frequently affected services included case management (33.3%), food bank services (22.2%), and housing-related services (22.2%). These services represent essential supportive components of the HIV care continuum. Reported drivers of waitlists included increased demand or client volume (44.4%), staffing shortages (33.3%), funding limitations (33.3%), and limited organizational capacity. Notably, one-third of reported waitlists extended beyond one year, indicating persistent capacity constraints rather than temporary service delays.

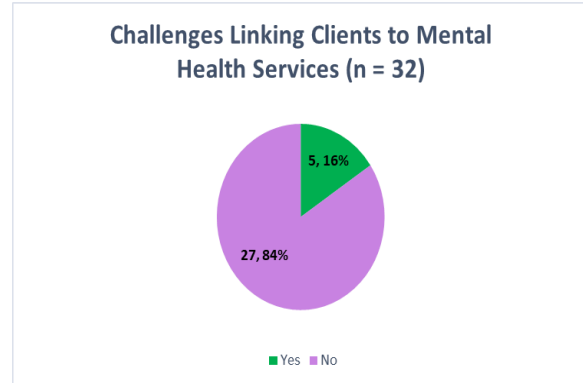
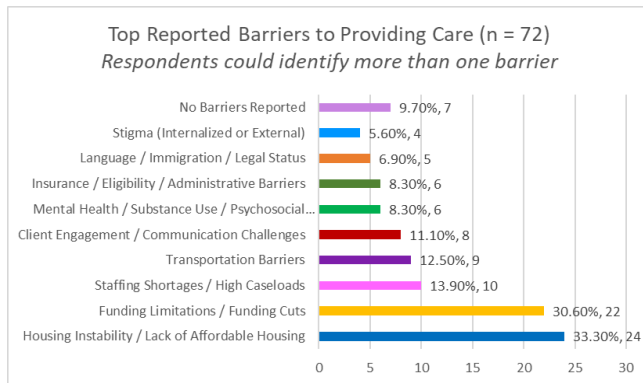
## Identified Service Gaps



Housing-related services emerged as the most frequently identified service gap, cited by approximately half of respondents. Secondary service gaps included food assistance and financial support services. Referral patterns for services not provided internally suggest heavy reliance on the Ryan White network to address service gaps, underscoring the importance of maintaining strong inter-agency coordination. Secondary referral locations include other local community-based organizations (CBOs) that are non-Ryan White funded, followed by other Palm Beach County programs that offer supportive services to county residents.

County-level responses similarly identified housing as a primary structural limitation within the local HIV service system. A little less than half of the respondents cited this as unavailable services for their clients. Other identified county level gaps, though reported at lower levels, include food and financial assistance similarly to agency level service gaps. The consistency of this finding across survey items underscores housing instability as a central capacity challenge, followed by food and financial assistance.

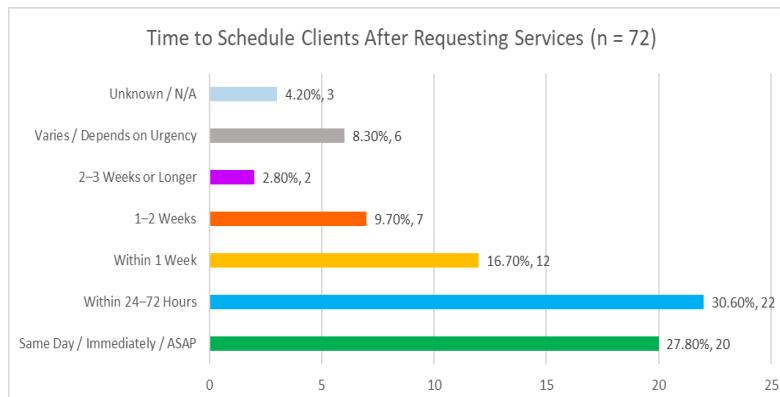
## Barriers to Care and Service Delivery



