The Status of HIV in Palm Beach County

2024

Presented by

Palm Beach County HIV Elimination Services

&

Palm Beach County HIV CARE Council

July 15th and 16th, 2024

Palm Beach County
HIV Elimination Services

DAY 1 – JULY 15, 2024

HIV, Behavioral Health, Substance Use Disorders, and Homelessness: A Syndemic Review

Casey Messer DHSc, PA-C, AAHIVS
Program Manager
Palm Beach County HIV Elimination Services
561-355-4730
cmesser@pbcgov.org

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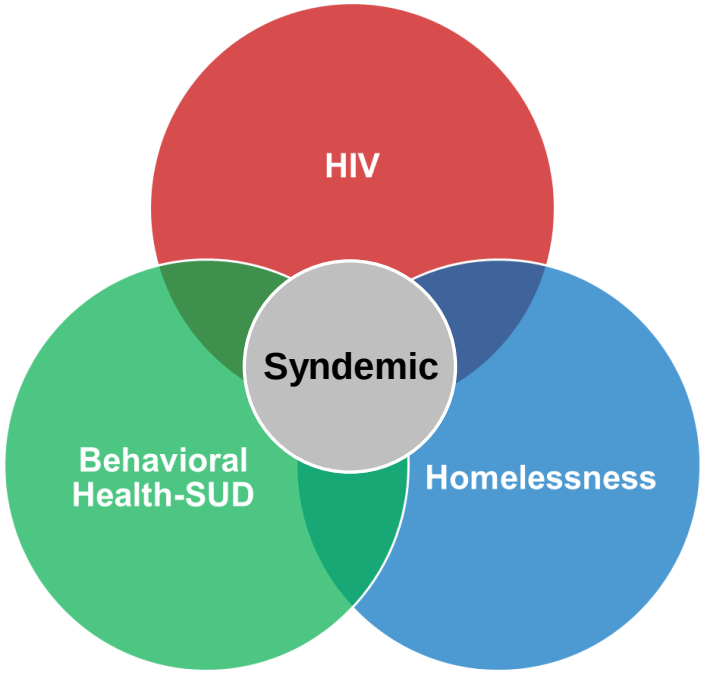
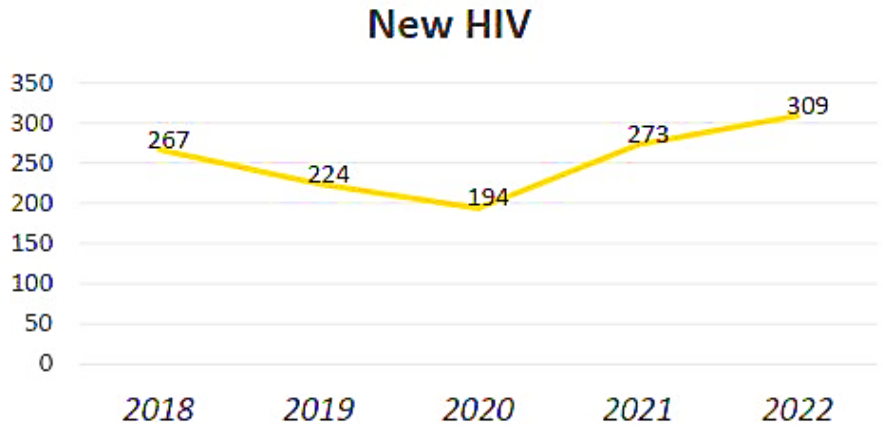
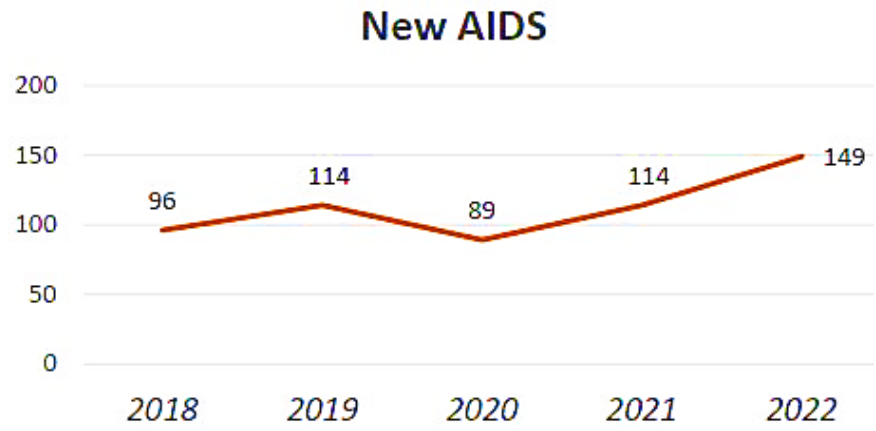
What is a Syndemic?

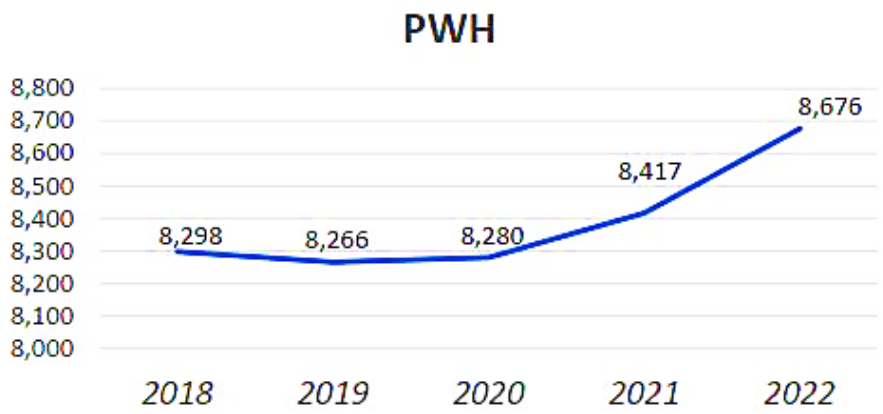
A syndemic is the aggregation of two or more concurrent or sequential biopsychosocial epidemics within a population which exacerbate the prognosis and burden of each, and are aggravated by the social, economic, environmental, and political milieu in which they exist.

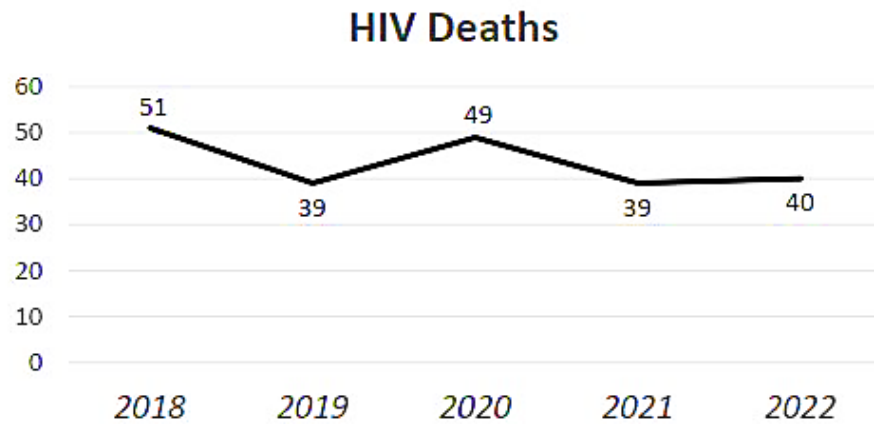


HIV Trends, Palm Beach County 2018-2022









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HIV Epidemiological Snapshot, Palm Beach County 2022

		Male #	%	Female #	%	Total #	%
Race/ Ethnicity	White	1,611	18%	353	4%	1,964	22%
	Black	2,728	31%	2,237	25%	4,965	57%
	Hispanic/Latino	1,244	14%	334	3%	1,578	18%
	Other	111	1%	49	<1%	160	1%
Age Group	13-19	20	<1%	16	<1%	36	<1%
	20-29	382	4%	116	1%	498	5%
	30-39	923	10%	366	4%	1,289	14%
	40-49	884	10%	666	7%	1,550	17%
	50+	3,485	40%	1,809	20%	5,294	61%
Mode of Exposure	MMSC	3,298	38%	0	<1%	3,298	38%
	IDU	257	3%	250	2%	508	5%
	MMSC/IDU	231	2%	0	<1%	231	2%
	HeterosexualContact	1,812	20%	2,643	30%	4,455	51%
	Other Sexual Contact	25	<1%	5	<1%	30	<1%
	Other risk	70	<1%	75	<1%	145	1%

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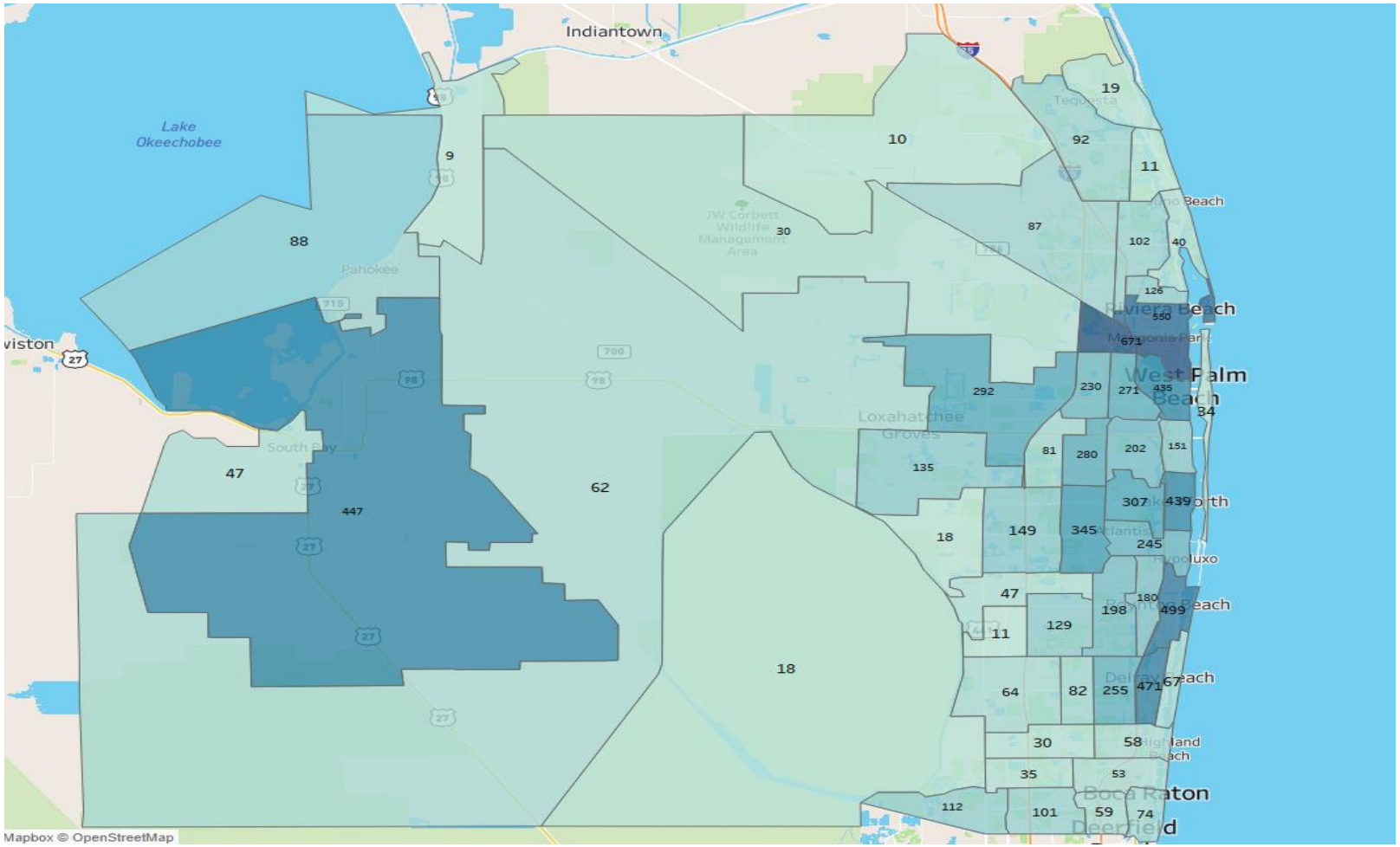
Subpopulations most overburdened by HIV identify as Male, Black, 50+, with Heterosexual and MMSC

HIV Prevalence by Zip Code, Palm Beach County 2022



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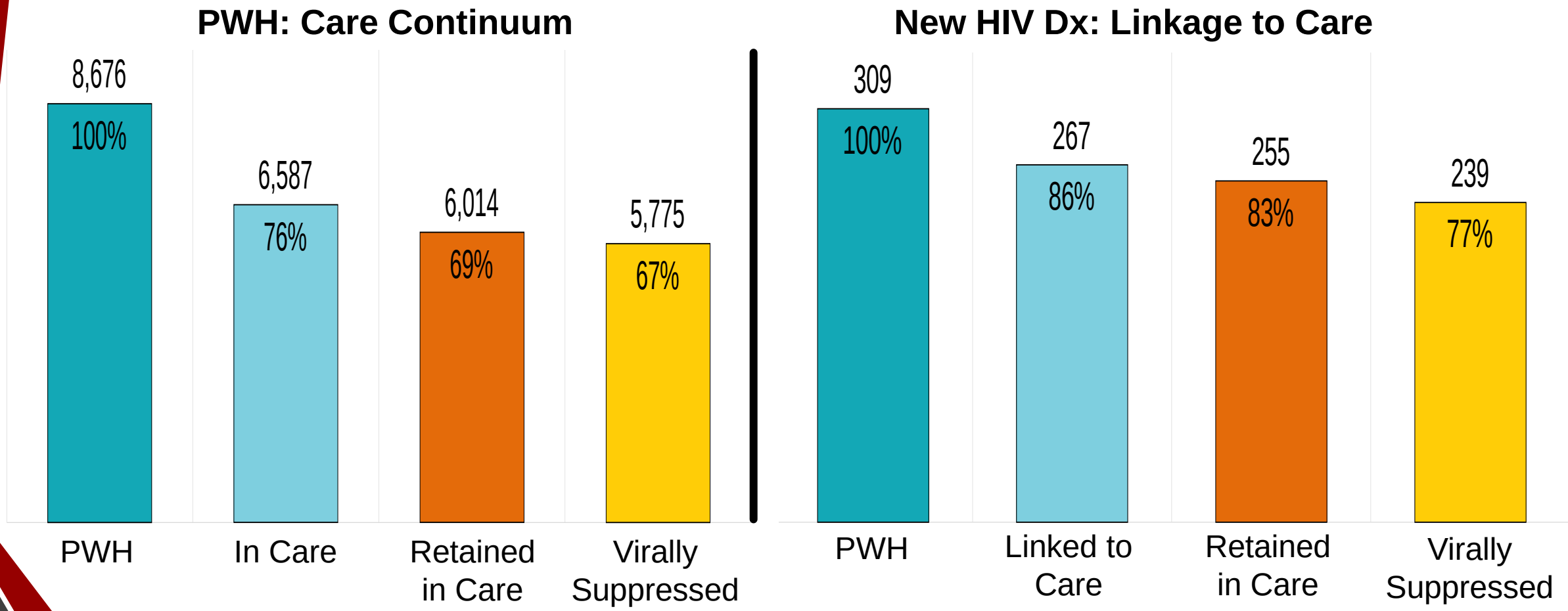
Communities most overburdened by HIV include Riviera Beach, West Palm Beach, Lake Worth, Boynton Beach, Delray Beach, and Belle Glade

HIV Care Continuum, Palm Beach County 2022



Not in Care: 2,089 (24%)

Never Linked to Care: 42 (14%)

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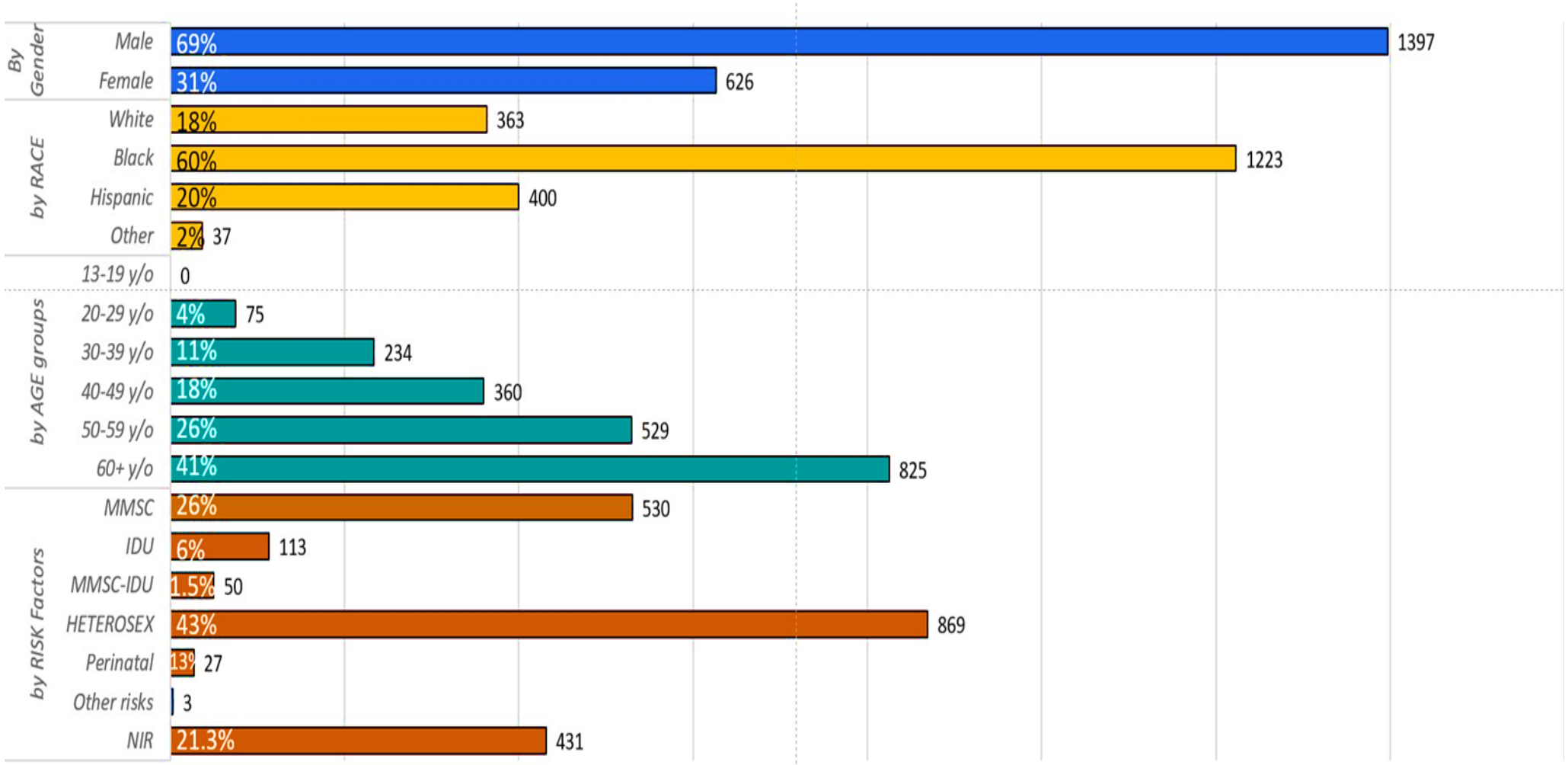
PWH Not in Care, Palm Beach County 2022



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HIV Elimination Services

Largest Subpopulations not in care identify as male, Black, 60+, with Heterosexual risk factors

Palm Beach County HIV System of Care

HIV Care Program	Lead Entity/Agent	Allocations (2023)
Ryan White HIV/AIDS Program (RW)		
Part A	Palm Beach County CSD	**$6,823,135**
Part B	Florida Department of Health (FDOH)	**$771,937**
Part C	AIDS Healthcare Foundation (AHF)	**$350,000**
Minority AIDS Initiative (MAI)	Palm Beach County CSD	**$612,398**
Ending the HIV Epidemic (EHE)	Palm Beach County CSD	**$2,000,000**
Syringe Services Program (SSP)	Palm Beach County CSD	**Unfunded**
Housing Opportunities for People with HIV/AIDS (HOPWA)	City of West Palm Beach/ PBC Housing Authority	**$3,552,143**
Palm Beach County HIV CARE Council (Planning Body)	Palm Beach County CSD	**$125,546**
	Grand Total	**$14,235,159**

Palm Beach County
HIV Elimination Services

The Palm Beach County HIV System of Care is nearly 100% funded by Federal Grants from HRSA & HUD.

Ryan White & Minority AIDS Initiative

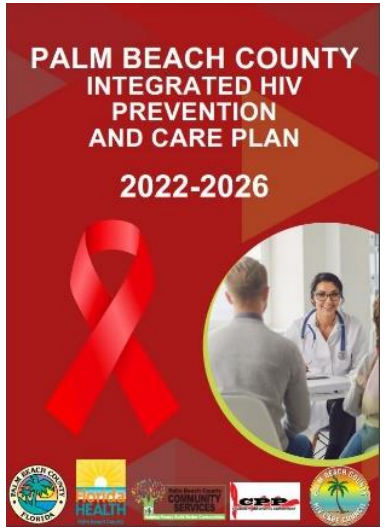
Core Medical Services

Ryan White

- Outpatient/Ambulatory Health Services
- Health Insurance Premium & Cost Sharing Assistance
- Local AIDS Pharmaceutical Assistance Program
- Early Intervention Services
- Home and Community Based Health Services
- Medical Case Management
- Medical Nutritional Therapy
- Mental Health Services
- Oral Health Care

MAI

- Medical Case Management
- Early Intervention Services



Support Services

Ryan White

- Emergency Financial Assistance
- Food Bank/Home Delivered Meals
- Housing Services (Emergency)
- Legal Services
- Medical Transportation Services
- Non-Medical Case Management Services
- Psychosocial Support Services

MAI

- Non-Medical Case Management Services
- Psychosocial Support Services

PBC Integrated HIV Prevention and Care Plan 2022-2026

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HIV Elimination Services

Ending the HIV Epidemic & HOPWA

Ending the HIV Epidemic

- Community Outreach, Response & Engagement (CORE)
- Tele-Adherence Counseling (TAC)
- Rapid Entry to Care (REC)
- Vocational Rehabilitation (VR)
- Harm Reduction Intervention Services (HRIS)
- Housing & Healthcare Opportunities (H2O)
- Health Insurance Premium Services (HIPS)
- 211 Transportation Services (211)

HOPWA

- Tenant-Based Residential Assistance (TBRA)
- Housing Case Management

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Syringe Services Program & HIV CARE Council

Syringe Services Program

Provides a 1:1 exchange of used needle/syringe for clean

- Narcan/naloxone distribution
- HIV Counseling & Testing
- HCV Testing
- Substance Use Disorder Treatment Referrals
- Health Care Access Referrals
- Peer Support
- Acute Wound Care

HIV CARE Council

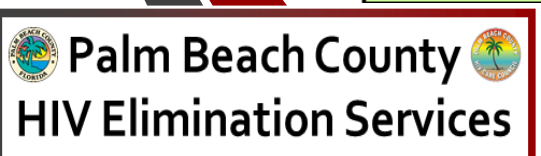
Legislative body responsible for conducting needs assessment, planning, resource prioritization and allocation, and directives to address needs of people with HIV

27 Members

- People with HIV & Community
- Public Health & Health Planning
- Health & Social Services Providers
- Federal HIV Programs

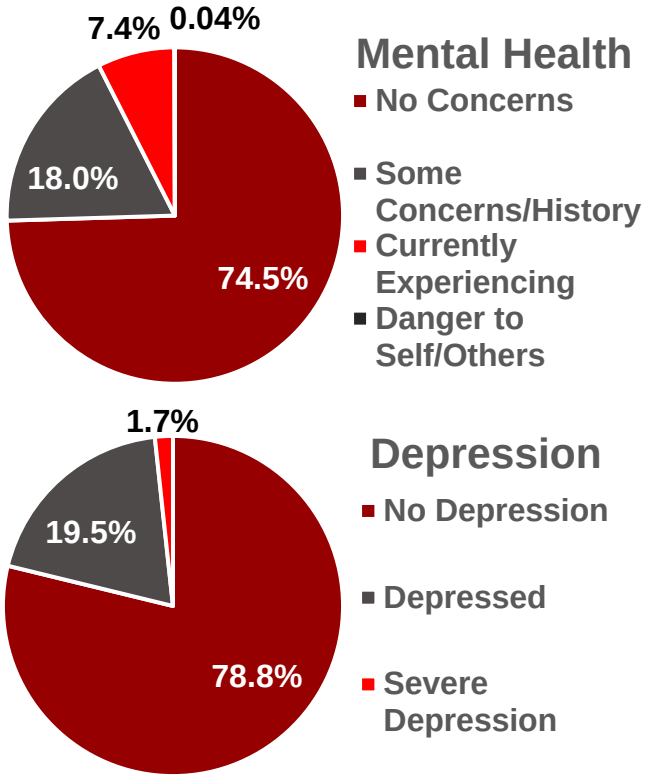
HIV Elimination Services Matrix

PALM BEACH COUNTY HIV Elimination Services Matrix Grant Year 2024 A = Part A Services B = Part B Services C = Part C Services E = EHE Services M = MAI Services U = Rebel Recovery	AIDS Pharmaceutical Assistance	Early Intervention Services (Part A & MAI)	Emergency Financial Assistance- Emergency Medications	Emergency Financial Assistance	Food Bank -Nutritional Supplements	Food Bank/Home Delivered Meals	Health Insurance Premium and Cost-Sharing Assistance	Legal Service	Mental Health Services	Medical Transportation	Medical Case Management (including Treatment Adherence) (Part A & MAI)	Non-Medical Case Management (Part A & MAI)	Oral Health Care	Outpatient/Ambulatory Health Services (including Lab Diagnostic Testing) (Part A & C)	Psychosocial Support Counseling (MAI Only)	Specialty Outpatient Medical Care	Registered Nurse Medical Case Management (Part C)	Linkage to Care (Part C)	Community Outreach Response & Engagement (CORE) (EHE)	Healthcare & Housing Opportunities (H2O) (EHE)	Rapid Entry to Care (REC) (EHE)	Tele-Adherence Counseling (TAC) (EHE)	Vocational Rehabilitation (VR) (EHE)	Harm Reduction Intervention Services (HRIS)	Syringe Services Program (SSP)	Medical Nutritional Therapy (FDOH Only)	Referral for Healthcare/Support Services (FDOH Only)
AIDS Healthcare Foundation (AHF)																												
West Palm Beach	A	A	A		A	A	A		A	A	A	A		A & C			C	C										
Delray Beach	A	A	A		A	A	A		A	A	A	A		A & C			C	C										
CAN Community Health	A													A							E							
Compass, Inc.		A		A			A		A	A	A	A																
FoundCare, Inc.																												
Belle Glade		A & M				A	A		A	A	A & M	A & M			M						E							
Boynton Beach		A & M				A	A		A	A	A & M	A & M									E							
Corporate Way									A												E							
North Palm Beach														A		A					E							
Yolette Bonnet Center- Okeechobee Blvd						A	A		A	A	A & M	A & M		A		A					E							
Palm Springs		A & M				A	A		A	A	A & M	A & M	A	A	M	A					E							
Greenwood														A		A					E							
Mobile Unit												A & M									E							
Health Council of Southeast Florida		A & M					A			A	A & M	A & M			M	A												
Legal Aid Society of Palm Beach County								A				A																
Midway Specialty Care Center																												
West Palm Beach											A	A		A														
Atlantis											A	A		A														
Monarch Health Services, Inc.		A									A	A		A							E							
The Poverello Center, Inc.						A																						
PBC Community Services Dept.																												
Belle Glade																			E	E		E	E					
Delray Beach																			E	E		E	E					
Riviera Beach																			E	E		E	E					
West Palm Beach																			E	E		E	E					
Rebel Recovery																								U	U			
Florida Department of Health																												
C.L. Brumbach Health Center (Belle Glade)		B & E			B	B			B	B	B			B							E					B	B
Delray Beach Health Center		B & E			B	B			B	B	B			B							E					B	B
Northeast Health Center (Riviera Beach)		B & E											B															
West Palm Beach Health Center		B & E			B	B			B	B	B			B							E					B	B



HIV & Behavioral Health/SUD

- Self-reported Behavioral Health of In-Care PWH in PBC, 2023 (N=2288)
  - Mental Health Concerns
    - No concerns regarding mental illness (1705, 74.52%)
    - Some concerns or history of mental illness (412, 18.0%)
    - Currently experiencing problems (170, 7.43%)
    - Danger to self or others (1, 0.04%)
  - Depression
    - No Depression (1803, 78.80%)
    - Depressed (446, 19.49%)
    - Severe Depression (39, 1.70%)

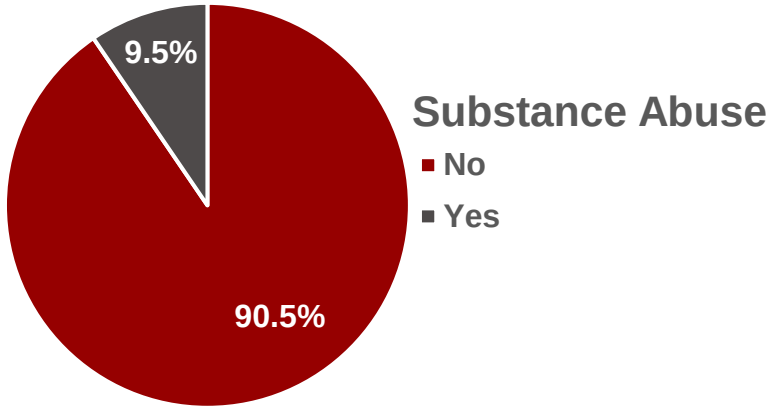


583, 25.48% PWH self-reported Mental Health Concerns

485, 21.19% PWH self-reported Depression

HIV & Behavioral Health/SUD

- Self-reported Substance Abuse of In-Care PWH in PBC, 2023 (N=2288)
  - Drug or Alcohol Abuse
    - No (2070, 90.47%)
    - Yes (218, 9.53%)

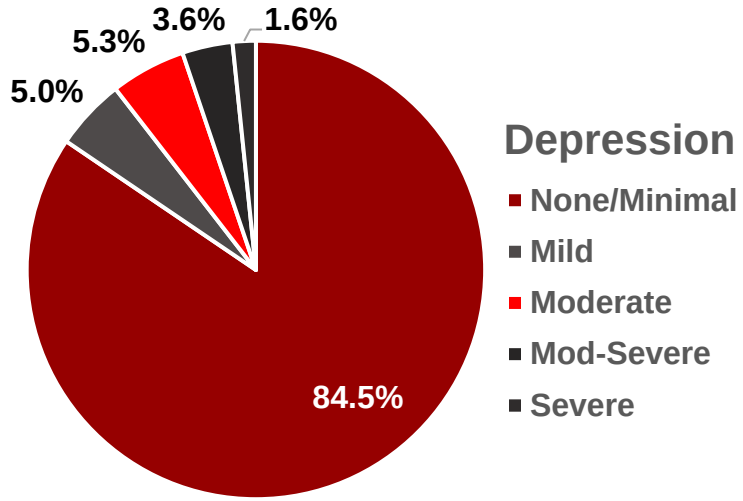


218, 9.5% PWH self-reported Drug or Alcohol Abuse

267, 11.67% PWH self-reported Mental Health AND Depression
125, 5.46% PWH self-reported Mental Health AND Substance Abuse
100, 4.37% PWH self-reported Depression AND Substance Abuse
86, 3.76% PWH self-reported Mental Health AND Depression AND Substance Abuse

HIV & Behavioral Health/SUD

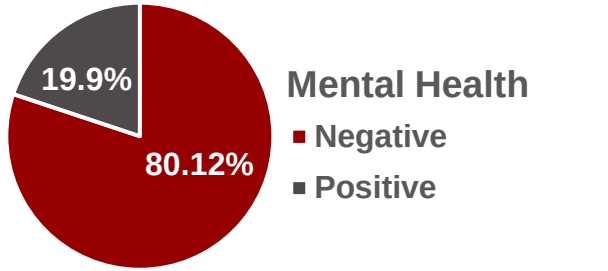
- Depression Screening of In-Care PWH in PBC, 2023 (N=1715)
  - Patient Health Questionnaire (PHQ-9)
    - None/Minimal (1449, 84.5%)
    - Mild Depression (86, 5.0%)
    - Moderate Depression (91, 5.3%)
    - Moderately Severe (61, 3.6%)
    - Severe (28, 1.6%)

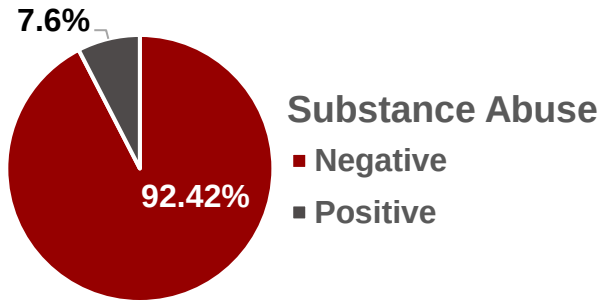


266, 15.5% PWH screened positive for Depression

HIV & Behavioral Health/SUD

- Mental Health & Substance Abuse Screening of In-Care PWH in PBC, 2023 (N=1715)
  - Substance Abuse and Mental Illness Symptoms Screener (SAMISS)
    - Mental Health
      - Negative (1374, 80.12%)
      - Positive (341, 19.88%)
    - Substance Abuse
      - Negative (1585, 92.42%)
      - Positive (130, 7.58%)





341, 19.88% PWH screened positive for Mental Health

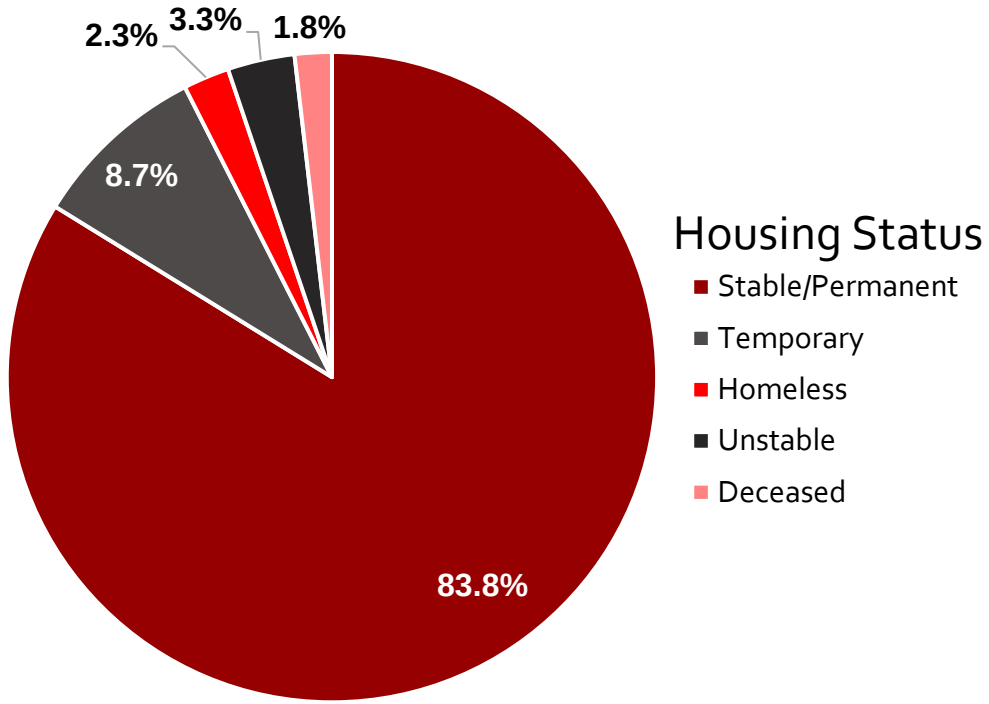
130, 7.58% PWH screened positive for Substance Abuse

Palm Beach County
HIV Elimination Services

For PWH, self-reported depression, mental health concerns, and substance abuse rates were slightly higher than positive screenings for the same, however, 573 fewer PWH completed screenings.

HIV & Homelessness

- Housing status of PWH in PBC, 2023 (N=8,676)
  - Active (*n*=3644, 42.0%)
    - Stable/Permanent (3075, 83.79%)
    - Temporary (416, 11.41%)
    - Unstable (153, 4.19%)
  - Inactive (*n*=2388, 27.52%)
    - Stable/Permanent (2197, 92.0%)
    - Temporary (134, 5.61%)
    - Unstable (57, 2.39%)
  - Deceased (*n*=116, 1.33%)
  - Unknown (*n*=2,528, 29.13%)



144, 2.29% PWH Experiencing Homelessness*

*There are 2,528 PWH with unknown housing status because they have not been engaged in care in the last year.

HIV, Behavioral Health/SUD, & Homelessness

- Depression and Homelessness of PWH in PBC, 2023 (N=1715)

	Depression Screening					
Housing Status	None/Minimal	Mild	Moderate	Moderately Severe	Severe	Total
Stable/Permanent	1283 (74.81%)	71 (4.14%)	74 (4.31%)	49 (2.86%)	22 (1.28%)	**1499**
Temporary	103 (6.01%)	**8 (0.47%)**	**9 (0.52%)**	**3 (0.17%)**	**2 (0.12%)**	**125**
Homeless	29 (1.69%)	**4 (0.23%)**	**5 (0.29%)**	**7 (0.41%)**	**3 (0.17%)**	**48**
Unstable	34 (1.98%)	**3 (0.17%)**	**3 (0.17%)**	**2 (0.12%)**	**1 (0.06%)**	**43**
Total	1449	86	91	61	28	

50, 2.92% of In-Care PWH have co-occurring depression AND non-stable/permanent housing status.

HIV, Behavioral Health/SUD, & Homelessness

- Mental Health and Homelessness of PWH in PBC, 2023 (N=1715)
- Substance Abuse and Homelessness of PWH in PBC, 2023 (N=1715)

	Mental Health Screening		Substance Abuse Screening		
Housing Status	Negative	Positive	Negative	Positive	Total
Stable/Permanent	1214 (70.79%)	285 (16.62%)	1394 (81.28%)	105 (6.12%)	**1499**
Temporary	96 (5.60%)	**29 (1.69%)**	113 (6.59%)	**12 (0.70%**	**125**
Homeless	33 (1.92%)	**15 (0.87%)**	41 (2.39%)	**7 (0.41%**	**48**
Unstable	31 (1.81%)	**12 (0.70%)**	37 (2.16%)	**6 (0.35%)**	**43**
Total	1374	341	1585	130	

56, 3.27% of In-Care PWH have co-occurring mental health AND non-stable/permanent housing status.

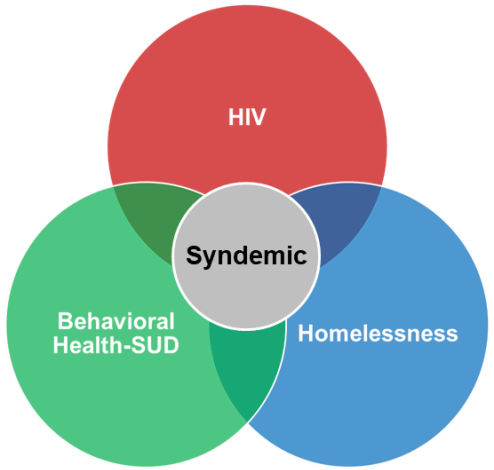
25, 1.46% of In-Care PWH have co-occurring substance abuse AND non-stable/permanent housing status.

HIV, Behavioral Health/SUD, & Homelessness

1) A statistically significant higher proportion of In-Care PWH with none/minimal depression had stable/permanent housing status. (p=0.023)

2) A statistically significant higher proportion of In-Care PWH with a negative mental health screening had stable/permanent housing status. (p=0.022)

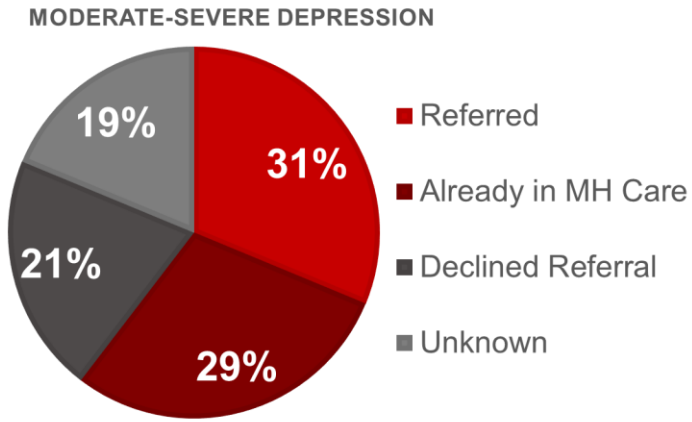
3) A statistically significant higher proportion of In-Care PWH with a negative substance abuse screening had stable/permanent housing status. (p=0.025)



Syndemic Successes

Create Equity Collaborative

- National collaborative from Centers for Quality Improvement and Innovation (CQII) with 100 HIV service sites across the US that began in 2022
- Aim Statement: Increase mental health screening rates among clients from 0% to 75% over first 18 months
- Root Causes: Medical Case Managers rely on client self-reporting; Physician/NP/PA focus primarily on treatment of HIV; No systems-level neutral assessment process to which clients can be referred
- Interventions: Medical Case Managers administer PHQ-2, then PHQ-9 if warranted; Substance Abuse and Mental Illness Symptoms Screener (SAMISS)



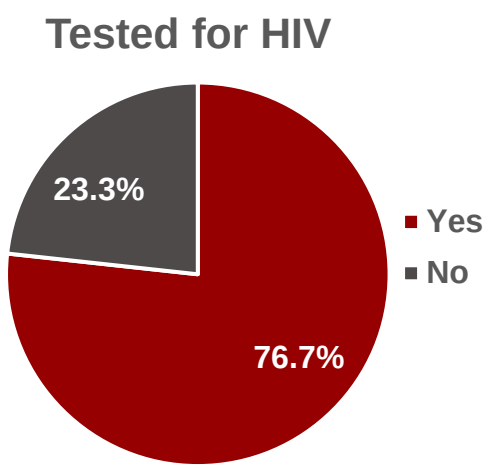
Syndemic Successes

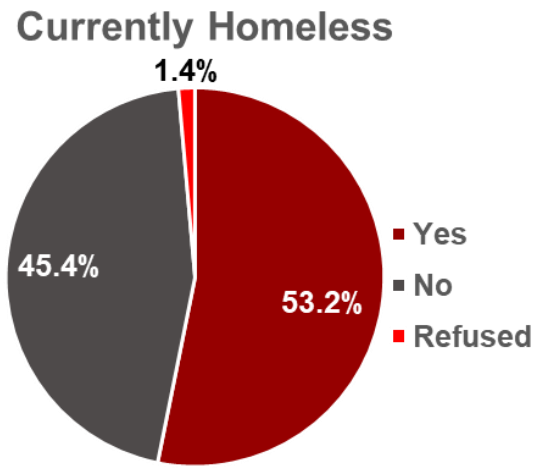
PL Cares (Positive Links®)

- A mobile health (mHealth) platform providing daily medication reminders, lab results, medication adherence/mood/stress check-ins, community message board, community resources, and direct contact with telehealth counseling service providers beginning in 2022.
- Participants are not virally suppressed; Newly diagnosed, out of care, or in-care but not virally suppressed. A smartphone and data plan support of up to $60 USD monthly provided to participants who achieve a 71% participation rate each month using the mobile application.
- 84 participants enrolled with a 81% viral suppression rate (previously 0%)

Syndemic Successes

- **Syringe Services Program (SSP)**
  - Florida Infectious Disease Elimination Act (IDEA), Section 381.0038(4), F.S. effective July 1, 2019
  - Palm Beach County Infectious Disease Elimination Ordinance, Ord. No. 2019-026 effective July 2, 2019
  - SSP Operator contract executed September 1, 2020; Services began April 2, 2021
    - 709 unduplicated participants served
    - 183,150 needles in; 167,670 needles out (1 to 0.92)
    - 7 HIV diagnoses identified
    - 269 referred for SUD counseling or treatment
    - 935 naloxone overdose reversals
    - 153 referred to shelter





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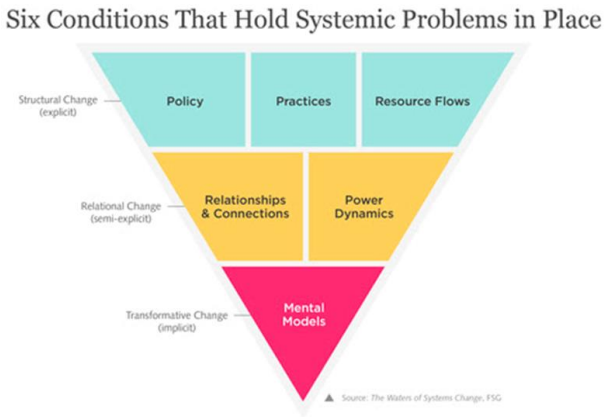
REBEL RECOVERY

Syndemic Successes

- **100 Day Challenge: Housing is Healthcare**
  - Palm Beach County quality improvement project facilitated by RE!NSTITUTE in 2022-2023 that incorporated a rapid systems change model for 300+ unsheltered PWH identified through a data match between Client Track (homelessness) and Provide Enterprise (HIV).
  - Goal: In 100 Days, 60 individuals with HIV and experiencing homelessness will be safely, stably housed and linked to care, with equitable exits based on Gender, Race, Ethnicity, Age, and Household type.
  - Result: 28 people connected to safe, stable housing and linked to care; Over 90% of people housed identified as Black, Indigenous, and other Persons of Color (BIPOC)
    - Previous 100 Days only 13 households were stably housed



Palm Beach County HIV Elimination Services

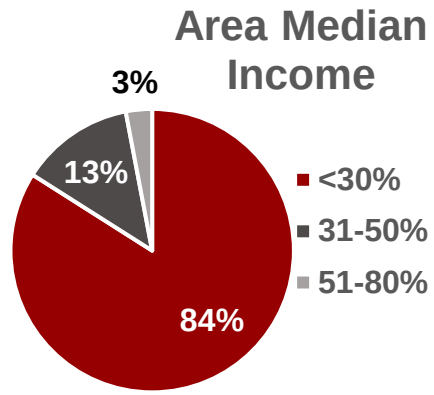
RE!NSTITUTE

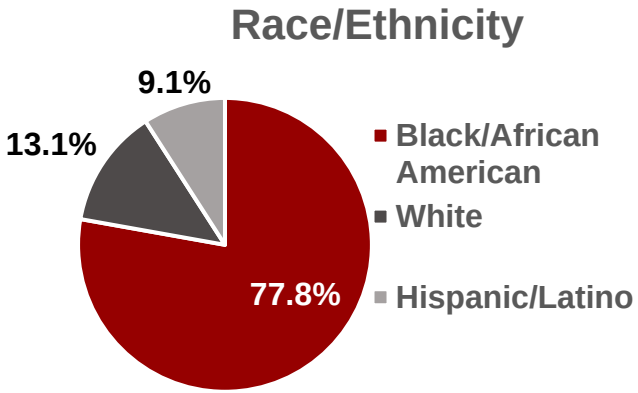
Syndemic Successes

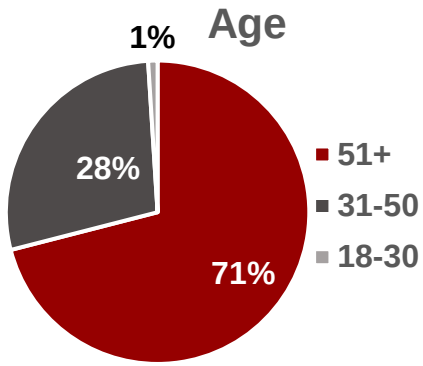
Housing Opportunities for People with HIV/AIDS (HOPWA)

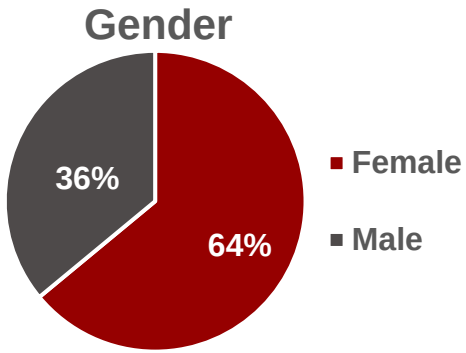
- City of WPB-Palm Beach County Housing Authority
  - Tenant-Based Rental Assistance (TBRA)-Permanent housing subsidy providing ongoing rent & utility assistance
  - 236 Households Served

- City of WPB-Palm Beach County (COVID)
  - Transitional Housing (hotel/motel); Short-Term Rent & Utility Assistance; Permanent Housing Placement (security deposit, first month's rent)
  - 214 Households Served









Palm Beach County
HIV Elimination Services

PBCHA
Palm Beach County Housing Authority

Syndemic Barriers

Stigma

- 2022 PBC HIV Needs Assessment Consumer Survey
  - Quality of Life Scale
    - **50.96% (186/365) of clients reported being moderately-extremely afraid of rejection by family, friends, and co-workers if they find out about their HIV status**
  - Access to Services
    - 7.57% (28/370) of clients reported needing mental health therapy/counseling but unable to get it
    - 3.31% (12/363) of clients reported needing substance use treatment but unable to get it
    - 12.77% (47/368) of clients reported needing housing services but unable to get them

- 2021 CSD Housing for Health LEAN Six Sigma Project
  - Rate of service from coordinated entry referrals; PWH 15.5% vs 24.7% General Population
  - 33% of PWH referred to coordinated entry did not disclose HIV status on VI-SPDAT
  - Most clients were referred back to Ryan White for services as a non-prioritized population

Syndemic Barriers

Structural

- Policies/Practices/Resource Flow
  - HIV prevalance (# of PWH) is increasing, but federal appropriations have been level-funded for a decade;
  - Ryan White HIV/AIDS Program allows only 25% of funds to be used for support services;
  - PBC HHA/CoC does not include PWH as a prioritized special population (victims of domestic violence, seniors, chronic homeless individuals, youth, and veterans);
  - WPB-PBCHA HOPWA waitlist currently includes 339 PWH

Relational

- Relationships & Connections/Power Dynamics
  - HIV, BH/SUD, Homelessness triad of stigma
  - PWH and/or HIV/AIDS Service Orgs not represented or meaningfully involved in BH/SUD and Homelessness Systems of Care (advisory boards, coordinated entry, BOD, etc.)
  - Systemic silos between physical, behavioral health/SUD, and social determinants of health providers

Syndemic Opportunities

Health Insurance Cost-Sharing Service Models

- Florida has not implemented expansion of Medicaid
- Safety net health programs often established as direct service delivery models
  - Limited or fragmented provision of services
  - Limited capacity (funding amounts, funding restrictions, physical space, geography, etc.)
  - Administratively cumbersome
  - Patients less likely to seek/receive preventive care[1,2,3,4]; higher mortality rates for uninsured[5,6,7]

- Providing health insurance premium, deductible, and co-pay assistance shown to be more cost-effective AND associated with improved patient outcomes for PWH in PBC
  - Increased access to comprehensive health care (not just HIV-specific services), including behavioral health-SUD, inpatient/surgical services, specialty medical care, wellness programs, etc.
  - Health care costs are shared with third-party payors, resulting in cost-savings to the program
  - Reimbursement rates from third-party payors may exceed actual cost of service, resulting in the generation of program income by service providers that can then be used to address social determinant of health inequities (housing, transportation, food, etc.) as unrestricted/general revenue.