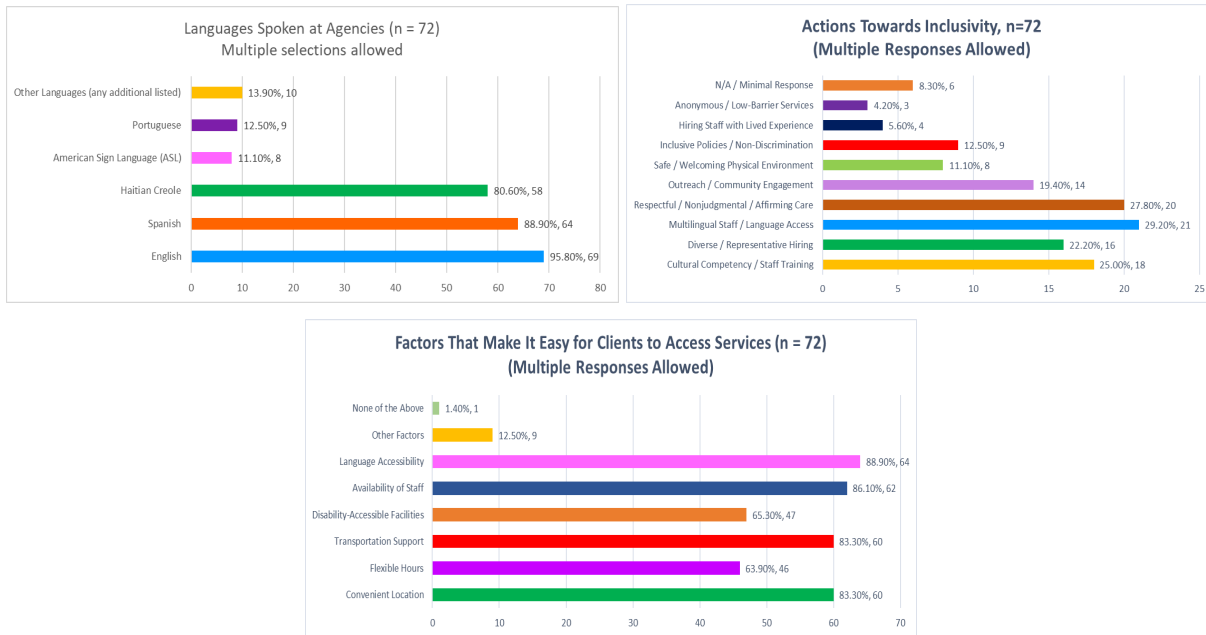
Respondents were asked to identify three barriers that their organization/agency has faced when providing care to people living with HIV/AIDS. Providers identified housing instability (33.3%) and funding limitations (30.6%) as the most significant barriers to delivering HIV services. Workforce constraints, including staffing shortages and workload demands, were also reported as barriers affecting service provision. These findings indicate the importance of housing stability to client's engagement and retention in care.

With respect to mental health linkage, 84% of respondents reported having no difficulty connecting clients to services, however the 16% that reported challenges cited insurance restrictions and provider availability. While mental health access appears largely functional and available, a few barriers persist for certain clients.

## Accessibility and Cultural Responsiveness

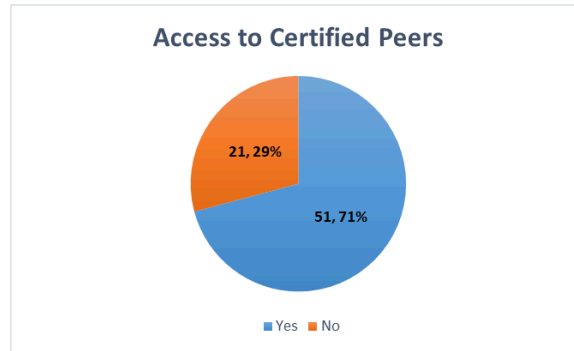


The majority of agencies reported scheduling clients within 72 hours of request, with many offering same-day appointments depending on urgency. This finding suggests timely access to services across much of the provider network. Respondents were asked whether their agency had staff members or services that reflect the needs of the people they serve. All respondents (100%) indicated that staff composition and services reflect client demographics.



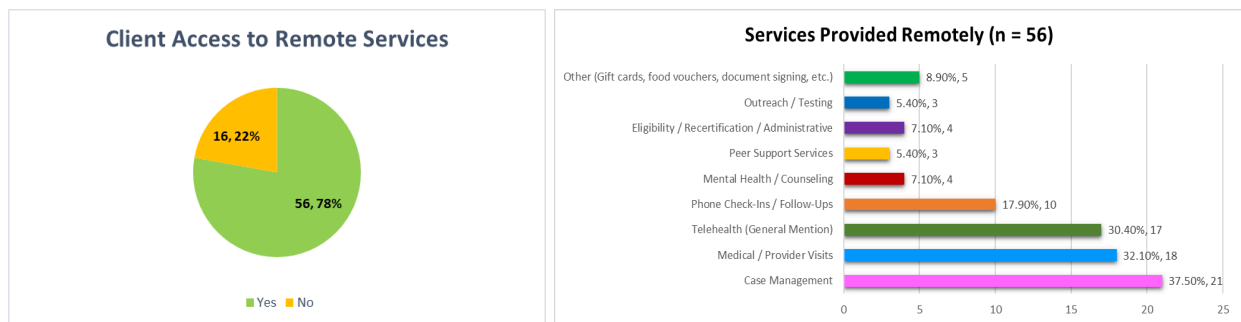
Agencies demonstrated substantial multilingual capacity, particularly in Spanish and Haitian Creole. Availability of ASL and Portuguese was more limited, though additional languages such as French, Turkish and Polish were reported. Providers reported multiple strategies to promote inclusivity, including multilingual staffing, affirming care practices, cultural competency training, and intentional recruitment of diverse personnel. Factors that make it easy for clients to access agency’s HIV services include language accessibility, staff availability, convenient location and transportation support. Additional access facilitators reported by respondents include mobile health services, medication delivery, insurance enrollment assistance, and strong community partnerships.

## Access to Certified Peer Support



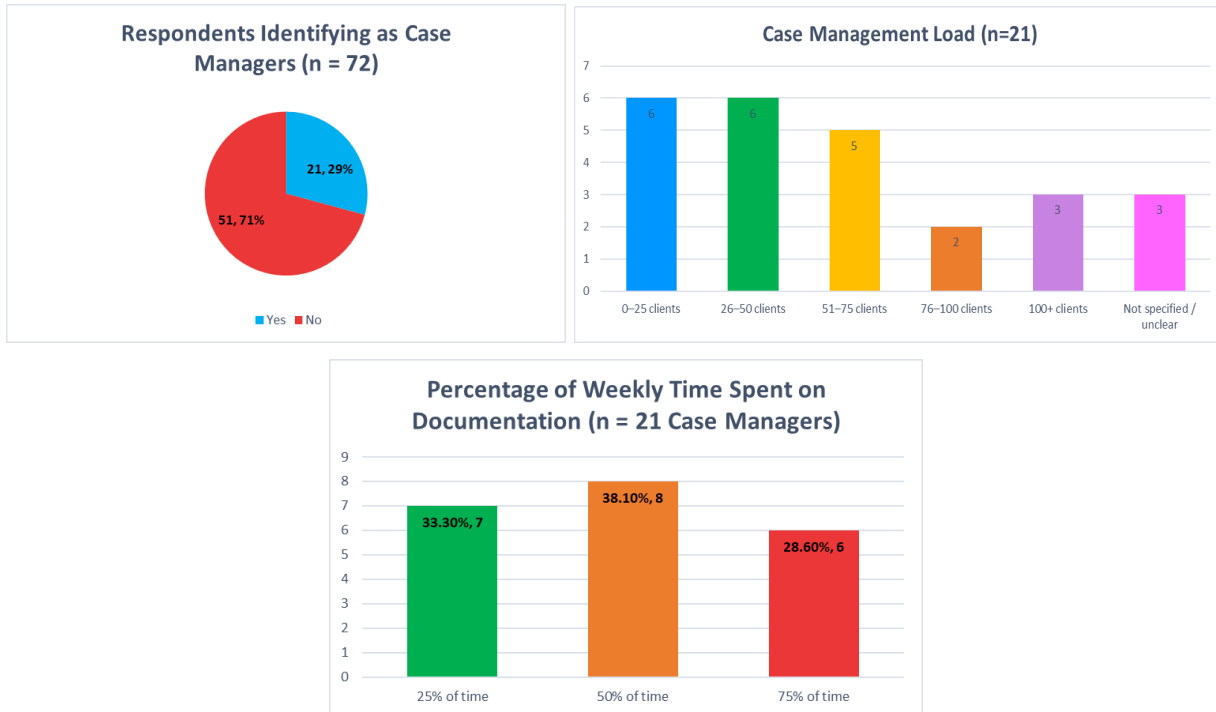
Seventy-one percent of respondents reported access to certified peer specialists, while 29% reported no access. The absence of peer capacity among nearly one-third of providers may indicate a potential gap in peer based engagement and retention support services. Among the 29% of providers reporting no access to certified peers, the primary barrier identified was lack of dedicated funding. Additional themes included absence of certified peer staff positions, referral to external agencies for peer services, and uncertainty regarding certification requirements. Some respondents stated confusion on what certification looks like for peers. Also cited was confusion about formal certification compared to peer support.