Syndemic Opportunities

Mobile Units

- Investment in System of Care mobile units made available for community partner use allows for comprehensive services to be co-located[8]
  - Effective in facilitating access to health care for vulnerable populations[9]
  - Operationally can overcome barriers to services resulting from:
    - Geographic isolation/transportation
    - Legal status
    - Linguistic and cultural barriers
    - Intimidation by healthcare settings
    - Limited Hours of operation
    - Anonymity concerns
  - Reducing healthcare costs from avoidable emergency department visits, hospitalizations and re-admissions, and increased uptake of preventive screenings/services

- Continuity of care can be difficult if mobile unit services are not provided or supported by lead entities of local health and human services

Syndemic Opportunities

- **Healthcare + Housing Opportunities (H2O)**
  - A new program offered by HIV Elimination services, providing a range of services intended to maximize access and adherence to comprehensive health care in coordination with stable, permanent housing for priority populations of PWH
    - H2O Case Management (including comprehensive assessment and collaborative goal-setting for HIV, BH/SUD, and Housing)
    - Transitional housing assistance
    - Budget-deficit rent/utility assistance
    - Transportation assistance
    - Vocational rehabilitation/Employment Counseling
    - GED/ESL Classes
    - Telehealth Counseling
  - This program will not provide standalone housing assistance to clients, rather it provides opportunities that support upward economic mobility leading to self-sufficiency in conjunction with physical and behavioral health services.

Syndemic Opportunities

Service & Data Integration

- Comprehensive syndemic services can be made available wherever any HIV, BH/SUD, or Homelessness services are offered. Potential benefits include:
  - Lower barriers to accessing services
  - Patient/client-centered approaches
  - Early intervention
  - Improved outcomes
  - Reduced stigma
  - Enhanced coordination of care
  - Reduced disparities/increased equity
  - Cost-savings from “waste” reductions (Lean Six Sigma)

- With consent, client data can be aggregated for more holistic analyses to inform service delivery, spark innovation, and advance understanding of the relationship that exists between HIV, BH/SUD, and Homelessness

Future Action Items/Considerations

- **Syndemic funding opportunities**
  - Whenever possible, prioritize allocations, proposals, and funding recommendations that address two or more syndemic components, or that intersect with two or more BCC strategic priorities
    - HIV-Homelessness; HIV-BH/SUD; BH/SUD-Homelessness; HIV-BH/SUD-Homelessness
- **Meaningful involvement of persons with lived syndemic experience**
  - HIV CARE Council
    - Established membership reflectiveness requirements to include lived experience of homelessness, behavioral health, and substance use disorders
    - Advisory Committee on Behavioral Health, Substance Use, and Co-Occurring Disorders (BHSUCOD) and Homeless and Housing Alliance/Continuum of Care (HHA/CoC) may consider establishing complement membership categories
- **Syndemic awareness**
  - We will not be successful in addressing HIV, BH/SUD, or Homelessness in PBC unless we transform our mental model toward collectively ending the epidemic, facing the crisis, and leading the way home.

References

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Questions?

Palm Beach County
HIV Elimination Services

Palm Beach County
Ryan White Services Report (RSR)

Shoshana Ringer, M.Ed.
Quality Management Coordinator
Palm Beach County Ryan White Program
sringer@pbc.gov
561-355-4788

Palm Beach County
HIV Elimination Services

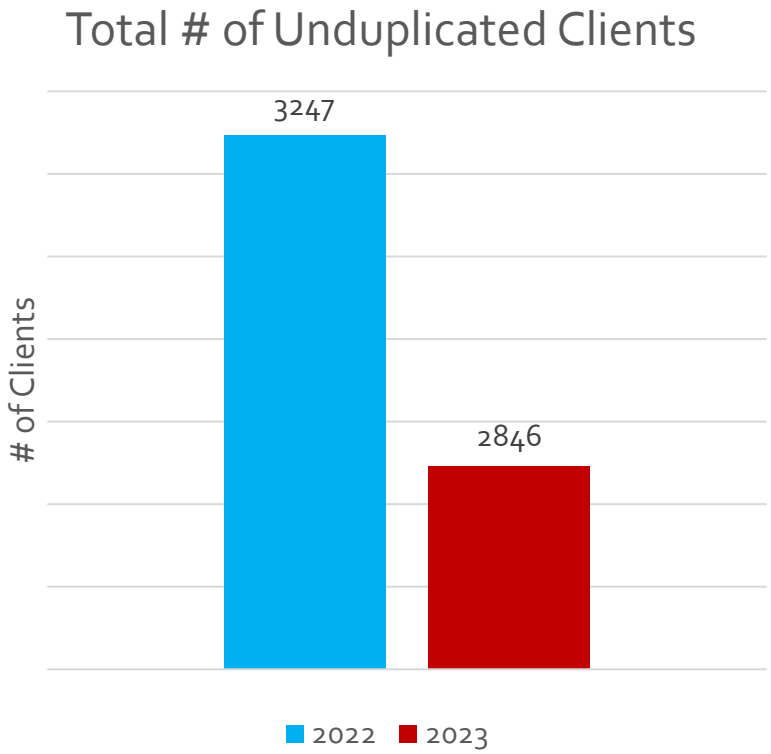
2023 Ryan White HIV/AIDS Program Service Report (RSR)

- The RSR is an annual Client summary report required by our funders Health Resources & Services Administration (HRSA).
- Funded Subrecipients, who provide services under the Part A program, are required to document and submit data on the clients they serve.
- Data is reported on a ***calendar* year** (January-December), not a *grant* year (March-February).
- These data sets are utilized by our program;
  - To understand the types of clients we served,
  - To make informed decisions on prioritizing needed services and allocating funds to services provided,
  - To explain how we are using our funds and supporting health outcomes of our clients, in our annual grant application.

2023 RSR Client Summary Report Data

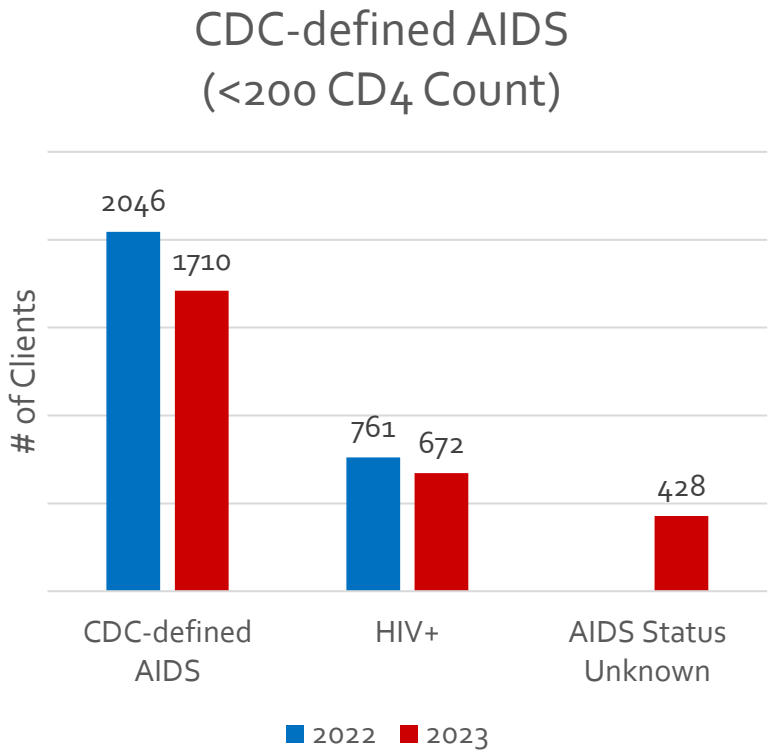
Number of Clients by HIV Status

•Reported a decrease of 401 clients between 2022 and 2023



Number of Clients by HIV/AIDS Status

•Reported a decrease of 336 clients diagnosed with AIDS between 2022 and 2023

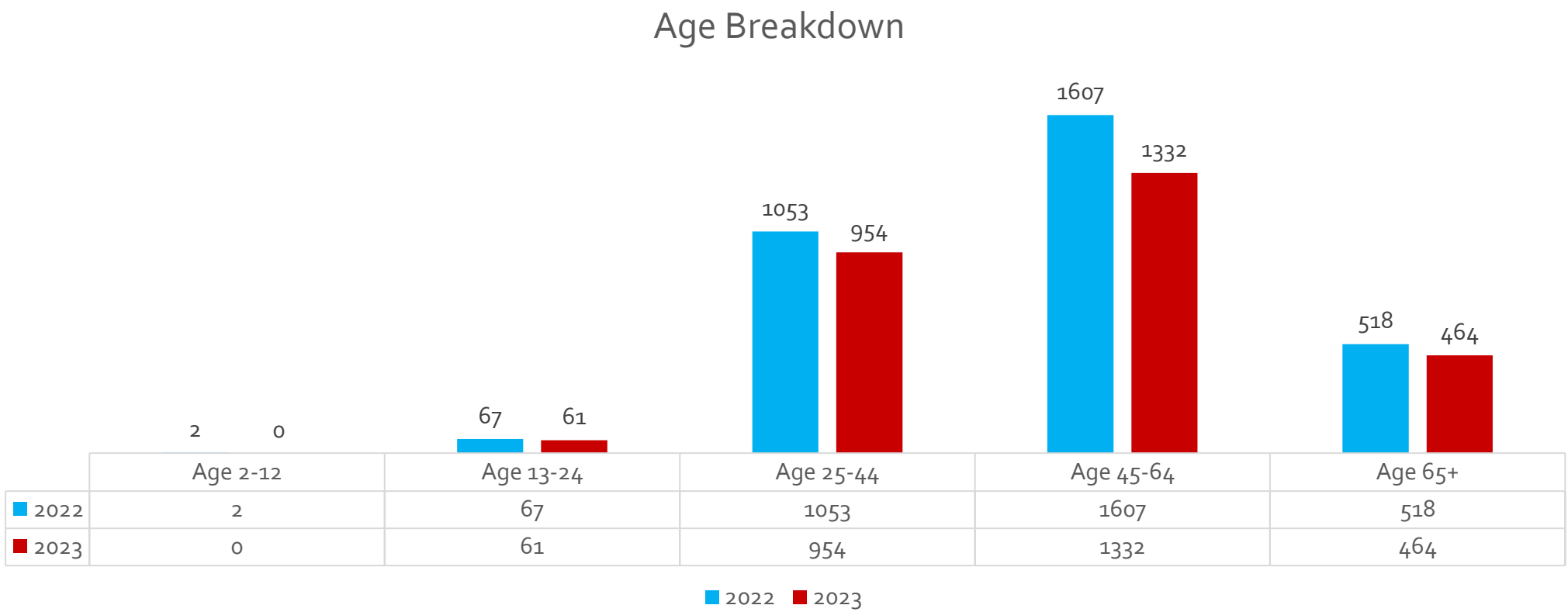


Palm Beach County
HIV Elimination Services

2023 RSR Client Summary Report Data cont.

Number of Clients by Age and HIV Status

- Largest group continues to remain 45-64 years old



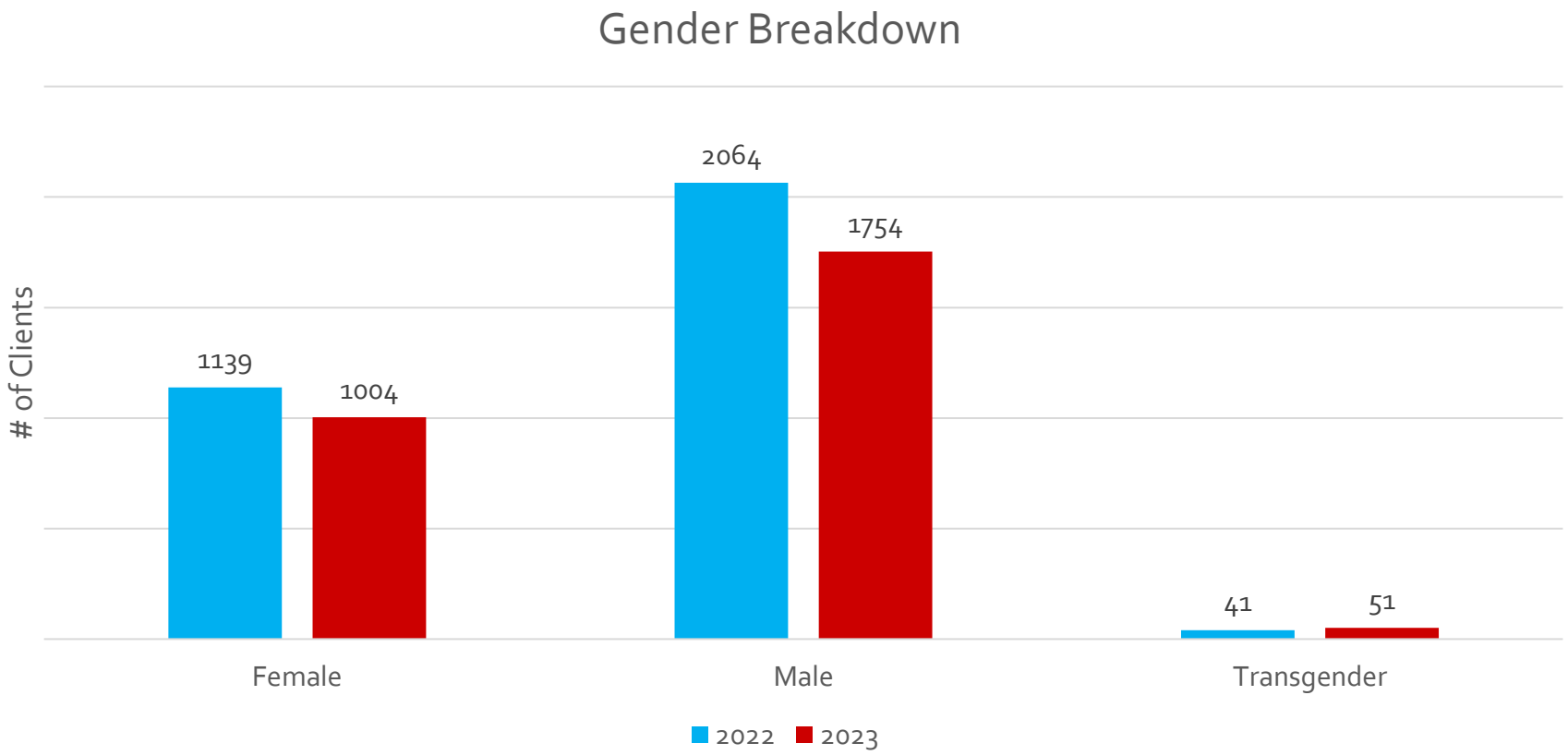
	Age 2-12	Age 13-24	Age 25-44	Age 45-64	Age 65+
2022	2	67	1053	1607	518
2023	0	61	954	1332	464

Palm Beach County
HIV Elimination Services

2023 RSR Client Summary Report Data cont.

Number of Clients by Gender and HIV Status

- Largest group continues to remain Males
- Increase of 10 reported Transgender between 2022 and 2023
- Larger decrease in total number of Males (310) versus Females (135) between 2022 and 2023

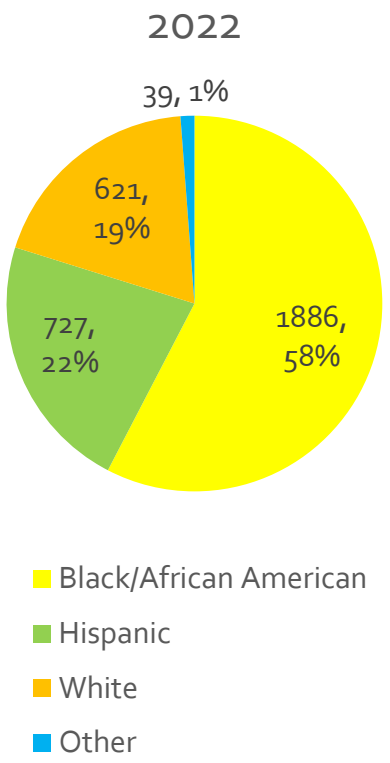


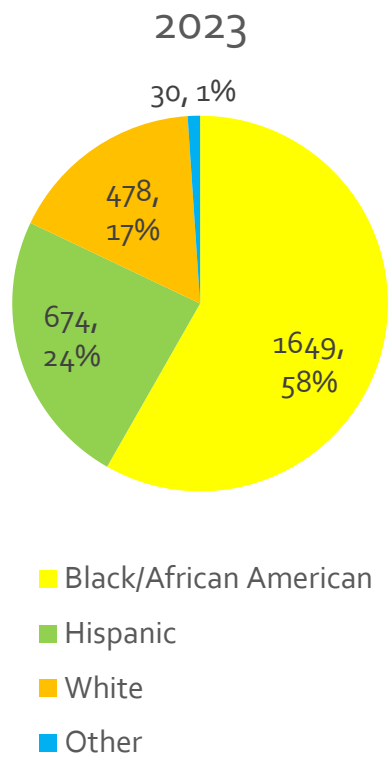
Palm Beach County
HIV Elimination Services

2023 RSR Client Summary Report Data cont.

Number of Clients by Race, Ethnicity and HIV Status

- Largest group continues to remain Black/African American

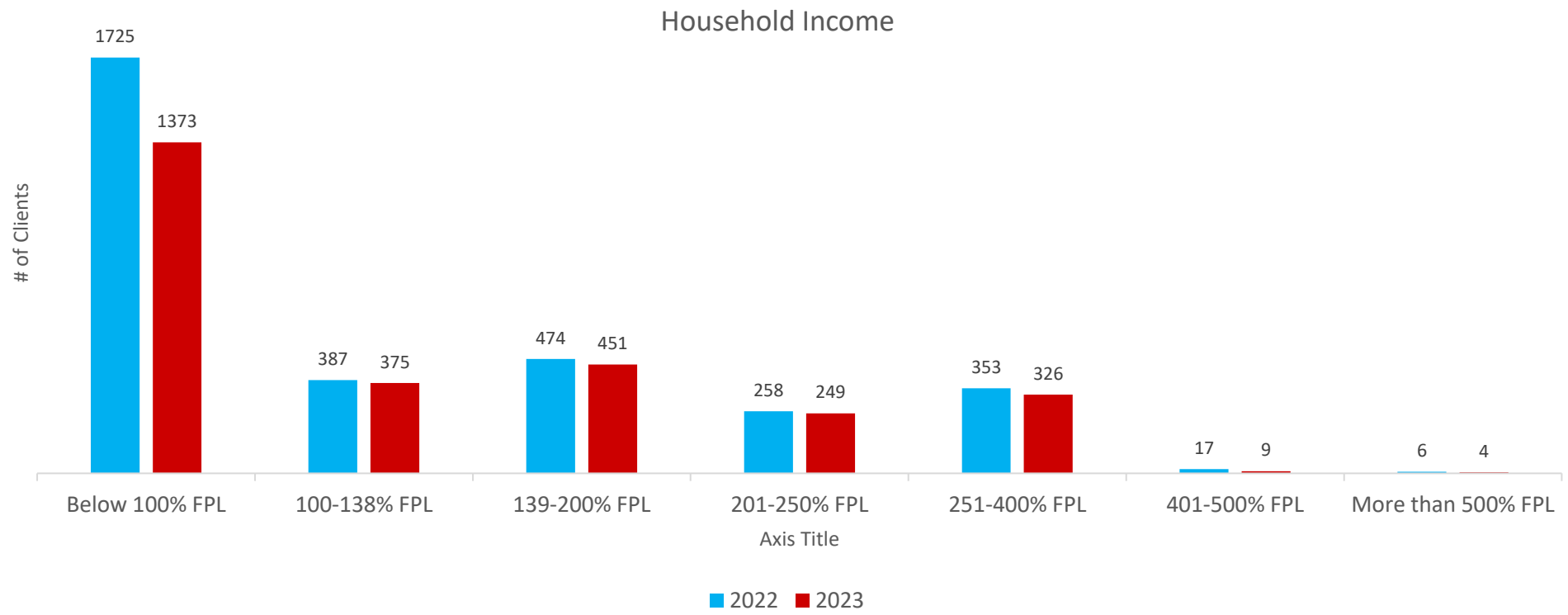




2023 RSR Client Summary Report Data cont.

Number of Clients by Household Income and HIV Status

- RSR collects the last documented FPL for clients.
- Largest group continues to remain Below 100% of the Federal Poverty Level (FPL)
- Number of clients below 100% FPL decreased by 352 between 2022 and 2023.

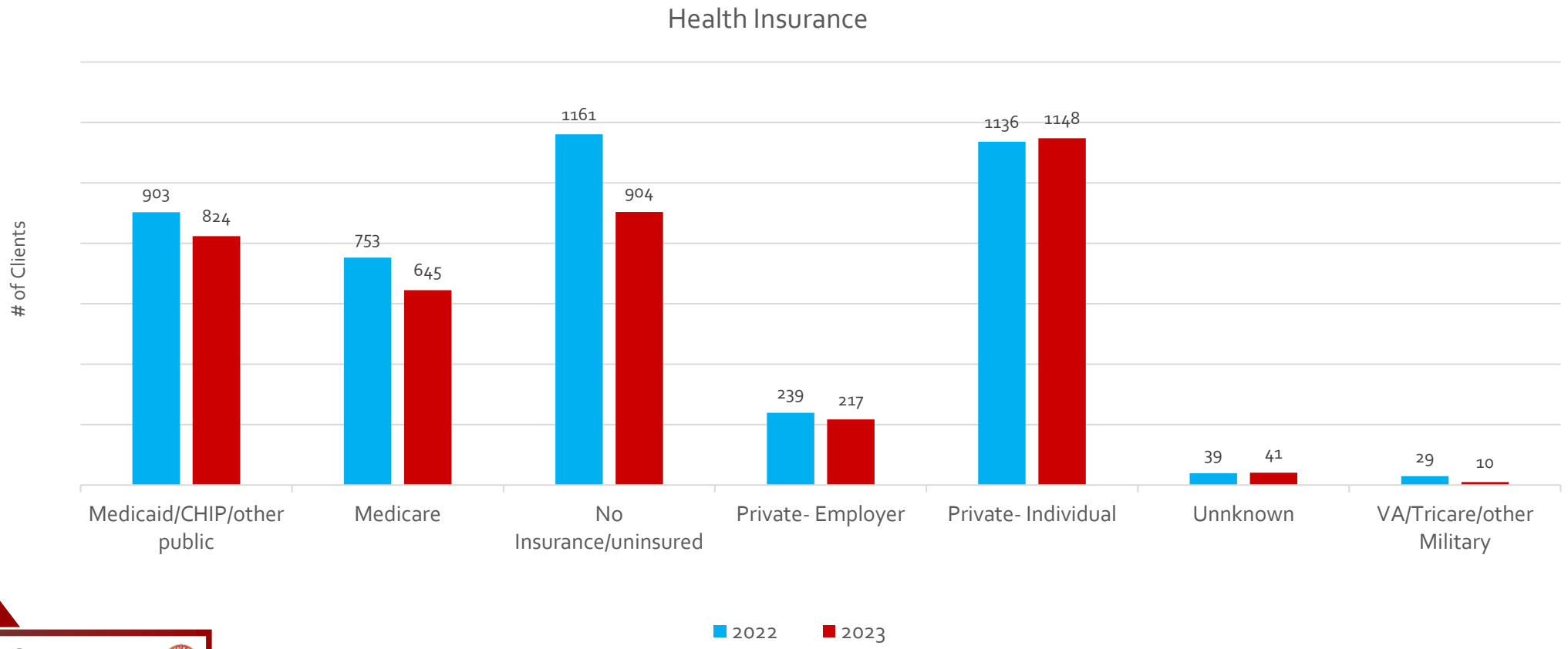


Palm Beach County
HIV Elimination Services

2023 RSR Client Summary Report Data cont.

Number of Clients by Medical Insurance and HIV Status

- **Largest group is no longer No Insurance/Uninsured but with Individual Insurance**
- Increase in Private coverage due to focus on ACA and Off-Market plan enrollments over the past 3 years. Closing the gap of Uninsured clients, there was a decrease of 257 reported uninsured between 2022 and 2023.

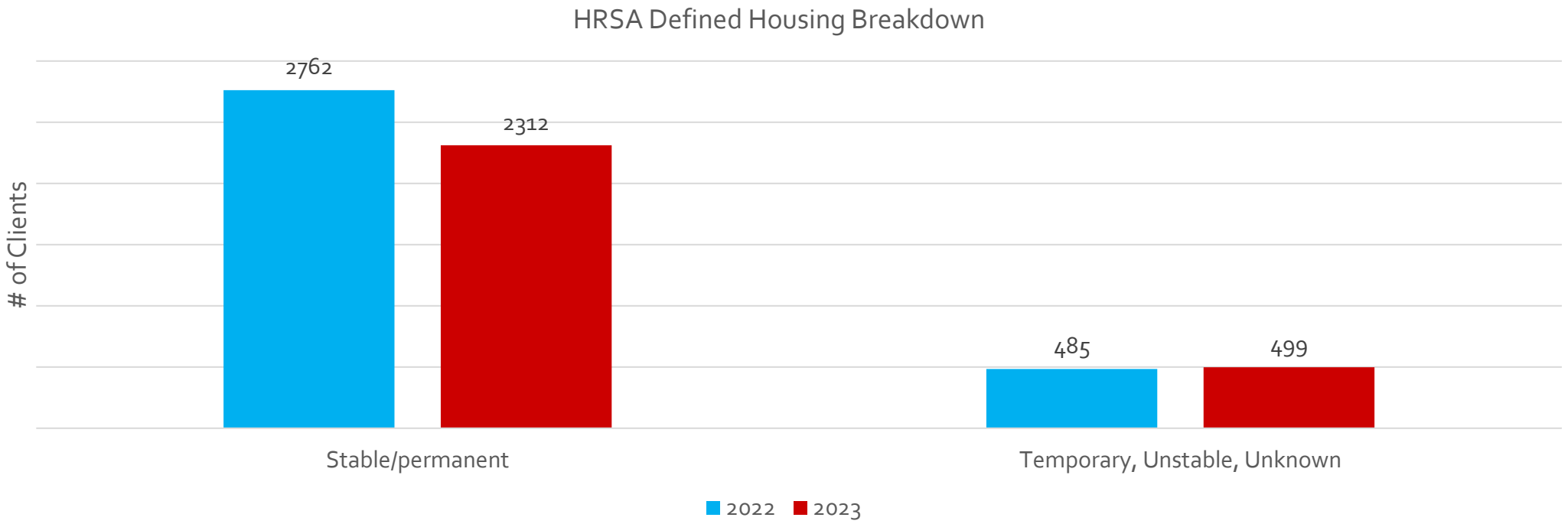


Palm Beach County
HIV Elimination Services

2023 RSR Client Summary Report Data cont.

Number of Clients by RSR Housing/Living Arrangement and HIV Status

- Largest group continues to remain Stable/permanent
- Temporary, Unstable, Unknown only Increased by 14 between 2022 and 2023.



Palm Beach County
HIV Elimination Services

2023 RSR Client Summary Report Data cont.

Number of Clients and Service Visits by Service Category

- The 3 top services utilized remains NMCM and MCM, with Food Bank taking over EIS for the 3rd spot between 2022 and 2023.
- Food Bank increased utilization between 2022 and 2023. An additional 1,733 vouchers were provided, to an additional 189 clients.
- NMCM had the largest increase in utilization, providing an additional 8,106 units of service between 2022 and 2023, to an additional 146 clients.
- Decreases remain evident in LPAP, EFA, and OAHS.

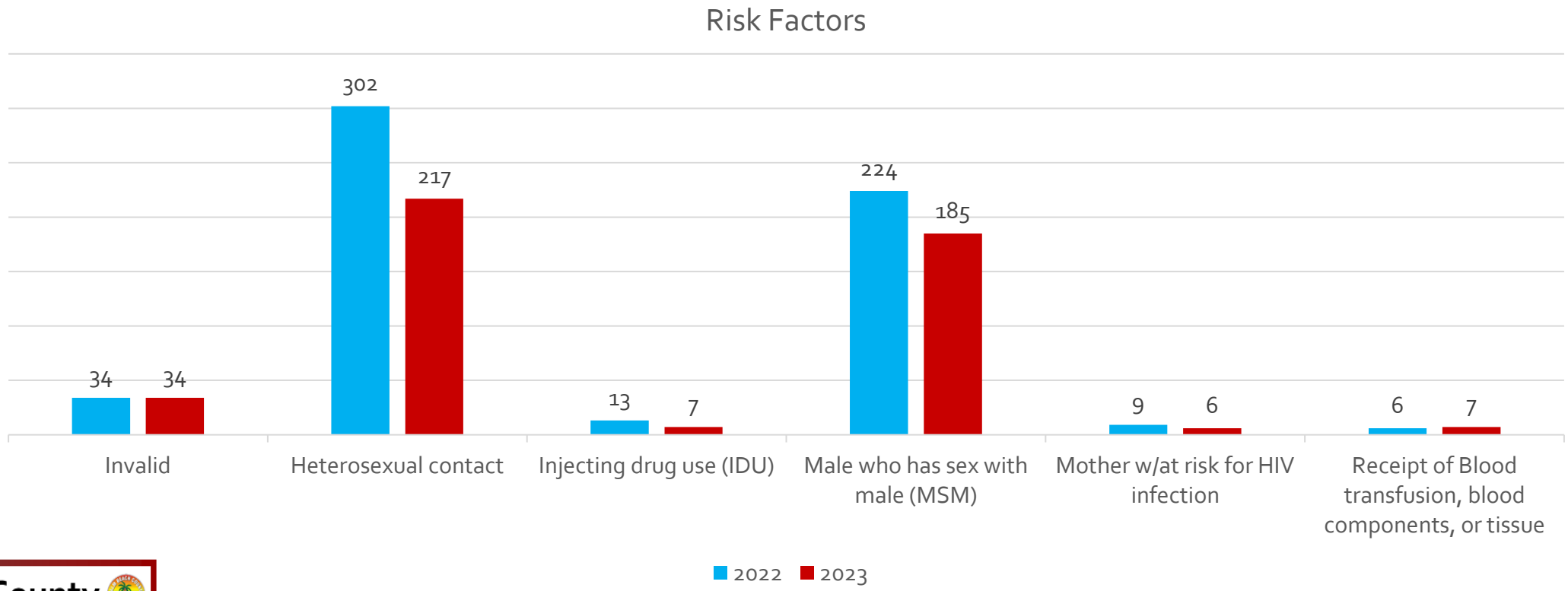
Service Category	# of Clients 2022/2023	# of Visits 2022/2023
Early Intervention Services	1189/726	5525/5927
Medical Case Management	1362/1756	19,490/20,190
Mental Health	74/80	369/667
Oral Health	525/28	1850/39
Outpatient Ambulatory Health Services	565/444	2539/1178
Local Pharmacy Assistance Program	55/24	164/87
Non-Medical Case Management	2299/2445	14,534/22,640
Emergency Financial Assistance (including EFA-Emergency Medication)	47/46	81/65
Food Bank (including Nutritional Supplements)	659/848	4402/6135
Health Insurance Program	516/472	2655/2524
Housing	24/28	164/125
Medical Transportation	273/389	1732/2753
Other Professional Services (Legal)	260/298	1666/2327
Psychosocial Support	725/619	3946/2700

2023 RSR Clinical Summary Report Data

The Clinical Summary reports on clients who have had a RW clinical service. Therefore, the numbers from the RSR Client Summary Report and the RSR Clinical Summary Report are different.

Number of Clients by Risk Factor

- Heterosexual and MSM contacts continue to remain the most common risk factors reported.
- Reminder that the RSR no longer collects data for Hemophilia/Coagulation Disorder (last reported in 2020 with 1 client).

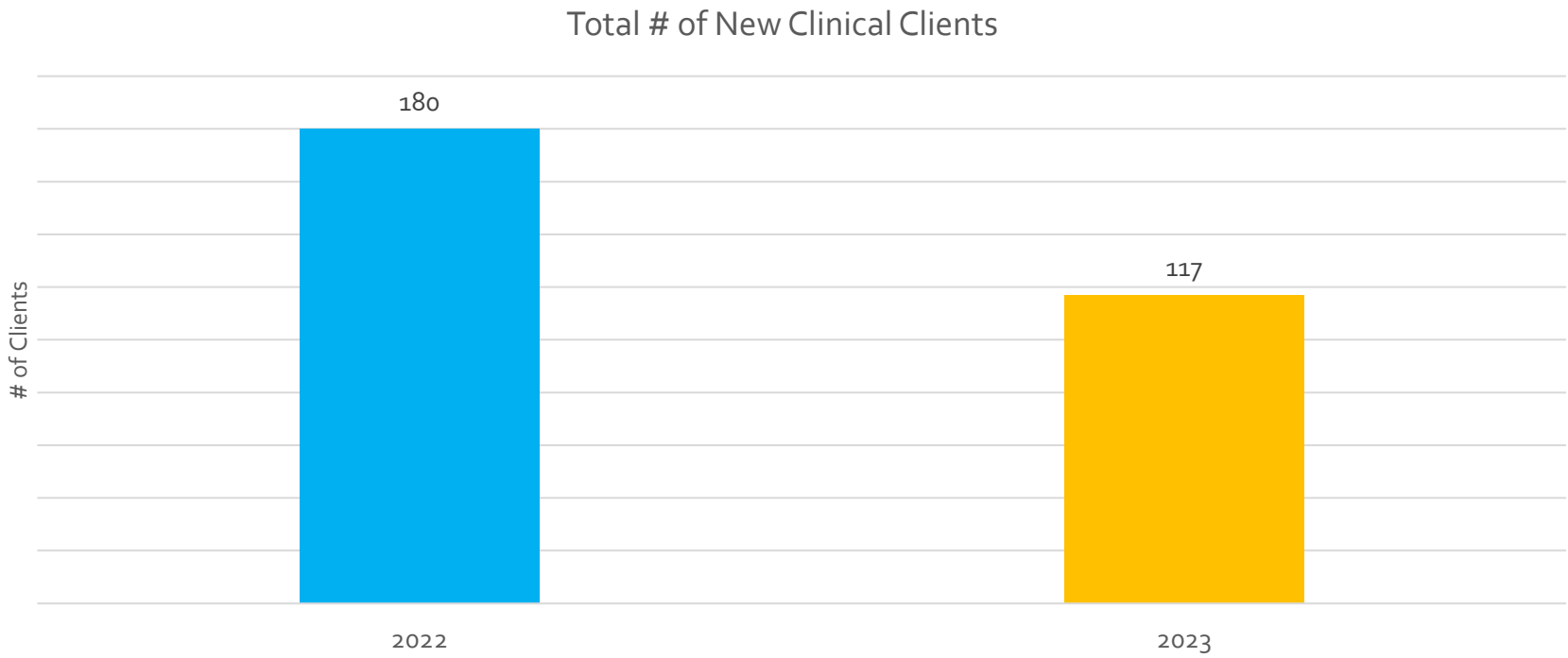


Palm Beach County
HIV Elimination Services

2023 RSR Clinical Summary Report Data cont.

Number of New Clinical Clients

•Decrease for the first time in a few years, with 63 less new clinical clients between 2022 and 2023. This could be a result in increased insurance coverage with clients not needing to receive RW medical services (services being paid under insurance coverage).

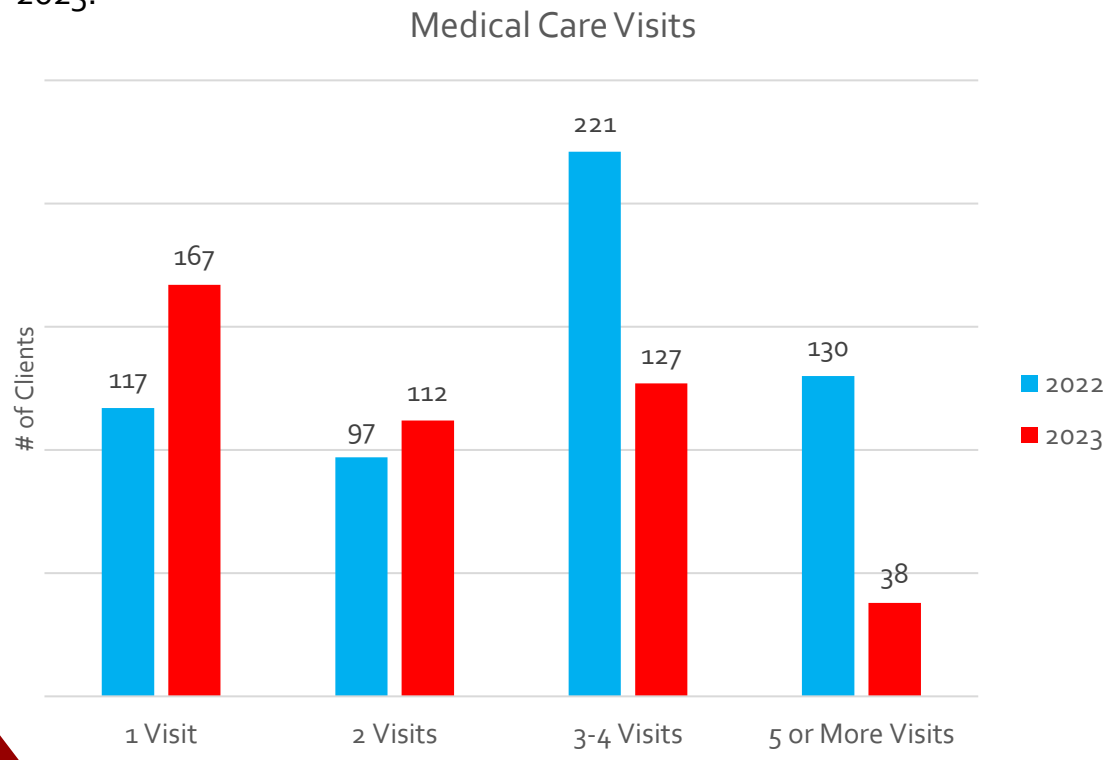


Palm Beach County
HIV Elimination Services

2023 RSR Clinical Summary Report Data cont.

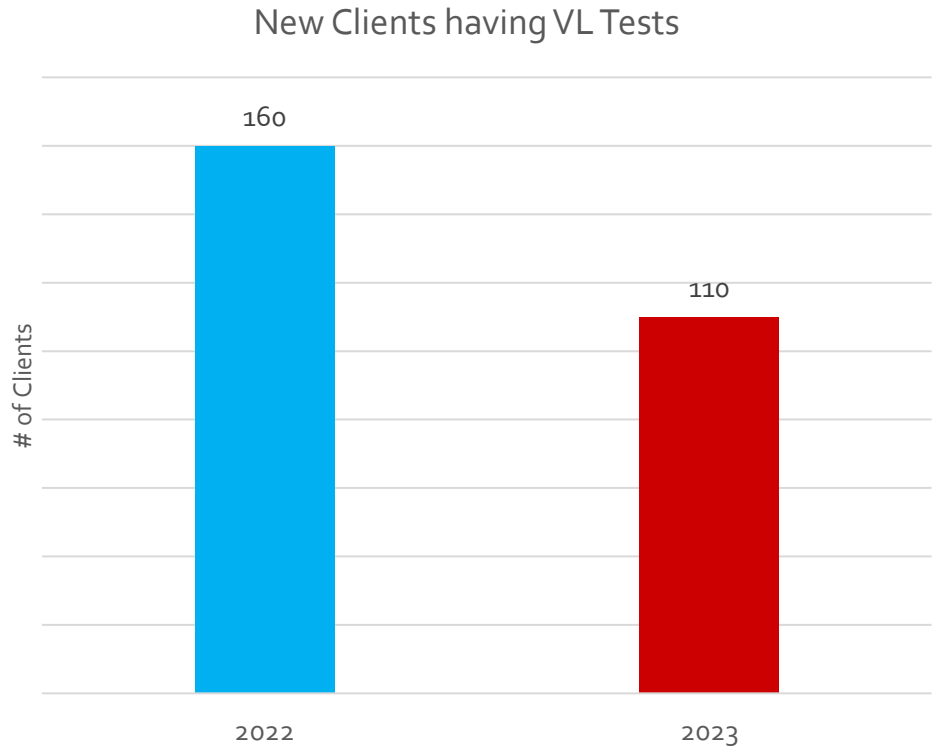
Number of Clients by Number of Medical Care Visits

- The most number of clients had reported 1 visit in 2023. While in the past, most clients reported 3-4 visits.
- There was an extreme drop in the number of clients reporting 3-4 visits (94 clients) and 5 or more visits (92 clients) between 2022 and 2023.



Number of New Clients Having Viral Load Test During Reporting Period

- Decrease of 50 New clients reporting a VL test.



Palm Beach County
HIV Elimination Services

2023 RSR Total Clients Served by Zip Code Summary

- The report resulted in a total of 2,833 clients served, within 55 zip codes in Palm Beach County. This compares to previous year of 3,271 clients within 62 zip codes.
- Zip codes are determined by the client profile address information entered into the database.
- Charted to the right are the 5 zip codes with the highest number of clients served, compared to the previous year.
- There were 15 zip codes in Palm Beach County that resulted in 10 or less clients served, compared to 21 last year.

2022 Zip Code	2022 Clients Served
33404	284
33407	264
33430 & 33460	192
33435	185
33401	166

2023 Zip Code	2023 Clients Served
33404	242
33407	226
33460	166
33430	162
33401	159
33435 & 33461	153

2023 RSR Summary Items

- Reported a decrease in the total number of unduplicated clients by 401 between 2022 and 2023. This will be reflected throughout the data, resulting in all numbers being reduced.
- Largest group of clients is no longer *No Insurance/Uninsured* but with *Individual Insurance*. There was an increase in Private coverage due to a focus on ACA and Off-Market plan enrollments over the past 3 years. Closing the gap of Uninsured clients, there was a decrease of 257 reported uninsured between 2022 and 2023.
- Food Bank increased utilization between 2022 and 2023, with an additional 1,733 vouchers provided to an additional 189 clients.
- NMCM had the largest increase in utilization, providing an additional 8,106 units of service to an additional 146 clients between 2022 and 2023.
- Decreases in services provided remain evident in LPAP, EFA, and OAHS.
- Decrease in New clinical clients reported for the first time in a few years, with 63 less new clinical clients between 2022 and 2023. This could be a result in increased insurance coverage with clients not needing to receive RW medical services (services being paid under insurance coverage).
- The largest number of Clinical report clients had reported 1 medical care visit in 2023. While in the past, most clients reported 3-4 visits in the reporting period. There was an extreme drop in the number of clients reporting 3-4 visits (94 clients) and 5 or more visits (92 clients) between 2022 and 2023.
- Zip code reporting, with the highest number of clients served in our program, resulted in very similar top 5 areas for the past several years. In 2023, for the first time there was an additional zip code that was included in the top areas- 33461 Lake Worth (tie with 33435 Boynton Beach, reporting 153 clients in each area).

Questions?

Palm Beach County
HIV Elimination Services

Palm Beach County Ryan White & MAI Service Utilization & Cost Analysis

Jeffrey J. Lesanti Jr., MBA
Financial Analyst II
PBC Ryan White HIV/AIDS Program
jlesanti@pbcgov.org
561-355-1945

Palm Beach County
HIV Elimination Services

GY 23 Grant Award Overview

Award Information	Current GY	Carryover	Total
Part A Formula	$4,392,430	$320,825	$4,713,255
MAI	$612,398	$99,867	$712,265
Part A Supplemental	$2,556,251	-	$2,556,251
Total	$7,561,079	$378,054	$7,981,771

GY23
Grant Expenditure Overview

Expenditure Categories	Amount	Percent
Core Medical Services	$5,081,457	64%
Support Services	$1,632,174	21%
Administration	$1,228,219	15%
Total	$7,941,850	99.9%

GY23 Award & Expenditure Summary

Award Category	Award	Expenditure	Balance
Part A	$7,269,506	$7,269,506	$0
MAI	$712,265	$672,343	$39,922
Total	$7,981,771	$7,941,850	$39,922

GY23 Core Medical Services Expenditures by Service Category

Core Medical Service Category	Amount	Percent
AIDS Pharmaceutical Assistance (LPAP)	$1,563	0.02%
Early Intervention Services-Part A	$577,120	8.60%
Early Intervention Services-MAI	$13,414	3.30%
Health Insurance Premium & Cost Sharing Assistance	$2,169,675	32.32%
Laboratory Diagnostic Testing	$103,474	1.54%

GY23 Core Medical Services Expenditures by Service Category…cont.

Core Medical Service Category	Amount	Percent
Medical Case Management	$954,119	14.21%
Medical Case Management - MAI	$178,784	2.66%
Mental Health Services	$127,588	1.90%
Oral Health Care	$324,017	4.83%
Outpatient/Ambulatory Medical Care	$149,626	2.23%
Specialty Outpatient Medical Care	$274,105	4.08%

GY23 Support Services Expenditures by Service Category

Support Service Category	Amount	Percent
EFA-Prior Authorizations	$3,707	0.06%
Emergency Financial Assistance	$21,897	0.33%
Emergency Housing Services	$213,374	3.18%
Food Bank/Home Delivered Meals	$347,882	5.18%
Food Bank/Nutritional Supplements	$829	0.01%
Legal Services	$280,000	4.17%

GY23 Support Services Expenditures by Service Category…cont.

Support Service Category	Amount	Percent
Medical Transportation	$78,683	1.17%
Non-Medical Case Management	$502,232	7.48%
Non-Medical Case Management-MAI	$68,738	1.02%
Psychosocial Support Services-MAI	$114,832	1.71%

Service Category Ordered by Expenditure

Health Insurance	32.32%
Medical Case Management	14.21%
Early Intervention Services	8.60%
Non-Medical Case Management	7.48%
Food Bank/Home Delivered Meals	5.18%
Oral Health Care	4.83%
Legal Services	4.17%
Specialty Outpatient Medical Care	4.08%
Early Intervention Services-MAI	3.30%
Emergency Housing Services	*3.18%*
All other service categories	12.65%

Service Category cost per unit- Part A

Core Medical Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
AIDS Pharmaceutical Assistance	$1,562.83	19	$82.25	70	$22.33
Early Intervention Services	$577,119.89	478	$1,207.36	9,134	$63.18
Early Intervention Services-MAI	$226,119.84	353	$640.57	5,830	$38.79
Health Insurance	$2,169,675.02	434	$4,999.25	2,422	$895.82
Laboratory Diagnostic Testing	$103,473.67	314	$329.53	5,540	$18.68
Medical Case Management	$953,760.84	1,307	$729.73	53,260	$17.91

Service Category cost per unit- Part A cont.

Core Medical Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Mental Health Services	$127,588.00	73	$1,747.78	590	$216.25
Oral Health Care	$324,017.13	31	$10,452.17	52	$6,231.10
Outpatient/Ambulatory Medical Care	$149,626.00	380	$393.75	1,522	$98.31
Specialty Outpatient Medical Care	$274,104.72	142	$1,930.31	582	$470.97

Service Category cost per unit- Part A cont.

Support Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
EFA-Prior Authorizations	$3,706.93	15	$247.13	49	$75.65
Emergency Financial Assistance	$21,897.00	21	$1,042.71	25	$875.88
Emergency Housing Services	$213,373.94	29	$7,357.72	2,185	$97.65
Food Bank/Home Delivered Meals	$347,882.40	832	$418.13	13,737	$25.32
Food Bank/Nutritional Supplements	$829.26	4	207.32	12	69.11

Service Category cost per unit- Part A cont.

Support Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Legal Services	$280,000.00	299	$936.45	2,566	$109.12
Medical Transportation	$78,682.56	381	$206.52	4,683	$16.80
Non-Medical Case Management	$502,231.99	1886	$266.29	57,206	$8.78

Service Category cost per unit - MAI

Core Medical Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Medical Case Management - MAI	$178,895.76	453	$394.91	11,213	$15.95
Early Intervention Services-MAI	$226,119.84	353	$640.57	5,830	$38.79
Non-Medical Case Management-MAI	$68,738.00	583	$117.90	8,325	$8.26
Psychosocial Support Services-MAI	$114,832.00	1091	$105.25	13,144	$8.74

Service Category Ordered by Persons Served

Category	Persons Served
Non-Medical Case Management	1,886
Medical Case Management	1,307
Psychosocial Support Services-MAI	1091
Food Bank/Home Delivered Meals	832
Non-Medical Case Management-MAI	583
Early Intervention Services	478
Medical Case Management - MAI	453
Health Insurance	434
Medical Transportation	381
Outpatient/Ambulatory Medical Care	380
Early Intervention Services-MAI	353
Laboratory Diagnostic Testing	314
Legal Services	299
Specialty Outpatient Medical Care	142
Mental Health Services	73
Oral Health Care	31
Emergency Housing Services	29
Emergency Financial Assistance	21
AIDS Pharmaceutical Assistance	19
EFA-Prior Authorizations	15
Food Bank/Nutritional Supplements	4

Service Category Ordered by Cost/Person – Top 10

#	Service Category	Cost Per Perso	Annual Expense
1	Emergency Housing Services	$7,358	$213,374
2	Health Insurance	$4,999	$2,169,675
3	Specialty Outpatient Medical Care	$1,930	$274,105
4	Mental Health Services	$1,748	$127,588
5	Early Intervention Services	$1,207	$577,120
6	Oral Health Care	$1,200	$324,017
7	Emergency Financial Assistance	$1,043	$21,897
8	Legal Services	$936	$280,000
9	Medical Case Management	$730	$953,761
10	Early Intervention Services-MAI	$641	$226,120

Service Category Ordered by Cost/Unit – Top Ten

#	Service Category	Cost Per Unit	Annual Expense
1	Health Insurance	$896	$2,169,675
2	Emergency Financial Assistance	$876	$21,897
3	Specialty Outpatient Medical Care	$471	$274,105
4	Oral Health Care	$333	$324,017
5	Mental Health Services	$216	$127,588
6	Legal Services	$109	$280,000
7	Outpatient/Ambulatory Medical Care	$98	$149,626
8	Emergency Housing Services	$98	$213,374
9	EFA-Prior Authorizations	$76	$3,707
10	Food Bank/Nutritional Supplements	$69	$829

3 Year Trends-Cost/Person by Service Category Summary

Core Medical Service Category	3 Year Trend-Cost/Person
AIDS Pharmaceutical Assistance (LPAP)	71%
Early Intervention Services	344%
Health Insurance	111%
Home and Community-based Health Services	No Longer Funded
Laboratory Diagnostic Testing	86%
Medical Case Management	101%

3 Year Trends-Cost/Person by Service Category Summary…cont.

Core Medical Service Category	3 Year Trend-Cost/Person
Medical Nutrition Therapy	No Longer Funded
Mental Health Services	143%
Oral Health Care	240%
Outpatient/Ambulatory Health Services	36%
Specialty Outpatient Medical Care	129%

3 Year Trends-Cost/Person by Service Category Summary

Support Service Category	3 Year Trend-Cost/Person
Emergency Financial Assistance	137%
Emergency Financial Assistance-Prior Auth.	421%
Food Bank/Home Delivered Meals	190%
Food Bank-Nutritional Supplements	43%
Housing	152% -No longer funded GY24.