## Remote/Telehealth Utilization



Telehealth is widely integrated into service delivery, particularly for case management and medical visits. Behavioral health and peer services are less commonly delivered remotely. The integration of telehealth expands flexibility and may support timely access to care, though it does not fully mitigate structural barriers such as housing instability or funding constraints.

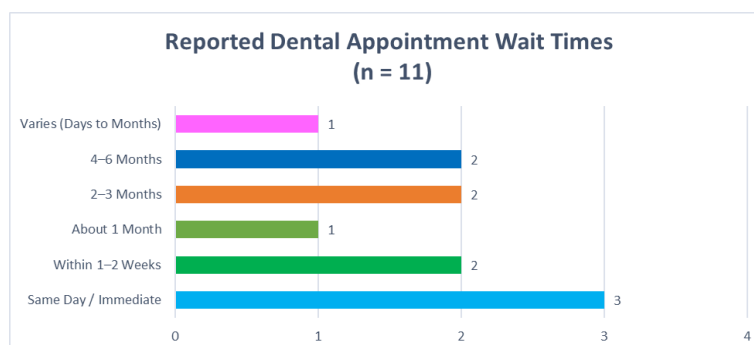
## Case Management Capacity and Administrative Burden



Twenty-one percent of respondents identified as case managers. Case management caseloads varied considerably. Most respondents reported caseloads between 26 and 75 clients, with several reporting caseloads exceeding 100 clients. These figures indicate variability in workload distribution across agencies.

Documentation burden emerged as a significant operational consideration. Most case managers reported spending at least 50% of their work week on documentation, with nearly one-third reporting that documentation consumes approximately 75% of their time.

## Dental Service Capacity



The dental appointment wait time question was directed only to respondents who identified as case managers (n = 21). Of those, 11 provided specific time estimates. Responses regarding dental appointment wait times indicate variability in service availability across providers. While some agencies reported immediate or short-term access to dental services, others indicated wait times extending up to six months. The remaining respondents indicated that dental services were not provided at their agency, were referred externally, or that wait time data was not available.