3 Year Trends-Cost/Person by Service Category Summary…cont.

Support Service Category	3 Year Trend-Cost/Person
Legal Services	98%
Medical Transportation	84%
Non-Medical Case Management	174%
Medical Case Management	101%

1 Year Trend-Cost/Person by Service Category Ordered by Percent Increase

Category	Cost Per Client	% Increase	Largest
EFA-Prior Authorizations	$247	421%	*
Early Intervention Services	$1,207	344%	*
Oral Health Care	$1,200	240%	*
Food Bank/Home Delivered Meals	$418	190%	*
Non-Medical Case Management	$266	174%	
Psychosocial Support Services-MAI	$287	163%	
Emergency Housing Services	$7,358	152%	*
Mental Health Services	$1,748	143%	
Emergency Financial Assistance	$1,043	137%	
Specialty Outpatient Medical Care	$1,930	129%	
Medical Case Management - MAI	$395	126%	
Health Insurance	$4,999	111%	*
Medical Case Management	$730	101%	
Legal Services	$936	98%	

Green = Salary-funded Blue = Direct assistance to clients *Largest increase by $$$

Summary

- Health Insurance is our largest expense. The cost of HI rose by 11% over 3 years.
- Housing is no longer funded.
- Non Medical case management cost-per-person has raised faster than Medical Case Management.
- Early Intervention Services has the highest three year cost escalator. This is due to not capturing all clients served in PE.

Questions?

Palm Beach County
HIV Elimination Services

DAY 1 – Lunch

Palm Beach County
HIV Elimination Services

Food Insecurity

Special Studies Assessment

Preliminary Results

Genève Simeus, MPH

Ryan White
HIV/AIDS Program

TABLE OF CONTENTS

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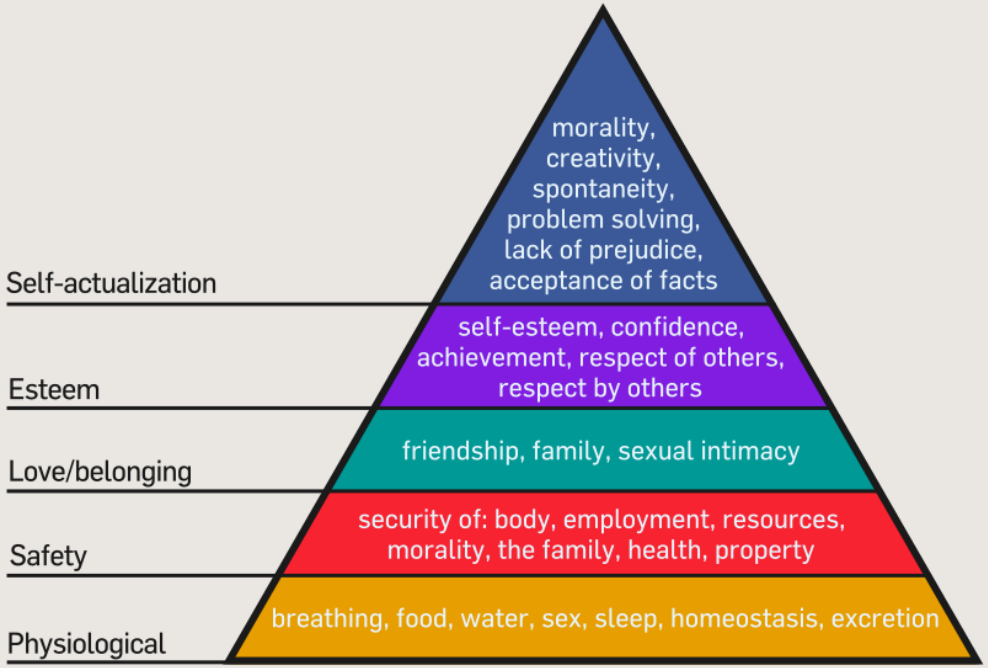
OBJECTIVES

Objective

- To better understand any gaps or barriers for the food bank/home delivered meals and nutritional supplements during CY 23-24
- Determine if there are any barriers that impact HIV medication adherence and health



2

Methodology

Methodology

Research

Any existing food insecurity survey for PWH??

Filter, Edit and Combine

Planning Committee utilized food insecurity index questions from reputable organizations such as USDA. 24 question survey created.

Community Involvement

Presenting opportunities for PWH involvement at Lunch and Learn Sessions

Review and Finalize

Sample plan reviewed, survey translated, and survey pilot tested before start of study

Methodology

Survey Incentives

Once finalized by Planning committee, the fiscal department ordered gift cards of $25 value for survey incentives. Western clients were given Winn Dixie cards and Non-Western clients given Publix cards

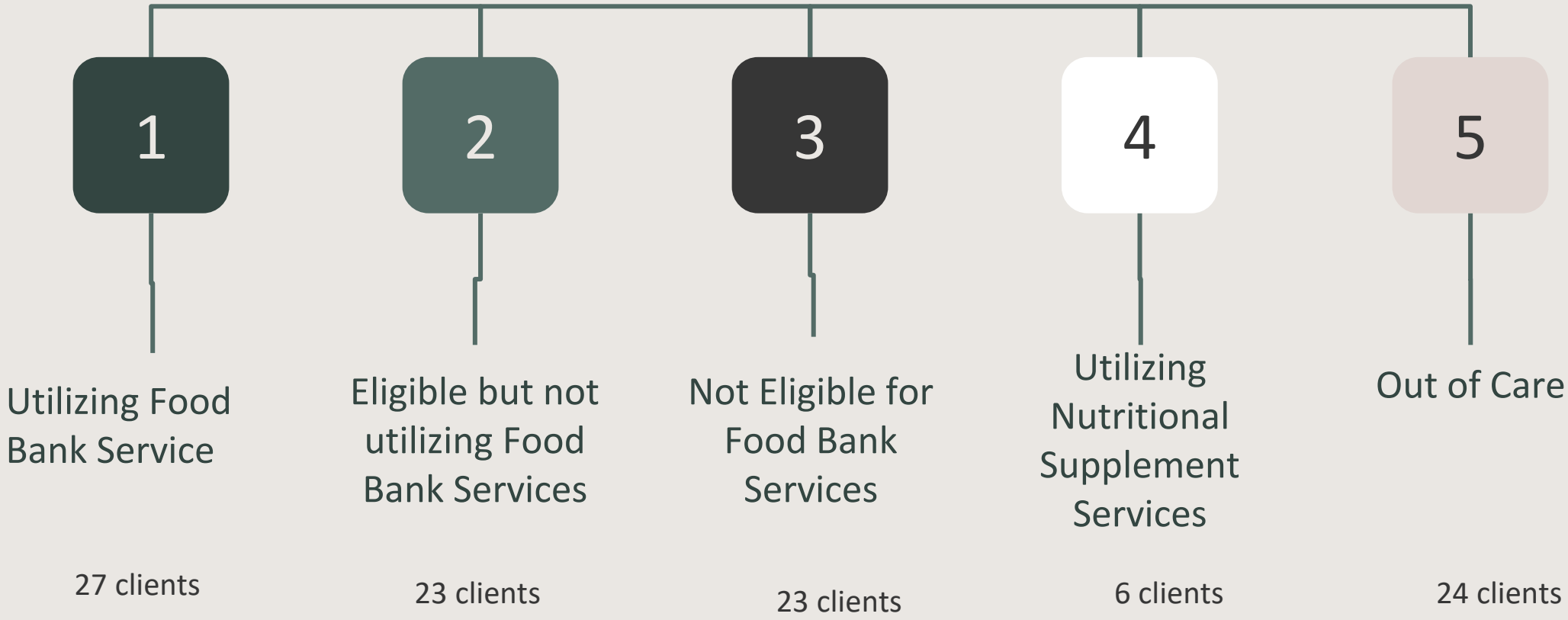
Survey Assistant Temp Staff

Survey Assistant Temp Staff position advertisement, recruitment and training

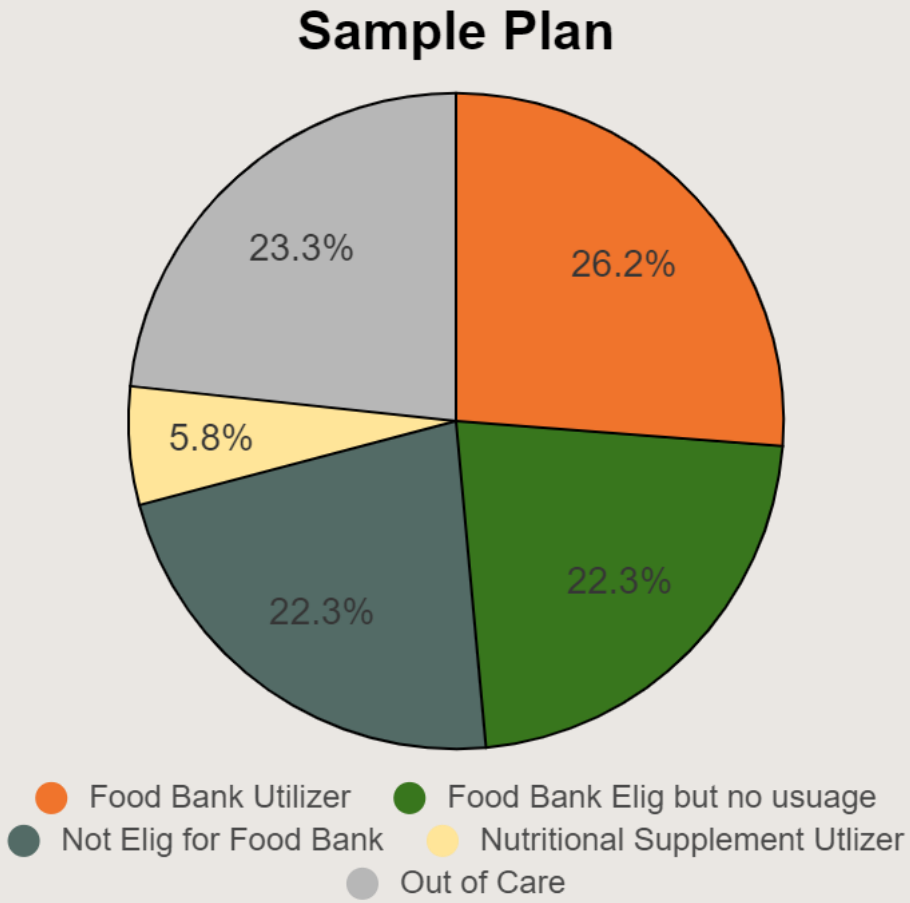
Data Collection

Survey administration and special studies data collection began. Working with CORE team for Out of Care clients

Sample Plan



*Client considered not eligible because they surpassed the current FPL



103 total clients

Stratification

Food Bank Agency

- Agency A
- Agency B

Geography

- Western Community
- Non-Western Community

Race and Ethnicity

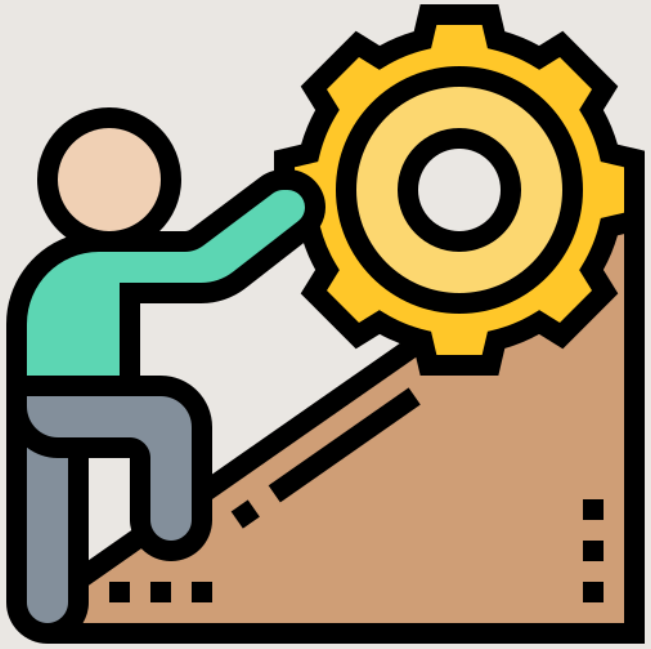
- Black/African American
- Haitian
- White/Caucasian
- Hispanic/Latinx
- Asian

3

Results

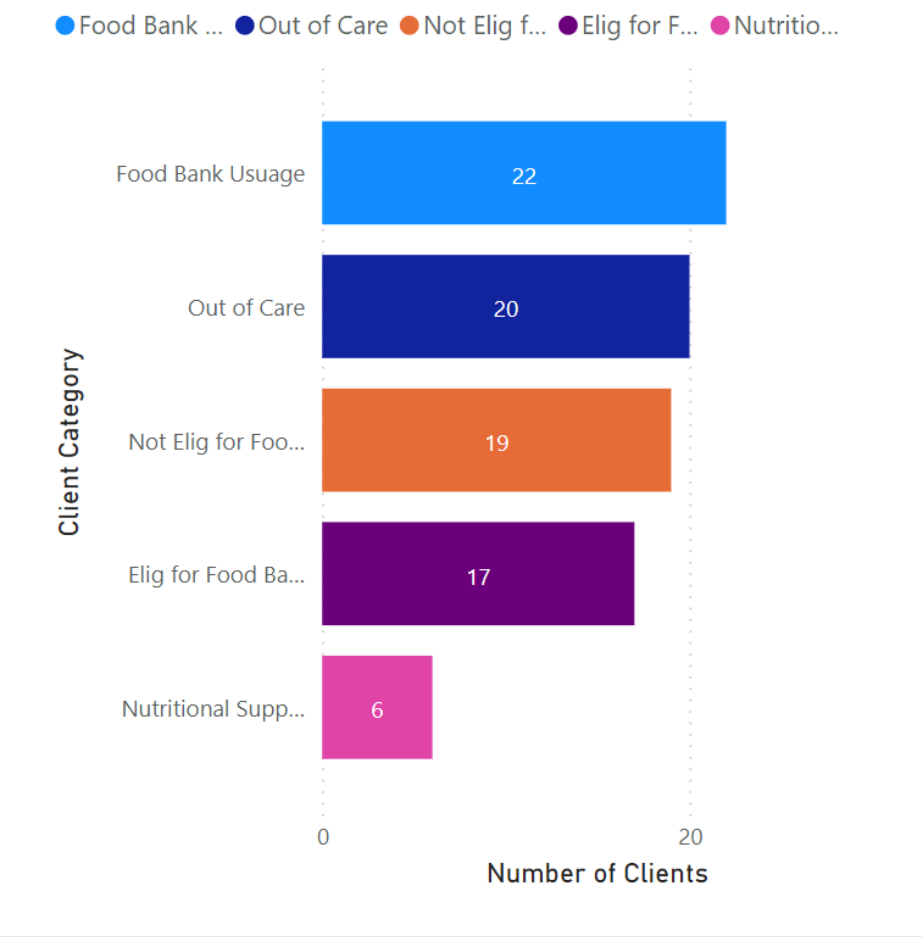
Initial Limitations

- Food Insecurity Special Studies is still being conducted
- 84/103 completed surveys as of 7/8/24
  - 81.5% completion rate
  - 38 English
  - 45 Haitian Creole
  - 1 Spanish (Out of Care)
- Challenges with hiring a 2nd English/Spanish Survey Assistant



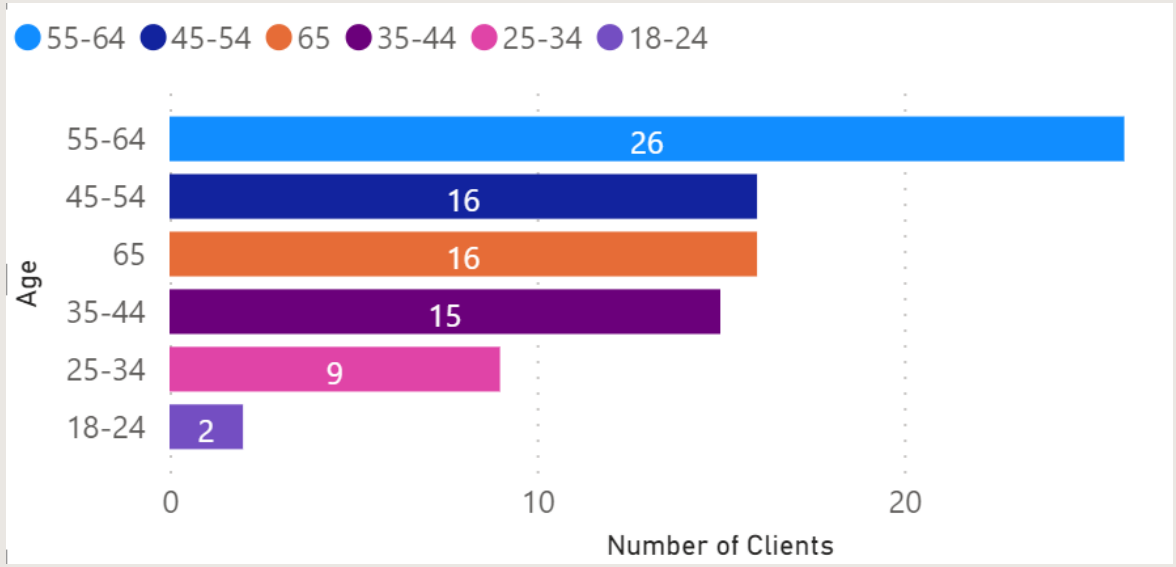
Demographic Section

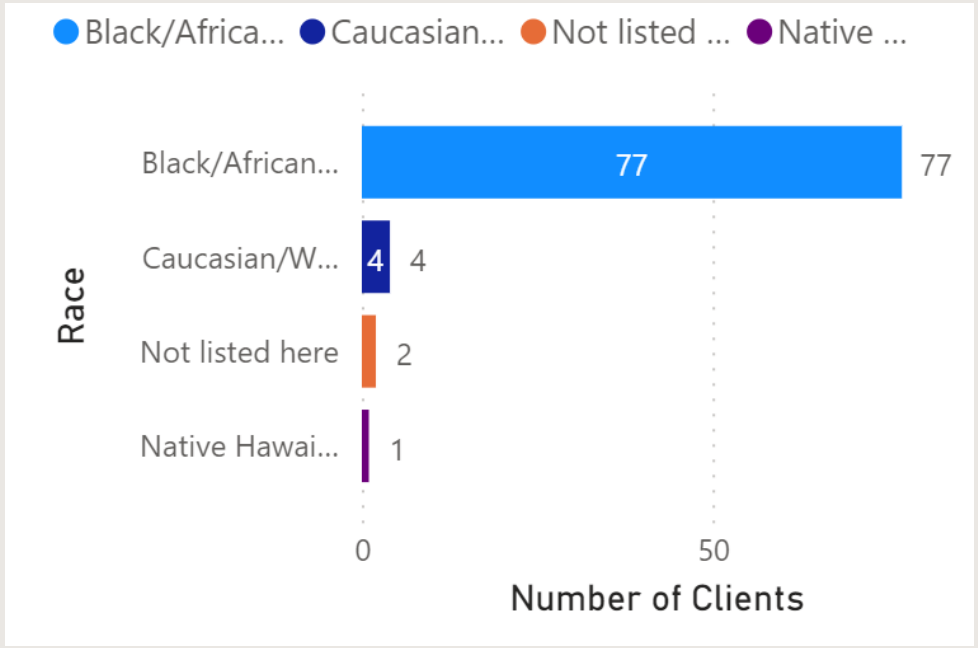
Client Service Category



- **26.2%** (22/84) of clients are **Food Bank Utilizer**
- **23.8%** (20/84) of clients are **Out of Care**
- **22.6%** (19/84) of clients are **Not Elig for Food Bank**
- **20.2%**(17/84) of clients are **Elig for Food Bank**
- **7.1%** (6/84) of clients are **Nutritional Supplement**

Age and Race





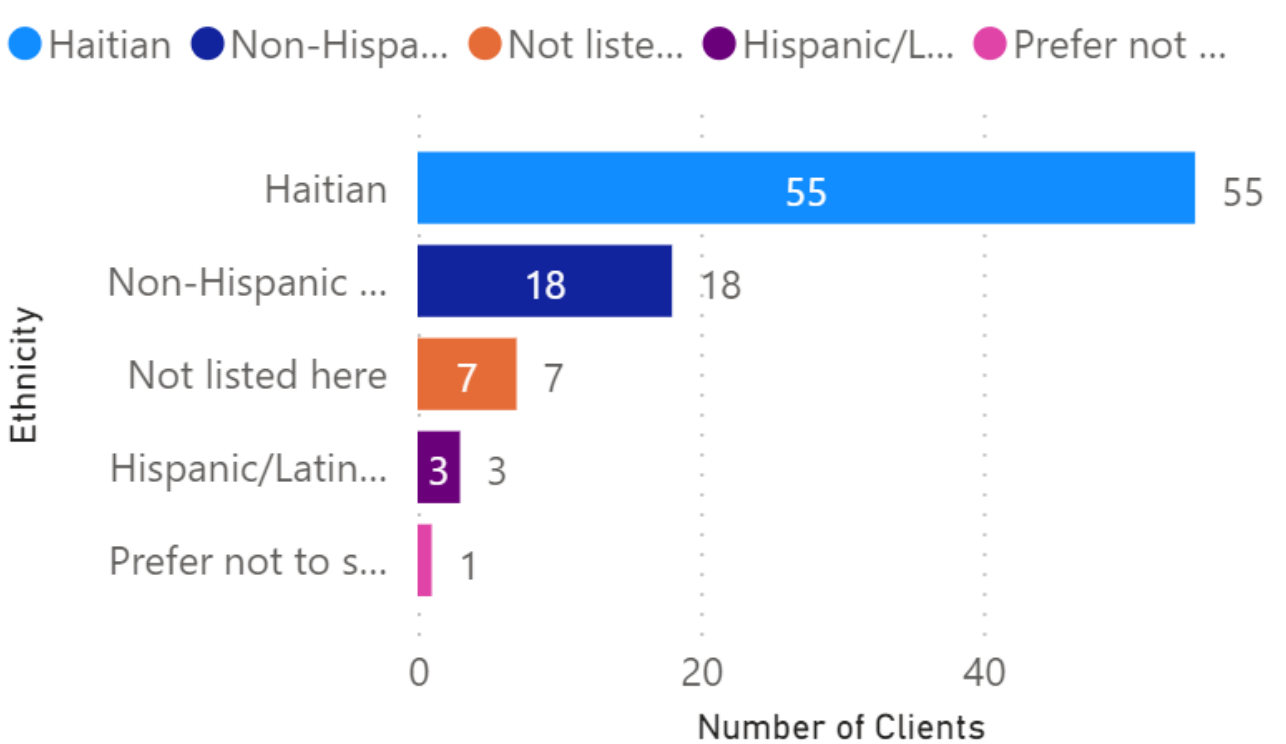
Age:

- **31.0%** (26/84) of clients are **55-64**
- **19.0%** (16/84) of clients are **45-54**
- **19.0%** (16/84) of clients are **65+**
- **17.9%** (15/84) of clients are **35-44**
- **10.8%** (9/84) of clients are **25-34**
- **2.4%** (2/84) of clients are **18-24**

Race:

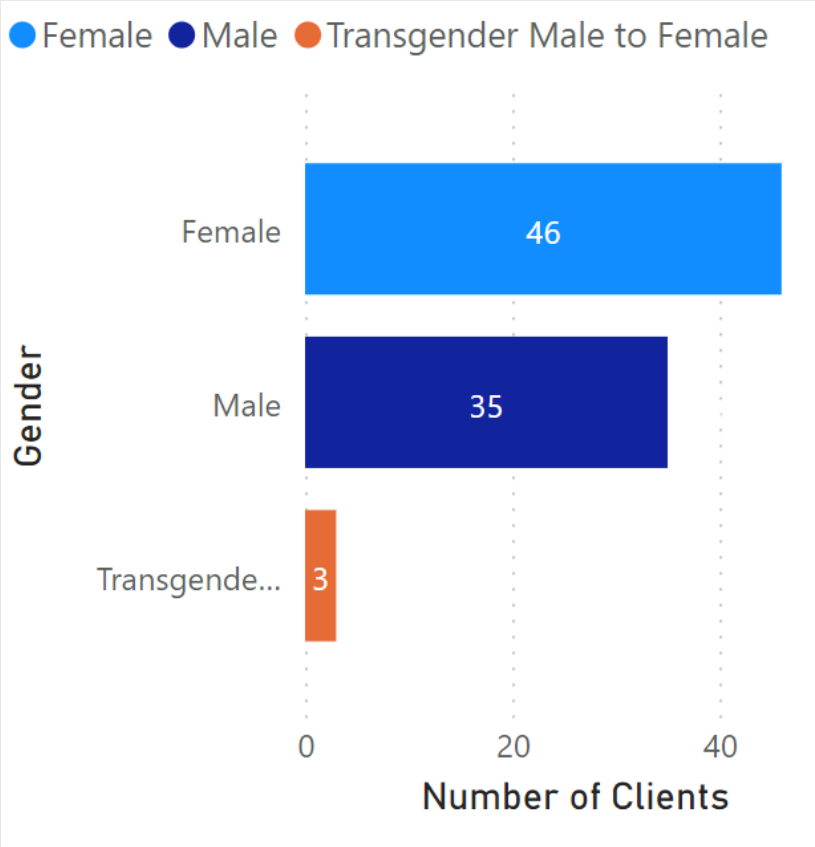
- **91.7%** (77/84) of clients are **Black/African American**
- **4.8%** (4/84) of clients are **Caucasian**
- **2.4%** (2/84) of clients race was **no listed here**
- **1.2%** (1/84) of clients are **Native American**

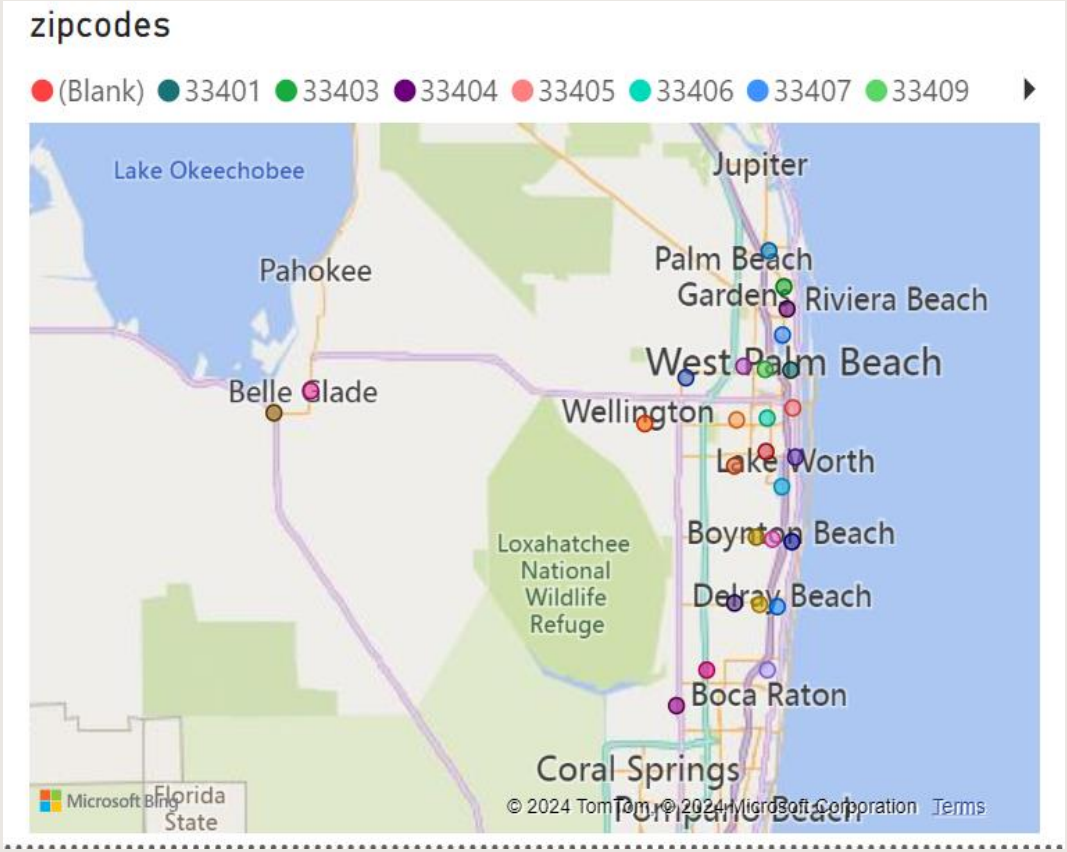
Ethnicity



- **65.5%** (55/84) of clients are of **Haitian ethnicity**
- **21.4%** (18/84) of clients are of **Non-Hispanic and Non Haitian ethnicity**
- **8.3%** (7/84) of clients **ethnicity is not listed here**
- **3.6%** (3/84) of clients are of **Hispanic/Latinx ethnicity**
- **1.2%** (1/84) of clients **preferred not to say their ethnicity**

Gender and Zipcode





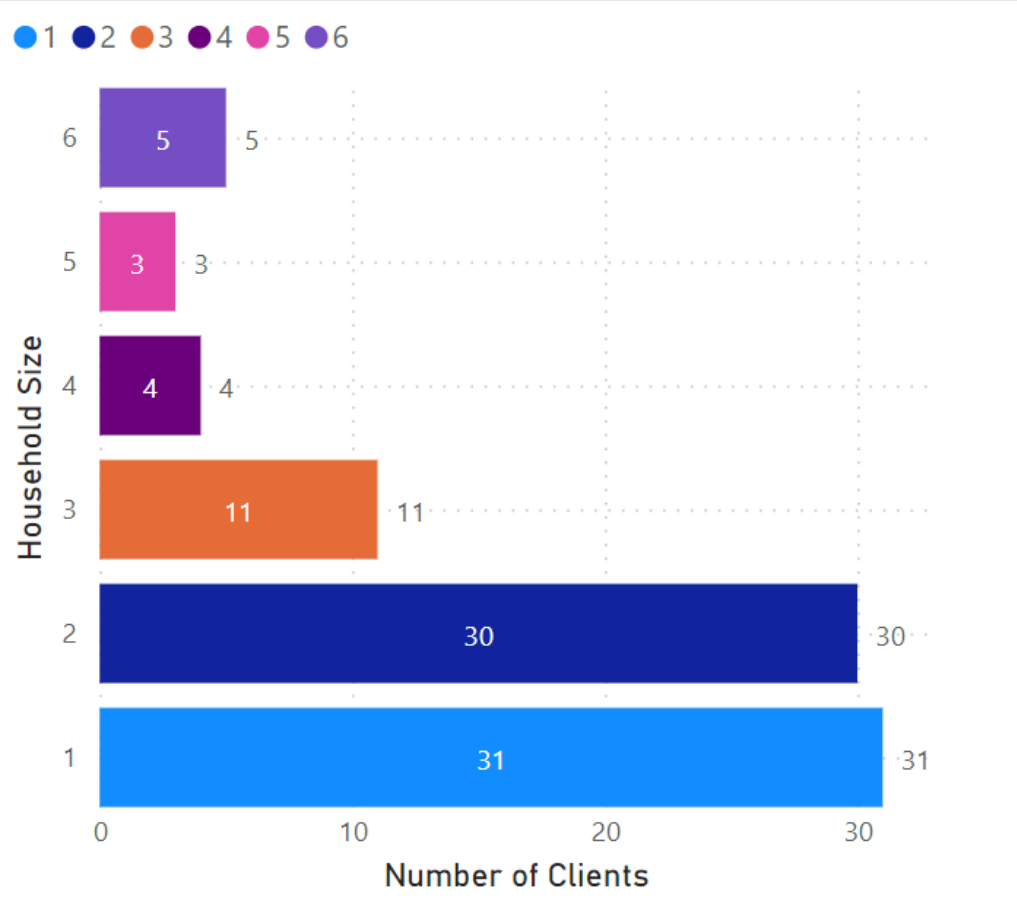
Gender:

- **54.8%** (46/84) of clients are **Female**
- **41.7%** (35/84) of clients are **Male**
- **3.6%** (3/84) of clients are **Transgender Male to Female**

Clients reside in:

11.9% (10/84) in **33444** area code **(Delray)**
8.3% (7/84) in **33435** area code **(Boynton)**
8.3% (7/84) in **33463** area code **(Greenacres)**
7.1% (6/84) **33430 area code (Belle Glade)**

Household Size



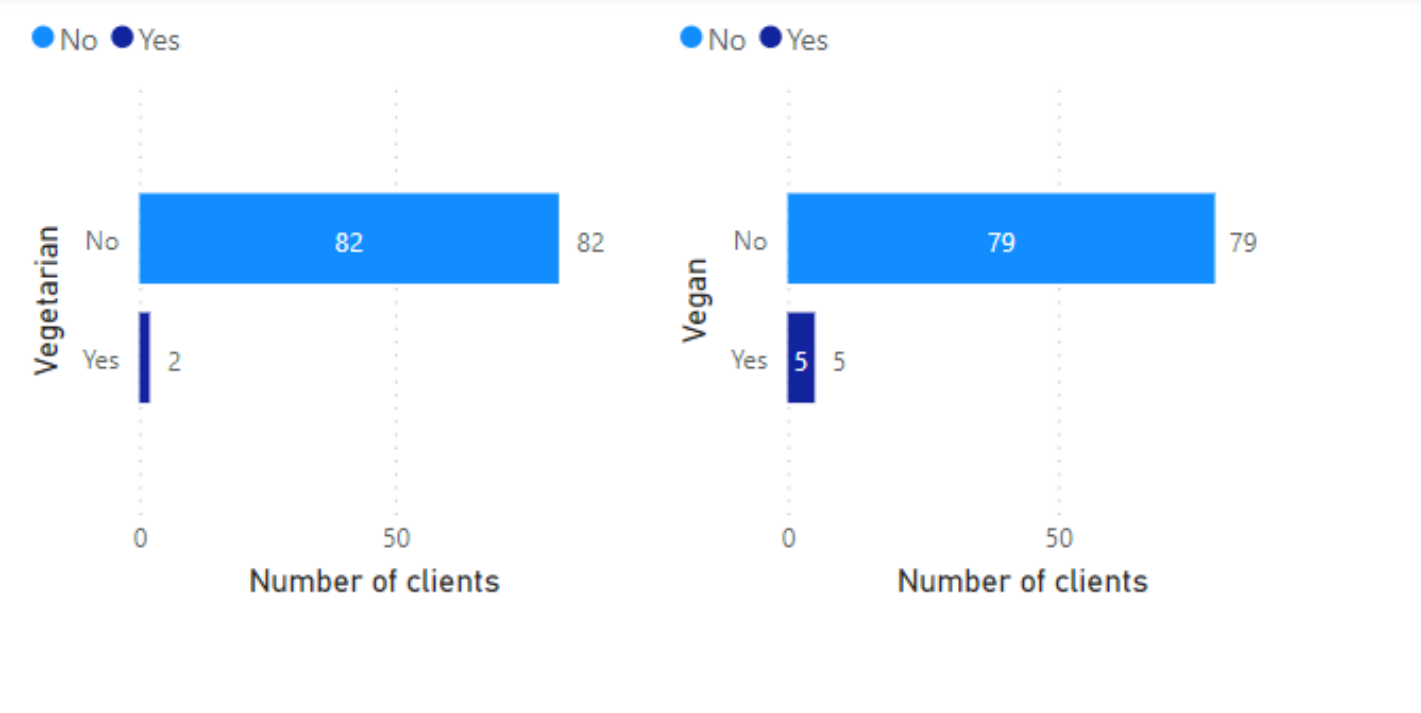
- **36.9%** (31/84) of clients have a **household size of 1**
- **35.7%** (30/84) of clients have a **household size of 2**
- **13.1%** (11/84) of clients have a **household size of 3**

Monthly Gross Income

monthly_income	Count of monthly_income
0	59
291	1
300	1
400	1
500	2
900	6
1000	2
1095	1
1180	1
1197	1
1500	2
1600	1
1700	1
2300	1
3000	2
10000	1
50000	1
Total	**84**

- **70.2% (59/84)** of clients did not want to report their monthly income despite the survey assistant explaining that their response will not impact their eligibility for services
- Of the **35.9% (23/84)** of clients who did provide an income, the **average was $1,194** minus the 2 outliers
- **2.4% (2/84)** of clients may not have complete understand the question asked for monthly income

Vegetarian and Vegan



- **97.6%** (82/84) of clients are **not vegetarian**
- **2.4%** (2/84) of clients are **vegetarian**
- **94.0%** (79/84)of clients are **not vegan**
- **6.0%** (5/84) of clients are **vegan**

Demographic Highlights

- **31.0%** (26/84)of respondents are between the ages of 55-64
- **91.7%** (77/84) of respondents are Black/African American
- **54.8%** (46/84) of respondents are female
- **28.5%** (24/84) of respondents living the areas of Greenacres, Boynton, Delray (South County)
- **72.6%** (61/84) of respondents live in a 1-2 person household

Food Insecurity Section

Access to food

In the next question, clients were asked the following

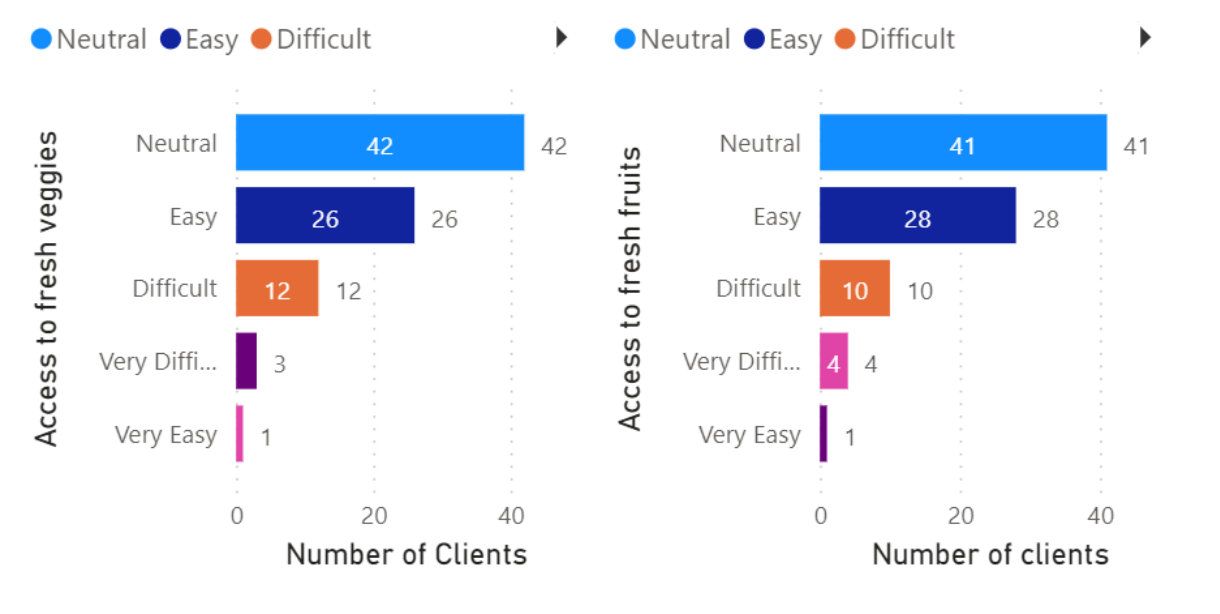
In the last 3 months, how easy has it been for you access the following? :

- Fresh vegetables
- Fresh fruits
- Fresh proteins
- Fresh dairy
- Fresh carbs
- Fresh grains
- Fresh meats

Answer choices ranged from the following on a likert scale:

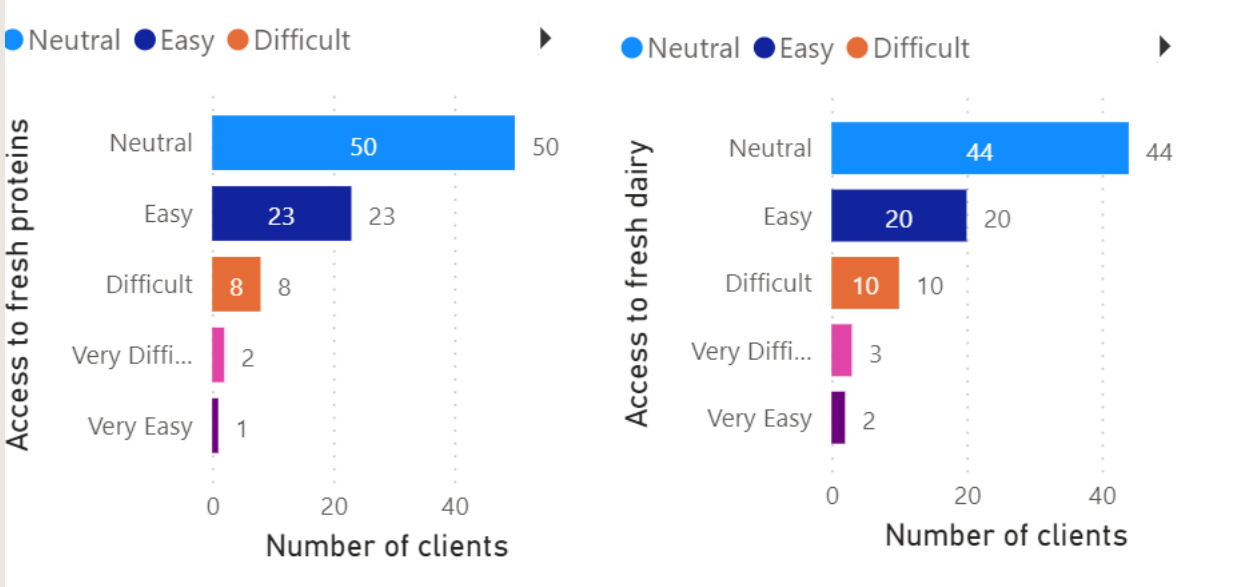
1. Very Difficult
2. Difficult
3. Neutral
4. Easy
5. Very Easy

Access to Veggies and Fruits

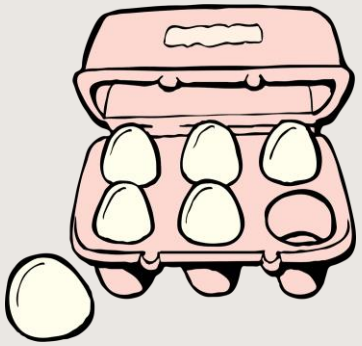


- **50%** (42/84) of clients have **neutral access to fresh veggies**
- **31.0%** (26/84) of clients have **easy access to fresh veggies**
- **17.9%** (15/84) of clients have **difficult/very difficult access to fresh veggies**
- **48.8%** (41/84) of clients have **neutral access to fresh fruits**
- **33.3%** (28/84) of clients have **easy access to fresh fruits**
- **16.7%** (14/84) of clients have **difficult/very difficult access to fresh fruits**

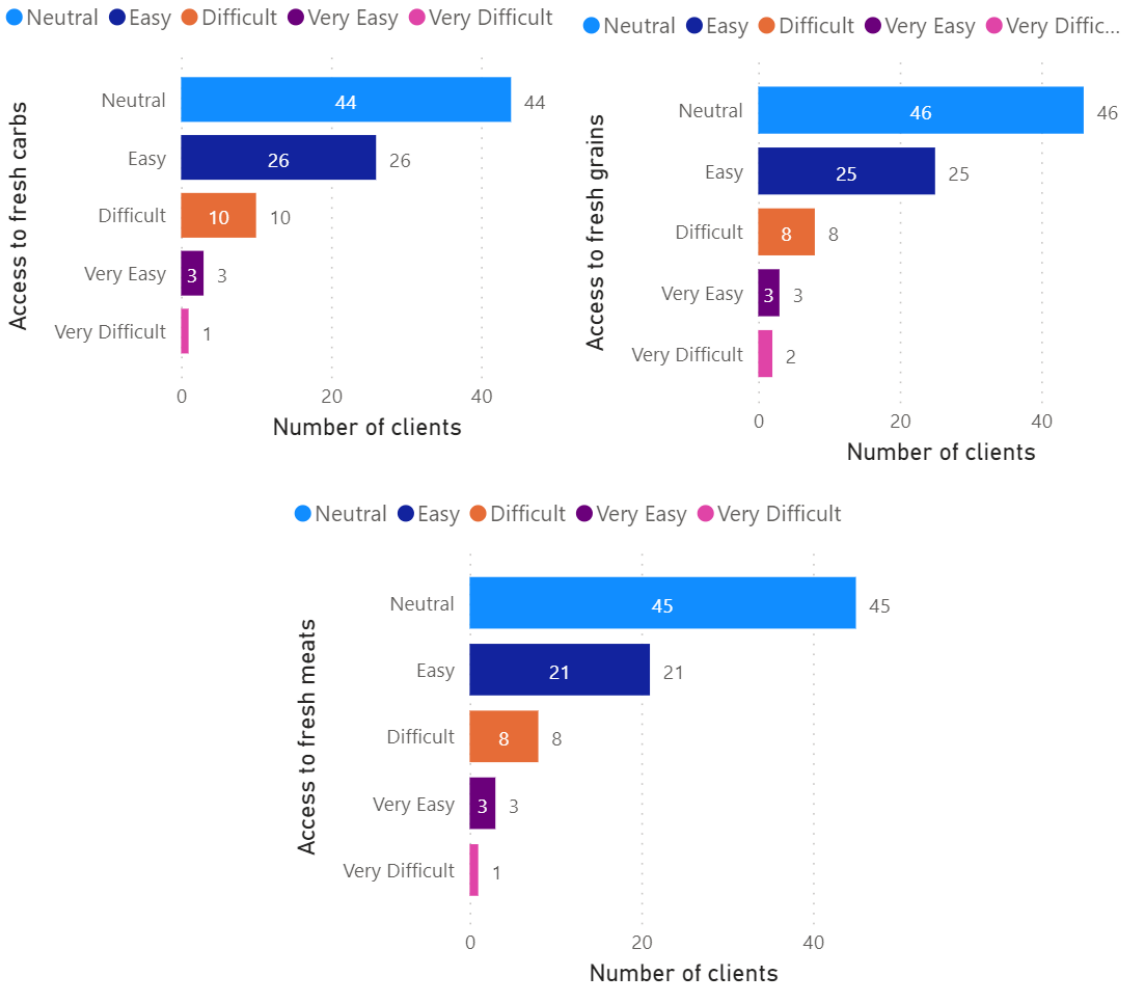
Access to Proteins and Dairy



- **59.5%** (50/84) of clients have **neutral access to fresh proteins**
- **27.4%** (23/84) of clients have **easy access to fresh proteins**
- **11.9%** (10/84) of clients have **difficult/very difficult access to fresh proteins**
- **52.4%** (44/84) of clients have **neutral access to fresh daisy**
- **23.8%** (20/84) of clients have **easy access to fresh dairy**
- **15.5%** (13/84) of clients have **difficult/very difficult access to fresh dairy**



Access to Carbs, Grains and Meat



- **52.4%** (44/84) of clients have **neutral access to fresh carbs**
- **31.0%** (26/84) of clients have **easy access to fresh carbs**
- **13.1%** (11/84) of clients have **difficult/very difficult access to fresh carbs**
- **54.8%** (46/84) of clients have **neutral access to fresh grains**
- **29.8%** (25/84) of clients have **easy access to fresh grains**
- **11.9%** (10/84) of clients have **difficult/very difficult access to fresh grains**
- **53.6%** (45/84) of clients have **neutral access to fresh meats**
- **25.0%** (21/84) of clients have **easy access to fresh meats**
- **10.7%** (9/84) of clients have **difficult/very difficult access to fresh meats**

Frequency of eating food

In the next question, clients were asked the following

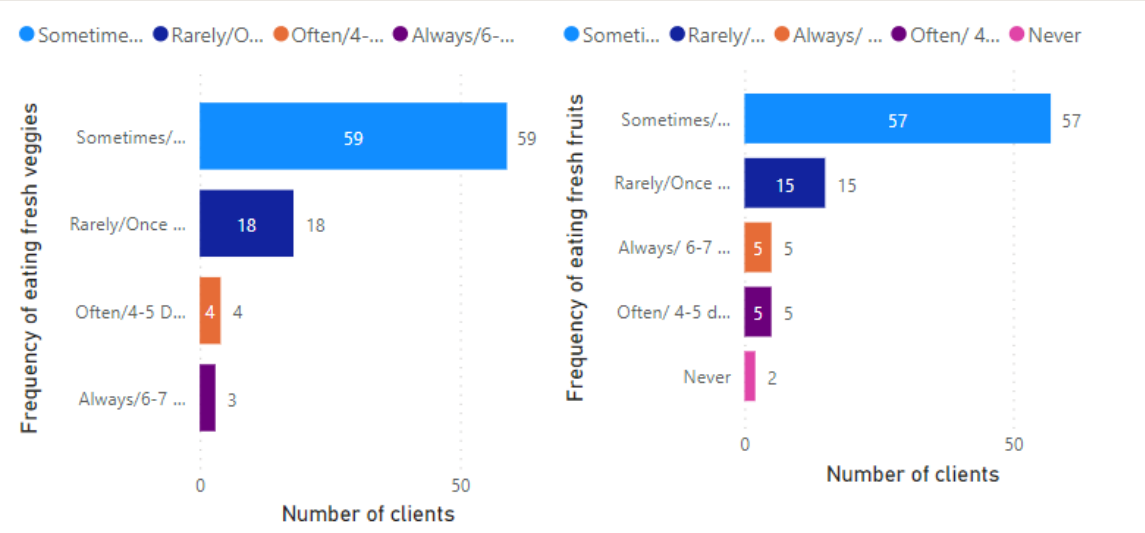
In the last 3 months, how often are you able to eat the following? :