### Case File Closures

| Theme                                     | Approx. Mentions | Core Pattern   |
|---|------------------|--|
| <b>Loss of Contact / Non-Engagement</b>   | ~8               | Client stops responding, inactive >6 months, no return calls |
| <b>Client Request / Voluntary Closure</b> | ~6               | Client requests closure or transfer                          |
| <b>Transfer to Another Agency</b>         | ~4               | Client prefers or is reassigned elsewhere                    |
| <b>No Longer Needs Services</b>           | ~3               | Client stabilized or completed program                       |
| <b>Incarceration</b>                      | 2                | Client enters correctional system                            |
| <b>Behavioral / Rule Violations</b>       | 2                | Antagonistic behavior or policy violations                   |
| <b>Non-Compliance</b>                     | 1–2              | Program requirements not met                                 |

Providers reported that case file closures most commonly occur due to client disengagement or voluntary request rather than administrative removal. The most frequently cited reasons included loss of contact or extended non-engagement, client-requested closure or transfer, and reassignment to another agency.

Additional reasons included stabilization or completion of program goals, incarceration, and behavioral or program compliance issues. Reports of closures due to rule violations or

non-compliance were limited in frequency. These findings suggest that case closures are primarily driven by client-level circumstances rather than provider-initiated termination of services.

### **Additional Feedback**

Approximately 10% of respondents (n≈7) provided additional comments in response to the open-ended question, “Is there anything else you would like us to know?” While the majority of respondents did not provide additional feedback, several recurring themes emerged among those who did respond.

Key themes included:

- **Case management compensation and workforce sustainability**, including suggestions to review salary structures and consider fiscal analysis to support retention.
- **Ongoing funding limitations**, particularly related to eligibility restrictions and service denials.
- **Emergency housing needs**, with at least one respondent recommending reinstatement or expansion of emergency housing supports to promote retention in care.
- **Communication access barriers**, including lack of phone access impacting appointment adherence.
- **Role clarity between providers and clients**, with some respondents emphasizing the importance of reinforcing client responsibility within care coordination.
- **Commitment to high-quality care**, with several respondents expressing pride in their programs and dedication to improving services.

Although limited in number, these comments reinforce broader themes identified throughout the assessment, particularly regarding housing instability, workforce capacity, and funding constraints.

### **Gap Analysis: Provider Capacity and Capability**

The Provider Capacity and Capability Assessment indicates that the HIV service delivery system in Palm Beach County demonstrates strong organizational capability across several key domains, including culturally responsive service delivery, multilingual access, telehealth implementation, and timely appointment scheduling. However, the assessment also identified targeted capacity constraints and select capability limitations that may impact sustained engagement in care.

Housing-related services emerged as the most consistently cited unmet need across survey domains, including services requested but unavailable, reported barriers to care, and waitlisted services. The recurrence of housing concerns across multiple questions suggests a structural capacity gap within the local service environment. While housing services are available within

the system, reported demand appears to exceed available resources. The prominence of housing-related barriers across provider responses indicates that housing instability remains a significant factor influencing service engagement and overall client stability.

Workforce sustainability also surfaced as an area requiring attention. Although respondents reported substantial experience serving people with HIV and demonstrated strong commitment to the field, case management caseloads varied considerably, with a subset of case managers reporting caseloads exceeding 100 clients. In addition, documentation requirements were reported to consume a significant proportion of weekly work time for many case managers. Collectively, these findings suggest potential workforce strain that may affect the intensity and quality of individualized service delivery over time.

While most providers reported no active waitlists, extended wait durations were noted for certain supportive services, including dental care and housing-related services. These findings reflect targeted areas of service strain rather than widespread system dysfunction, but they indicate that capacity pressures exist in specific service categories.

In terms of system capability, access to certified peer support services was not universal. Nearly one-third of respondents reported no access to certified peers, most frequently citing funding limitations or the absence of certified peer positions. Given the established role of peer support in enhancing engagement and retention in care, limited peer service availability represents a capability gap within the provider network.

Although the majority of providers reported successful linkage to mental health services, a subset reported challenges related to insurance restrictions, provider availability, and administrative requirements. These responses suggest variability in behavioral health coordination capacity across agencies. While behavioral health services are present within the system, access may be inconsistent depending on insurance coverage and provider network limitations.