- Fresh vegetables
- Fresh fruits
- Fresh proteins
- Fresh dairy
- Fresh carbs
- Fresh grains
- Fresh meats

Answer choices ranged from the following on a likert scale:

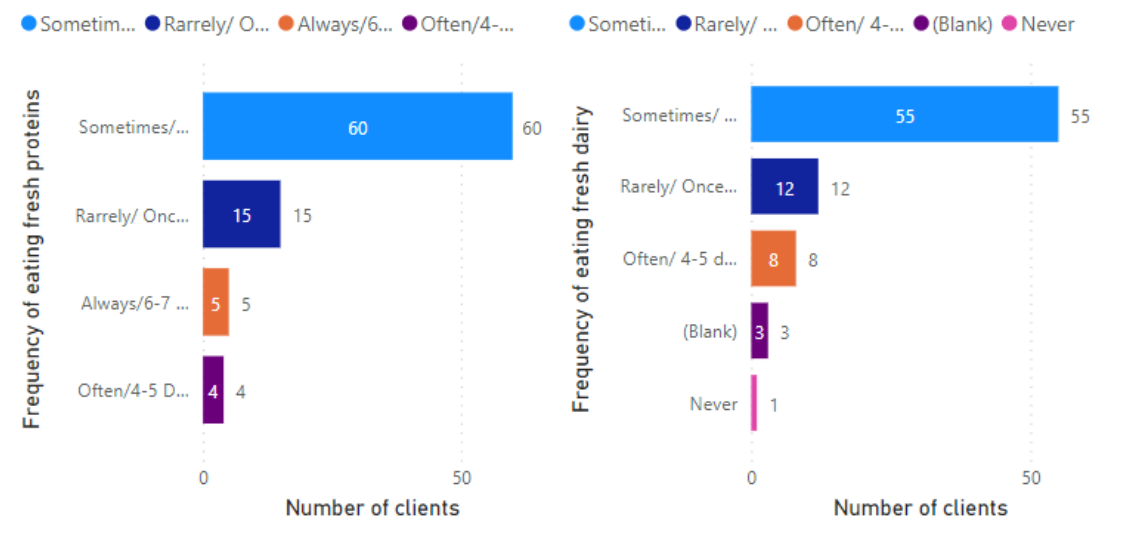
1. Never
2. Rarely/Once a week
3. Sometimes/2-3 days a week
4. Often/4-5 days a week
5. Always/6-7 days a week

Frequency of eating Veggies and Fruits

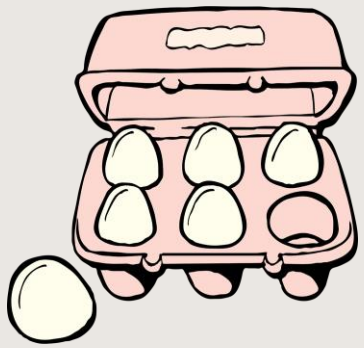


- **70.2%** (59/84) of clients **sometimes eat fresh veggies**
- **21.4%** (18/84) of clients **rarely/once a week eat fresh veggies**
- **8.3%** (7/84) of clients **often/always eat fresh veggies**
- **67.9%** (57/84) of clients **sometimes eat fresh fruits**
- **17.9%** (15/84) of clients **rarely/once a week eat fresh fruits**
- **11.9%** (10/84) of clients **often/always eat fresh fruits**

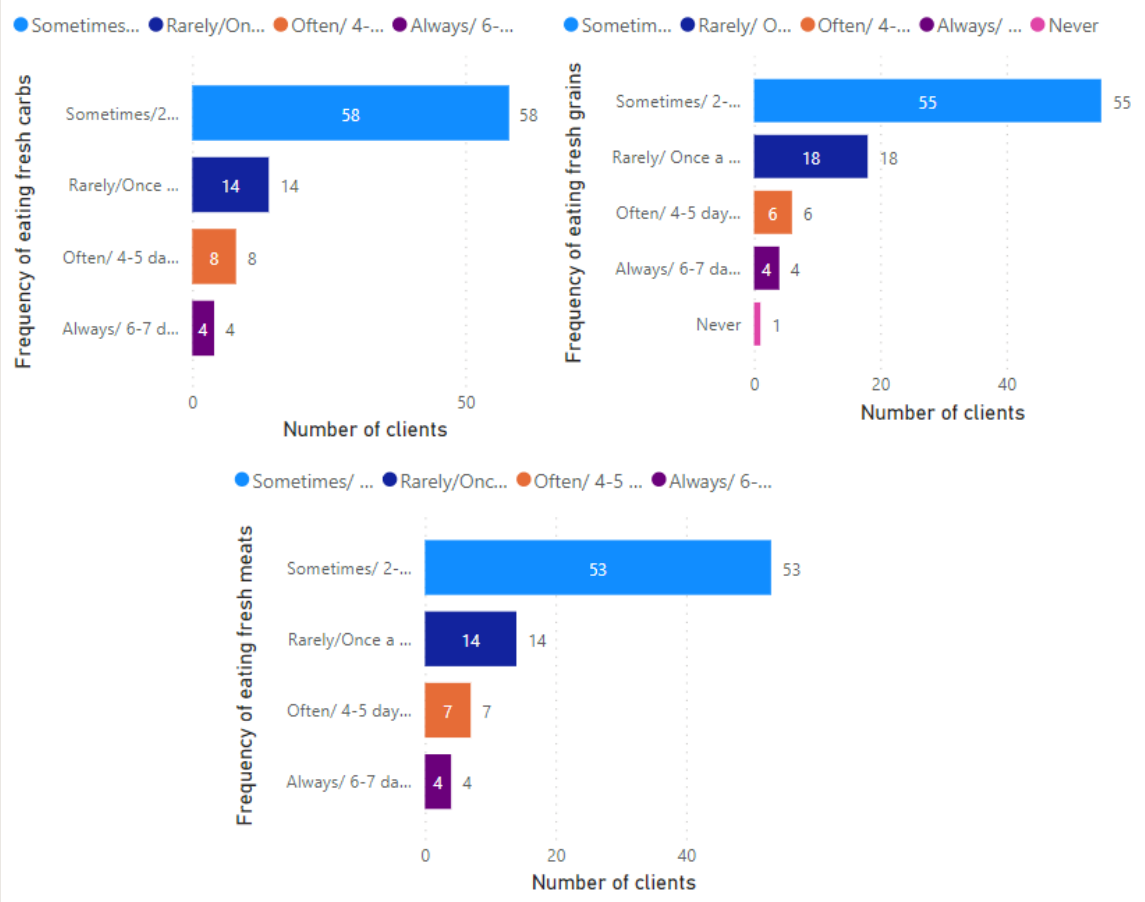
Frequency of eating Proteins and Dairy



- **71.4%** (60/84) of clients **sometimes eat fresh proteins**
- **17.9%** (15/84) of clients **rarely/once a week eat fresh proteins**
- **10.7%** (9/84) of clients **often/always eat fresh proteins**
- **65.5%** (55/84) of clients **sometimes eat fresh dairy**
- **14.3%** (12/84) of clients **rarely/once a week eat fresh dairy**
- **9.5%** (8/84) of clients **often eat fresh dairy**

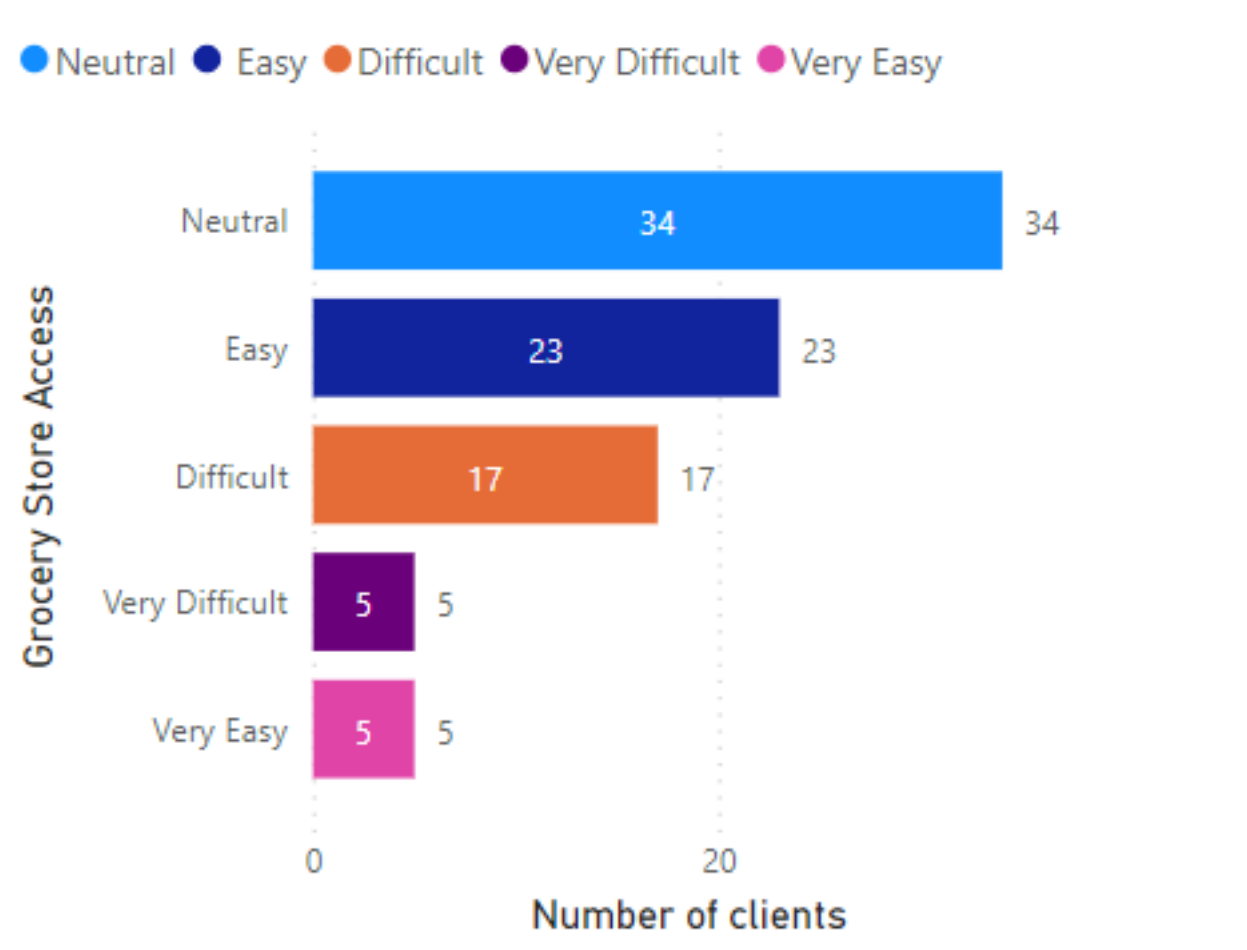


Frequency of eating Carbs, Grains and Meat



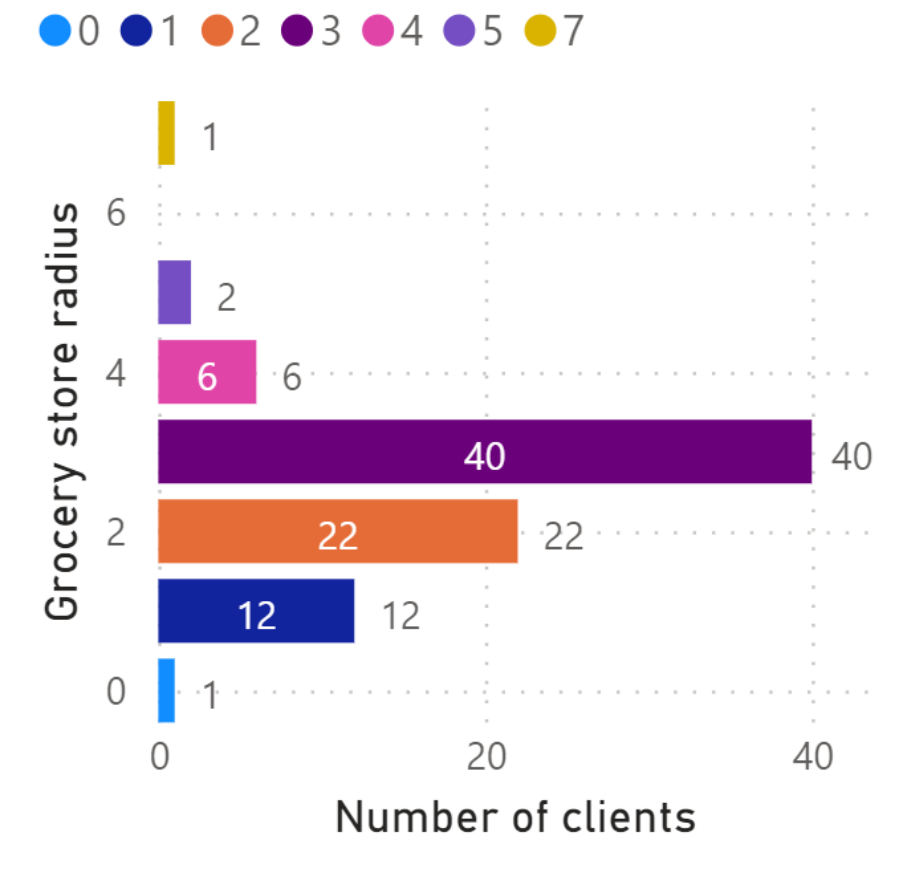
- **69.0%** (58/84) of clients **sometimes eat fresh carbs**
- **16.7%** (14/84) of clients **rarely/once a week eat fresh carbs**
- **14.3%** (12/84) of clients **often/always eat fresh carbs**
- **65.5%** (55/84) of clients **sometimes eat fresh grains**
- **21.4%** (18/84) of clients **rarely/once a week eat fresh grains**
- **11.9%** (10/84) of clients **often/always eat fresh grains**
- **63.1%** (53/84) of clients **sometimes eat fresh meats**
- **16.7%** (14/84) of clients **rarely/once a week eat fresh meats**
- **13.1%** (11/84) of clients **often/always eat fresh meats**

Grocery Store Access



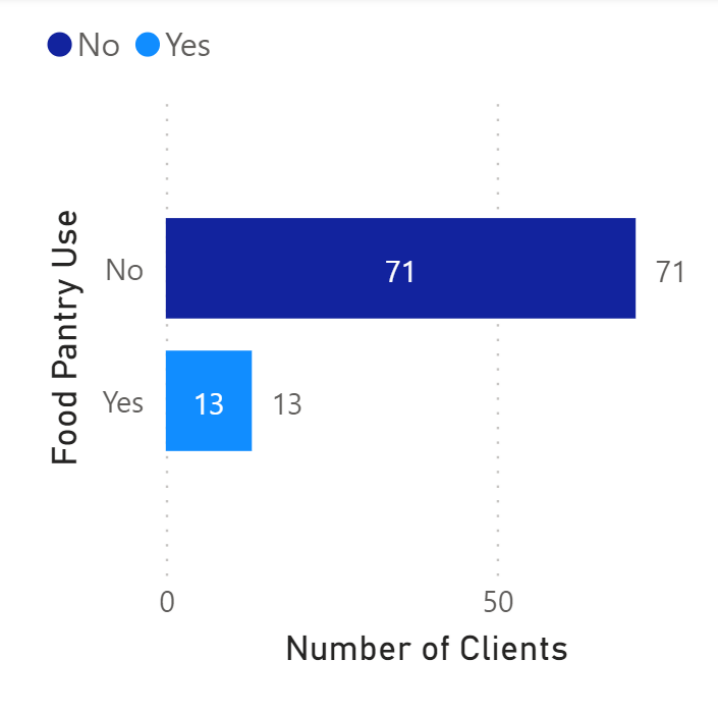
- **40.5%** (34/84) of clients reported that they have **neutral access** to a grocery store
- **27.4%** (23/84) of clients reported that they have **easy access** to a grocery store
- **20.3%** (17/84) of clients reported that they have **difficult access** to a grocery store
- **5.9%** (5/84) of clients reported that they have **very difficult** access to a grocery store
- **5.9%** (5/84) of clients reported that they have **very easy** access to a grocery store

Grocery Store Radius



- **47.6%** (40/84) reported **3 grocery stores** within 3 miles from their home
- **26.2%** (22/84) reported **2 grocery stores** within 3 miles from their home
- **14.3%** (12/84) reported **1 grocery stores** within 3 miles from their home

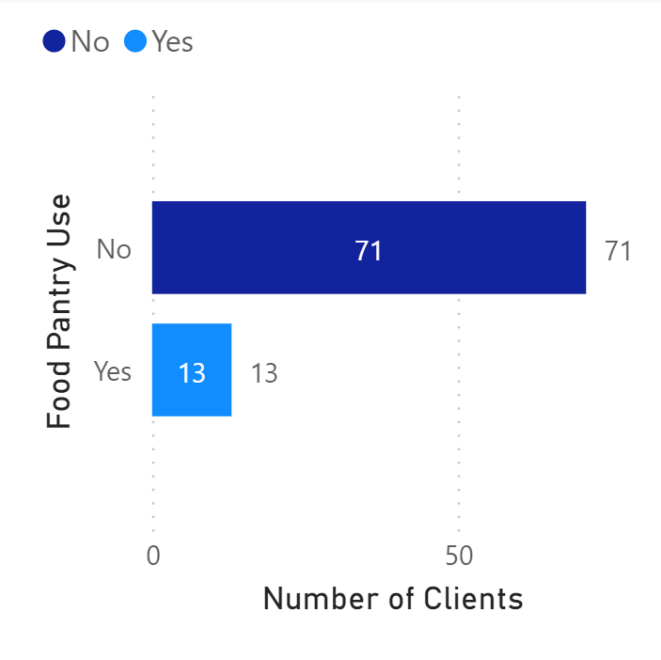
Food Pantry Usage and Locations



Agencies	Counts
FoundCare	2
Some in the area	1
Boca Helping Hands	1
Church by the grace	1
Conference community center	1
some	1
Tru Fast Ministries	1
Church	2
Close	1
Too far	1
Pantry	1

- **84.5%** 71/84 clients **do not use a food pantry**
- **15.5%** 13/84 clients **utilize a food pantry**
- Out of the 13/84 clients who reported using a food pantry, various locations include:
  - Churches
  - Community centers/agencies

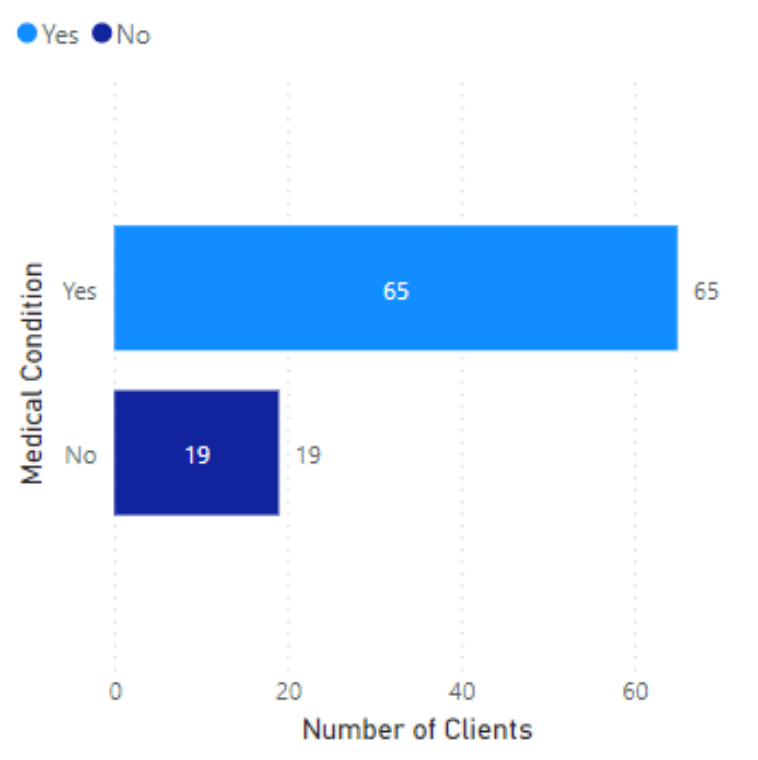
Non Food Pantry Usage



not_using_food_pantry	Count of not_using_food_pantry
n/a	26
lwen	6
Not interested	4
no transportation	3
transportation	3
pa rinmin sa	1
Because I don't have enough money to buy any	1
Because they only have can foods	1
Can't find any	1
Doesn't know the locations	1
don't know any	1
far	1
I don't know about it.	1
I don't know of any	1
I don't know their locations.	1
I don't want to use food pantry	1
move	1
no	1
No knowledge	1
No transportation to get there	1
no transpotation	1
non	1
none	1
not close	1
not going	1
Not interested in it	1
not sure	1
Not sure where they are located or when food is available	1
Out dated food in cans	1
pa konin	1
Pakonen	1
pakonin kote yo ye	1
time	1
transportasyon	1
Total	**71**

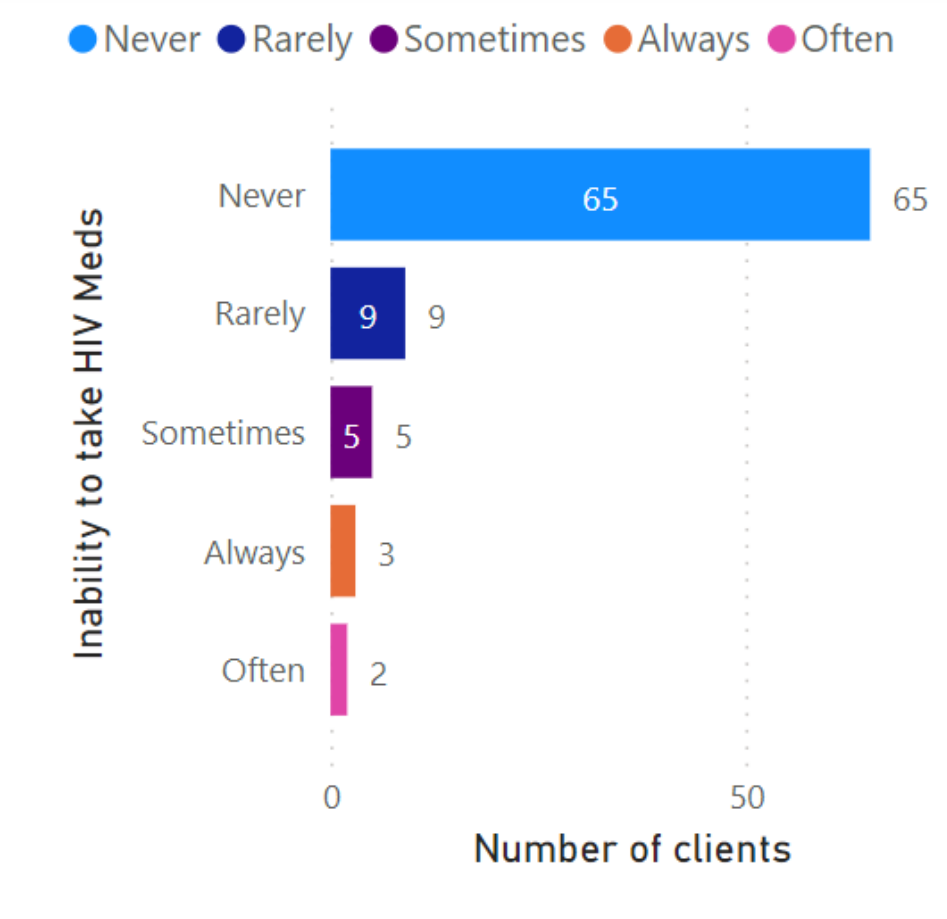
- **84.5%** (71/84) of clients are **not utilizing food pantries**, some reasons why include the following:
  - **36.6%** N/A (26/71)
  - **11.3%** Too far (8/71)
  - **5.6%** Not interested (4/71)
  - **11.3%** No transportation (8/71)
  - **7.0%** No knowledge (5/71)

Medical Condition and Specific Diet



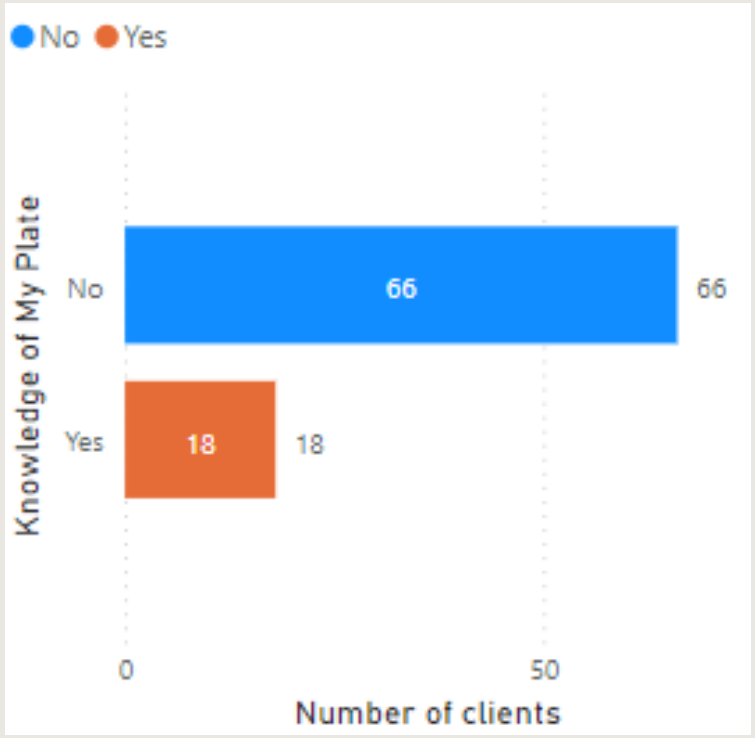
- **77.4%** (65/84) clients have been advised to **follow a specific diet/regimen** by a healthcare professional due to a medication condition
- **22.6%** (19/84) clients have **not been advised to follow a specific diet/regimen** by a healthcare professional due to a medical condition

HIV Meds Nonadherence and Food Insecurity

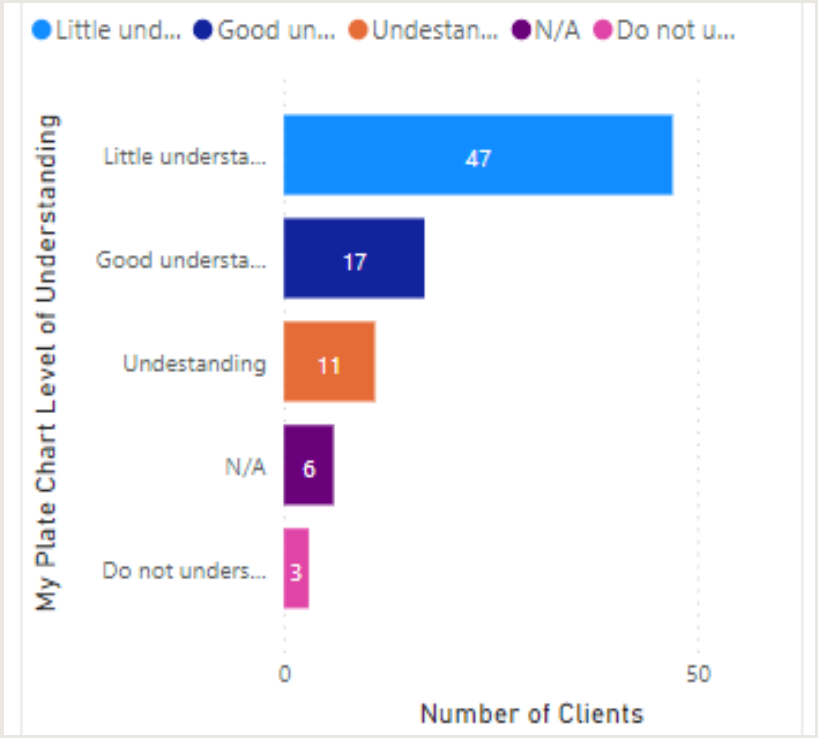


- **77.4%** (65/84) of clients are **never** unable to take HIV meds bc of food insecurity
- **10.7%** (9/84) of clients are **rarely** unable to take HIV meds bc of food
- **5.6%** (5/84 of clients are **sometimes** unable to take HIV meds bc of food insecurity
- **3.6%** (3/84) of clients are **always** unable to take HIV meds bc of food
- **2.4%** (2/84) of clients are **often** unable to take HIV meds bc of food

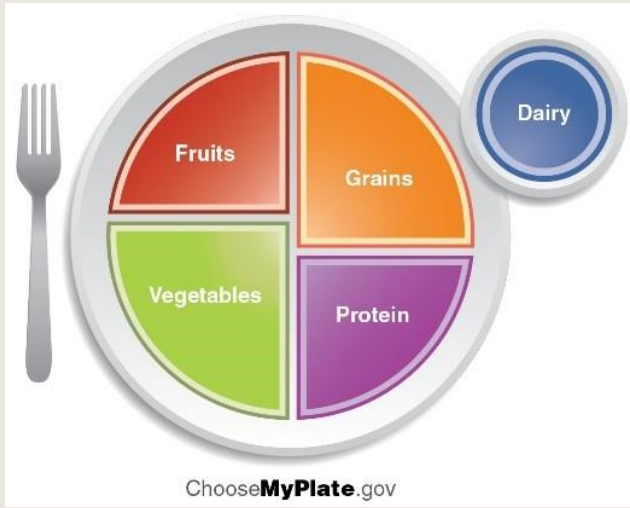
My Plate Chart



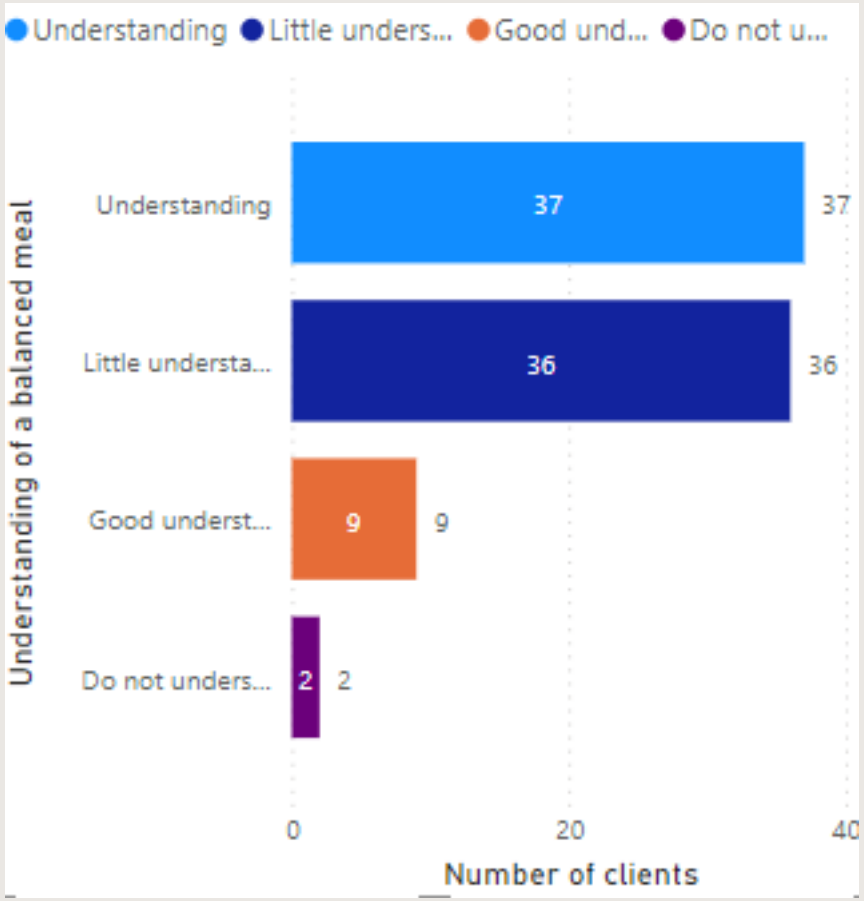
- **78.6%** (66/84) of clients have **no knowledge** of the My Plate Chart
- **21.4%** (18/84) of clients **have knowledge** of the My Plate Chart



- **55.9%** (47/84) of clients have **little understanding** of the My Plate Chart
- **20.2%** (17/84) of clients have **good understanding** of the My Plate Chart
- **13.1%** (11/84) of clients have **general understanding** of the My Plate Chart



Importance of a Balanced Meal



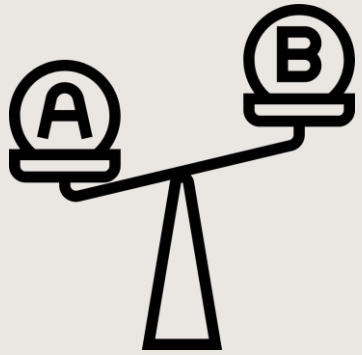
- **44%** (37/84) of clients have **general understanding** of the importance of a balanced meal
- **42.9%** (36/84) of clients have **little understanding** of the importance of a balanced meal
- **10.7%** (9/84) of clients have **good understanding** of the importance of a balanced meal
- **2.4%** (2/84) of clients **do not understand** the importance of a balanced meal

Additional Feedback

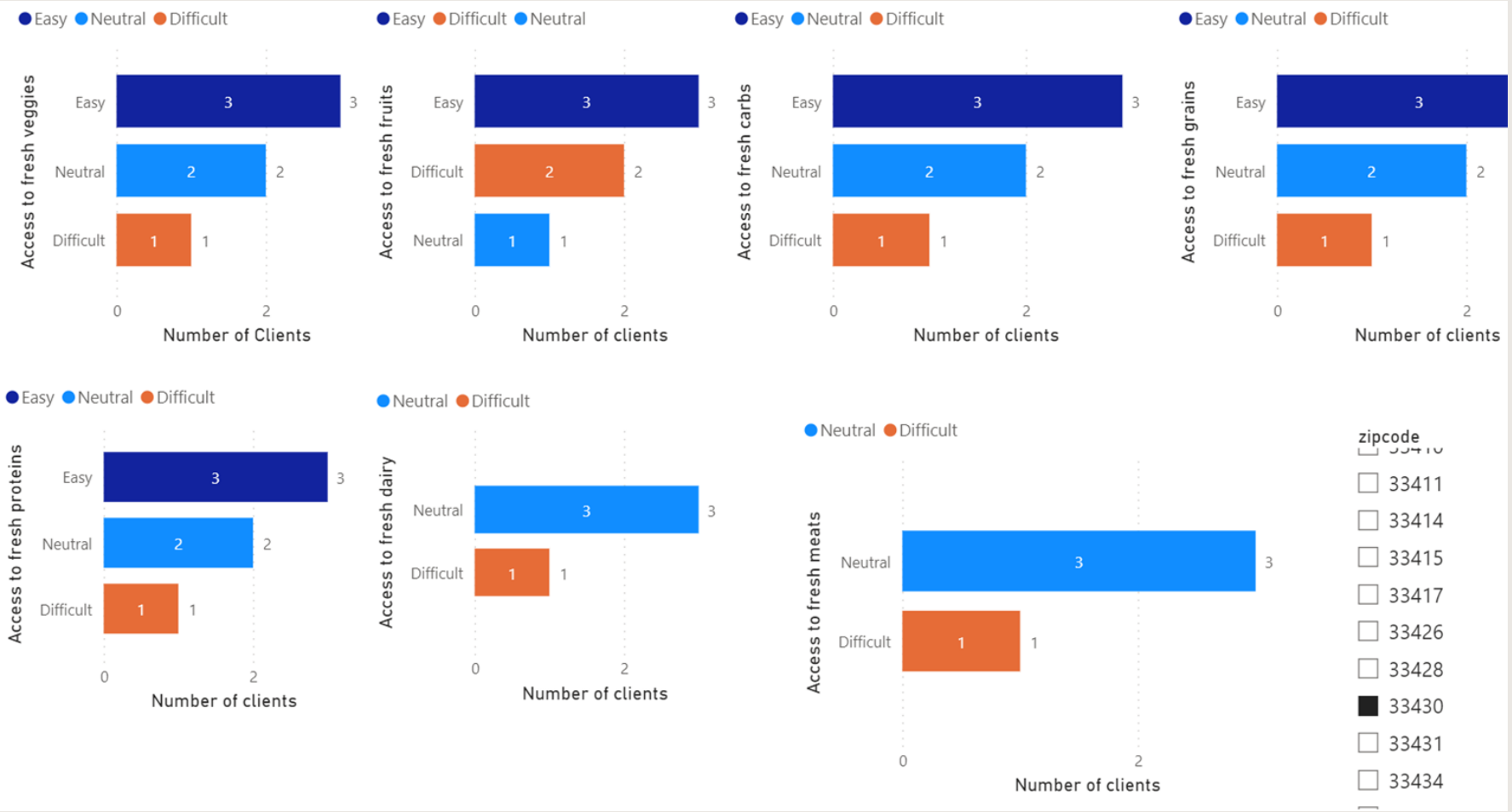
Additional Feedback	Counts
Grateful for Ryan White	1
I have received good service	1
Lot fwa (Another time)	1
My food stamps are taken away from me. I also don't have reliable transportation	1
Service too far	2
N/A	55
No	20
Receive food stamps to purchase food	1
Ryan White ensure payments are not enough. Food pantries need more options	1
Total	83

- **89.3%** (75/84) of clients had **no additional feedback** or comments
- **10.7%** (9/84) of clients **provided other feedback** such as :
  - Services too far away
  - Being grateful for Ryan White
  - Ryan White ensure payments are not enough

Comparison Groups



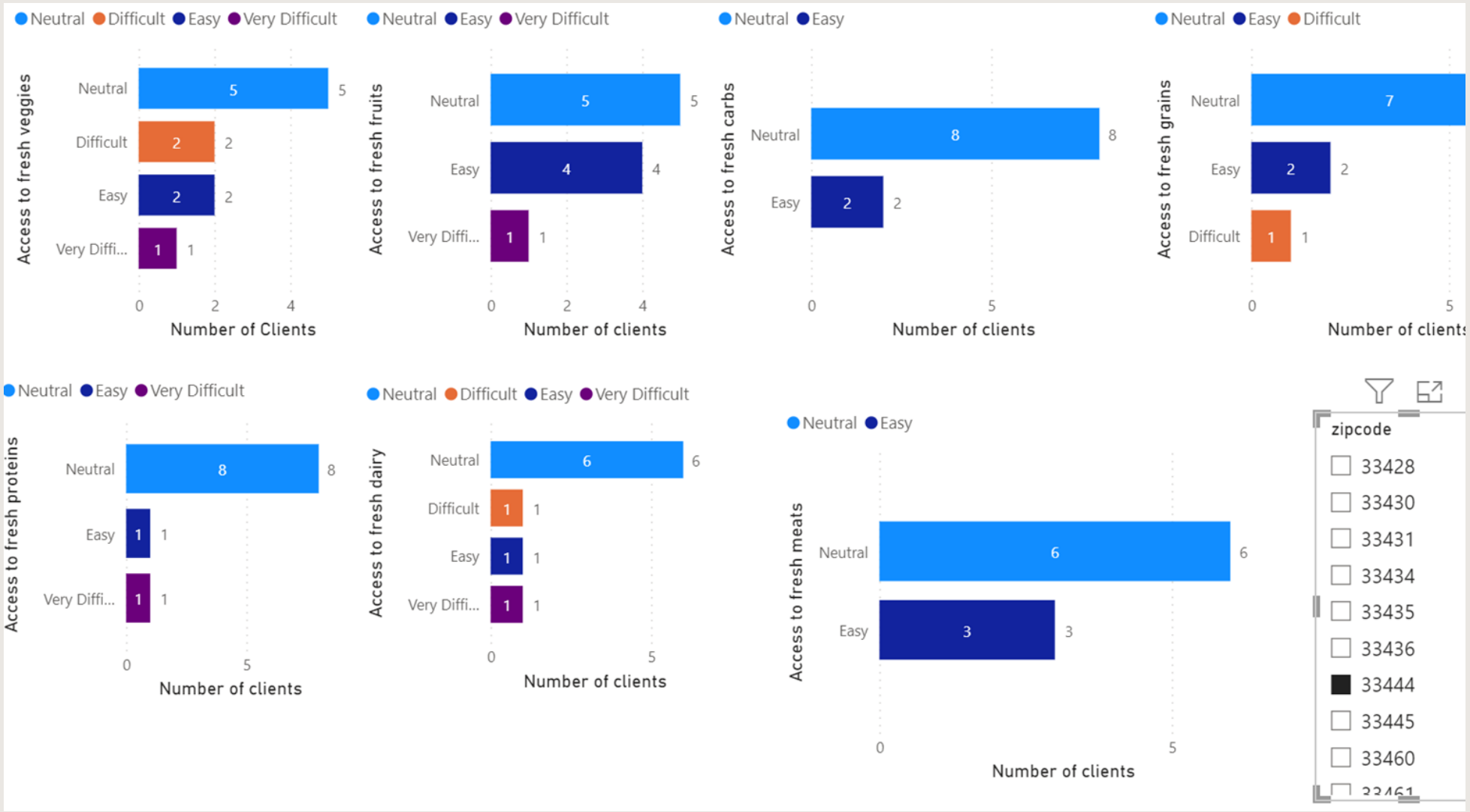
Belle Glade Food Access



33430 area code: Belle Glade

- Majority of respondents have easy/neutral to food items
- 1-2 individuals with difficult access
- Total=6

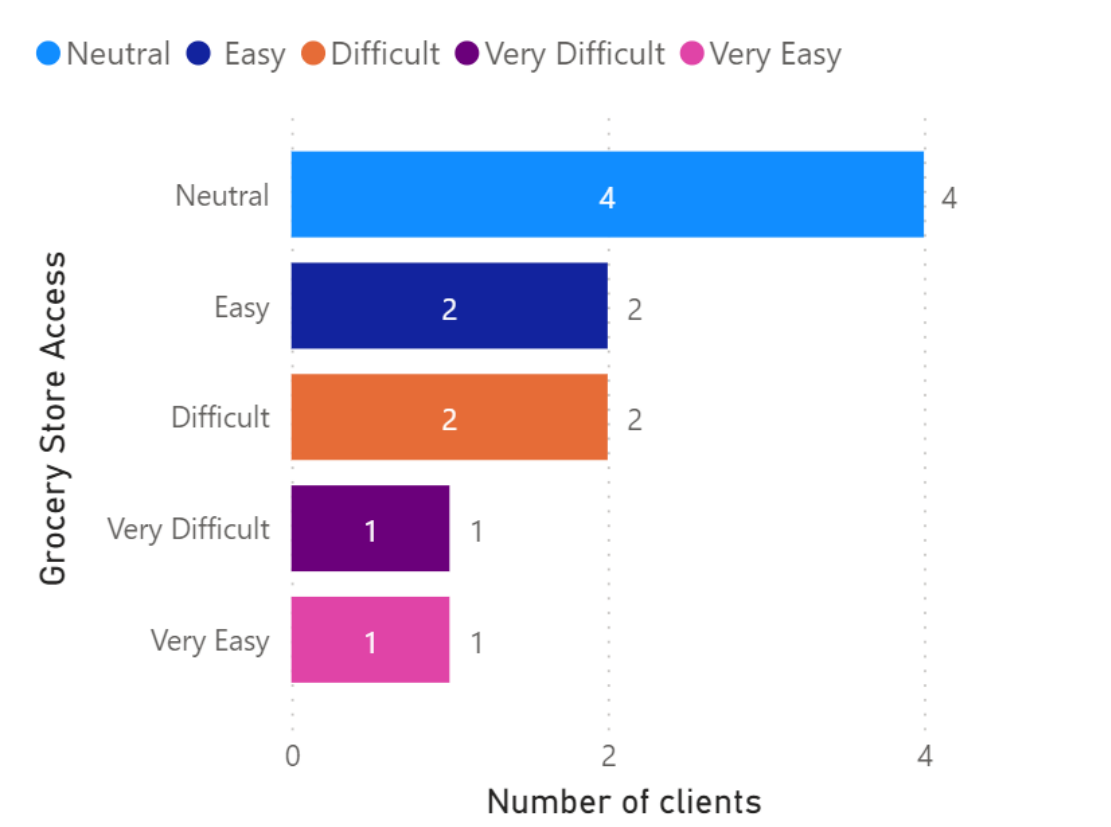
Delray Food Access



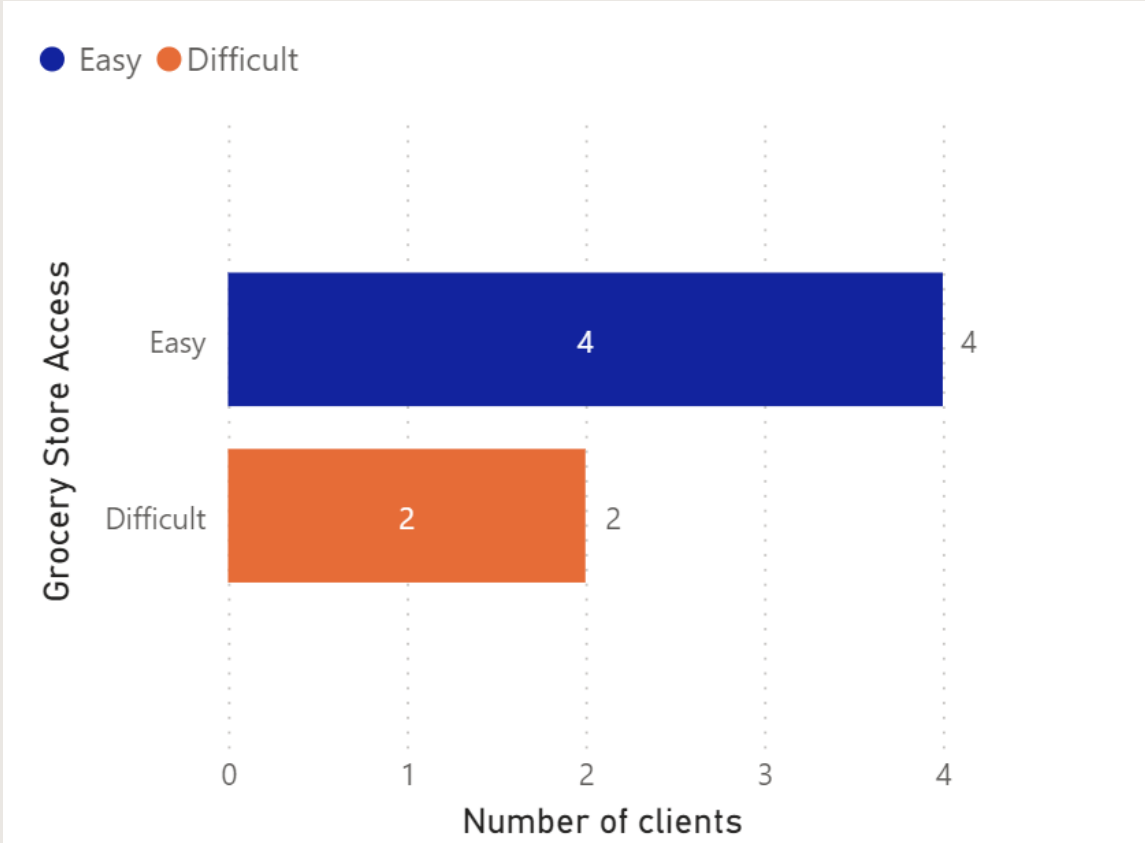
33444 area code: Delray

- Majority of clients from this area have neutral access to food items
- Total=10