Qualitative responses also indicated occasional challenges related to client engagement and role expectations within case management. Although not widespread, these comments highlight opportunities to strengthen engagement strategies and reinforce client-centered care coordination approaches.

Importantly, the assessment also identified substantial system strengths. Providers reported strong multilingual staffing and interpreter access, universal commitment to culturally responsive practices, rapid appointment scheduling—often within 72 hours—and widespread telehealth implementation. These findings demonstrate that the local provider network possesses strong foundational capability and operational responsiveness.

Collectively, the findings suggest that the Palm Beach County HIV service system is stable and functionally responsive, with strong capability in culturally competent service delivery.

However, targeted capacity constraints—particularly related to housing services, workforce sustainability, and certain supportive service categories—represent priority areas for system strengthening.

These findings have implications across multiple stages of the HIV Care Continuum. Timely scheduling and telehealth implementation support rapid linkage to care, while structural challenges such as housing instability, workforce strain, and limited peer access may influence retention in care and sustained viral suppression outcomes. Addressing these targeted capacity and capability gaps may strengthen long-term engagement and improve care continuum performance indicators.

### **Data Limitations**

As with all self-administered survey instruments, findings are subject to certain limitations.

First, responses were self-reported and reflect the perspective of individual provider representatives at the time of survey completion. Responses may not reflect agency-wide policies or practices in all cases.

Second, several questions utilized survey branching logic. Subgroup analyses were conducted only among respondents for whom the question was applicable (e.g., case management-specific questions were analyzed among respondents confirming active case management responsibilities). As a result, denominators vary across analyses and are clearly indicated throughout the report.

Third, for certain service categories (e.g., dental services), not all respondents directly provide or track service-specific operational metrics. In these instances, respondents may have indicated “N/A,” “Unknown,” or provided no response. Reported findings therefore reflect available data from applicable respondents rather than system-wide administrative records.

Finally, the survey represents a cross-sectional assessment conducted at a single point in time. Findings should be interpreted as a snapshot of system capacity during the assessment period.

Despite these limitations, the survey provides valuable insight into workforce capacity, service accessibility, and perceived system gaps to inform Planning Council decision-making.

# Assessment of Service Needs and Gap Analysis

## Overview

This section synthesizes findings from all components of the comprehensive needs assessment, including the epidemiologic profile, estimates of unmet need and individuals unaware of their status, the HIV client survey, focus groups, the resource inventory, and the provider capacity and capability assessment. Together, these data sources provide a comprehensive understanding of the current HIV service landscape in Palm Beach County and highlight areas where service needs exceed the existing system capacity.

Findings from the assessment indicate that while Palm Beach County has a strong network of HIV prevention, care, and support services, several persistent gaps continue to affect access to care, retention in treatment, and overall health outcomes for people living with HIV (PLWH). These gaps are driven by a combination of structural, social, and system-level factors.

The key service gaps identified through this assessment are summarized below.

## **Housing Stability and Support Services**

Housing instability emerged as one of the most significant barriers affecting individuals living with HIV in Palm Beach County. Findings from both the HIV client survey and focus group discussions indicated that unstable housing and homelessness can significantly disrupt engagement in care. Participants reported that when basic needs such as shelter, food, and safety are uncertain, maintaining consistent medical appointments and medication adherence becomes more difficult.

The epidemiologic profile and unmet need estimates further reinforce the importance of stable housing as a determinant of health outcomes. Individuals experiencing housing instability are more likely to experience interruptions in care, delayed treatment, and poorer health outcomes.

Although housing assistance programs such as Housing Opportunities for Persons with AIDS (HOPWA) are available within the county, the demand for housing-related services often exceeds available resources. Participants in the focus groups also emphasized the need for expanded housing programs and supportive housing models that can provide stable living environments for individuals experiencing housing insecurity.

Strengthening housing support services remains an important opportunity to improve care engagement and long-term health outcomes for PLWH in Palm Beach County.

## **Transportation and Geographic Access to Services**

Transportation barriers were frequently identified across multiple assessment components. Survey respondents and focus group participants described difficulty traveling to medical appointments, pharmacies, and service providers, particularly for individuals without reliable personal transportation or those living in areas with limited public transit options.

Geographic distribution of services also contributes to this challenge. While many HIV services are concentrated in larger urban areas such as West Palm Beach and Delray Beach, individuals living in other areas of the county may need to travel longer distances to access care. This can result in missed appointments, delays in medication access, and interruptions in treatment.

Expanding transportation assistance programs, improving coordination between service providers, and exploring additional service locations in underserved areas could help address these access barriers and improve continuity of care.

## **Mental Health and Behavioral Health Services**

Mental health needs were consistently identified as an important component of HIV care. Both survey respondents and focus group participants emphasized the importance of counseling, therapy, and emotional support services to help individuals cope with the psychological impact of living with HIV.

Participants described experiencing stress, trauma, stigma, and social isolation following their diagnosis, highlighting the need for integrated behavioral health services within HIV care systems. Providers also noted the importance of addressing mental health challenges that may affect medication adherence, retention in care, and overall well-being.

Although mental health services are available through several community organizations, participants expressed that access can sometimes be limited due to availability, wait times, or lack of awareness about available programs.

Expanding mental health services and strengthening the integration of behavioral health support within HIV care programs may help improve engagement in care and overall quality of life for individuals living with HIV.

## **HIV Stigma and Community Education**

Stigma remains a persistent barrier affecting individuals living with HIV in Palm Beach County. Focus group participants described experiencing stigma and discrimination in multiple settings, including families, communities, housing environments, and sometimes within healthcare systems.

Many participants reported that misinformation about HIV transmission continues to contribute to fear and misunderstanding within the community. Misconceptions about how HIV is spread can lead to social isolation, discrimination, and reluctance to disclose HIV status.

Stigma also affects healthcare engagement. Some individuals expressed concerns about confidentiality and privacy when accessing HIV-related services, particularly when services are visibly separated from general healthcare settings.

Addressing HIV-related stigma requires continued investment in community education, culturally responsive outreach efforts, and public health campaigns that promote accurate information about HIV prevention, treatment, and living with HIV.

### **Language Access and Culturally Responsive Services**

Language barriers were identified as an important challenge for individuals in linguistically diverse communities, particularly among Spanish-speaking and Creole-speaking populations. Participants noted that navigating healthcare systems can be more difficult when services, information, and communication are not available in a language that individuals fully understand.

Ensuring that HIV services are culturally responsive and linguistically accessible is essential for improving engagement in care and ensuring that individuals are able to understand treatment options, program eligibility requirements, and available support services.

Strengthening language access services and culturally competent care models may help improve healthcare navigation and overall service utilization among diverse populations in Palm Beach County.

### **Service Coordination and System Navigation**

Another theme that emerged across the assessment was the complexity of navigating multiple service systems. Participants described challenges related to communication with providers, delays in responses from healthcare offices, and confusion about eligibility requirements for certain programs.

While Palm Beach County has a wide network of HIV service providers, navigating this system can sometimes be difficult for individuals who are newly diagnosed, returning to care, or experiencing other life challenges such as housing instability or incarceration reentry.

Participants emphasized the importance of case management and coordinated care systems that help individuals connect with medical services, supportive programs, and community resources.

Strengthening coordination across service providers and expanding patient navigation services could improve access to care and reduce barriers to engagement in treatment.

### **Summary**

Overall, the comprehensive needs assessment demonstrates that Palm Beach County has a well-developed network of HIV services that provide prevention, medical care, and supportive programs for people living with HIV. However, several key gaps remain that affect individuals' ability to access and remain engaged in care.

The most significant gaps identified through this assessment include housing instability, transportation barriers, mental health service needs, persistent HIV-related stigma, language accessibility challenges, and system navigation difficulties.