Grocery Store Access of Delray and Belle Glade

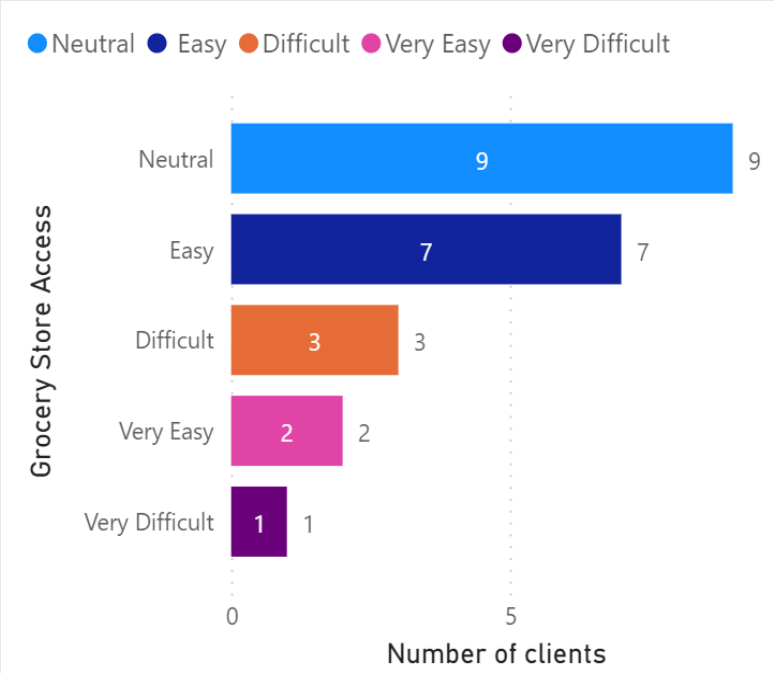


33444 zip code: Delray
Total:10

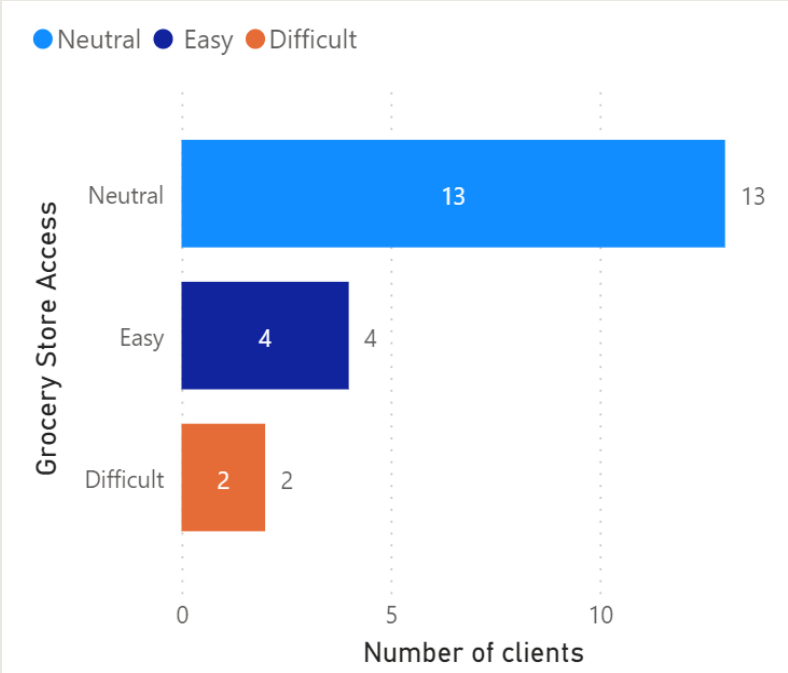


33430 zip code: Belle Glade
Total:6

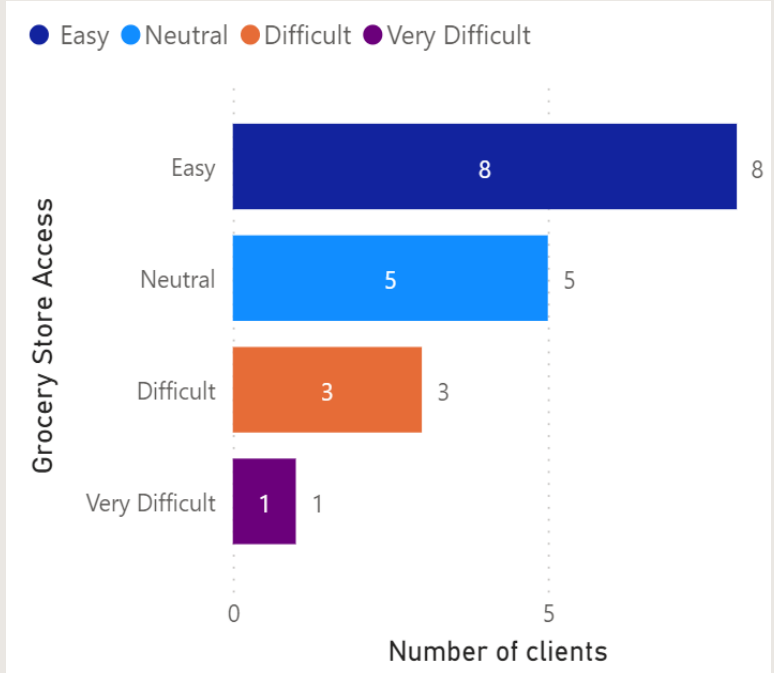
Grocery Store Access among different client service groups



- **Food Bank Utilizer**
- Total=22

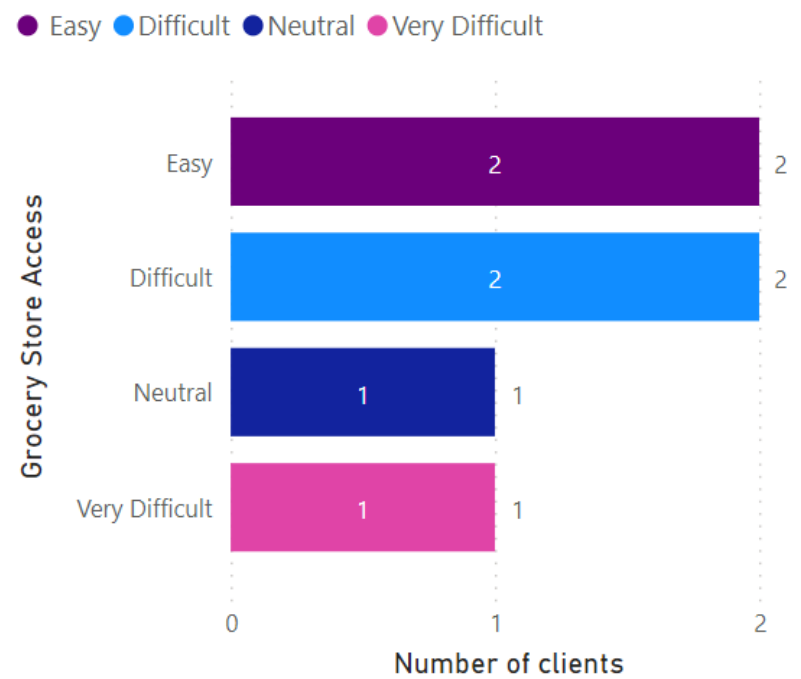


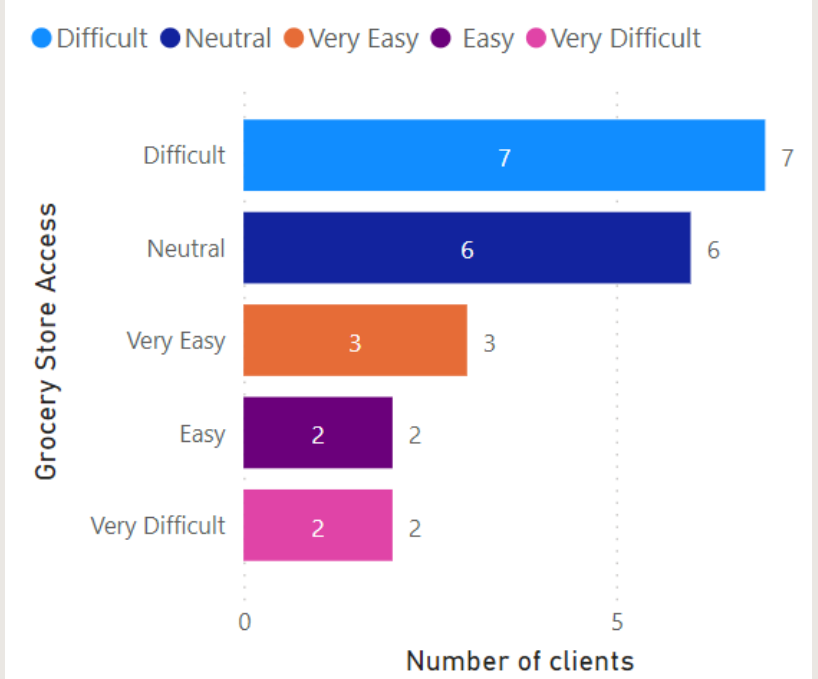
- **Not Eligible for Food Bank**
- Total=19



- **Food Bank eligible but non-utilizer**
- Total=17

Grocery Store Access among different client service groups

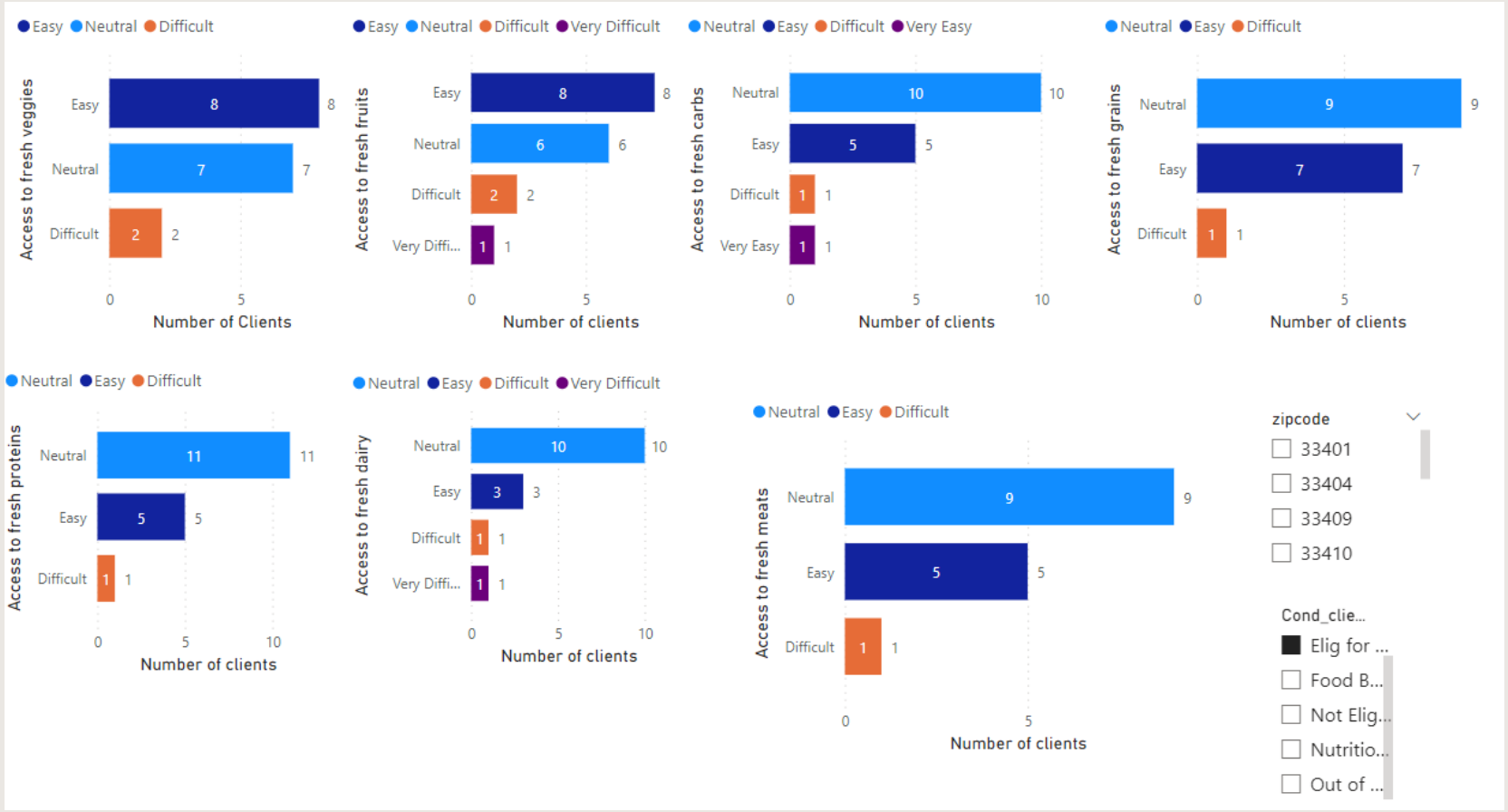




- **Nutritional Supplement**
- Total=6

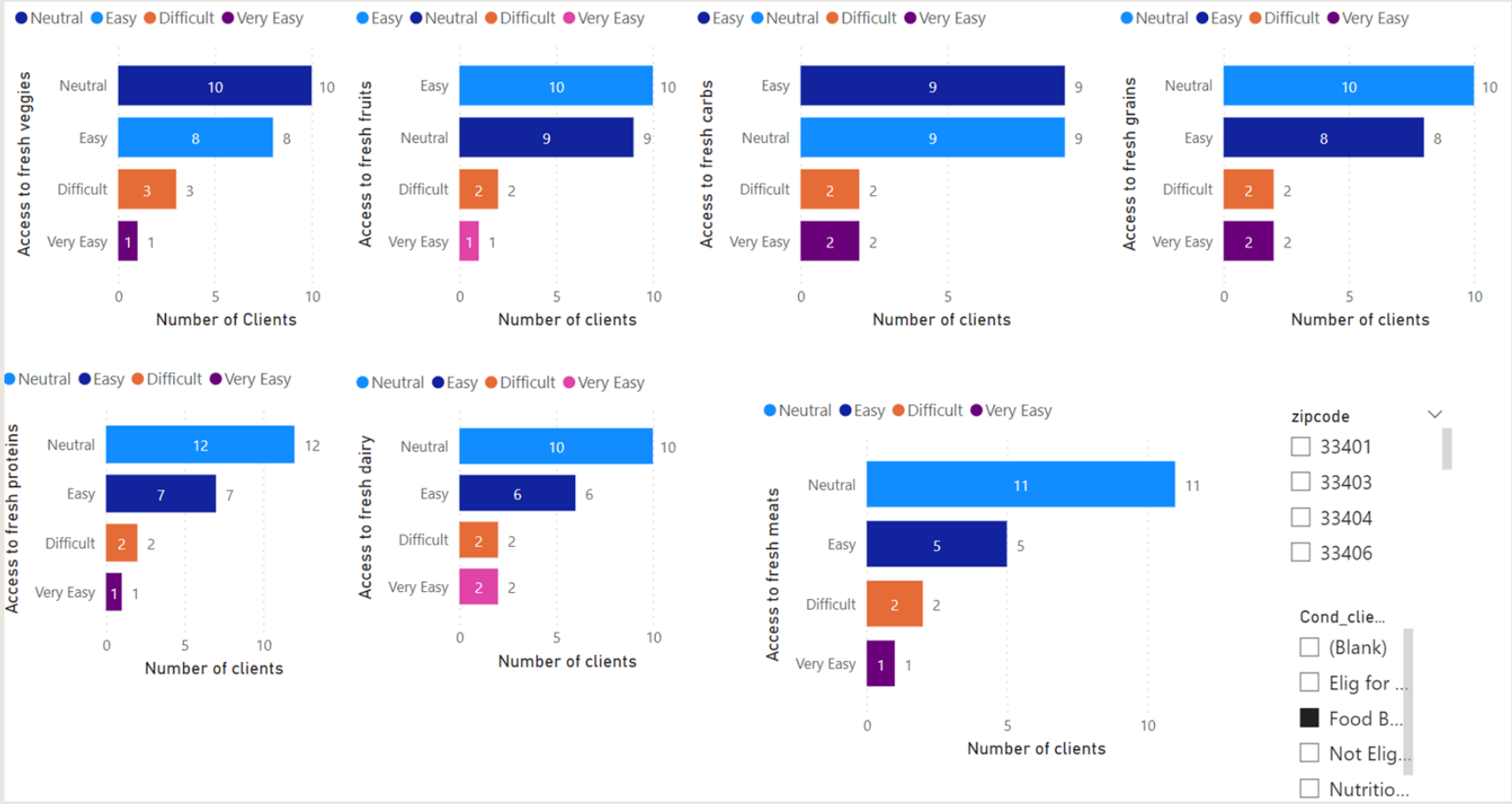
- **Out of Care**
- Total=20

Access to foods items: Eligible for Food Bank but not utilizing



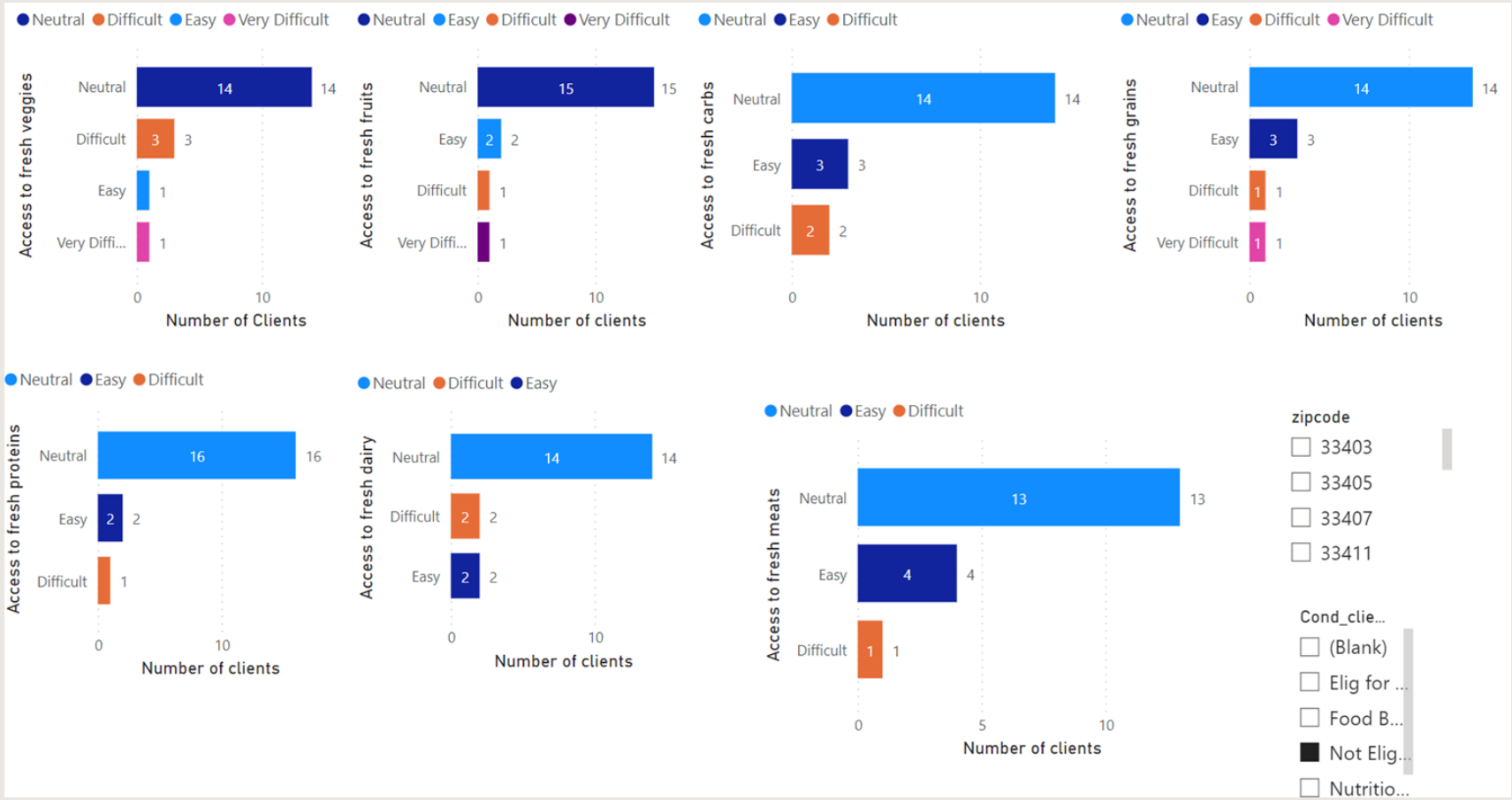
- Neutral access to food items followed by easy access for most individuals
- Total=17

Access to foods items: Food Bank Utilizers



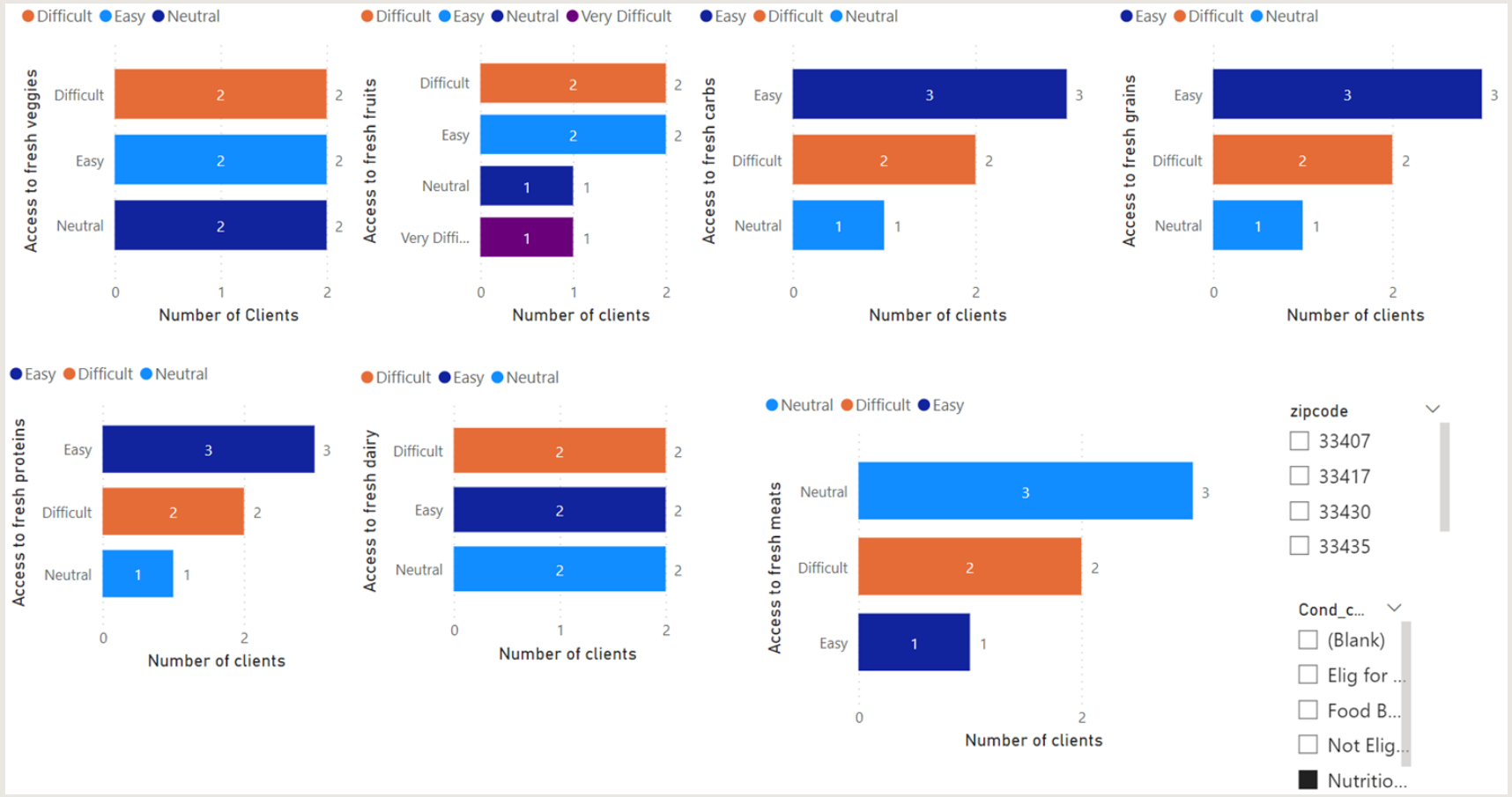
- Neutral or easy access to food items for most individuals
- Total=22

Access to foods items: Not Eligible for Food Bank



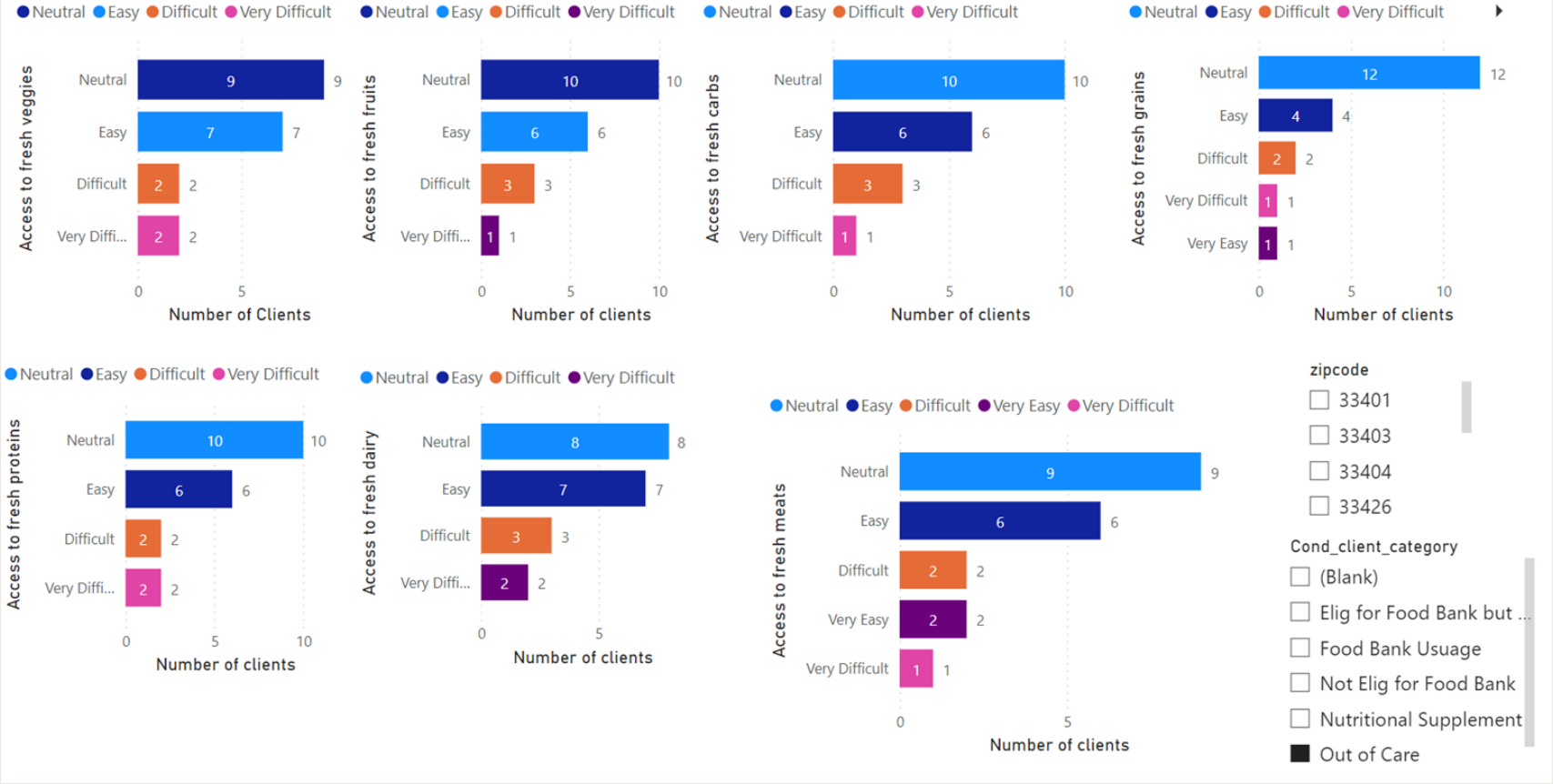
- Neutral access to food items for most individuals
- Total=19

Access to foods items: Nutritional Supplements



- More difficulties with access to some food items for at least 2 individuals
- Total=6

Access to foods items: Out of Care



- Neutral access, followed by easy access to food items for most individuals
- Total=20

4

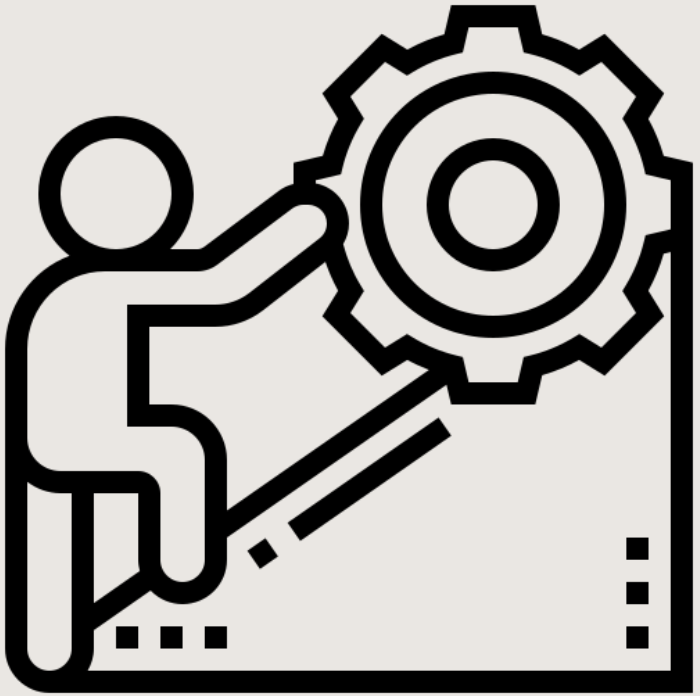
Conclusion

Key Takeaways

- Majority of clients have neutral access, followed by easy access to fruits, veggies, protein,dairy, grain, crabs, and meats throughout most groups
    - Can access be increased?
- Majority of clients are able to eat fruits, veggies, protein,dairy, grain, crabs, and meats sometimes/(2-3 times a week)
- Majority of clients have neutral followed by easy access to a grocery store however:
    - **26.2%** (22/84) of clients reported difficult or very difficult access to a grocery store
- **47.6%** (40/84) have at least 3 grocery stores within 3 miles of their home
- **84.5%** (71/84) of clients are not utilizing food pantries
- **77.4%** (65/84) of clients have been advised to follow a specific diet by a health care professional due to a medical condition
- Low knowledge of understanding of My Plate Chart or the importance of a balanced meal
- Lack of access to food has not impacted HIV medication adherence for a majority of clients **(77.4%)**

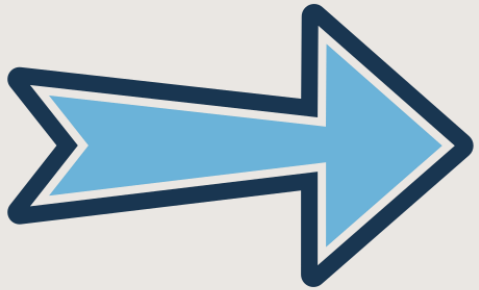
Challenges

- Out of care/ recently engaged in care client group can not be randomized
    - Takes a while to engage clients in this group
- Ended up with more Haitians in the Out of Care group, increasing overall count of Haitian clients who took the survey (65.5%)
- Clients not feeling comfortable disclosing their monthly income
- Correct language for client being documents in Provide
- Survey is 81.5% completed
    - There may be slight variations in aggregate results at the conclusion of study



Possible Next Steps

- Case managers sharing food pantry information with clients utilizing food bank/nutritional supplement services
  - Including food bank services in resource inventory
  - One on one opportunity to learn more about reasons for non food pantry usage
- Food pantry usage can help substitute for some food items that are only eaten sometimes or not often
- Nutritional assessment training for case managers
  - Clients to be educated on nutrition/balanced meal during case management session
  - Nutritional check in when clients pick up cards



THANKS!

Any questions?
Email: gsimeus@pbc.gov

Genève Simeus, MPH

Ryan White
HIV/AIDS Program

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Ending the HIV Epidemic Case Management Assessment

Sean Conklin, MNM (He/Him/His)
Program Evaluator
Palm Beach County Ending the HIV Epidemic Initiative
Sconklin@pbcgov.org
561-274-1096

Palm Beach County
HIV Elimination Services

Case Management Assessment

- Case Management Assessment began in March of 2022
- Three stages of the project:
  - Survey with Case Management and EIS Staff
  - Interviews with Case Management and EIS staff
  - Interviews with clients who received Case Management or EIS services within the last 12 months
- CAI compiled aggregate descriptive data from the surveys conducted

Surveys & Interviews

- 28 RWHAP Case Managers completed a survey asking about their experiences and perceptions as a case manager
- 42 Case managers and case management supervisors were interviewed one-on-one
- Topics include
  - Case Management Process
  - Onboarding & Supervision
  - Monitoring & Evaluation
  - Suggestions for the recipient

Identifying Clients & Assessing Needs

- The system lacks a clear referral pathway and process for understanding which organizations are accepting new clients
- Case management agencies do not always coordinate activates and referrals because they are concerned about losing clients to other agencies
- Case management referrals are sometimes not processed and clients get referred but not linked to case management, particularly between agencies

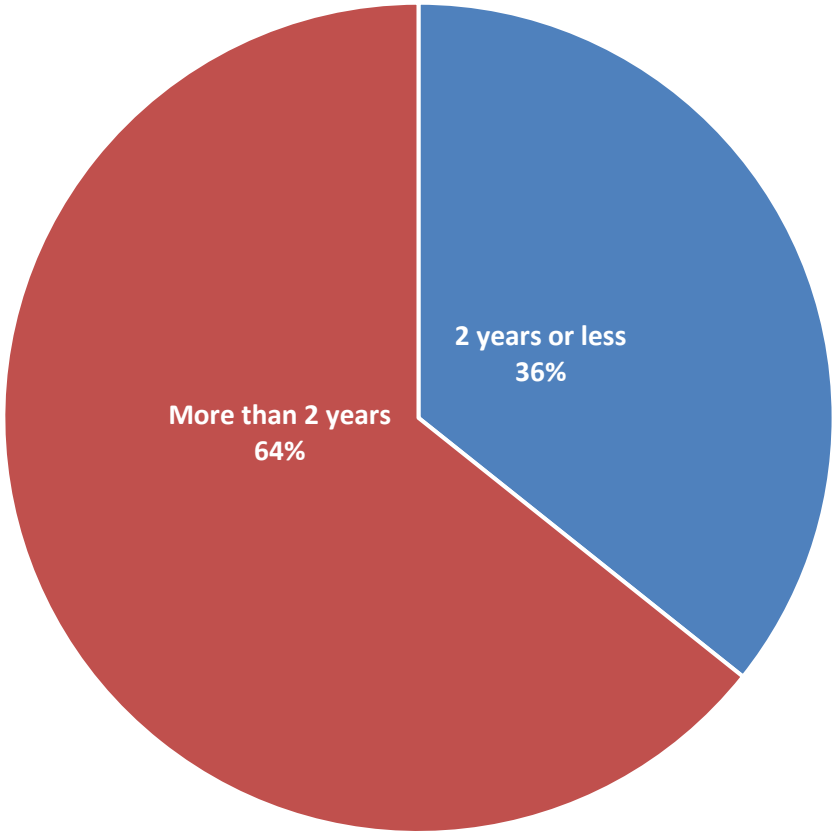
Identifying Clients & Assessing Needs

- Case managers were often unclear of the process for case management eligibility, if there was one
- Case managers were often assigned clients based on caseload and language and not needs

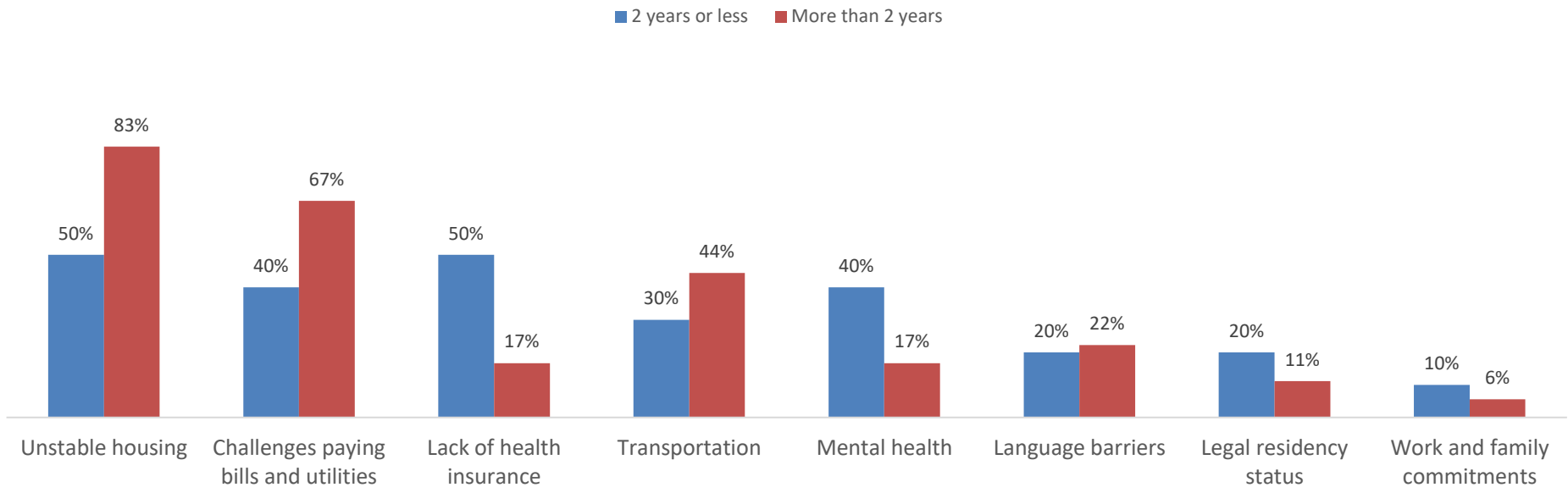
Client Needs

- Case managers were asked about the most common issues faced by clients they work with
  1. Unstable housing
  2. Challenges paying bills and utilities
  3. Health insurance
  4. Transportation
  5. Mental Health
  6. Language barriers
  7. Legal Residency Status
  8. Work and Family Committments

How long have you been providing case management / EIS services?



What are the three most dominant challenges clients express while engaging in HIV care?



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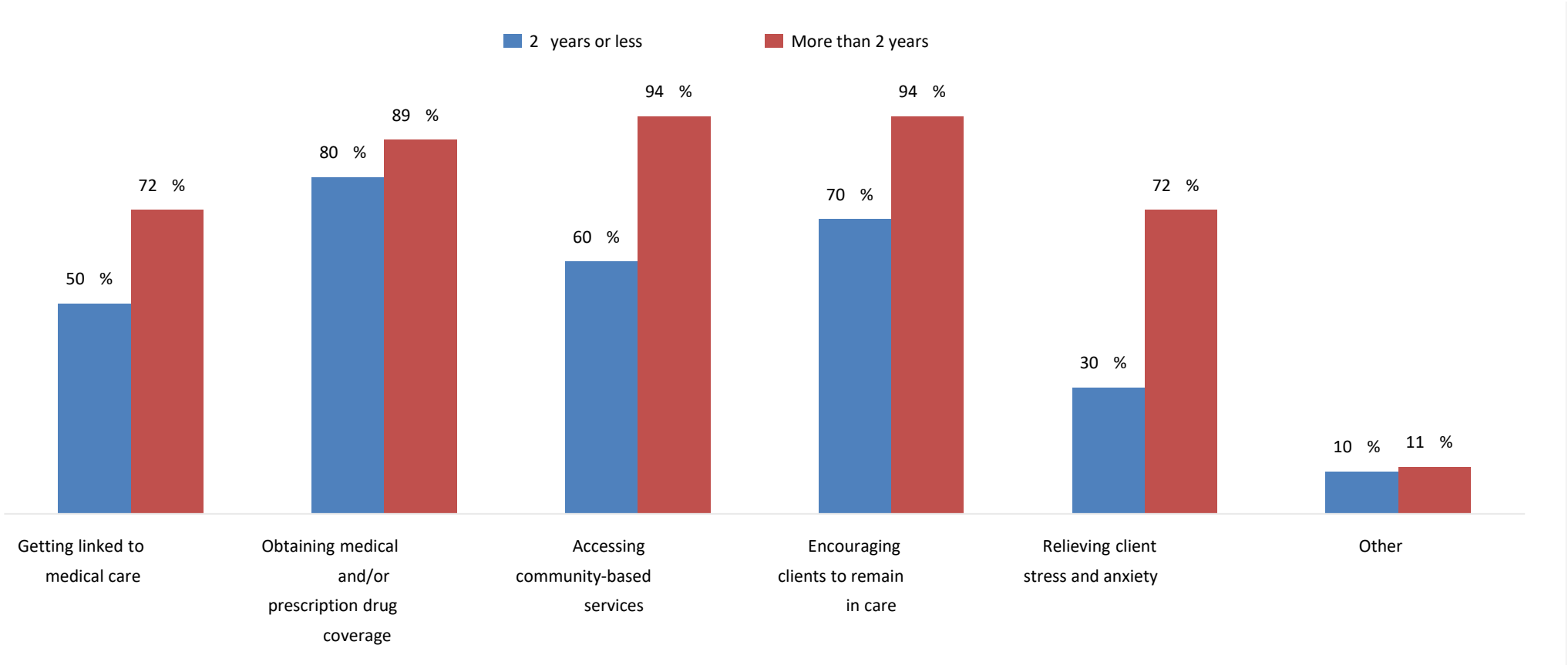
Considerations

- Create processes and incentives for agencies to make cross referrals so caseloads are more appropriately distributed
- Create a process for agencies to easily communicate if they are accepting new clients
- Adopt a standardized assessment tool to streamlin interagency referrals, ensure similar quality of service, and provide a tool to monitor client needs and the agencies abilities to meet needs.

I primarily help my clients with the following…
Percent of Survey Respondents by Years of Experience



Getting Linked to Medical Care

- Case managers primarily focus on linking those who:
  - Have fallen out of care (64%)
  - Are newly diagnosed (57%)
  - Are new to the jurisdiction (43%)

Supporting Medical and/or Prescription Drug Coverage

- Case Management agencies enroll clients in Ryan White, ADAP, and marketplace insurance
- Case managers spend a large amount of time on eligibility determination
- Collecting documents is also a challenge

Payment Assistance (Premiums & Copays)

- Case managers are not always sure what the difference between ADAP and Health Insurance Premium assistance eligibility is
- Epilepsy Alliance, FL has been crucial in supporting case managers with payments
- Sometimes issues with payments arise that are not the fault of case manager
- When there is staff turnover, some clients do not get payments on time or health insurance enrollment completed on time.

Social Support Services

- Available resources were not always available
- Biggest barrier is housing which has the fwest resources
  - Overworked case managers
  - Lack of funding
  - Lack of true solution
- Send referrals knowing that the client will not likely be able to access the service
- Cannot provide everything they would like to provide, generally because of funding limitations and not allow ability

Considerations

- Educate non-RWHAP providers who may engage with case managers on HIV care, RWHAP, the value of case management, and importance of sharing clinical data with case managers.
- Consider polling case managers to prioritize and develop additional service packages, such as hurricane preparation kits, hygiene kits
- Ensure all organizations have the funding and tools to provide transportation services, including ride sharing, and emergency housing assistance.

Communication

- Large caseloads often interfere wit ability to meet timeliness expectations for communication
- Varying client needs often overtake each other and minimize client access to case manager
- Drop in visits are expected but disrupt case manager time
- Most case managers use phone to communicate with clients the most

Strategies to Address Client Barriers

- **Providing clients with cell phones**: Some organizations, like Compass, have funding through EHE to provide clients with cell phones that has been beneficial for communication purposes.
- **Find clients during other appointments**: Case managers check client schedules to see when they are planning to come in for a medical or other appointment. They make sure to connect with clients at this time to understand needs and obtain new contact information if needed.
- **Search for other numbers in clinical records and applications:** Case managers recognize that they might not have clients' latest contact information, so they review other documentation and electronic health record (EHR) systems to find additional numbers.
- **Conduct home visits:** Case managers who have flexibility to visit client homes can "stop by" to deliver items, such as food cards.
- **Conduct internet searches**: Google, Blotter, and social media sites can point to a client's nearest location.
- **Identify emergency contacts**: Finally, emergency points of contact can be crucial for staying in contact with clients. However, when identifying these individuals with clients, case managers must determine whether emergency contacts know the client's HIV status and the type of information that can be shared with them.

Considerations

- Ensure all case managers have the necessary communication tools, including cell phones and laptop computers.
- Give more case managers the tools and resources necessary to conduct home visits if needed.
- Establish a program to support client cell phone use, either through referrals to an existing program, new phones, or payment for phone minutes.
- Ensure caseloads allow case managers sufficient time to address client emergencies. See next section for more details.
- Incorporate best practices in communication and finding clients who are not in consistent communication into training materials.

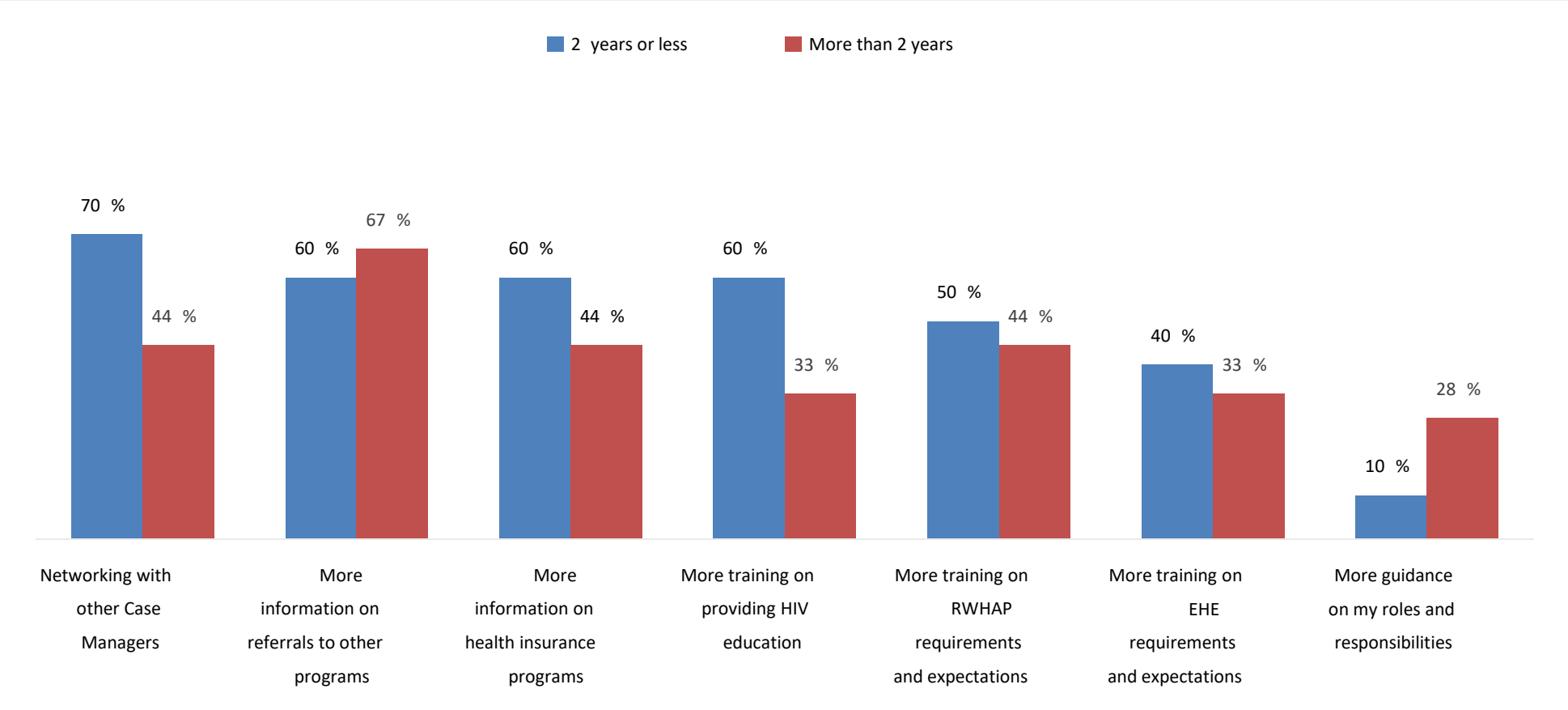
Staffing Issues

- Intensity and time of training is not consistent across agencies
- Agencies provide different tools for onboarding
- Case managers indicated that shadowing other case managers was integral to their success
- A majoriyty of case managers feel supported by their supervisors

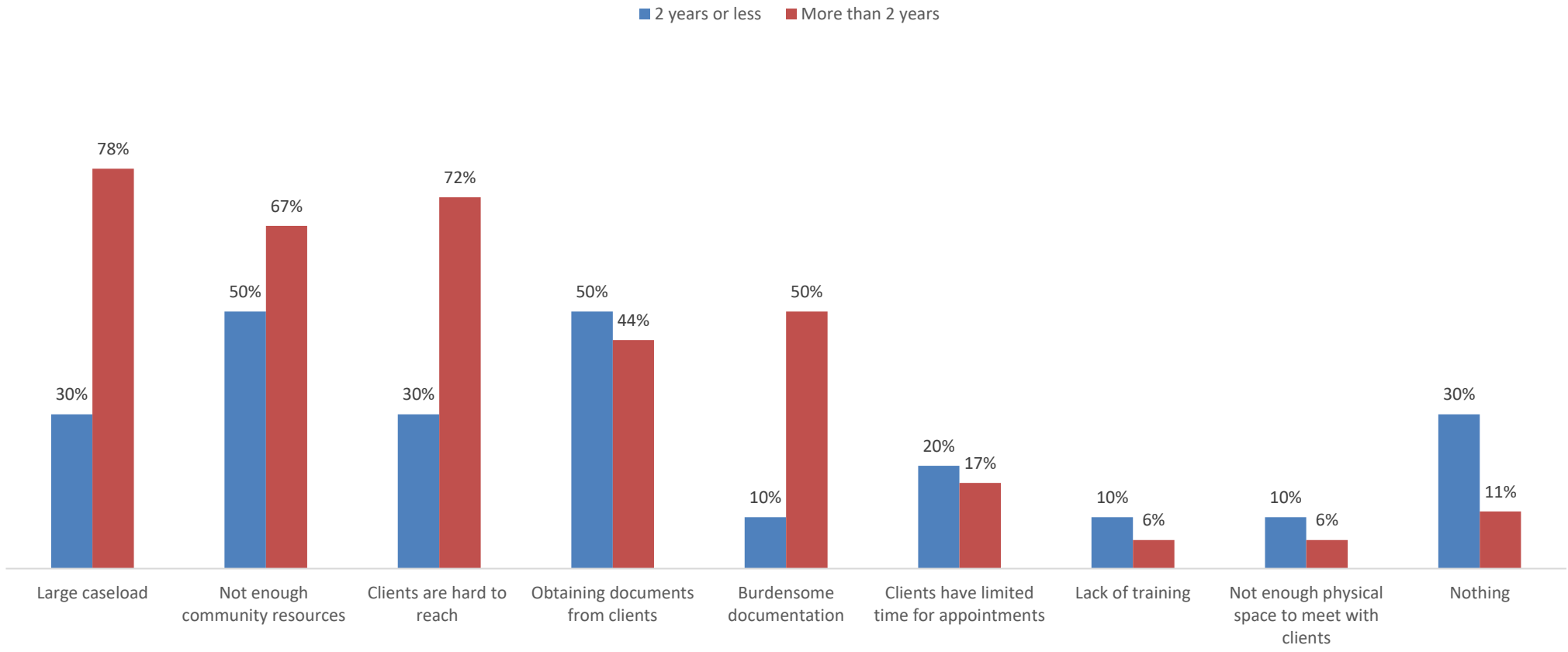
Identified challenges

- **Recruitment challenges and turnover:** Many organizations have open case management positions that they struggle to fill, impacting the capabilities of employed staff to meet client demands. Staff members also noted that the COVID-19 pandemic contributed to staff turnover and required restructuring in some organizations.
- **High workload**: Across all organizations, case managers are tasked with eligibility determination, medical support services and care coordination, and assistance with transportation, housing, food, and financial services. Given this amount of responsibility, case managers often have a reactive approach, where they juggle these responsibilities while attempting to address issues as they arise. As a result, case managers report that it has become more challenging to meet clients' needs, especially as client populations grow due to expanded eligibility. Some case managers also reported that acuity is increasing due to housing, substance use, and mental health issues, which also strains workload.
- **Low compensation:** A few case managers noted that the wages offered are not sufficient for a livable standard, leading some staff members to relocate while attempting to maintain their workload. In other instances, staff members leave the agency.
- **Responsibility creep**: Due to often being short-staffed, case managers are tasked with responsibilities outside of their core role. Responsibility creep includes supporting events like pride celebrations and support groups, while also covering front desk duties. One case manager reported that they were asked to make home visits to deliver food. Case managers may also have to act as translators or interpreters for non-English speaking clients, disproportionately affecting the workload of bilingual case managers.
- **Consolidation of medical case management and non-medical case management:** Another change to the role involves the combination of medical and non-medical case manager roles, which previously were separate roles and functions. Though many organizations have merged these responsibilities to streamline services to clients, this change in policy affects case manager responsibilities and documentation needs.