Addressing these gaps will require continued collaboration between public health agencies, healthcare providers, community-based organizations, and planning bodies such as the CARE Council. Strengthening these areas can help improve access to care, reduce disparities, and support better health outcomes for people living with HIV in Palm Beach County.

## **Limitations**

While this comprehensive needs assessment provides valuable insight into the HIV service system and the needs of people living with HIV in Palm Beach County, several limitations should be considered when interpreting the findings.

Participation in the HIV client survey and focus groups was voluntary; therefore, the results may not fully represent the experiences of all individuals living with HIV in the county. In addition, some clients were reluctant to participate in the survey, particularly when contacted by phone, and declined participation despite being offered multiple survey completion options.

Recruitment for the client survey required extensive outreach to reach the final sample of 291 participants. Some subpopulations were more difficult to reach than others, which created challenges in achieving balanced representation across all demographic groups. For example, the “Other/Multicultural” client group had a smaller client list, and very few clients from that group expressed interest in participating, making it more difficult to fully represent the experiences of that population within the client survey sample.

Language access also presented a temporary challenge during the data collection period. For approximately six months, the program did not have a dedicated English/Haitian Creole bilingual staff member available. During this time, Creole-speaking case managers and other staff members assisted Haitian Creole-speaking clients when their workload and schedules allowed. Although some surveys were completed during this period, the absence of a dedicated bilingual English/Haitian Creole staff member may have limited outreach and engagement with some Haitian Creole-speaking clients.

Additionally, some survey distribution challenges occurred during data collection. There was an unintended overrepresentation of Haitian male participants in the client survey sample after the new English/Haitian Creole survey assistant began conducting outreach. While their participation provided valuable perspectives, the distribution may not fully reflect the broader population proportions of people living with HIV in Palm Beach County.

Focus group participation also experienced minor recruitment limitations. For example, three individuals who had confirmed participation in the Spanish-language focus group were unable to attend on the day of the session, resulting in a final group size of seven participants rather than the originally anticipated ten participants.

The provider survey was conducted over a five-month period in order to allow sufficient time for staff from multiple agencies within the local HIV system of care to participate. While this extended timeframe helped improve representation across providers, it also meant that responses were collected over a longer period rather than within a single data collection window.

Finally, certain epidemiological estimates included in this report, such as the number of individuals living with HIV who may be unaware of their status, rely on surveillance data and statistical modeling methods. Updated jurisdiction-specific estimates are periodically released by the Florida Department of Health, and updated local estimates were pending confirmation at the time this report was prepared.

Despite these limitations, the findings presented in this report provide a strong foundation for understanding the current HIV service environment in Palm Beach County and identifying opportunities to strengthen services and improve health outcomes for people living with HIV.

## Next Steps

The findings from this comprehensive needs assessment will support ongoing planning and decision-making related to HIV prevention, care, and treatment services in Palm Beach County. The information gathered through this process provides valuable insight into the needs of people living with HIV, the availability of services, and areas where additional resources or system improvements may be needed.

Results from the needs assessment will be shared with the Palm Beach County HIV CARE Council to inform priority setting and resource allocation decisions. The findings may also support the development of quality improvement initiatives aimed at strengthening the local HIV system of care and improving health outcomes for people living with HIV.

Information gathered through this assessment may also help inform potential special projects focused on priority subpopulations identified through the data, updates to service delivery standards, and strategic outreach initiatives designed to improve HIV testing, early diagnosis, and rapid linkage to care.

Additionally, the findings may support future planning activities related to the Integrated HIV Prevention and Care Plan. The insights gathered from this assessment can help guide prevention and treatment strategies aimed at reducing new HIV infections, improving retention in care, increasing viral suppression rates, and strengthening the overall quality of care for individuals living with HIV in Palm Beach County.

Through continued collaboration between the HIV CARE Council, the Florida Department of Health, service providers, and community stakeholders, Palm Beach County can continue to strengthen its HIV prevention and care system while working toward improved health outcomes for all individuals affected by HIV.