What would better support you in your job?
Percent of Survey Respondents by Years of Experience



What prevents you from supporting clients?



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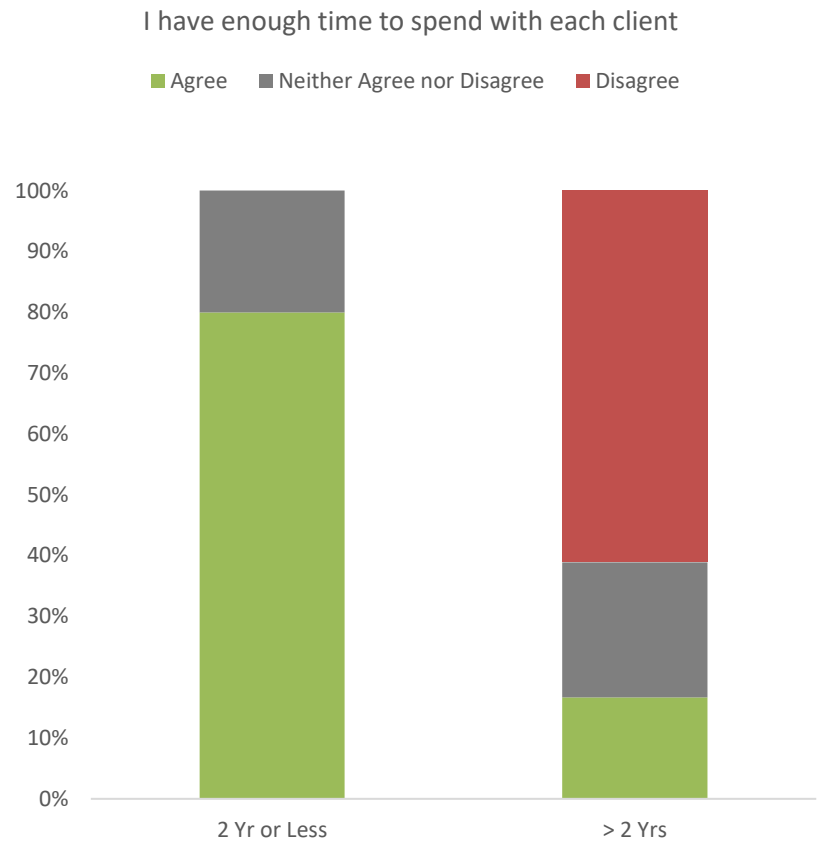
Feedback on Time with Clients and Caseload



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Considerations

- Provide more peer-to-peer learning opportunities across case management agencies. In-person trainings with all case managers could bolster relationships across agencies, improve knowledge sharing, and facilitate cross agency referrals.
- Continue to conduct trainings for case managers and specify which trainings should be done in-house by the case management agency. A few case managers suggested that there should be separate roles for those who administer training and those who supervise case managers, as this could relieve supervisor time and allow them to meet one-on-one with the case manager. Palm Beach County should continue to take the lead on some training topic areas to reduce supervisor burden and promote standardization.
- Consider using a central eligibility process, so case managers do not have to perform eligibility determination as part of their jobs. As stated in the previous section, eligibility is a large part of their work. Removing this responsibility would free up more time for case managers to focus on client needs.
- Reduce caseload, so case managers have time to address all client issues. This may require leveraging EHE funds to hire more case managers or increasing compensation. Funds could also be used to hire staff who specialize in eligibility, insurance assistance, or housing to reduce work in these areas for existing case managers.

Future Plans

- Ending the HIV Epidemic will go into a new 5 year cycle in 2025
- A new grant application will be submitted this year
- Coordination between Care Council and EHE coordination will assure clients receive the best quality care

Questions?

Palm Beach County
Ending the HIV Epidemic

Healthcare + Housing Opportunities (H2O)

Andres Correa, PhD, MJ, MS
Casework Supervisor
Palm Beach County Ending the HIV Epidemic Iniatitive
acorrea@pbcgov.org
561-274-1097

Palm Beach County
HIV Elimination Services

Program Description

Healthcare + Housing Opportunities (H2O) provides clients with access to a range of services intended to maximize access and adherence to comprehensive health care in coordination with stable, permanent housing for priority populations of people with HIV. This program does not provide standalone housing assistance to clients, rather it provides opportunities that support upward economic mobility leading to self-sufficiency through increased engagement in health care and support services to obtain and maintain stable, permanent housing.

Program Guidance

Healthcare + Housing Opportunities (H2O) services may include:

- H2O Case Management (including comprehensive assessment and collaborative goal-setting, financial planning/literacy, employment counseling, housing resource identification, referrals for health care and support services, etc.)
- Transitional housing assistance
- Relocation assistance
- Budget-deficit rent/utility assistance
- Transportation assistance
- Employment counseling
- Vocational rehabilitation
- GED/ESL classes
- Tele-Adherence Counseling

H2O Criteria & Required Documentation

1. Client is currently **experiencing homelessness OR Severely cost-burdened** (defined as spending more than 50% of earned income on housing costs (mortgage/rent/utilities); **AND**

2. Client ability and willingness to adhere to HIV treatment plans to achieve and maintain viral suppression; **AND**

3. Client ability and willingness to achieve self-sufficiency to obtain and maintain stable, permanent housing

H2O Caps/Limitations

- One-time enrollment
- Transitional housing limited to 14 days, with potential re-authorization contingent on achieving progress with H2O service goals/objectives
- Rental assistance limited to 12 months with a maximum amount equal to the annual severely cost-burdened budget-deficit amount (defined as the difference between 50% of client's earned income minus actual rental cost OR Rent Reasonableness if no current lease exists)
- Utility Assistance limited to 100% for months in which rental assistance is provided
- Transportation Assistance limited to trips necessary to achieve H2O service goals/objectives
- Relocation Assistance limited to 3 x monthly rent
- H2O Case Management will not be limited

H2O Definitions & Typology

Definitions

- Severely Cost-Burdened - Greater than 50% of earned income expended on rent
- Rent Reasonableness - 120% Fair Market Rent
- Homelessness - Sleeping in settings not designated for shelter including cars, parks, encampments, bus stops, abandoned buildings, streets, sidewalks, and other public spaces.

Typology

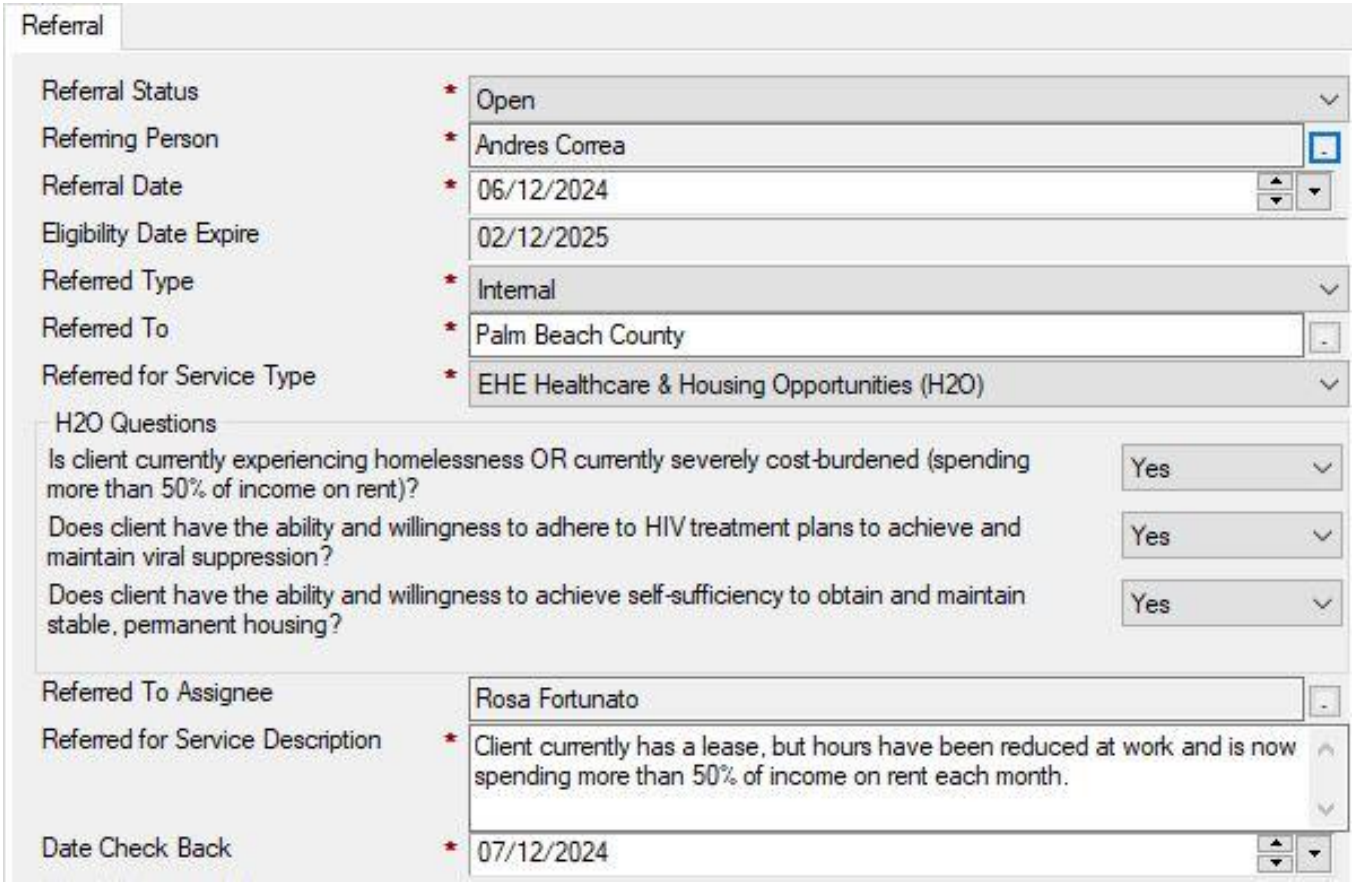
- Income, Lease
- No Income, Lease
- Income, No Lease
- No Income, No Lease

	Income	No Income
Lease	IL	NIL
No Lease	INL	NINL

H2O Referrals

Referrals should be sent in Provide Enterprise (PE)

- H2O Questions must be answered, and all 3 criteria must be met in order to send a referral
- EHE Enrollment is not required prior to referral for H2O



H2O Service Documentation

All H2O Service Documentation will be completed by H2O Case Managers

- Screening Assessment
- Coordinated Services Network (CSN) (In PE)
- Consent To Release Information
- Participation Agreement
- Transitional Housing Client Responsibilities (If Applicable)
- Housing Assessment
- Financial Assessment
- Mental Health And Substance Abuse Screening (In PE)
- Self-sufficiency Matrix
- H2O Care Plan (In PE)
- Monthly Budget Planner
- Savings Plan
- Viral Suppression Log
- A Week of Meaningful Activities
- New Property Checklist
- Self-Sufficiency Estimator
- Rental Assistance Plan

Open Forum Discussion/Q & A

END OF DAY 1

The Status of HIV in Palm Beach County

2024

Presented by

Palm Beach County HIV Elimination Services

&

Palm Beach County HIV CARE Council

July 15th and 16th, 2024

Palm Beach County
HIV Elimination Services

DAY 2 – JULY 16, 2024

Summary of the Ryan White HIV/AIDS Program (RWHAP) Grant Year 2023 Subrecipient Monitoring Findings

Anna Balla
Grant Compliance Specialist II
Palm Beach County HIV Elimination Services
aballa@pbc.gov
(561) 355-4665

Palm Beach County
HIV Elimination Services

Purpose of the Summary

- U.S.Health Resources & Services Administration (HRSA) recommends that Ryan White HIV/AIDS Program (RWHAP) Recipients provide a summary of annual Subrecipient monitoring findings to the HIV CARE Council.
- Palm Beach County (Recipient) will provide a summary of findings highlighting systemic issues, or patterns across more than one agency.
- The summary will note how the Recipient is addressing the systemic findings.

RWHAP Monitoring Process Overview

- All Ryan White HIV/AIDS Program (RWHAP) Sub-recipients are monitored, minimally on an annual basis, in accordance with the U.S. Health Resources & Services Administration (HRSA) Standards and contract agreement.
- The annual site visit must test compliance with HRSA Monitoring Standards, programmatic and fiscal standards.
- The comprehensive monitoring tool is used for each agency.
- There are four parts to the tool:
  1. Program Operations Review
  2. Fiscal Review
  3. Service Delivery Standards Review
  4. Continuous Quality Management
- The Community Services Department Contracts, Compliance and Program Performance (CCPP) Section is in charge of scheduling the agency visit and issuing the final report to the agency.

RWHAP Monitoring Process

- The Grant Compliance Specialist (GCS) develops a draft monitoring schedule at the beginning of the grant year
- After the GCS sets the Monitoring dates in consultation with the Sub-Recipients, the GCS sends a confirmation e-mail to the sub-recipient designee. The e-mail will confirm the date(s), time(s), location(s), and staff to be made available during the visit.
- The GCS sends the sub-recipient designee a packet that includes a confirmation letter, monitoring tools, Document Request Form, and Monitoring Planning Agenda.
- The week prior to the site visit the GCS will forward the sub-recipient designee a Client ID list indicating the client charts to be reviewed during the site visit.

Entrance Conference Meeting

- Visits will start with an Entrance Conference (opportunity for program review team to explain visit and the opportunity for the sub-recipient to present its program). The Entrance Conference is designed to facilitate introductions of all individuals involved, describe the review process, and address any questions and/or concerns presented prior to the beginning of the review.

RWHAP Sub-recipient Contracts

- In GY 2023 - 9 Sub-recipients contracted with Palm Beach County Ryan White HIV/AIDS Program to provide Core Medical and Support Services -21 Service Categories
- A total of 250 client files were reviewed across all service categories.

Core Services

- AIDS Pharmaceutical Assistance
- Early Intervention Services
- Early Intervention Services-MAI
- Health Insurance
- Laboratory Diagnostic Testing
- Medical Case Management
- Medical Case Management - MAI
- Mental Health Services
- Oral Health Care
- Outpatient/Ambulatory Medical Care
- Specialty Outpatient Medical Care

Support Services

- EFA-Prior Authorizations
- Emergency Financial Assistance
- Emergency Housing Services
- Food Bank/Home Delivered Meals
- Food Bank/Nutritional Supplements
- Legal Services
- Medical Transportation
- Non-Medical Case Management
- Non-Medical Case Management-MAI
- Psychosocial Support Services-MAI

RWHAP Monitoring Findings

- Program Operations Review Findings
  - 1 of 9 (11%) Subrecpients had findings in Submission of documents.
- Fiscal Review Findings
  - 4 of 9 (44%) Subrecipients had findings due to Program Income, incorrect or incomplete submission of documents.
- Service Delivery Standards Review
  - 8 of 9 (89%) Subrecipients had findings in Service Delivery Standards

- *Service Standards* outline the elements and expectations a Ryan White HIV/AIDS Program (RWHAP) service provider must follow when implementing a specific service category. The purpose of service standards are to ensure that all RWHAP service providers offer the same fundamental components of the given service category across a service area.

GY23 RWHAP Monitoring Findings-Detail

Program Operations Review

- Governance-Meeting Minutes
- Facilities- Fire Inspection Reports

Fiscal Review

- Program Income
- Incomplete or insufficient submission of documents

RWHAP Monitoring Findings-Detail (cont'd)

Service Delivery Standards: FINDINGS BELOW BY SERVICE CATEGORY

- **MCM vs. NMCM**: Ensuring NMCM is documented for activities related to clients needing assistance with accessing services. MCM should be documented for activities related to clients needing assistance with adherence to care issues.
- **Medical Case Management Services (MCM)**: Missing required client documentation, service notes, labs, referral follow up.
- **Non Medical Case Management Services (NMCM)**:
  - Insufficient documentation regarding referral to Early Intervention Services (EIS): for assistance to maintain Eligibility.
  - Lack of follow-up and additional client needs not updated. Communication was not continued between staff and client.

- **Early Intervention Services (EIS)**
  - Insufficient documentation of provision of all 4 required EIS components with Part A or other funding (testing/referral/linkage/education and training).

- **Emergency Financial Assistance Service (EFA**.Multiple presceipitons dispensed were recurring for greater than 60 days.
- **Food Bank/Home Delivered Meals**: Missing Food Stamp data in PE.
- **Psychosocial Support Services**: Documentation did not support "counseling" services as defined by this services category.
- **Legal Services:** Insufficient documentation of notification to referring Subrecipeint of outcome for resolution. Insufficient documentation on how it was related to HIV status needs.

Corrective Action Plan

The monitoring report acknowledges Subrecipient's strengths, areas of improvement including any findings and recommendations.

- Findings are addressed through a Corrective Action Plan (CAP), which must adhere to the following:
  - Sub-recipient must respond to the Grant Compliance Specialist within 30 calendar days of site visit report with a formal Corrective Action Plan (CAP).
  - The Plan must detail the timeline (e.g. 45 days from receipt of the site visit report), responsible parties and steps that the sub-recipient will take to rectify the problem and prevent it from occurring again.
  - Any CAP that do not meet the approval of the Recipient, must be revised and resubmitted. The GCS will send sub-recipient a written notification of CAP approval/denial.
  - Recipient GCS shall conduct follow-up and provide Technical Assistance with Sub-Recipient (if required or requested).
  - Recipient GCS must be ensure that Sub-Recipient Findings are resolved.

Technical Assistance (T/A)

T/A Provided to Sub-recipients

- **Bi-Monthly Sub-recipient Meetings**
  - **PROGRAM ADMINISTRATION**
    - Review and discuss outstanding corrective action plans updates, Key Staff Changes, Progress toward implementation goals, Client Complaints, Grievance, RSR, Etc.
  - **FISCAL:**
    - Review and discuss Expenditure to date; Invoicing /Reimbursement, Under/Overspending, Budget Revisions, Etc. Service Category Expenditures Spreadsheet/Ledger Attached
  - **CQM:**
    - Review and discuss QM Plan; Performance Measurements, QI Projects, Use of Data Reports, Program changes, Training, Etc.
- **Quarterly Provider Meetings**
- **Palm Beach County HIV/AIDS Program Manual**
- **Provide Enterprise Trainings Recordings**
  - **Database Trainings**
  - **Reimbursement Trainings**
  - **Billing/Contract Management Trainings**

Other T/A Resources

- **Regional AIDS Education and Training Centers (AETC)** offer a wide range of training opportunities for health professionals, including lectures, preceptorships, webinars, and conferences.
- **Target HIV** website is the one-stop shop for technical assistance (TA) and training resources for HRSA's Ryan White HIV/AIDS Program (RWHAP). Resources include webinars, tools, training materials, manuals, and guidelines that focus on RWHAP service delivery and agency

Key Takeaways

Subrecipients, including their sub-contractors, shall be monitored annually by the Recipient to ensure compliance with all applicable HRSA standards.

- Obtain a better understanding of the Subrecipient Program in Palm Beach County;
- Ensure compliance with legislative mandates and program requirements;
- Review fiscal and administrative systems and process, quality management (QM), and internal controls;
- Asses the system of HIV care;
- Assess community and consumer involvement; and
- Identify technical assistance (TA) needs.

PBC Ryan White Part A/MAI Continuum of Care

Daisy Wiebe, PhD, MPH
Quality Management Clinician
PBC Ryan White HIV/AIDS Program
dwiebe@pbc.gov
(561) 355-4760

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Care Continuum Optimized Report Performance Measures Definitions

- **In Care**
  - Percentage of PWH who had at least one medical care service in the reporting period (12 months)
  - Numerator: Number of clients who are HIV+ who had medical care in the reporting period (12 months)
    a) Client has a "Kept" medical appointment OR
    b) Client had a CD4 or Viral Load test result OR
    c) Client has a Payment Request "Paid" (Co/pay or Deductible) OR
    d) Client had a prescription dispensed
  - Denominator: Clients that are HIV+ and received at least one service from the selected service category(s) in the reporting period (12 months) from the selected agency(s)

Care Continuum Optimized Report Performance Measures Definitions

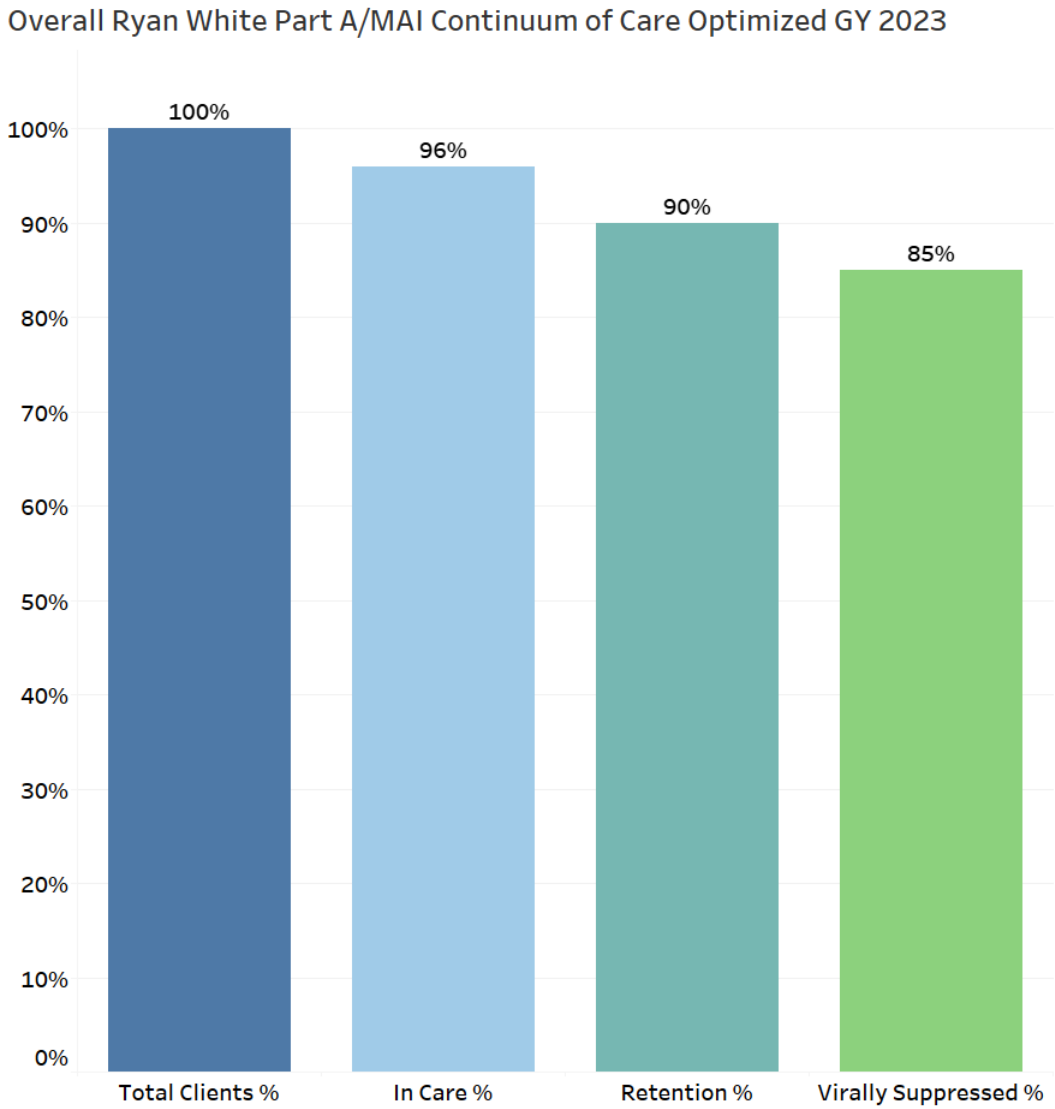
- **Retention in Care:**
  - Percentage of PWH who had two or more medical care services at least three months apart in reporting period among those who also received at least one service from the selected service category(s) in the first 6 months of the reporting period from the selected agency(s)
  - Numerator- Retention in Care Svc First 6 Mo: Number of clients who are HIV+ who had two or more HIV medical care services at least three months apart within a 12-month measurement year among those who had at least one service from the selected service category(s) in the FIRST 6 MONTHS of the reporting period from the selected agency(s)*
    a) Client has a "Kept" medical appointment during the reporting period OR
    b) Client had a CD_4 or Viral Load test result during the reporting period OR
    c) Client has a Payment Request "Paid" during the reporting period (Co/pay or Deductible) OR
    d) Client had a prescription dispensed during the reporting period
  - Denominator- Svc in First 6 Mo: Clients who are HIV+ and received at least one service from the selected service category(s) in the FIRST 6 MONTHS of the reporting period from the selected agency(s)

Care Continuum Optimized Report Performance Measures Definitions

- **Viral Load Suppression:**
  - Numerator: HIV+ clients whose most recent viral load test result record is less than 200 and the test result is from the reporting period (12 months)
  - Denominator: Clients who are HIV+ and received at least one service from the selected service category(s) in the reporting period (12 months) from the selected agency(s)

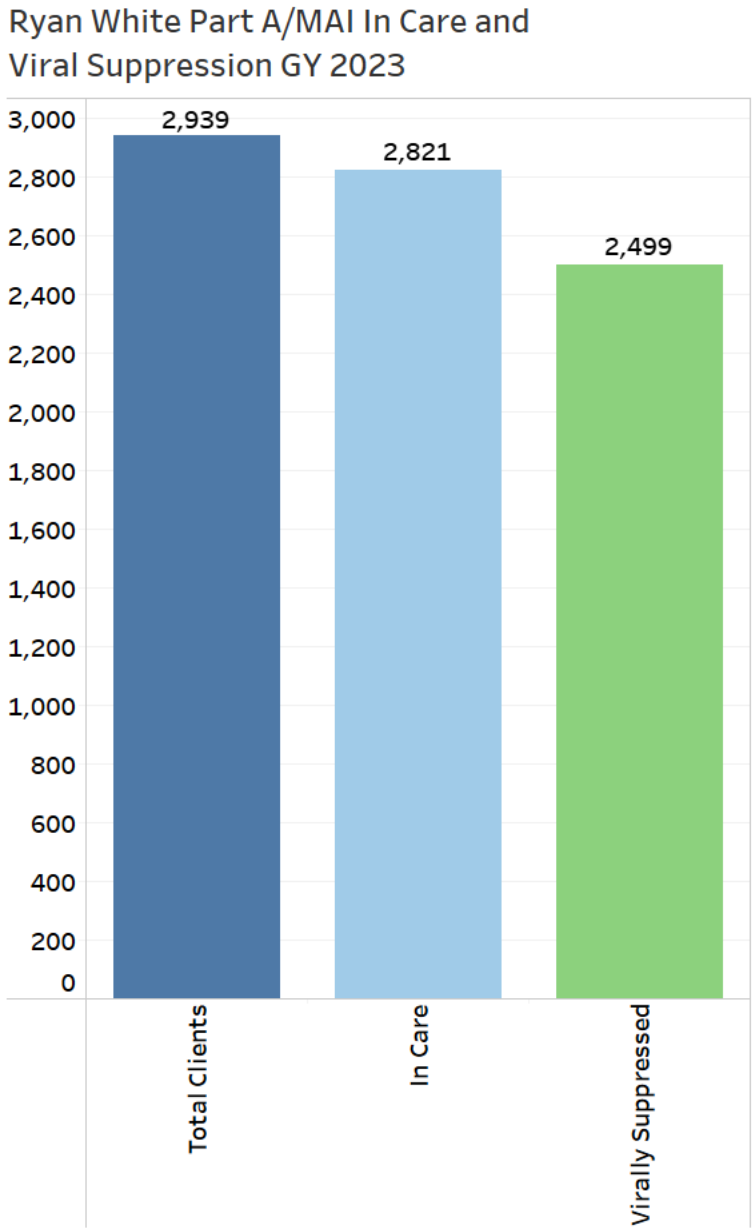
Care Continuum Optimized Report Grant Year 2023

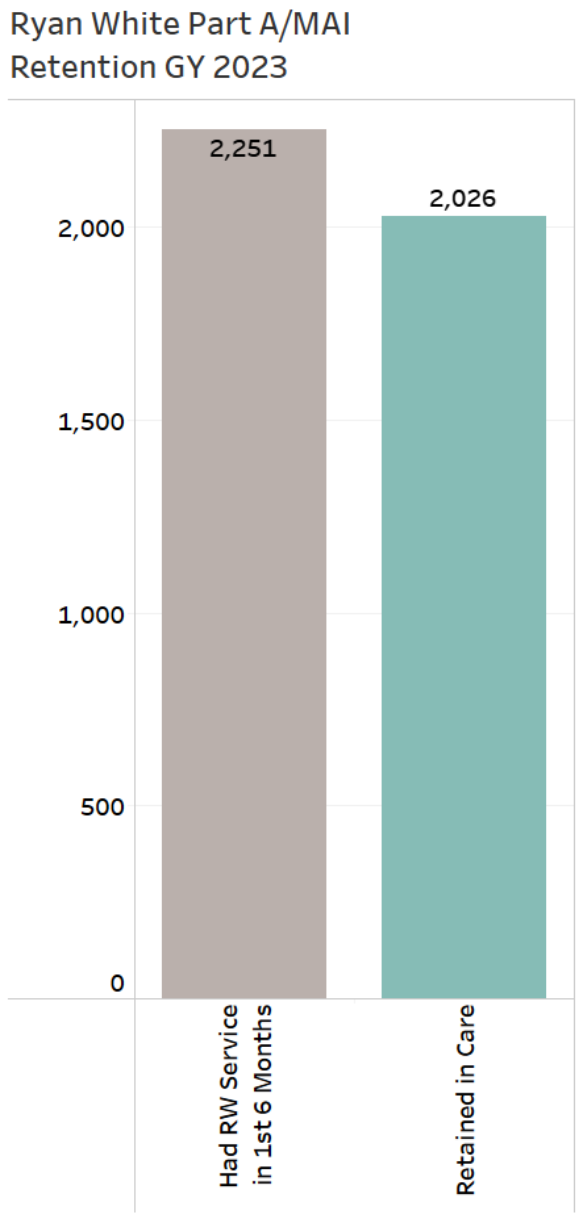
- Reporting period for the next set of slides is Grant Year 2023 (March 1, 2023 - February 29, 2024)
- All services and agencies were selected in the report
  - All individuals with any service from any agency from the Ryan White Part A/MAI Program are included in the next set of slides
- The report has benefited from having Florida Department of Health HIV surveillance viral load lab results imported into the Ryan White Part A/MAI data to fill in missing viral load data (i.e. when clients use health insurance for outside providers)



Overall, the Ryan White Part A/MAI System of Care has successful outcomes for engaging clients in care, retaining clients and getting clients to viral suppression

The largest gaps for Ryan White Part A/MAI are clients **who were not virally suppressed (n=440),** followed by clients **who were not retained (n=225)**





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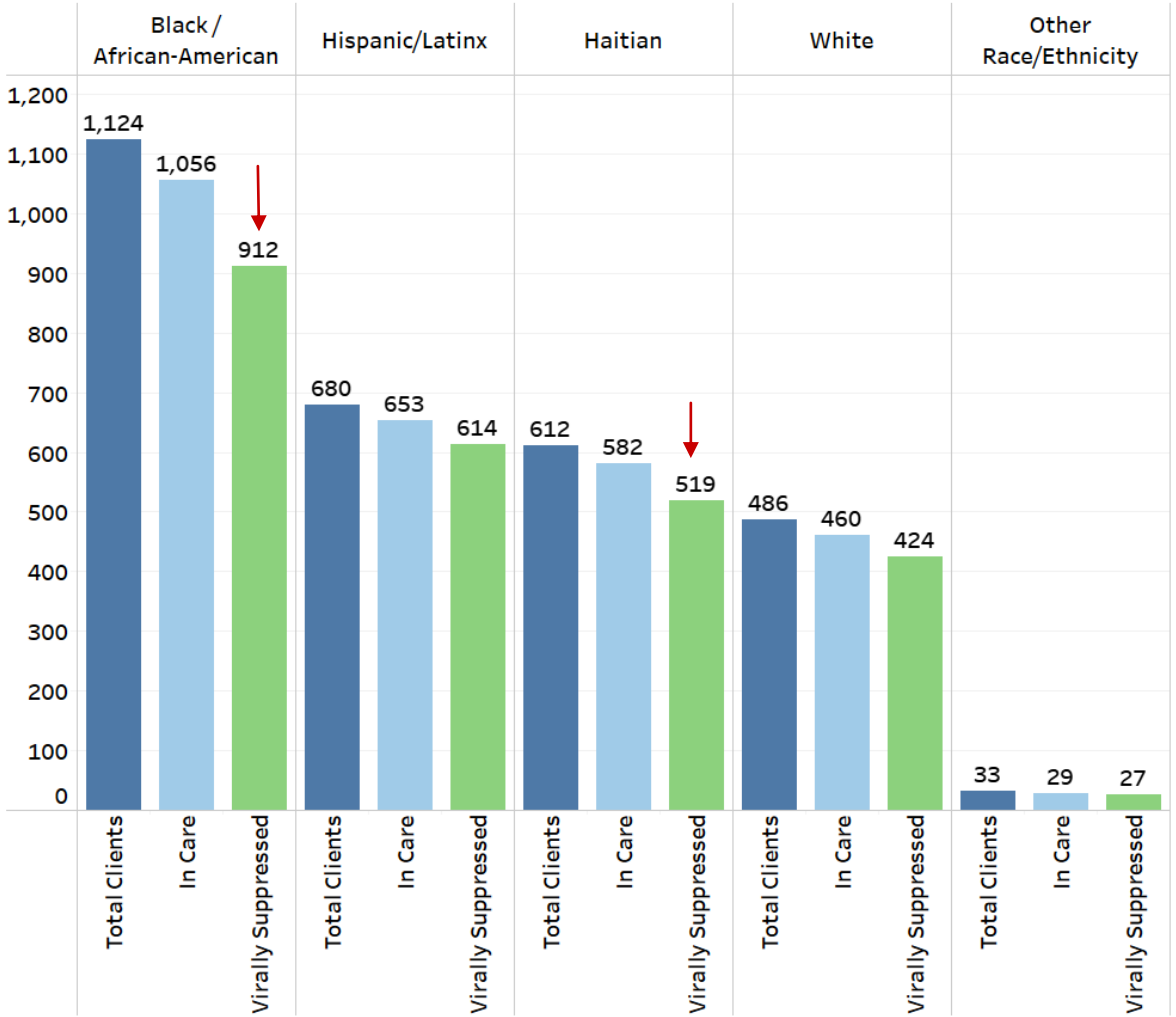
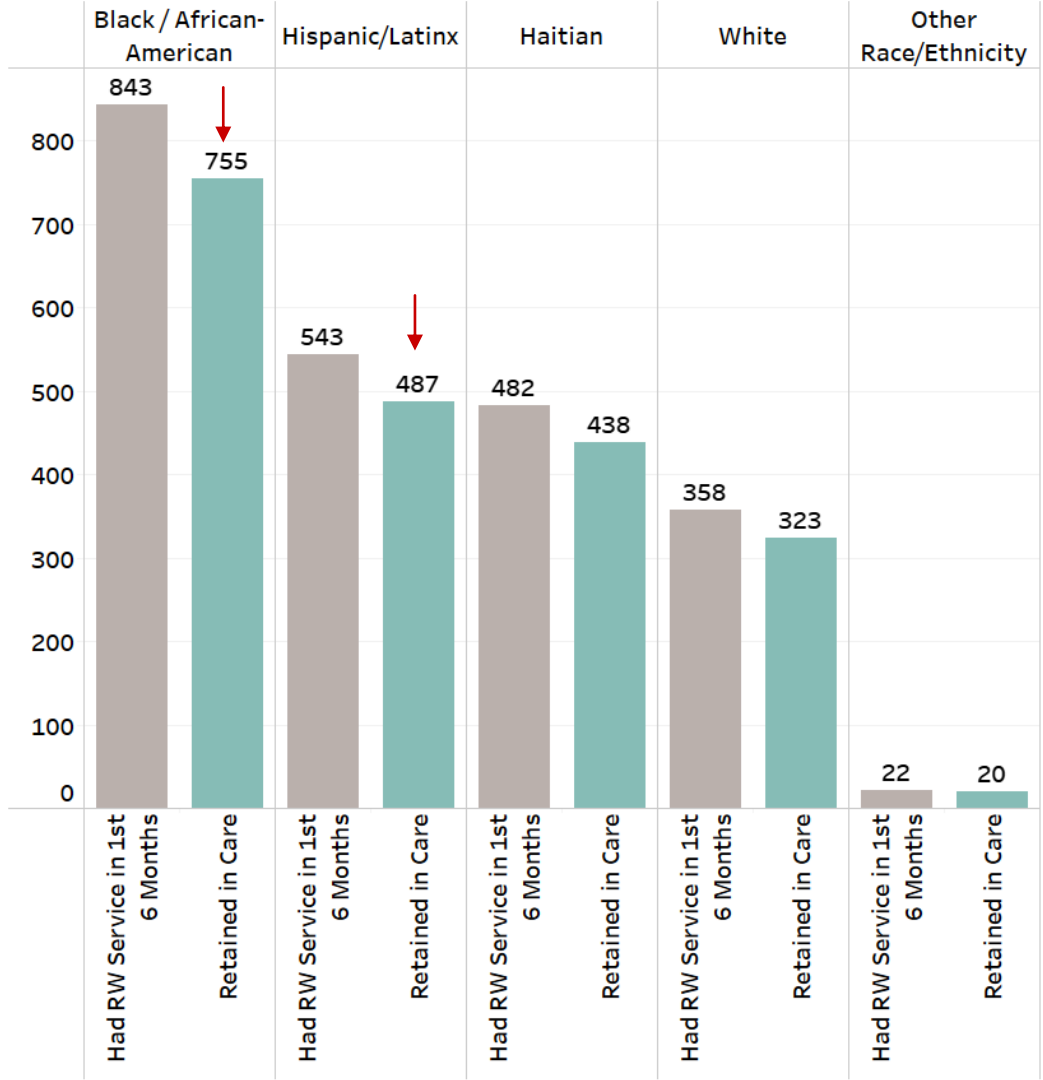
Ryan White Part A/MAI In Care and Viral Suppression GY 2023:
By Race/Ethnicity



Ryan White Part A/MAI Retention GY 2023:
By Race/Ethnicity



Black/African-Americans in Ryan White Part A/MAI are the **largest demographic group who is not virally suppressed (n=212) and not retained (n=88).** The next largest group **not virally suppressed are Haitian individuals (n=93),** and the next largest group **not retained are Hispanic/Latinx individuals (n=56).**

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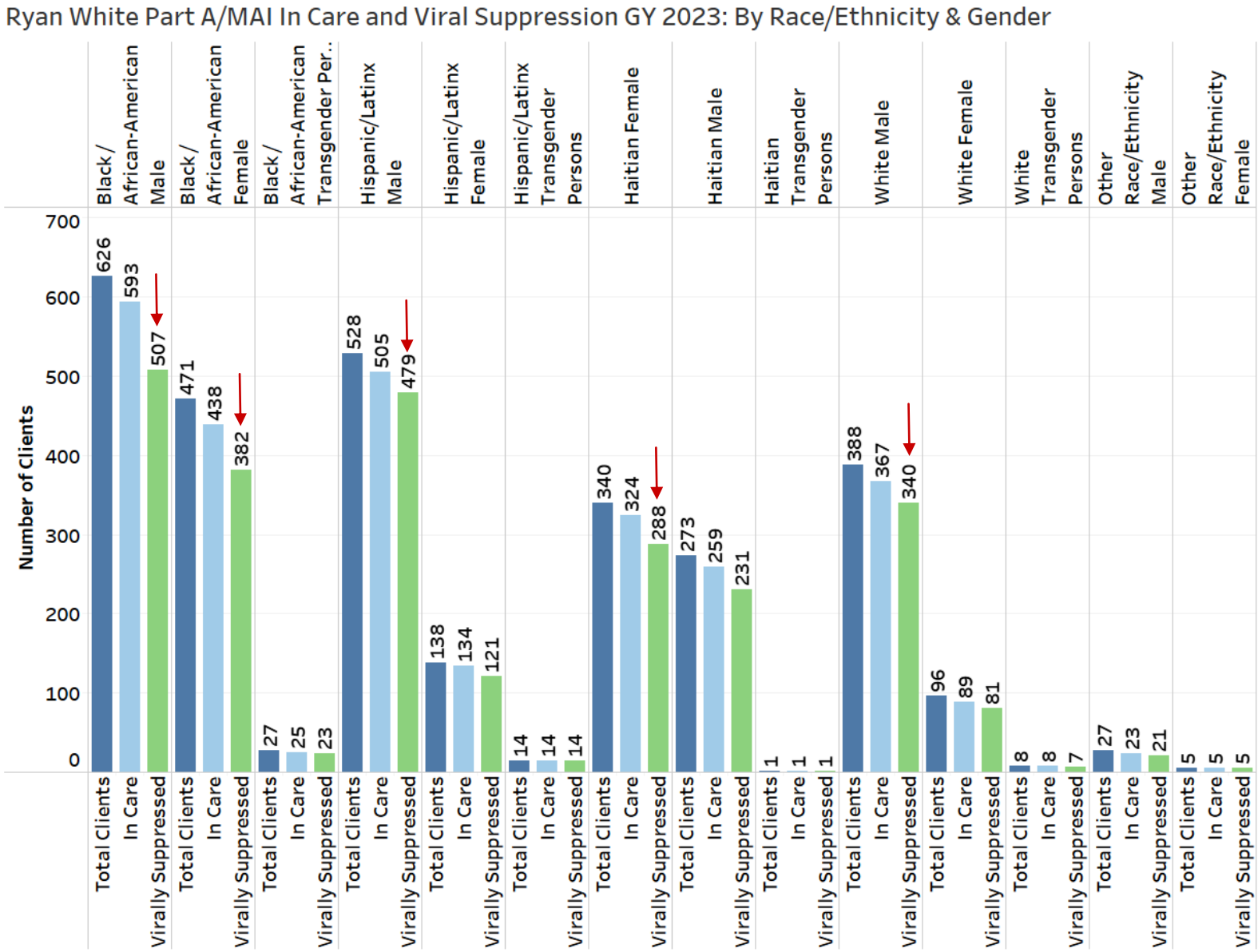
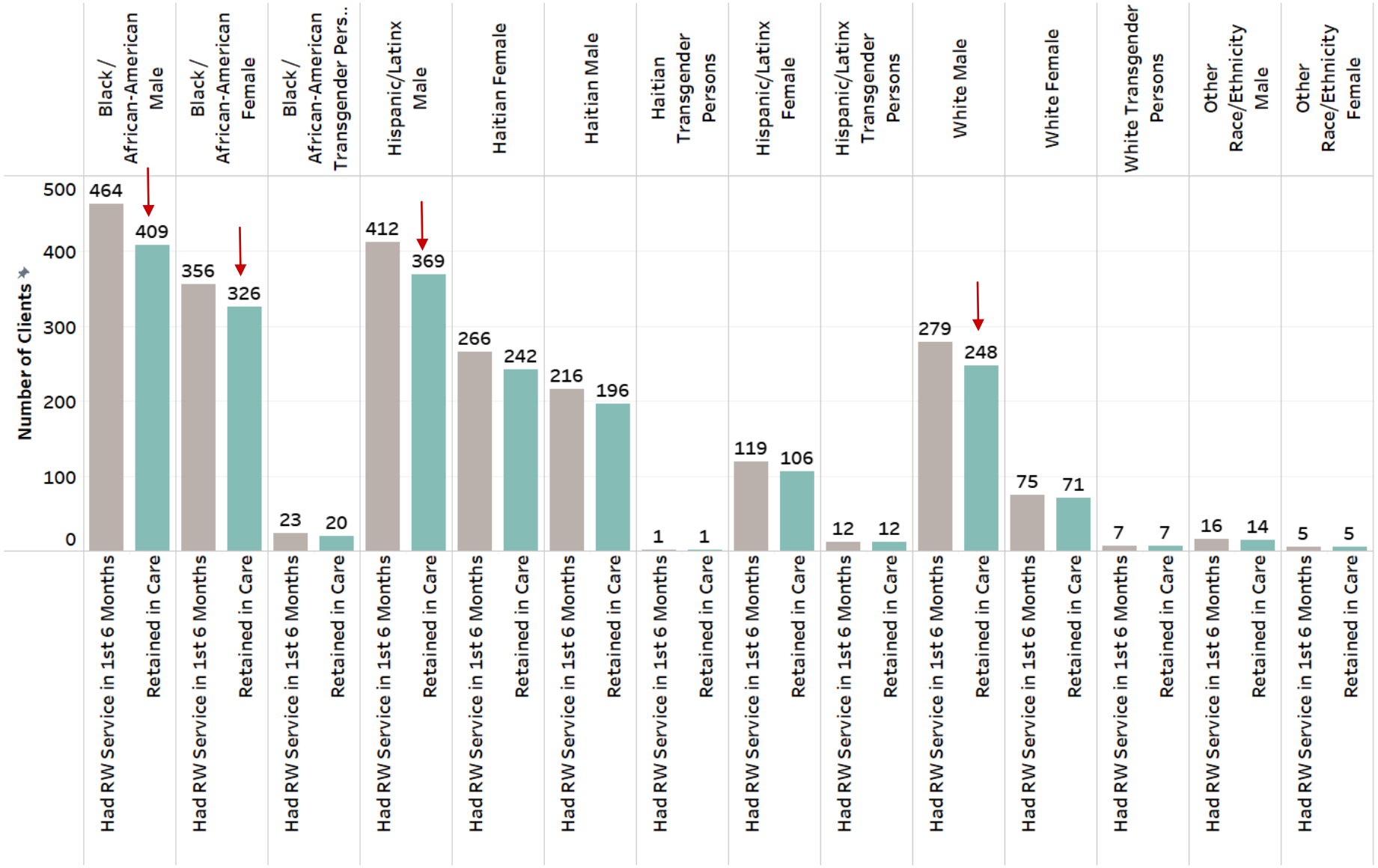


Black/African-American male and females in Ryan White Part A/MAI are the largest group **who are not virally suppressed (n=119 and n=89),** followed by **Haitian females (n=52), Hispanic/Latinx males (n=49)** and **White males (n=48)**

Ryan White Part A/MAI Retention GY 2023: By Race/Ethnicity & Gender



Black/African-American males in Ryan White Part A/MAI are the largest group **who are not retained (n=55),** followed by **Hispanic/Latinx males (n=43), White males (n=31) and Black/African-American females (n=30)**

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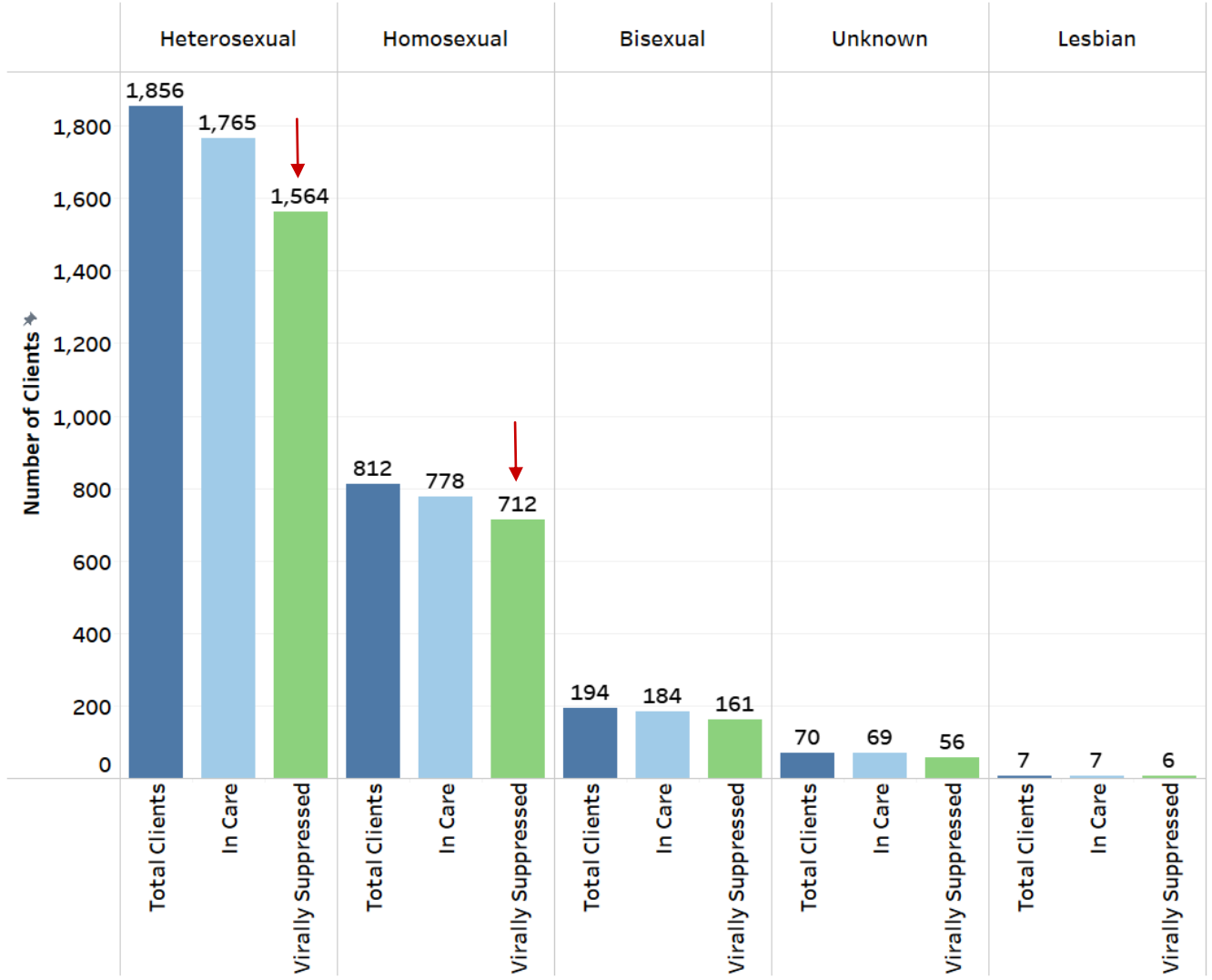
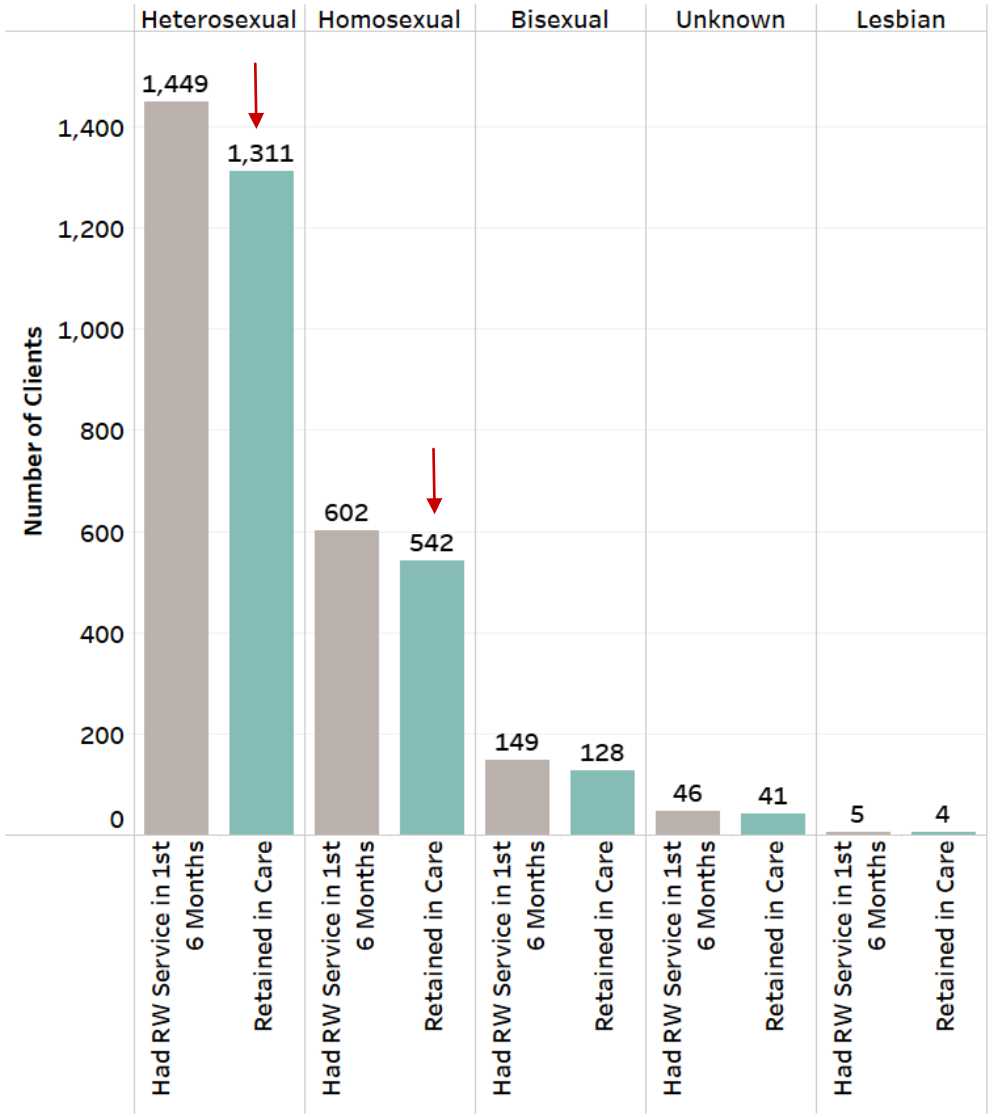
Ryan White Part A/MAI In Care and Viral Suppression GY 2023:
By Sexual Orientation

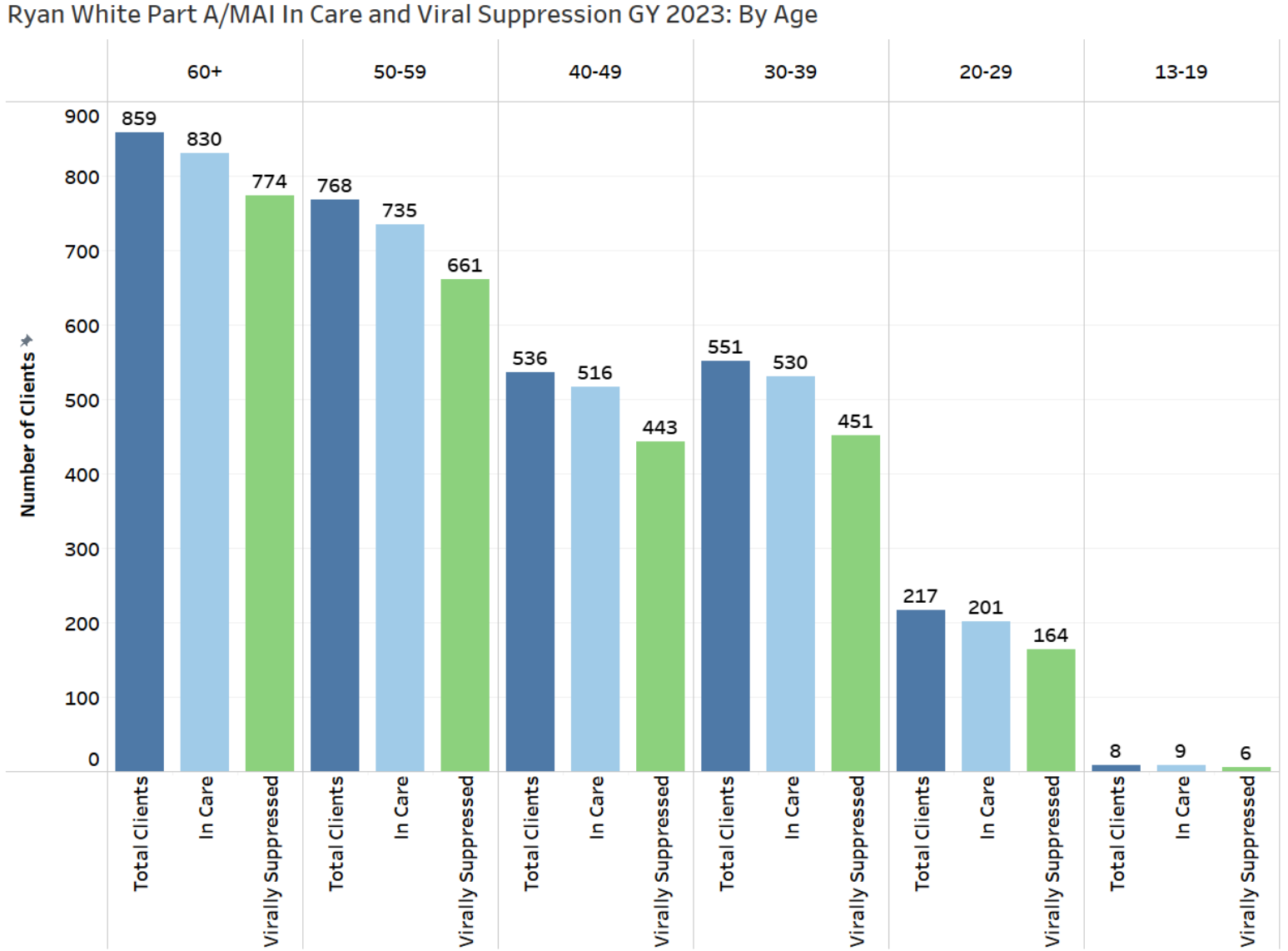


Those who identify as heterosexual in Ryan White Part A/MAI are the largest group **who are not virally suppressed (n=292),** followed by **those who identify as homosexual (n=100)**

Ryan White Part A/MAI GY 2023 Retention:
By Sexual Orientation



Those who identify as heterosexual in Ryan White Part A/MAI are the largest group **who are not retained in care (n=138),** followed by **those who identify as homosexual (n=60)**



Ryan White Part A/MAI serves an **aging population**. However, the gaps in care can be found throughout the continuum.

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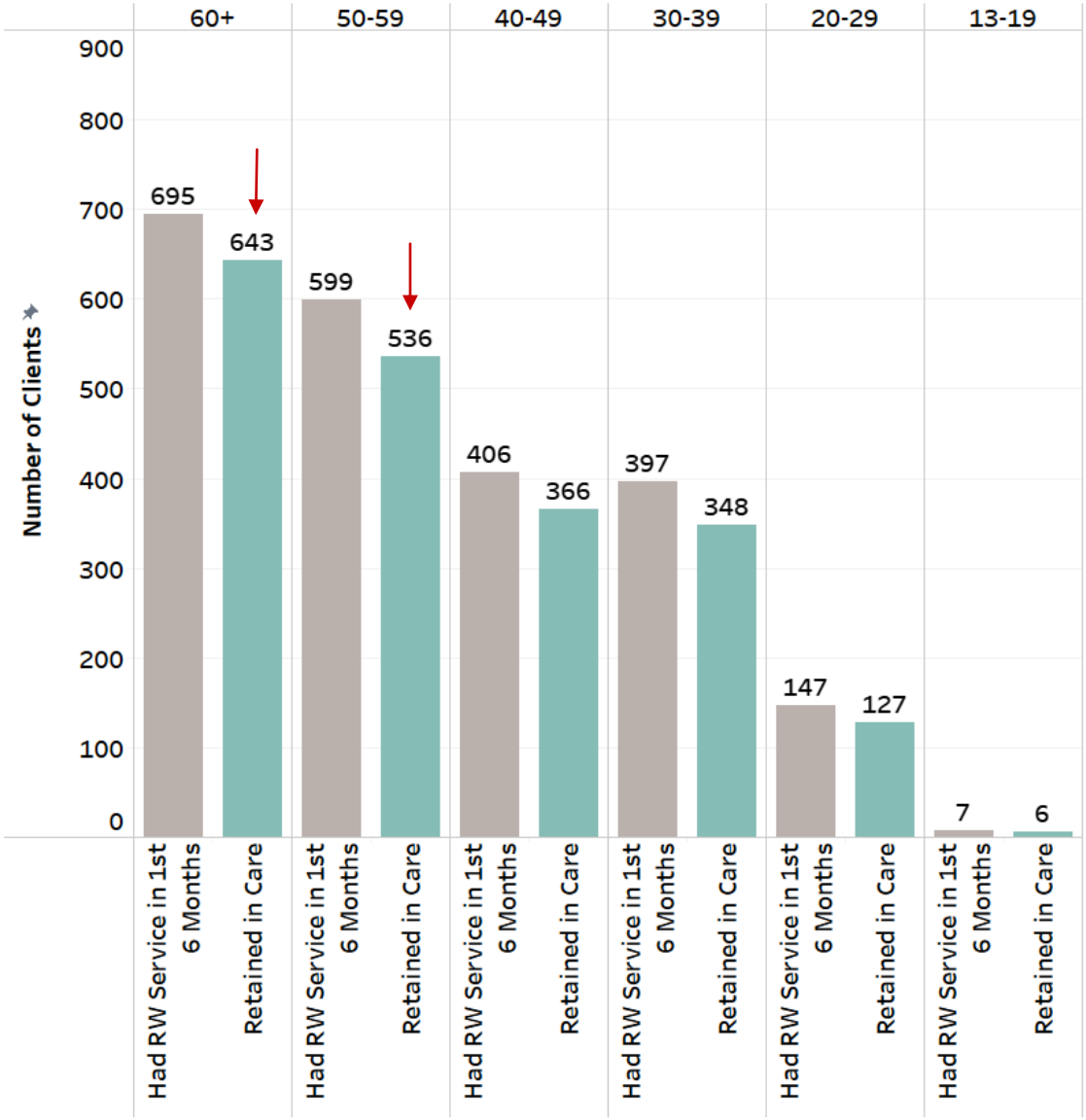
Ryan White Part A/MAI GY 2023 Retention:
By Age



The **largest group not retained are those 50-59 years of age (n=63),** followed by **those 60+ (n=52)**

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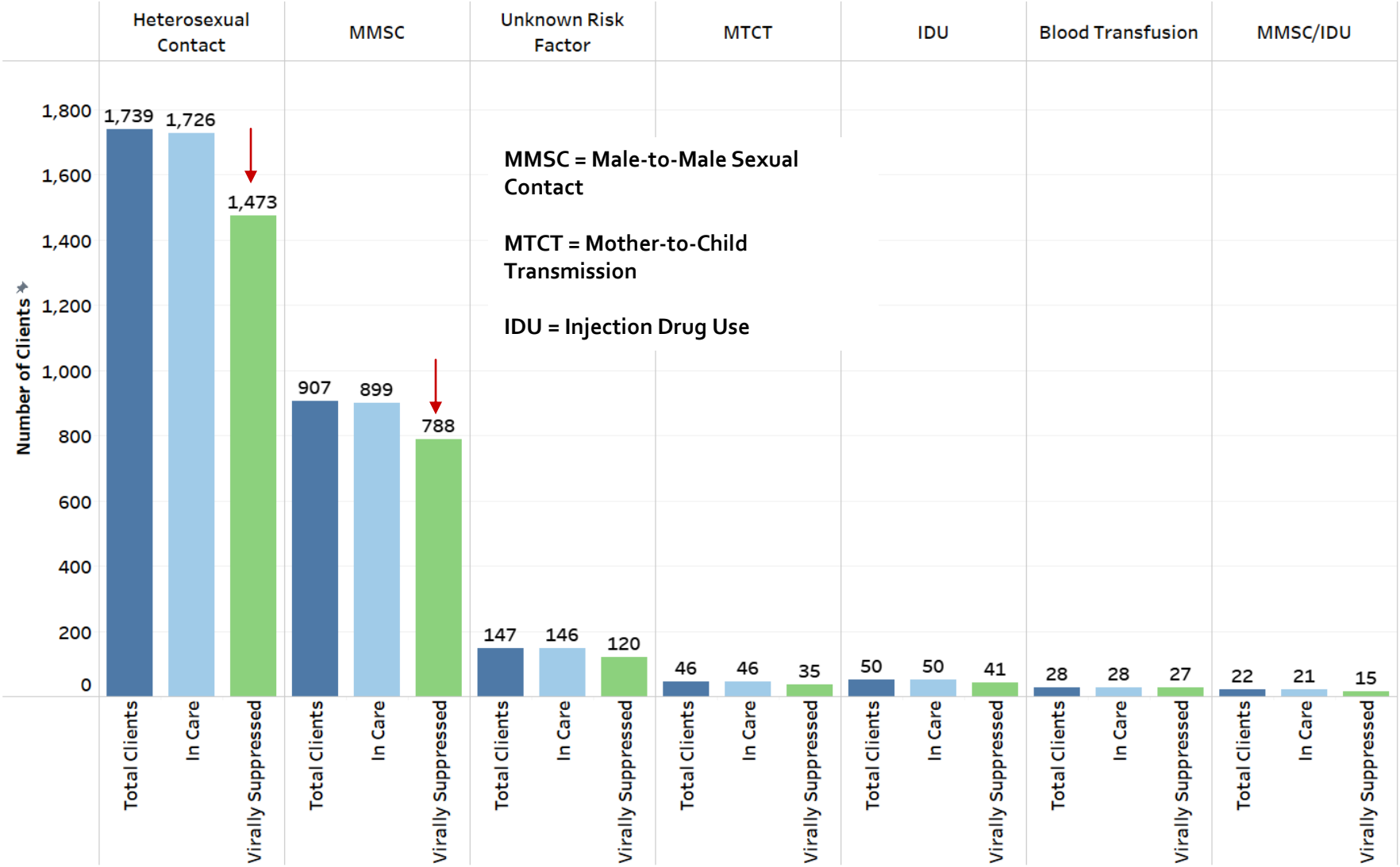
Ryan White Part A/MAI In Care and Viral Suppression GY 2023: By Risk Factor



Those with heterosexual contact histories in Ryan White Part A/MAI are the largest group **who are not virally suppressed (n=266),** followed by **those with Male-to-Male Sexual Contact (MMSC) histories (n=119)**

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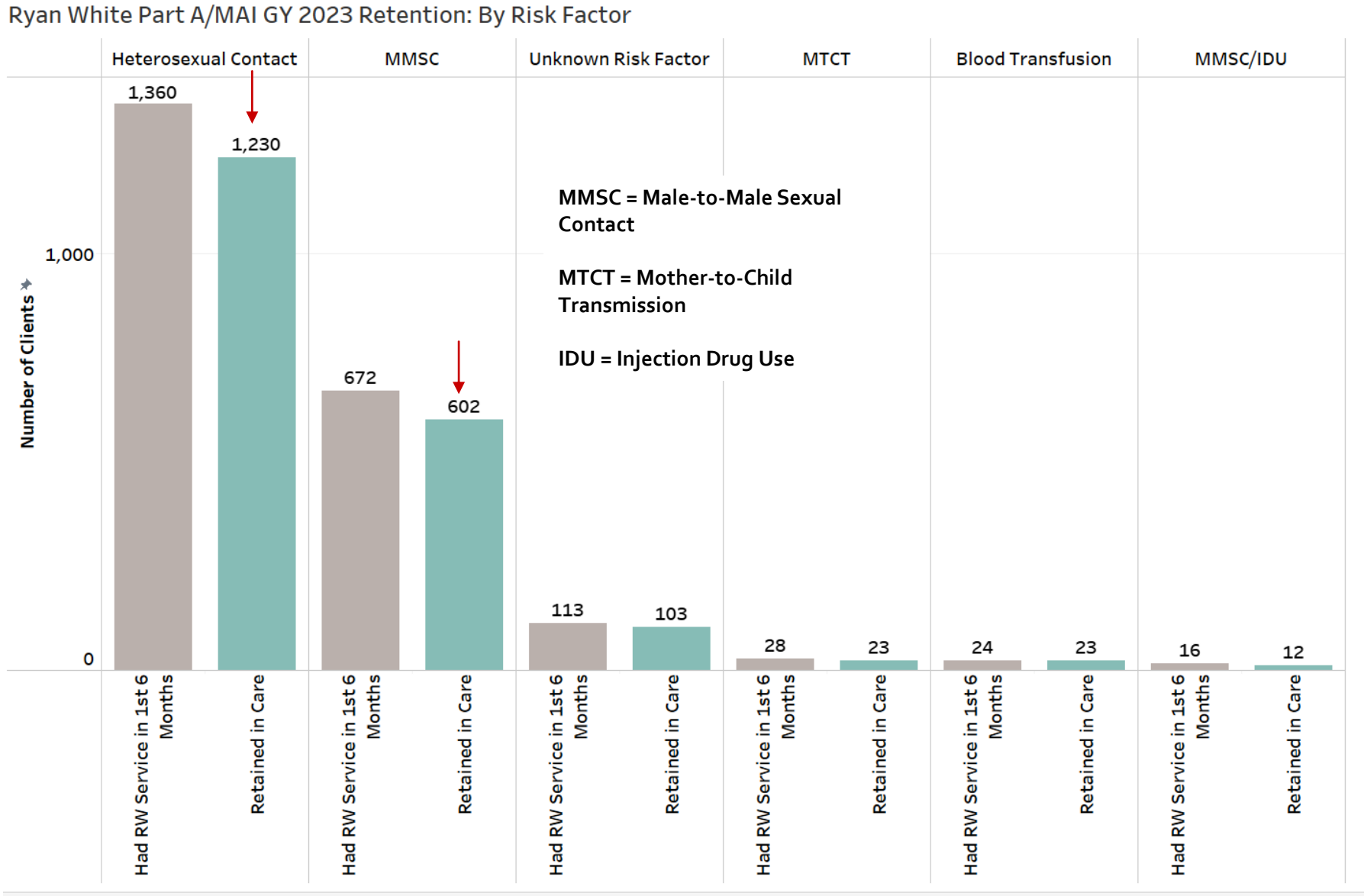

Those with heterosexual contact histories in Ryan White Part A/MAI are the largest group **who are not retained in care (n=130),** followed by **those with Male-to-Male Sexual Contact (MMSC) histories (n=70)**

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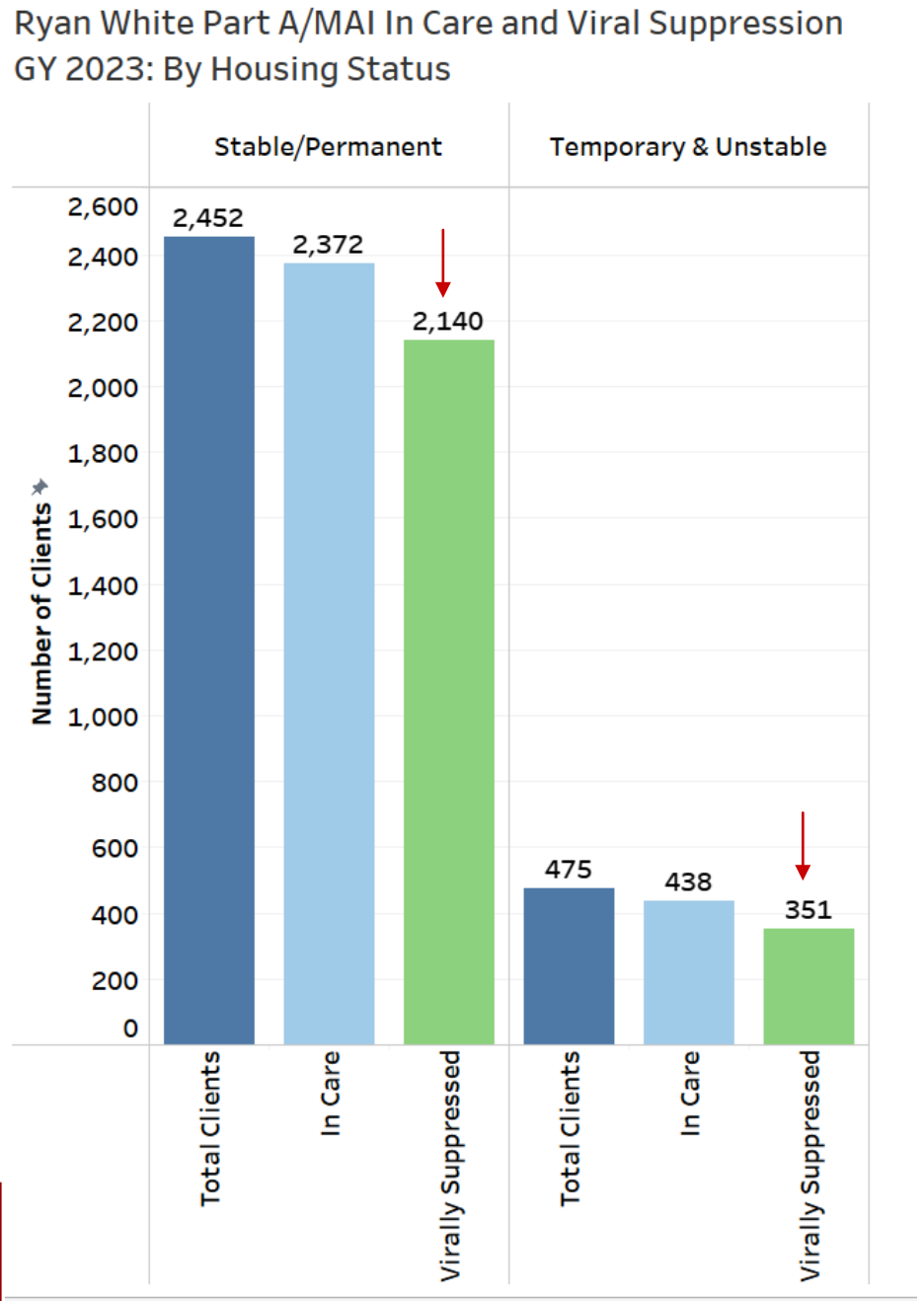
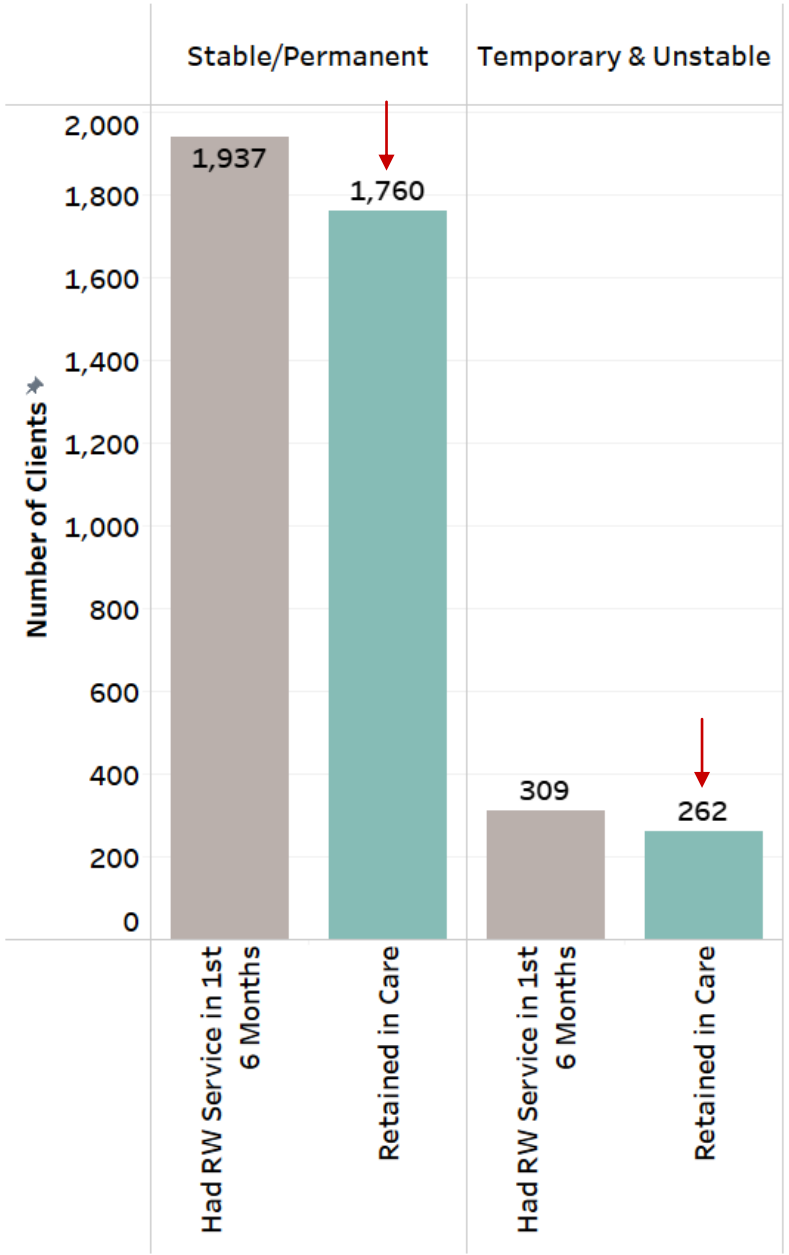


Most individuals in Ryan White Part A/MAI have **stable/permanent housing.** Those who are in **stable housing** are the **largest group** of those who are **not virally suppressed (n=312).**

However, those with **temporary or unstable housing** have **lower rates of viral suppression (74% compared to 87%** for those stably housed), which equals to **124 individuals who are not virally suppressed** who have temporary or unstable housing.

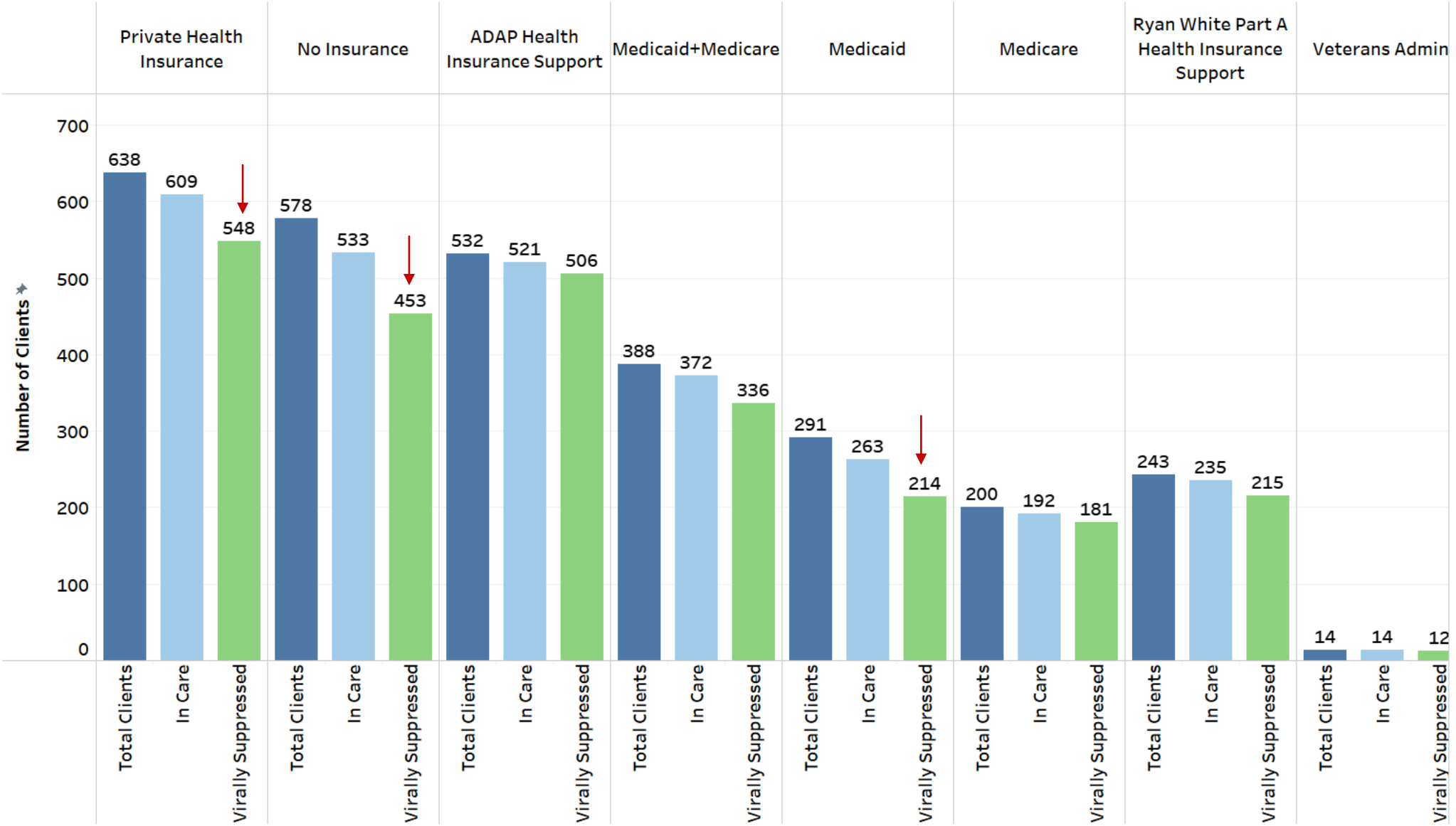
Ryan White Part A/MAI GY 2023 Retention: By Housing Status



Those who are in **stable housing** are the **largest group** of those who are **not retained in care (n=177).**

However, those with **temporary or unstable housing** have **lower rates of retention (85% compared to 91%** for those stably housed), which equals to **47 individuals who are not retained** who have temporary or unstable housing.

Ryan White Part A/MAI In Care and Viral Suppression GY 2023: By Insurance



Those who have no health insurance in Ryan White Part A/MAI are the largest group **who are not virally suppressed (n=125),** followed by **private health insurance (n=90)** and **Medicaid (n=77)**

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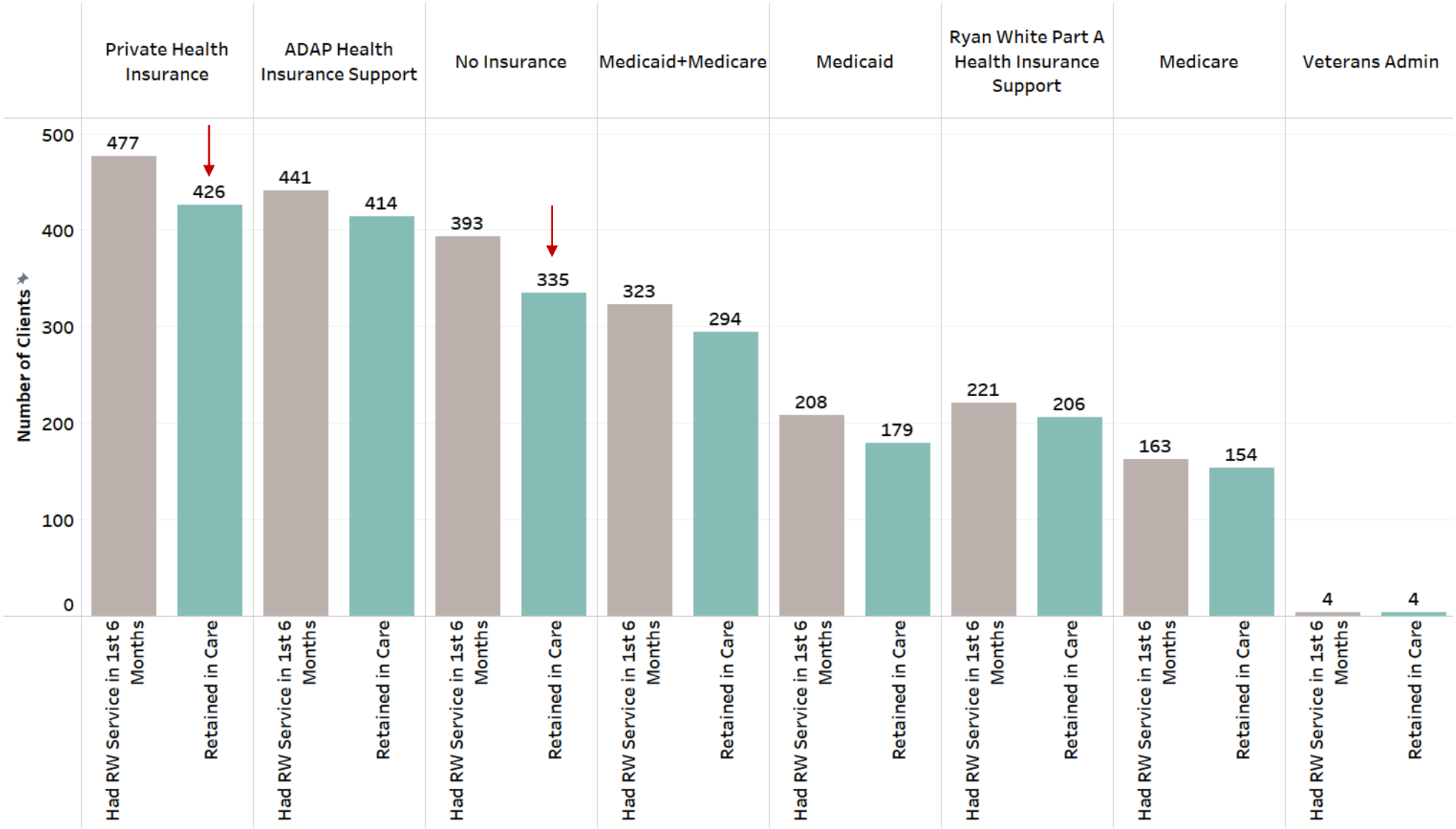
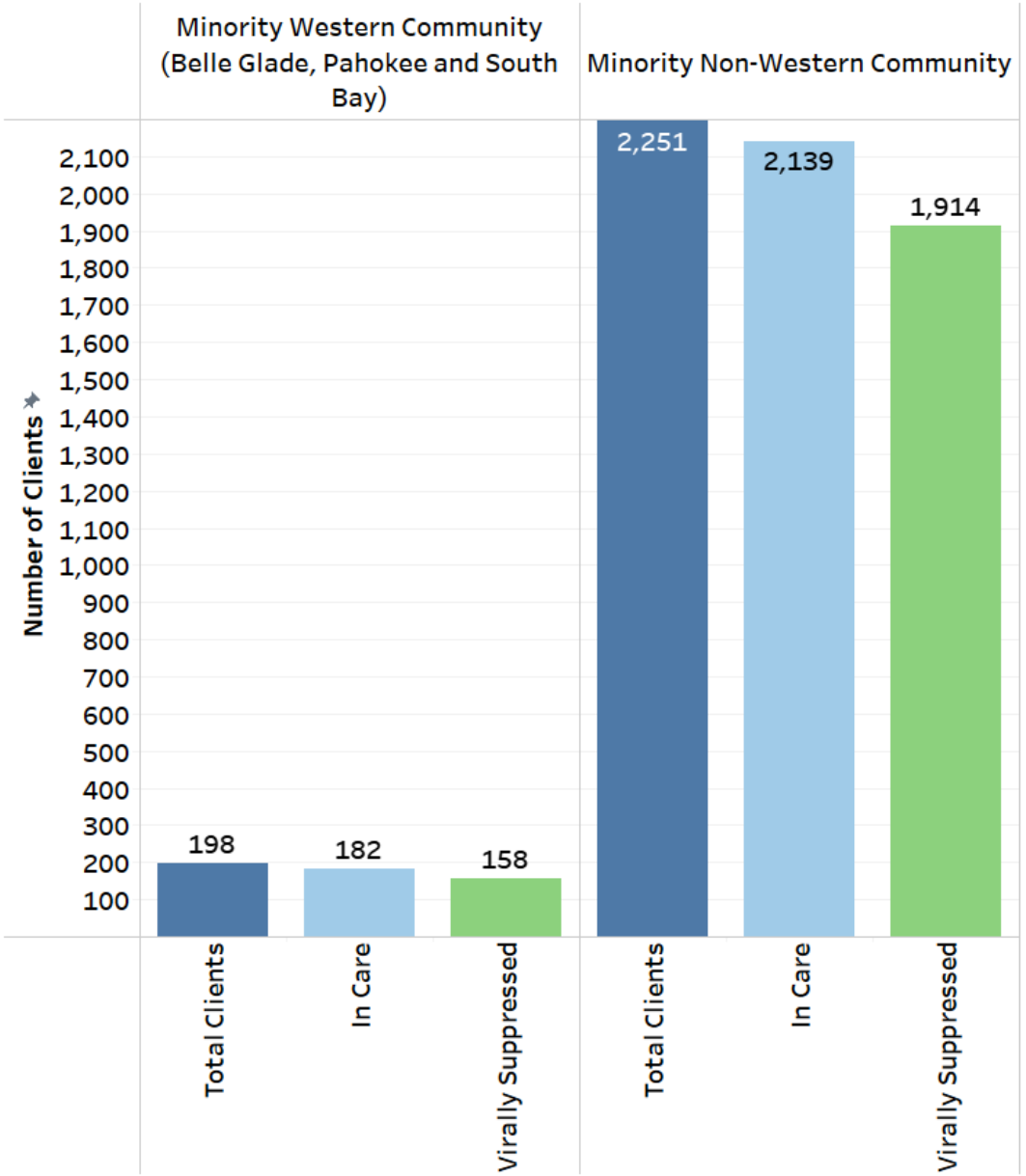
Ryan White Part A/MAI GY 2023 Retention: By Insurance



Those who have no health insurance in Ryan White Part A/MAI are the largest group **who are not retained in care (n=58),** followed by **private health insurance (n=51)**

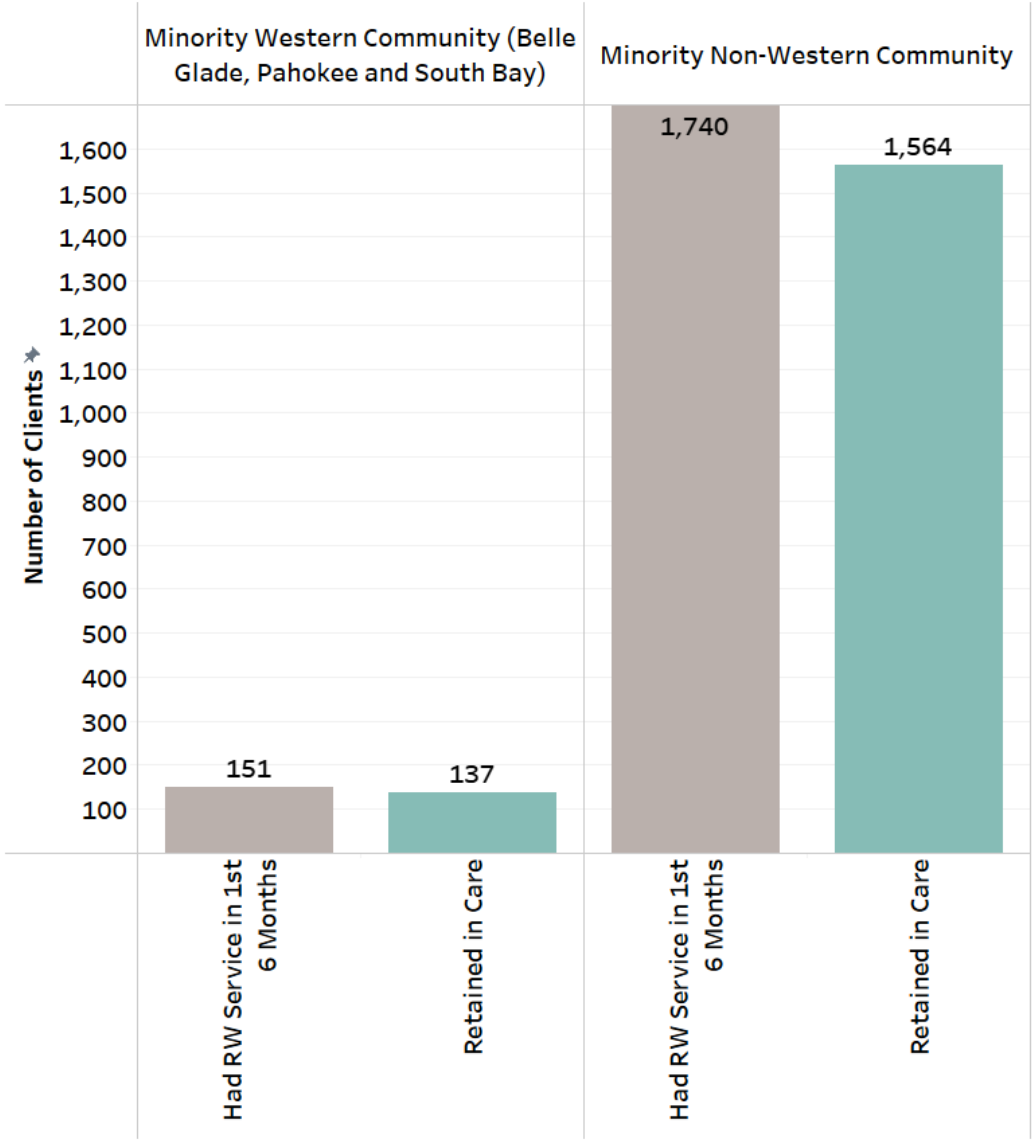
Ryan White Part A/MAI In Care and Viral Suppression
GY 2023: By Geography



Most minority individuals in Ryan White Part A/MAI do not live in the Western Community**.** Minorities who do not live in the Western Community are the **largest group** of those who are **not virally suppressed (n=337).**

However, minorities who live **in the Western Community** have **lower rates of viral suppression (80% compared to 85%** for minorities who do not live in the Western Community), which equals to **40 individuals who are not virally suppressed.**

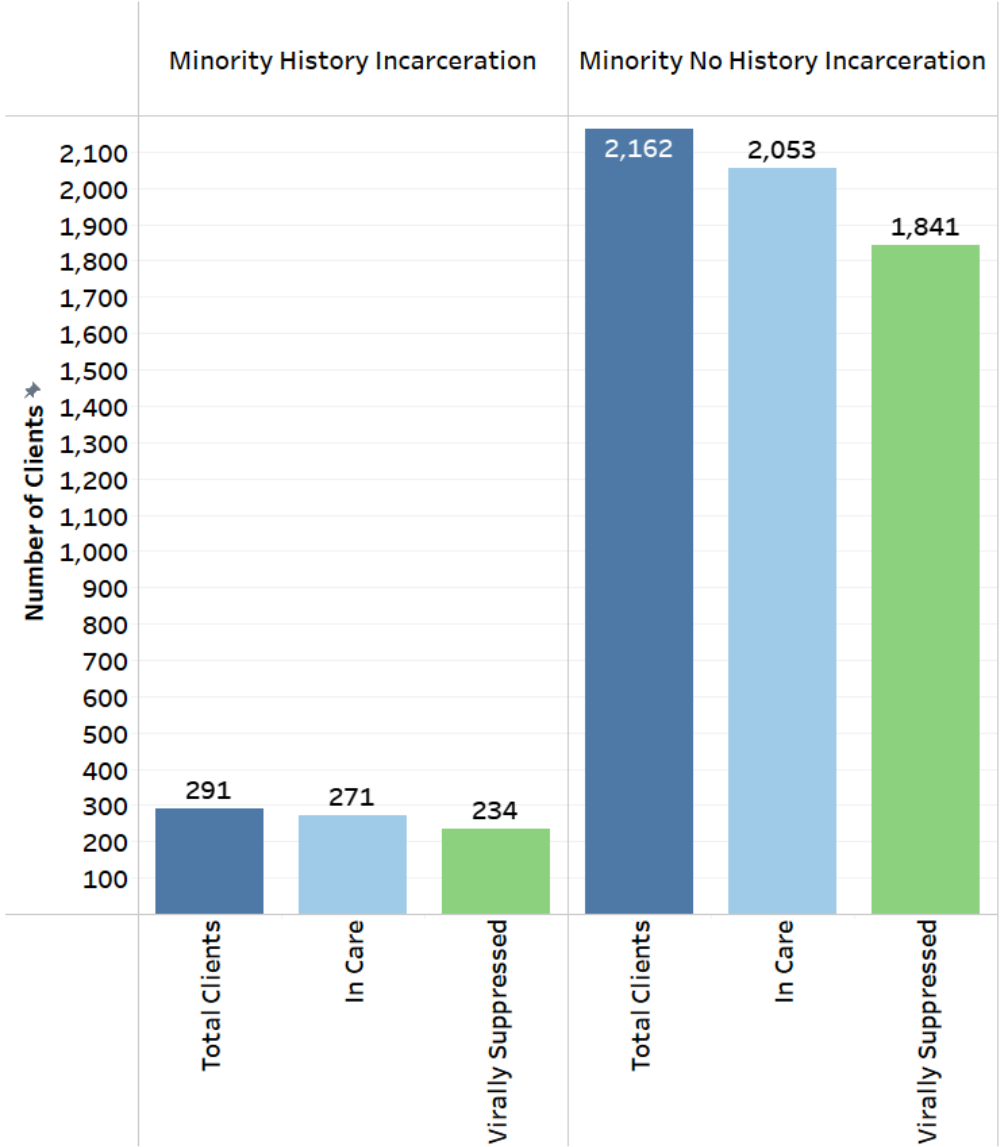
Ryan White Part A/MAI GY 2023 Retention:
By Geography



Minorities who do not live in the Western Community are the **largest group** of those who are **not retained (n=176).** There is a smaller number of individuals who live in the Western Community who are not retained (n=14).

Minorities who live **in the Western Community** have **similar rates of retention (91%** compared to **90%** for minorities who do not live in the Western Community).

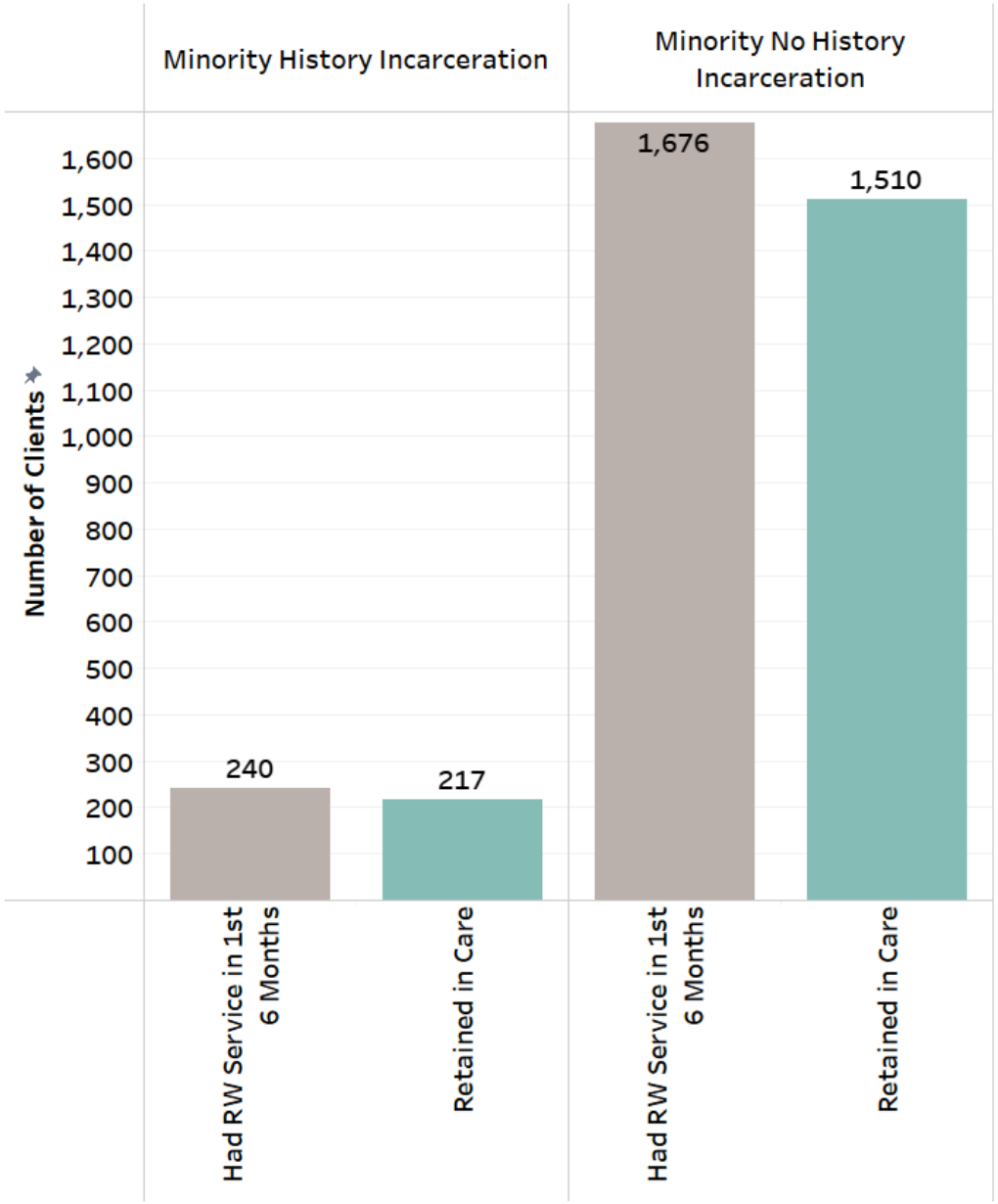
Ryan White Part A/MAI In Care and Viral Suppression
GY 2023: By Geography



Most minority individuals in Ryan White Part A/MAI do not have incarceration histories. Minorities without incarceration histories are the **largest group** of those who are **not virally suppressed (n=321).**

However, minorities who do have **incarceration histories** have **lower rates of viral suppression (80% compared to 85%** for minorities without an incarceration history), which equals to **57 individuals who are not virally suppressed.**

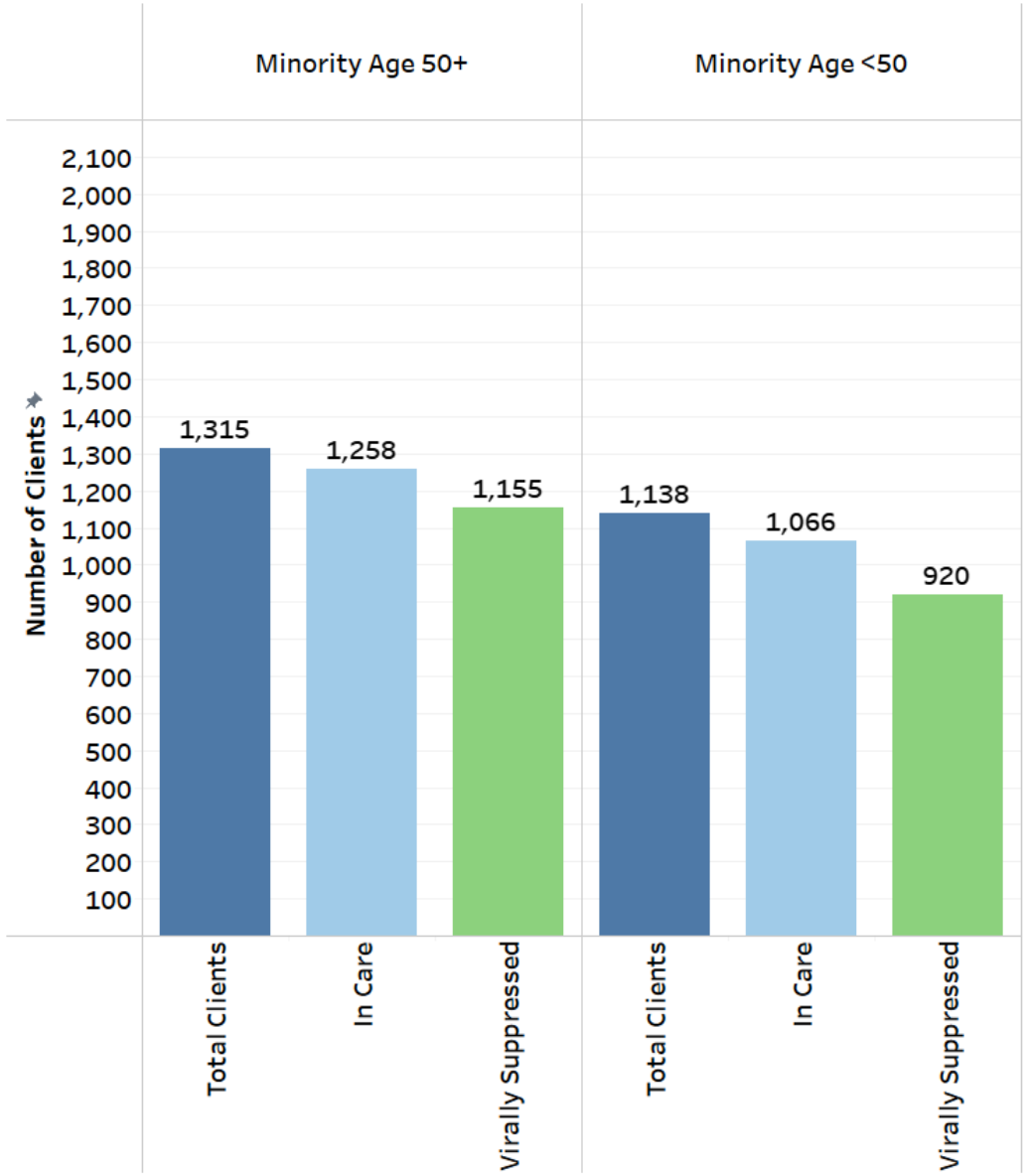
Ryan White Part A/MAI GY 2023 Retention:
By Geography



Minorities who do not have incarceration histories are the **largest group** of those who are **not retained (n=166).** There is a smaller group of minority individuals with incarceration histories who are not retained (n=23).

Minorities who do or do not have incarceration histories have **the same rates of retention (90%**).

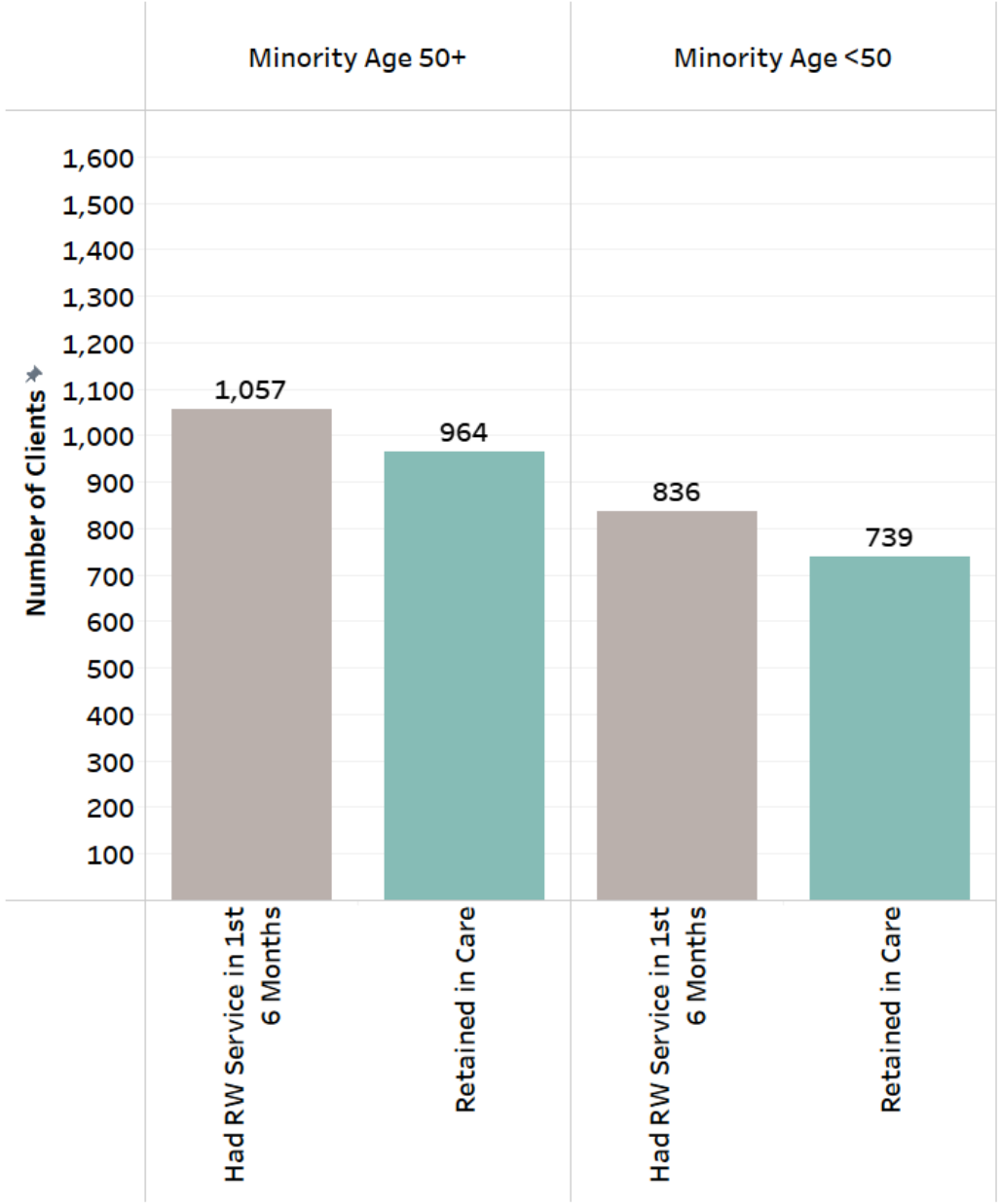
Ryan White Part A/MAI In Care and Viral Suppression
GY 2023: By Geography



Most minority individuals in Ryan White Part A/MAI are older than 50 years old. **However, minorities who are younger than 50** are the **largest group** of those who are **not virally suppressed (n=218).** There is a smaller but substantial group of not virally suppressed individuals among minorities 50 years+ (n=160).

In addition, minorities who are younger than 50 years old have **lower rates of viral suppression (81% compared to 88%** for minorities 50+ years old).

Ryan White Part A/MAI GY 2023 Retention:
By Geography



There are about the same number of minorities who are younger than 50 and 50 and older who are not retained.

Minorities who are younger than 50 years old have slightly lower rates of viral suppression (88% compared to 91% for minorities 50+ years old).

Key Takeaways

- Overall, the Ryan White Part A/MAI System of Care has successful outcomes for engaging clients in care, retaining clients and getting clients to viral suppression
- Quality improvement projects focus on the remaining 10-15% gaps in care along with the disparities identified
  - Black/African-American and Haitian populations have the largest number of individuals not virally suppressed and the lowest rates of viral suppression
  - Opportunity for MAI Program to also try new things (see next slide)
- Those with temporary/unstable housing and lack of health insurance also experience worse health outcomes
  - Important programs to address this includes
    - Healthcare & Housing Opportunities Program (H2O) through Ending the HIV Epidemic
    - Providing health care insurance to individuals (ADAP or Ryan White Part A which have better outcomes)

Key Takeaways Continued

- MAI Opportunities
  - MAI should tailor its services toward its prioritized populations
  - GY 2024 prioritized populations for MAI
    - Individuals living in Western geography
    - Individuals who are 50+ Years
    - Individuals who are justice-involved or re-entering society from incarceration
  - HIV CARE Council can consider all continuum of care data presented in making MAI priority population decisions for coming years

Questions?

Palm Beach County Ryan White Program Care Continuum Optimized Performance Measures

Jasmine Parrish, MPH, BSN, RN
Quality Management Clinician
PBC Ryan White HIV/AIDS Program
jparrish@pbc.gov
(561) 274-1102

Palm Beach County
HIV Elimination Services

HIV/AIDS Bureau (HAB) Policy

- **HRSA PCN #15-02:**

  https://hab.hrsa.gov/sites/default/files/hab/Global/HAB-PCN-15-02-CQM.pdf

  - "Performance measurement is the process of collecting, analyzing and reporting data regarding patient care, health outcomes on an individual or population level, and patient satisfaction. **In order to appropriately assess outcomes, measurement must occur.** Measures should be selected that best assess the services the recipient is funding and that reflect local HIV epidemiology and identified needs of people with HIV."

  - Recipients should analyze performance measure data to assess quality of care and health disparities and use the performance measure to inform quality improvement activities.

HIV/AIDS (HAB) Health Outcome Measures

- In the Ryan White Program, the Performance Measures are connected to each funded service category. The measures we have been tracking for client health outcomes are:
  1) **In Care**
     - Early Intervention Services (EIS)
  2) **Retention in Care**
  3) **Viral Load Suppression**
- We collect and analyze these measures to identify low performance and determine how we can improve these performance measures through quality improvement (QI) activities.

Care Continuum Optimized Report Performance Measures Definitions

- **In Care**
  - Percentage of PWH who had at least one medical care service in 90 days
  - Numerator: Number of clients who are HIV+ who had medical care within 90 days of opening a client to an agency
    a) Client has a "Kept" medical appointment within 90 days OR
    b) Client had a CD_4 or Viral Load test result within 90 days OR
    c) Client has a Payment Request "Paid" within 90 days (Co/pay or Deductible) OR
    d) Client had a prescription dispensed within 90 days
  - Denominator: HIV+ Clients

Care Continuum Optimized Report Performance Measures Definitions

- **Retention in Care:**
  - Percentage of PLWH who had two or more medical care services at least three months apart in reporting period
  - Numerator- Retention in Care Svc First 6 Mo: Number of clients that are HIV+ who had two or more HIV medical care services (with the first occurring in the first 6 months) at least 90 days apart within a 12-month measurement year.
    a) Client has a "Kept" medical appointment during the reporting period OR
    b) Client had a CD_4 or Viral Load test result during the reporting period OR
    c) Client has a Payment Request "Paid" during the reporting period (Co/pay or Deductible) OR
    d) Client had a prescription dispensed during the reporting period

    WHO ALSO RECEIVED AT LEAST ONE SERVICE FROM THE SELECTED SERVICE CATEGORY(S) IN THE FIRST 6 MONTHS OF THE REPORTING PERIOD FROM THE SELECTED AGENCY(S)
  - Denominator- Svc in First 6 Mo: Clients that are HIV+ and received at least one service from the selected service category(s) in the FIRST 6 MONTHS of the reporting period from the selected agency(s)

Care Continuum Optimized Report Performance Measures Definitions

- **Viral Load Suppression:**
  - Numerator: HIV+ clients whose most recent viral load test result record is less than 200 and the test result is from the reporting period.
  - Denominator: Clients that are HIV+ and received at least one service from the selected service category(s) in the reporting period from the selected agency(s)

Grant Year (GY) 2024

- Annual Performance Measures (Core Measures)
  - Metrics are reported quarterly (grant year) for each funded service category
- Report on the overall Ryan White program core measures (bold/gray):
  1. Linkage to Care (In Care)
  2. Retention in Care
  3. Viral Load Suppression
- Report on individual funded service categories that are connected to each core performance measure
  - Larger categories require 2 measurements
- **Target**: Improve all VS rates to 90%+ and RIC rates to 85%+

PBC Ryan White Program, PM Quartely Metrics	Baseline Thru Date 2/29/2024		Q1 Thru Date 5/31/2024	
Service Category	N/D	Metric	N/D	Metric
In Care	**2871/2926**	**98%**	**2846/2954**	**96%**
Early Intervention Services	635/636	100%	585/625	94%
Early Intervention Services - MAI	340/344	99%	308/318	97%
Retention in Medical Care	**2004/2238**	**90%**	**2104/2348**	**90%**
Emergency Financial Assistance	17/18	94%	20/20	100%
Food Bank - Nutritional Supplements	5/5*	100%	1/1*	100%
Food Bank/Home Delivered Meals	728/762	96%	697/730	95%
Health Insurance Premium & Cost-Sharing Assistance	381/413	92%	386/414	93%
Housing	26/28	93%		
Legal Services	241/261	92%	214/225	95%
Medical Case Management	1293/1404	92%	1334/1447	92%
Medical Case Management - MAI	362/399	91%	340/373	91%
Medical Transportation	315/341	92%	312/337	93%
Mental Health Services	64/66	97%	85/92	92%
Non-Medical Case Management	1719/1888	91%	1803/1965	92%
Non-Medical Case Management - MAI	445/495	90%	431/468	92%
Oral Health Care	380/395	96%	165/167	99%
Psychosocial Support Services - MAI	384/416	92%	171/184	93%
Viral Load Suppression	**2473/2926**	**85%**	**2555/2954**	**86%**
AIDS Pharmaceutical Assistance	19/19	100%	13/14	93%
Emergency Financial Assistance - Emergency Medication	12/15*	80%	6/9*	67%
Laboratory Diagnostic Testing	348/392	89%	362/399	91%
Medical Case Management	1478/1617	91%	1510/1627	93%
Medical Case Management - MAI	407/456	89%	372/417	89%
Non-Medical Case Management	2031/2307	88%	2104/2334	90%
Non-Medical Case Management - MAI	515/586	88%	477/533	89%
Specialty Outpatient Medical Care	132/142	93%	143/154	93%
Outpatient/Ambulatory Health Services	715/819	87%	737/817	90%

≥ 90%
80% - 89%
≤ 79%

Palm Beach County
HIV Elimination Services

Questions?

PBC Ryan White Part A/MAI Clinical Quality Management & Quality Improvement Projects

Daisy Wiebe, PhD, MPH
Quality Management Clinician
PBC Ryan White HIV/AIDS Program
dwiebe@pbc.gov
(561) 355-4760

Jasmine Parrish, MPH, BSN, RN
Quality Management Clinician
PBC Ryan White HIV/AIDS Program
jrohoman@pbc.gov
(561) 274-1107

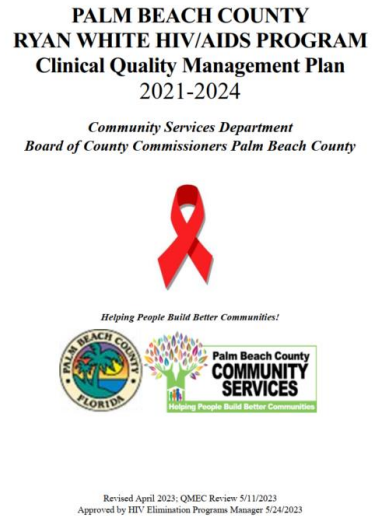
Palm Beach County
HIV Elimination Services

Quality Improvement Projects (QIP)

- Quality improvement involves the development and implementation of activities to make changes to the program in response to the performance data results. To do this, Recipients and Sub-recipients are required to implement quality improvement activities aimed at improving patient care, health outcomes, and patient satisfaction.
- Once QIPs are created and tested, we are then able to understand if specific changes or improvements had a positive impact on patient health outcomes or if further changes in RWHAP funded services are necessary.

Ryan White Quality Management Program

- **Recipient and Sub-Recipient Clinical Quality Management (CQM) Plans**
  - Document that includes an implementation description of the 3 items required of a CQM program:
    - Infrastructure
    - Performance Measurement
    - Quality Improvement
- **Plan, Do, Study, Act (PDSA) Template**
  - Standardized form
    - Form for recipients to track their progress
- **Monthly Quality Improvement Workgroup**
  - Agencies are required to keep track of what they are doing and report back at the workgroup
    - Challenges, feedback

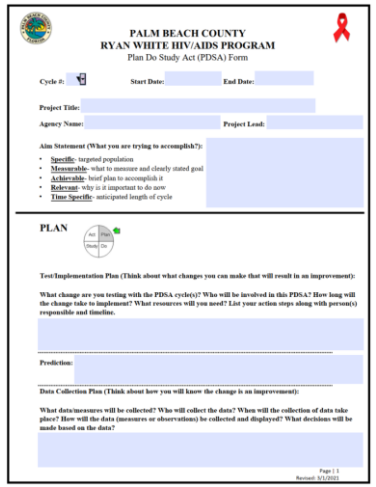

PALM BEACH COUNTY
RYAN WHITE HIV/AIDS PROGRAM
Clinical Quality Management Plan
2021-2024

Community Services Department
Board of County Commissioners Palm Beach County

Helping People Build Better Communities!

Palm Beach County COMMUNITY SERVICES
Helping People Build Better Communities

Revised April 2023; QMEC Review 5/11/2023
Approved by HIV Elimination Programs Manager 5/24/2023


PALM BEACH COUNTY
RYAN WHITE HIV/AIDS PROGRAM
Plan Do Study Act (PDSA) Form

Cycle #: Start Date: End Date:

Project Title:

Agency Name: Project Lead:

Aim Statement (What you are trying to accomplish?):

- Specific- targeted population
- Measurable- what to measure and clearly stated goal
- Achievable- brief plan to accomplish it
- Relevant- why is it important to do now
- Time Specific- anticipated length of cycle

PLAN

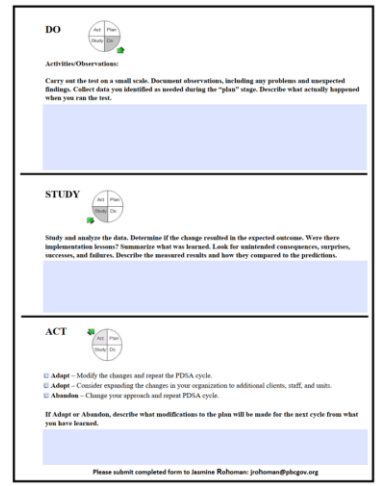
Test/Implementation Plan (Think about what changes you can make that will result in an improvement):

What change are you testing with the PDSA cycle(s)? Who will be involved in this PDSA? How long will the change take to implement? What resources will you need? List your action steps along with person(s) responsible and timeline.

Prediction:

Data Collection Plan (Think about how you will know the change is an improvement):

What data/measures will be collected? Who will collect the data? When will the collection of data take place? How will the data (measures or observations) be collected and displayed? What decisions will be made based on the data?


DO

Activities/Observations:

Carry out the test on a small scale. Document observations, including any problems and unexpected findings. Collect data you identified as needed during the "plan" stage. Describe what actually happened when you ran the test.

STUDY

Study and analyze the data. Determine if the change resulted in the expected outcome. Were there implementation lessons? Summarize what was learned. Look for unintended consequences, surprises, successes, and failures. Describe the measured results and how they compared to the predictions.

ACT

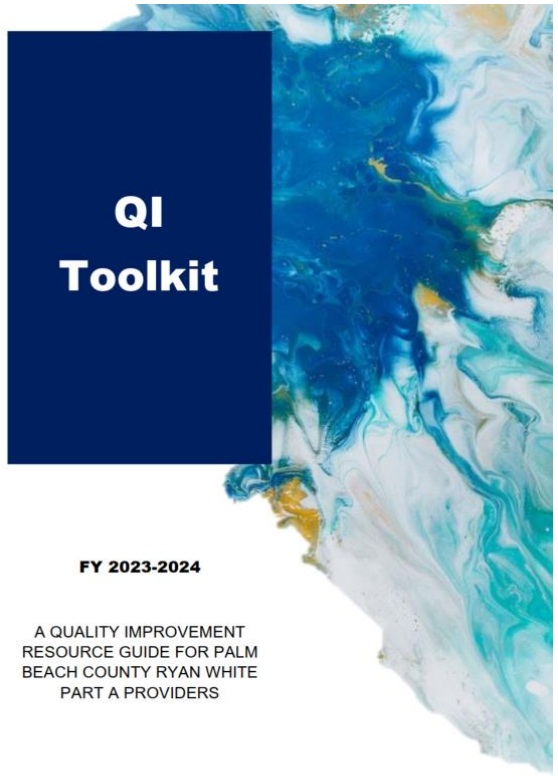
- Adapt – Modify the changes and repeat the PDSA cycle.
- Adopt – Consider expanding the changes in your organization to additional clients, staff, and units.
- Abandon – Change your approach and repeat PDSA cycle.

If Adapt or Abandon, describe what modifications to the plan will be made for the next cycle from what you have learned.

Please submit completed form to Jasmine Rahoman: jrahoman@pbcgov.org

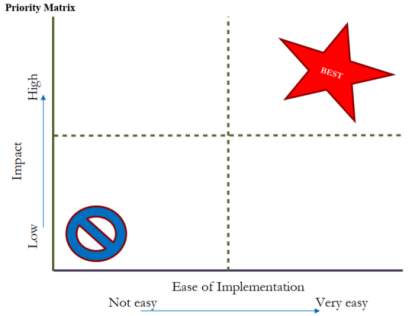
Palm Beach County
HIV Elimination Services

Ryan White Quality Improvement Toolkit



A Brainstorm, Priority Matrix or Force Field Analysis may be helpful in selecting a project and generating consensus among stakeholders.

Priority Matrix



The Priority Matrix helps you to:

- Evaluate the impact and ease of implementation
- Gain additional clarity on moving forward with improvements
- Take into account available resources
- Remember: It's a guide and does not take into account organizational or legislative imperatives

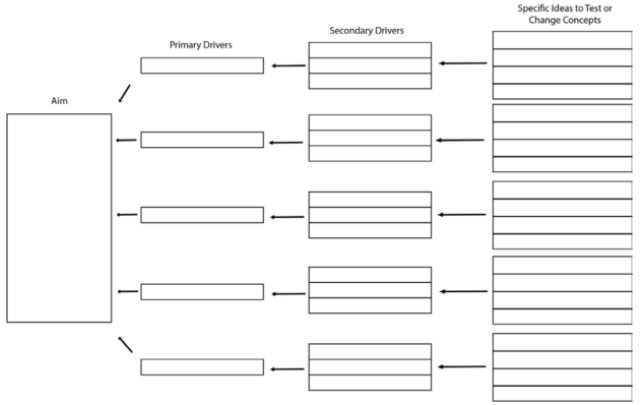
Checkpoint 1: Identify Focus Areas for Quality Improvement Projects

Quality Improvement Projects (QIPs) aim to improve the quality of care provided to consumers within the EMA. The goal for all consumers within the EMA is sustained retention in care and viral suppression. There are many issues faced by consumers that impact their ability to achieve this.

Please identify one to three areas that could be targeted with a QIP.

Issue:	
Prevalence/Frequency/Incidence:	
Population(s) Affected:	
Seriousness/Urgency:	
Available Data Sources:	
Possible Interventions:	
Current Interventions:	

Materials Adapted From:
• Schlueter, J., Washington, E., & Moore, J. (2019, November 21). *Choosing an Improvement Project.* Retrieved from Target HIV: https://targethiv.org/library/choosing-improvement-project



Checkpoint 3: Aim Statement

What are you trying to accomplish?

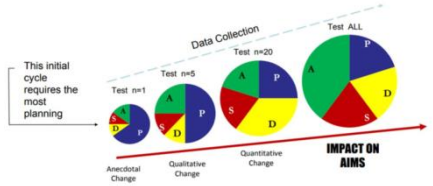
• What do you hope to accomplish with this project? Aims should be SMART, specific, clear, well defined, and at a **minimum**, describe the target population, the desired improvement, and the targeted time frame.

Use the following table to put together your aim statement.

To increase/decrease		(process/outcome)
from		(baseline %, rate, #, etc.)
to		(goal, target %, rate, #, etc.)
by		(date)
in		(group, population)

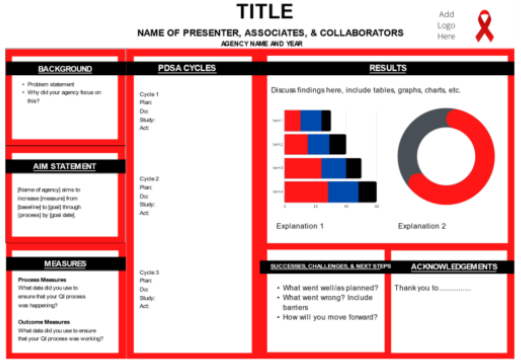
Ramping Up your PDSA Cycles:

Complete multiple rounds of PDSA cycles. After several cycles, your team should have a good idea of which ideas have the most significant impact, and which to discard. As each cycle finds, successes and limitations are accounted for, testing at grander scales become feasible.



PDSA cycles are practical and useful tools, but one difficulty is keeping the momentum. It is essential to understand that it is okay if it does not work, but rather than restarting, modifying the process is often a better alternative towards implementation at a larger scale.

Appendix D



Palm Beach County
HIV Elimination Services

Questions?

Identifying Disparities to Engage Action (IDEA) QIP:

Hybrid RWHAP System-level & Agency-level Project

March 2023 - February 2024

Palm Beach County
HIV Elimination Services

Background of IDEA

The Identifying Disparities to Engage Action (IDEA) Quality Improvement Project (QIP) was created to identify and address disparities among certain demographic groups in our county

This was a hybrid systems-and-agency-level project, that allowed for each agency to create a tailored intervention to address the disparity at their organization and improve health outcomes.

IDEA Agency Project Successes

Increased viral suppression rate by over 10%; helped a client enter detox and achieve viral suppression

Trained case management and EIS staff in Motivational Interviewing; have successfully piloted MI sessions for a client who has re-engaged in care

Implemented viral suppression counseling for all oral health clients; one client has achieved viral suppression, and one has greatly reduced their viral load

Helped 10 clients achieve viral suppression and learned the individual needs of clients

Helped case managed clients understand importance of medication adherence

IDEA Project

Successes Continued

Ageny whose focus is not medical was able to connect two individuals to care and one did reduce their viral load; planning to incorporate viral load labs at intake

Barriers to medication access being addressed through insurance transportation and delivery options; so far has impacted 3 clients

Re-engaged 7 clients back into care & created a successful call-back system

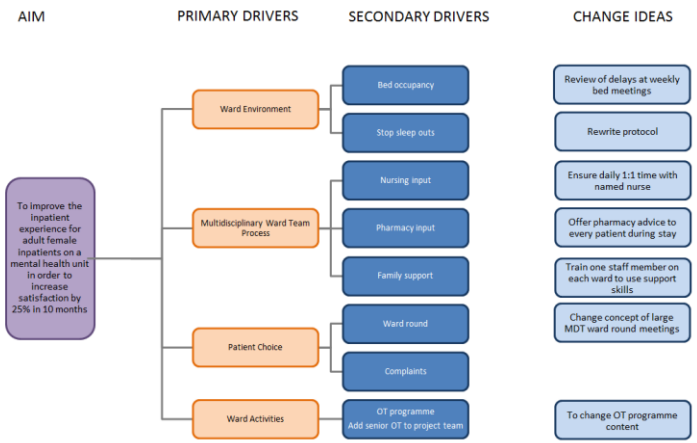
Helped 16 clients achieve viral suppression through appropriate screenings and peer navigations

Grant Year 2024-2025 QIPs:

- Each agency has identified a service category and/or a specific subpopulation they would like to focus on based on their data. A few examples include:
  - Retention in Care in
    - Clients receiving food bank services
    - Clients being case managed
  - Viral Suppression in
    - Black/African American Males in Medical Case Management
    - Medical Case Managed MAI Clients
    - Non-Medical Case Managed Clients
    - Non-Medical Case Managed Clients receiving legal services
    - EIS Clients
    - Continuing OAHS Clients

Grant Year 2024-2025 QIPs:

- Agencies have completed:
  - Baseline data
  - Driver diagrams/Fish bone diagrams
  - Creation of an AIM statement
  - Identifying process and outcome measurements



In Progress:

- Agencies are currently carrying out interventions through Plan-Do-Study-Act (PDSA) Cycles and will monitor outcomes of interventions through November-December.

Questions?

Palm Beach County Ending the HIV Epidemic (EHE) & Syringe Services Program (SSP)

Sean Conklin, MNM (He/Him/His)
Ending the HIV Epidemic Program Evaluator
Palm Beach County Community Services/Ryan White Part A
Sconklin@pbcgov.org
561-274-1096

Palm Beach County
Ryan White HIV/AIDS Program

Ending the HIV Epidemic Program Overview

Palm Beach County
Ryan White HIV/AIDS Program

Vision & Philosophy

- **Vision:** The vision of the Palm Beach County EHE is to end the HIV epidemic through innovative services and strategies, new dynamic relationships and collaborations with community stakeholders, and input and involvement from the greater community.
- **Philosophy:** PBC EHE's philosophy is that the gaps that exist in the current system of care are not able to be addressed by current resources, strategies, and activities, so new and innovative strategies must be developed for and led by persons with HIV.

EHE Programs and Activities Overview

- PBC EHE Active Services:
  - Community Outreach, Response & Engagement (CORE)
  - Tele-adherence Counseling (TAC)
  - Rapid Entry to Care (REC)
  - Vocational Rehabilitation
  - Healthcare & Housing Opportunities (H_2O)
  - Harm Reduction Intervention Services (HRIS)
- PBC EHE Community Engagement Activities
  - Community Engagement Activities
  - EHE Marketing Campaign
  - Social Media Marketing

Community Outreach, Response and Engagement (CORE)

- CORE services identify PWH who care currently out of care and rapidly reengage them into care
- CORE staff:
  - Locate and reengage PWH who are out of care in our jurisdiction
  - Assist PWH in addressing any barriers to care they may face
- CORE is provided by a CORE Specialist (Case Manager) and a Peer in a CORE Team
- CORE services look different for each client receiving them based on client needs

Community Outreach, Response and Engagement (CORE)

- CORE Specialists and Teams are able to:
  - Provide transportation for clients to medical appointments
  - Meet clients wherever they need
  - Keep non-standard hours
  - Provide intensive, strengths-based case management for clients to address their barriers
  - Be dispatched by the EHE Registration clerk to assist clients when needed
  - Refer clients to other services, both HIV and not HIV related
  - Develop relationships with local service providers
  - Respond to HIV clusters and outbreaks to provide these services in coordination with prevention partners

Who Should be Referred to CORE?

- Clients who have disengaged from or fallen out of care
- Clients who are not reached by EIS, DIS or Partner Services
  - These clients should be referred even if no contact was made, instead of closing out
- Clients who receive a positive HIV test and are not linked to care successfully
- Clients who have been out of care and are interested in returning to care

What to Expect from CORE

- Improved coordination with local service coordinators
- Regular communication between CORE teams and provider staff
- Regular in-person visits from CORE staff
- Increased number of linkages to care
- Increase in total clients served
- Increased access to other available services
- Support for capacity building activities
- Support for adherence to care plan
- Improved access to clients

Rapid Entry to Care (REC)

- Rapid Entry to Care (REC) will be a service that guaranteed access to an introductory healthcare appointment for HIV+ clients who are newly diagnosed or returning to care, regardless of income or residency status
- REC is a Clinical Service
- REC guarantees an appointment within 3 days of referral
- REC guarantees clients are seen at their appointment time without a long wait
- REC provides rapid ART initiation for clients
- REC can be used for clients who are returning to care or who are newly diagnosed

Tele-Adherence Counseling (TAC)

- Tele-Adherence Counseling (TAC) will be provided directly by county staff
- Clients are enrolled in an online platform called PL Cares which helps to develop self monitoring skills and improve adherence to care
- Clients have daily check-ins to keep track of:
  - Medication Adherence
  - Stress Level
  - Mood
- Clients may also input their medical appointments
- CD_4 and Viral Load Labs are imported regularly
- Tele-Adherence counselor will reach out to clients who indicate missing appointments or medication to develop a strategy to improve adherence
- Tele-Adherence Counseling works in tandem with non-medical and medical case management service and does not replace them

Tele-Adherence Counseling

- Clients have access to an anonymous community message board to ask questions and have conversations with other affected community members without fear of disclosing their identity
- The message boards are in English, Spanish and Creole
- Tele-Adherence Counselor (English, Creole) and Registration Clerk (Spanish) monitor message boards to remove any inappropriate or personally identifying posts
- Clients may request a Tele-Adherence session with Tele-Adherence Counselor through a HIPPA-compliant virtual call or in person
- Clients may privately message with the Tele-Adherence Counselor, but not other members
- Providers and other case managers are not invited to participate on the platform in the implementation phase

Which clients should be referred to TAC services?

- Newly Diagnosed Clients
- Clients who are returning to care or who have recently returned to care (within 6 months)
- Clients who are in care but not virally suppressed or struggling to adhere to a care plan

TAC by the Numbers

- Clients Active: 84
  - Viral suppression Rate: 72%
  - Undetectable Rate: 60%
  - Average Response Rate: 80%
  - Average Mood (1-5, low to high): 3.4
  - Average Stress (1 – 10, low to high): 2.5

Assessments & Projects

- Three projects and assessments are ongoing:
  - Jail Linkage Project
  - Case Management Assessment
  - Transportation Assessment

Jail Linkage Project

- Jail Linkage Project began in September of 2021
- Over the course of 2022, our Technical Assistance Provider CAI conducted interviews with 6 different stakeholders who all currently have or previously had involvement in the county jails
  - FDOH
  - Rebel Recovery
  - Palm Beach County Reentry Program
  - Palm Beach Sheriffs Office Reentry Unit
  - Wellpath (Jail healthcare provider)
  - The Lords Place

Main Findings

- The average daily population (ADP) across both jail locations is approximately 3000 people
  - 20% are sentenced
  - 50 PWH are in jail between the two locations
  - PWH make up 1.6% of the ADP
  - 8-16 PWH are released from county jail per month
  - Without specific intervention, an average of 1 person is released from the jail every other day without HIV-specific linkage and supportive services

Identified Gaps and Opportunities

- Gaps
  - Current reentry assessment does not include medical considerations
  - Wellpath no longer schedules appointments for clients post-release due to now-shows
    - Clients did not keep their scheduled appointments
  - Some clients leave with only as 14 day supply or a 30 day prescription for medication.
  - No collaboration between Wellpath medical discharge and in-jail discharge planners
- Opportunities
  - Jail-based reentry providers express desire to develop a comprehensive linkage process for PWH
  - Reentry providers are able to provide in-person work with the clients in the jail
  - Space for programming in the jail is available
  - Video visitation is available in the jail

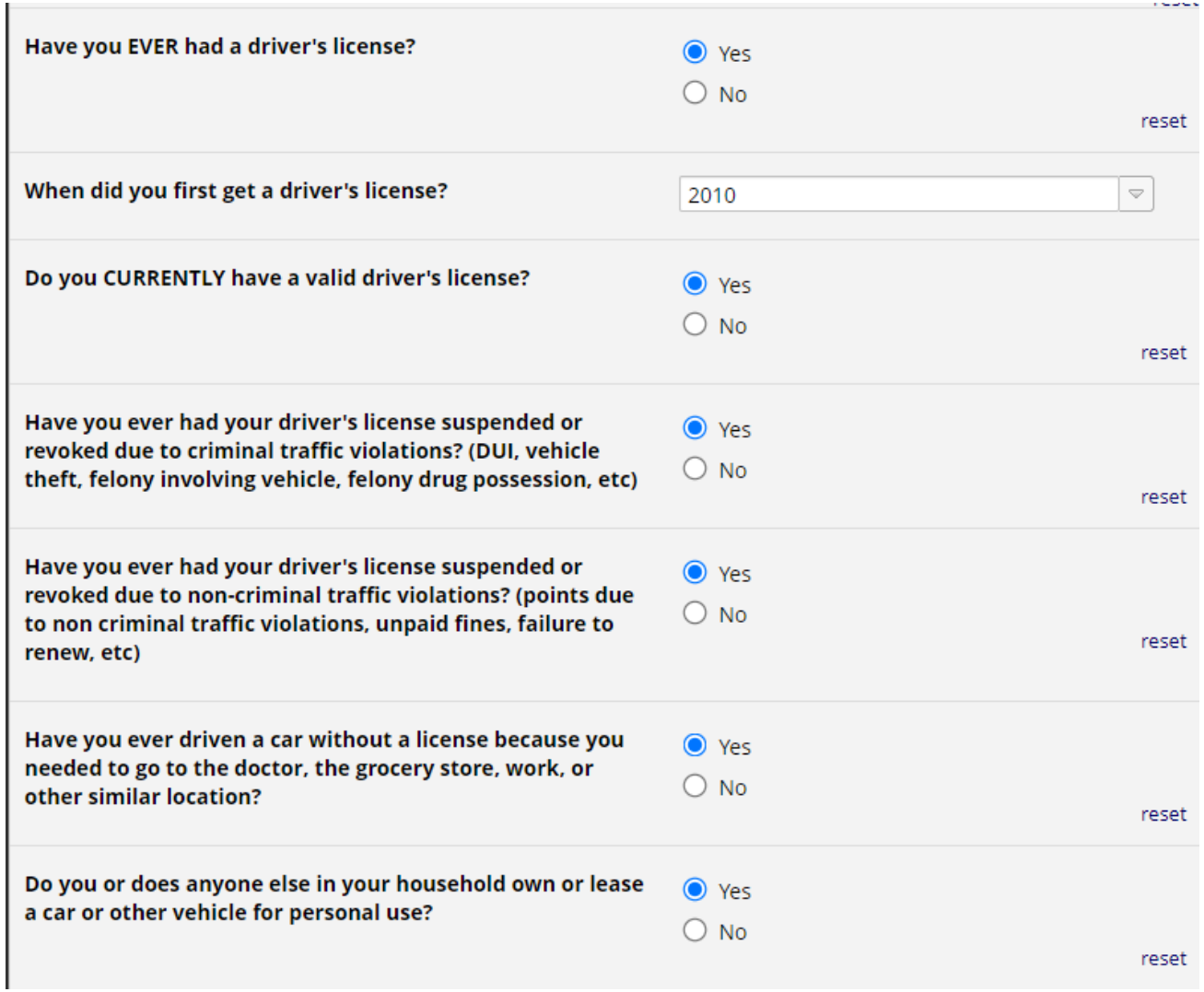
Next steps

- Jail linkage workgroups were conducted through 2023 and 2024
- Key stakeholders from the Palm Beach County Sheriffs Office, community partners, and Palm Beach County Community Services worked together to identify solutions to identified problems
- PBC and PBSO will sign an MOU to provide services directly in the jail

Transportation Needs Assessment

- Transportation was identified as an issue for clients
- EHE is interested in identifying root causes in order to develop an intervention that can provide long term improvement
- Identified the TSI-16, a validated tool used to identify levels of "transportation insecurity"
- PBC EHE developed questions to identify specific factors that may be contributing to the transportation insecurity and which factors have the largest influence in transportation insecurity

Sample of Transportation Assessment data



Have you EVER had a driver's license?	(•) Yes ( ) No reset
When did you first get a driver's license?	2010
Do you CURRENTLY have a valid driver's license?	(•) Yes ( ) No reset
Have you ever had your driver's license suspended or revoked due to criminal traffic violations? (DUI, vehicle theft, felony involving vehicle, felony drug possession, etc)	(•) Yes ( ) No reset
Have you ever had your driver's license suspended or revoked due to non-criminal traffic violations? (points due to non criminal traffic violations, unpaid fines, failure to renew, etc)	(•) Yes ( ) No reset
Have you ever driven a car without a license because you needed to go to the doctor, the grocery store, work, or other similar location?	(•) Yes ( ) No reset
Do you or does anyone else in your household own or lease a car or other vehicle for personal use?	(•) Yes ( ) No reset

Next Steps

- A randomized list of PWH stratified by zip code has been created
  - Zip codes were selected based on HIV prevalence
- Clients are contacted to complete the survey either over the phone or in person
- Clients will receive a $25 gift card for participating

Vocational Rehabilitation

- EHE partnered with the Palm Beach County Community Action Partnership (CAP) to provide Vocational Rehabilitation services for PWH
- Eligible clients are able to access CAP programs through EHE, rather than using the standard process to access CAP
- Available services include:
  - Vocational Training
  - Debt management planning
  - Financial Literacy
  - GED Classes
  - ESL Classes
  - Interview Preparation
  - Resume Building
  - And more

Vocational Rehabilitation

- To Date, 62 clients have been referred for Vocational Rehabilitation Services
- To date, 1 client has completed their training program
- 45 have not begun the process due to trouble contacting them
- 15 are in some stage of the process for getting training or other services

Background

Palm Beach County (PBC) Housing Opportunities for Persons with HIV/AIDS (HOPWA) served 232 persons from the community in 2022. The biggest challenge clients faced in attaining and maintaining affordable housing was housing affordability.

The majority of clients had income at or below 100% of the federal poverty level, with a majority of those clients having no income at all.

Barriers to housing included physical disabilities, behavioral health issues, and other complications from HIV.

Vocational Rehabilitation

Vocational Rehabilitation refers to a process in which clients are provided assistance in changing their vocation due to a change in health status. Services available through vocational rehabilitation programs are traditionally:

- **Vocational training**
- **Interview and resume coaching**
- **Budgeting**
- **GED courses**
- **Job Placement**
- **Skills assessment**

Step 1: Identify the Problem

Three specific problems were identified in this population:

1. Ryan White Part A and HOPWA clients were struggling to pay housing costs, including rent and utilities.

2. Ryan White Part A and HOPWA clients were struggling to find housing units that were in their price range.

3. Ryan White Part A and HOPWA clients were struggling to be approved for leases.

Step 2: Identify the Root Cause

A root cause analysis was conducted to determine the primary reasons each problem existed.

1. Client income was not enough to cover costs.

2. Client income and/or savings was not enough to cover move in or rental costs.

3. Client background affected ability to pass background or credit checks.

Step 3: Identify an Intervention

- Of the three identified root causes, the program combined #1 and #2 to focus on addressing client income.
- The program identified the best way to increase income was through gainful employment.
- Barriers to Employment were explored and identified:
  - Lack of appropriate experience or training
  - Lack of a High School Diploma or GED
  - Challenges with identifying appropriate jobs
  - Lack of appropriate interview skills
  - Residency status
  - Legal background
  - Physical/mental health issues

Step 3: Identify an Intervention

Barrier	Intervention	Feasibility	Impact	Total
Lack of appropriate training	Provide appropriate vocational training	9	9	81
Lack of high school diploma or GED	Provide access to GED programs	9	9	81
Challenge with identifying appropriate jobs	Provide job search and job placement services	7	6	42
Lack of appropriate interview skills	Provide interview skills coaching	7	6	42
Residency status	Provide immigration services	2	7	14
Legal background	Provide expungement services	2	5	10
Physical/mental health issues	Provide comprehensive healthcare services	10	9	90

Step 3: Identify an Intervention

- Based on feasibility matrix, three interventions were selected:
  - Provide comprehensive healthcare services
  - Provide access to appropriate vocational training
  - Provide access to GED courses

- Comprehensive healthcare services are already provided by Ryan White Part A, MAI, and EHE
- Vocational Rehabilitation includes access to vocational training and GED courses, so vocational rehabilitation was selected as the intervention

Step 4: Identify Key Stakeholders

- Palm Beach County Community Action Partnership (CAP) runs a family self-sufficiency program
  - This program provides access to GED courses, employment counseling, vocational training, job placement, and related services to eligible clients
  - Homeless persons are not eligible for this service through CAP
  - Clients are required to complete a series of orientations and trainings before being able to apply to the program

Step 5: Establish Relationship

- PBC EHE and CAP met to determine the best way to improve access to services for persons with HIV
- It was determined that EHE would utilize CAP infrastructure with EHE funding and eligibility to provide the associated services

Step 6: Establish Procedures

- A PPM was developed to determine programmatic procedures, including:
  - Eligibility
  - Referral process
  - Required documentation
  - Expectations
  - Funding sources

Step 6: Establish Procedures

- Some specific components of the PPM included:
  - Clients did not have to complete the CAP orientation and only needed a referral from a RWHAP case manager.
  - Clients did not need to meet the housing requirements of the program.
  - Clients did not need to meet the income limit for the program
  - EHE would assess all clients for eligibility before CAP
  - Established Vocational Rehabilitation Eligibility
    - Income at or below 80% AMI
    - Expressed desire to improve income through vocational rehabilitation
  - EHE would refer to CAP after verifying eligibility

Successes

- The program received 135 referrals since launching in November 2022
- 6 unique clients enrolled in and/or completed vocational training programs
- 5 unique clients received improved employment status
- 3 unique clients were enrolled in ESOL classes

*All above numbers are unique and unduplicated

Challenges

- Client Unresponsiveness
  - Despite asking for the service, most clients did not respond to case manager or employment counselor contact
  - Many responded to contact but did not complete the required paperwork or respond to further contact
- Conflicting Grant Requirements
  - CAP and EHE are funded by different grants and therefore some conflict exists between the expectations and deliverables of each grant

Syringe Services Program

- The Syringe Services Program is NOT an Ending the HIV Epidemic Initiative service
- The Syringe Services program does not receive operational funding from Palm Beach County in any way
- Ending the HIV Epidemic funds a specialized linkage specialist who provides Harm Reduction Intervention Services
- Ending the HIV Epidemic manages the data for the Syringe Services Program

Syringe Services Program

- The FLASH Syringe Services Program is operated by Rebel Recovery FL, a recovery community organization in Palm Beach County specializing in peer support, harm reduction, and medication assisted treatment
- FLASH offers 1 to 1 needle exchange, safe injection supplies, opioid overdose reversal (Narcan/Noloxone), linkage to treatment, HIV and HPV Testing, and a wound care clinic

Flash by the Numbers

- Total Enrolled Clients – 481
- April 2022 – May 2023
  - Clients using exchange - 265
  - Total Needles In – 76,732
  - Total Needles Out – 70,976
  - Average needles in/visit – 54.3
  - Average Needles out/visit – 50.3
  - Average Needles in /client – 289.6
  - Average Needles Out/ client – 267.83
- Cases of Narcan Given – 1,302
- Number of overdose reversals – 204
  - 17 reversals/month

Demographics

- Enrolled from May 1 2022 – April 30 2023 - 189
- Average Age – 40 years old
- Average # of visits per client – 5.3
- Number of clients who never received a HIV Test – 48
- Number of clients who were tested within the last 90 days (Excluding those never tested) – 67
- Total HIV Tests Performed - 62

Race Breakdown

- Race Breakdown
  - White - 156 (82.5%)
  - Black/African American – 23 (12.2 %)
  - Native American – 4 (2.1%)
  - Multiracial – 6 (3.2%)

Gender Breakdown

- Men – 114 (60.3%)
- Women – 70 (37%)
- Transgender – Female to Male – 1 (.5%)
- Transgender – Male to Female – 2 (1.1%)
- Other – 2 (1.1%)

Harm Reduction Intervention Services

- Harm Reduction Intervention services funds a highly-skilled HIV linkage navigator to provide Harm Reduction Intervention Services
- These services include targeted testing, harm reduction training

Questions?

Palm Beach County HIV CARE Council Administrative Assessment Report 2023-2024

Neeta Mahani
HIV CARE Council Coordinator
PBC Community Services Department
nmahani@pbcgov.org
561-355-4820

Palm Beach County
Ryan White HIV/AIDS Program

Palm Beach County HIV CARE Council Administrative Assessment Report

https://redcap.pbcgov.org/redcap/redcap_v13.4.12/DataExport/index.php?pid=52&report_id=321&stats_charts=1

Questions?

END OF DAY 2

Palm Beach County
Ryan White HIV/AIDS Program

Open Forum/Discussion/Q&A