
PALM BEACH COUNTY
HIV CARE
COUNCIL'S
ANNUAL RETREAT
2026
AND DATA PRESENTATION
DATA DRIVEN
EQUITY FOCUSED
COMMUNITY STRONG
TOGETHER WE CAN END HIV
USING DATA TO DRIVE EQUITY, IMPROVE OUTCOMES,
AND END THE HIV EPIDEMIC IN PALM BEACH COUNTY.
COLLABORATE.
ANALYZE.
TRANSFORM LIVES.

The Visionary Leadership Award

- Presented in recognition of her exceptional leadership, guidance, and unwavering commitment to the success of the Palm Beach County HIV CARE Council from day ONE!
- We wish her a relaxing and rewarding retirement. You will be missed.

Palm Beach County HIV CARE Council's Mission

- The CARE Council shall be a collaborative and balanced body of HIV infected and affected individuals, service providers, community leaders and interested individuals whose responsibilities shall be to plan, develop, monitor, evaluate and advocate for a medical and supportive services system for individuals and families affected by HIV/AIDS.

The CARE Council shall:

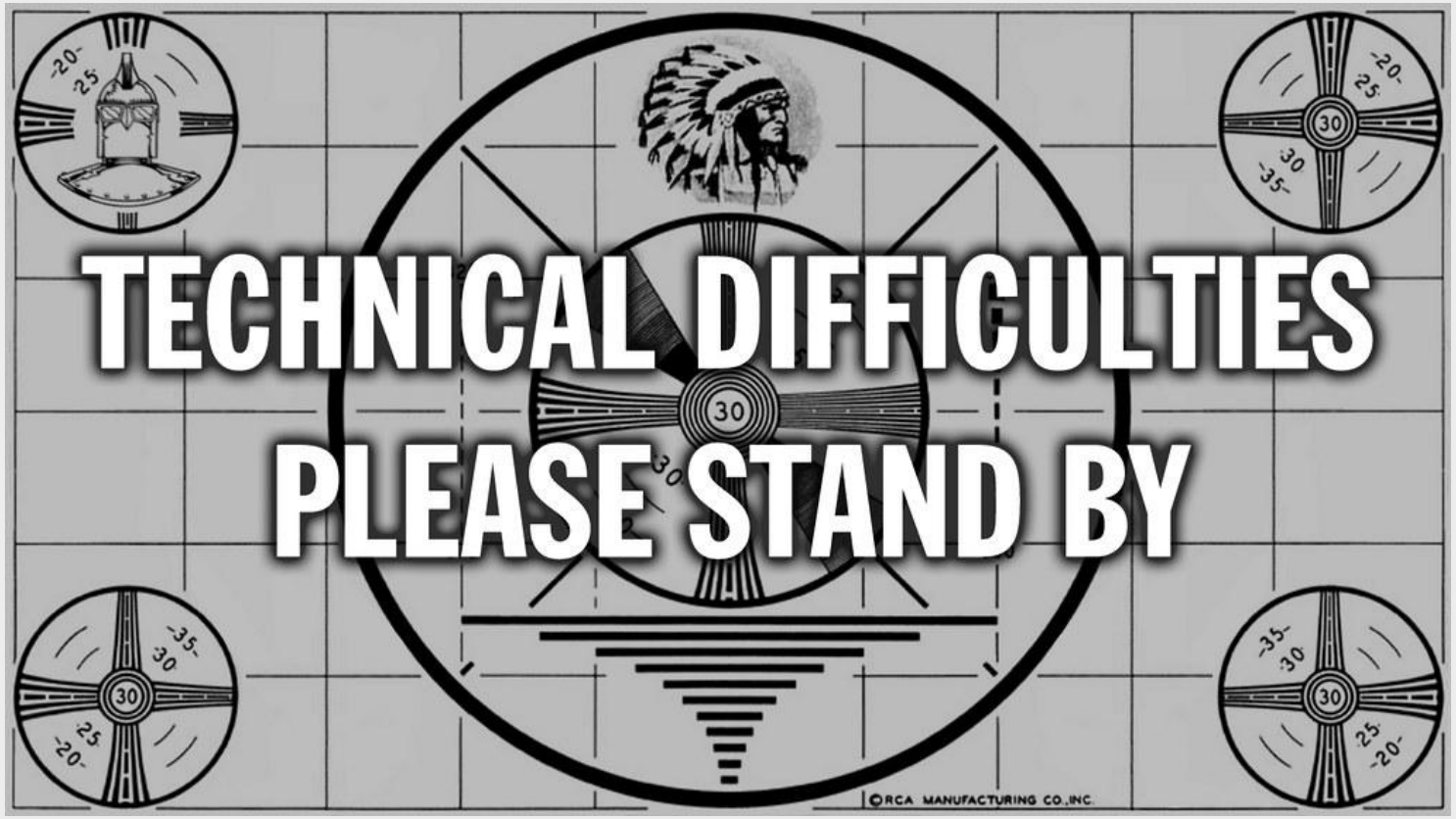
- Develop a comprehensive plan for the entity and delivery of health services described in the Ryan White CARE Act, as it may be amended (hereinafter referred to as the Ryan White Act) that is compatible with any existing State or local plan regarding the provision of health services to individuals with HIV disease.
- Establish priorities for the allocation of Ryan White Act Part A and Ryan White Part B funds, State of Florida 4B General Revenue and Patient Care Network, and other appropriate funds within Palm Beach County, including how best to meet each such priority and additional factors that the grantees or Lead Agency shall consider based on:
  - Documented needs of the HIV infected population;
  - Cost and outcome effectiveness of proposed service strategies and interventions, to the extent that such data are reasonably available (either demonstrated or probable);
  - Priorities of the HIV infected communities for whom the services are intended; and
  - Availability of other governmental and non-governmental resources.

Palm Beach County HIV CARE Council's Vision

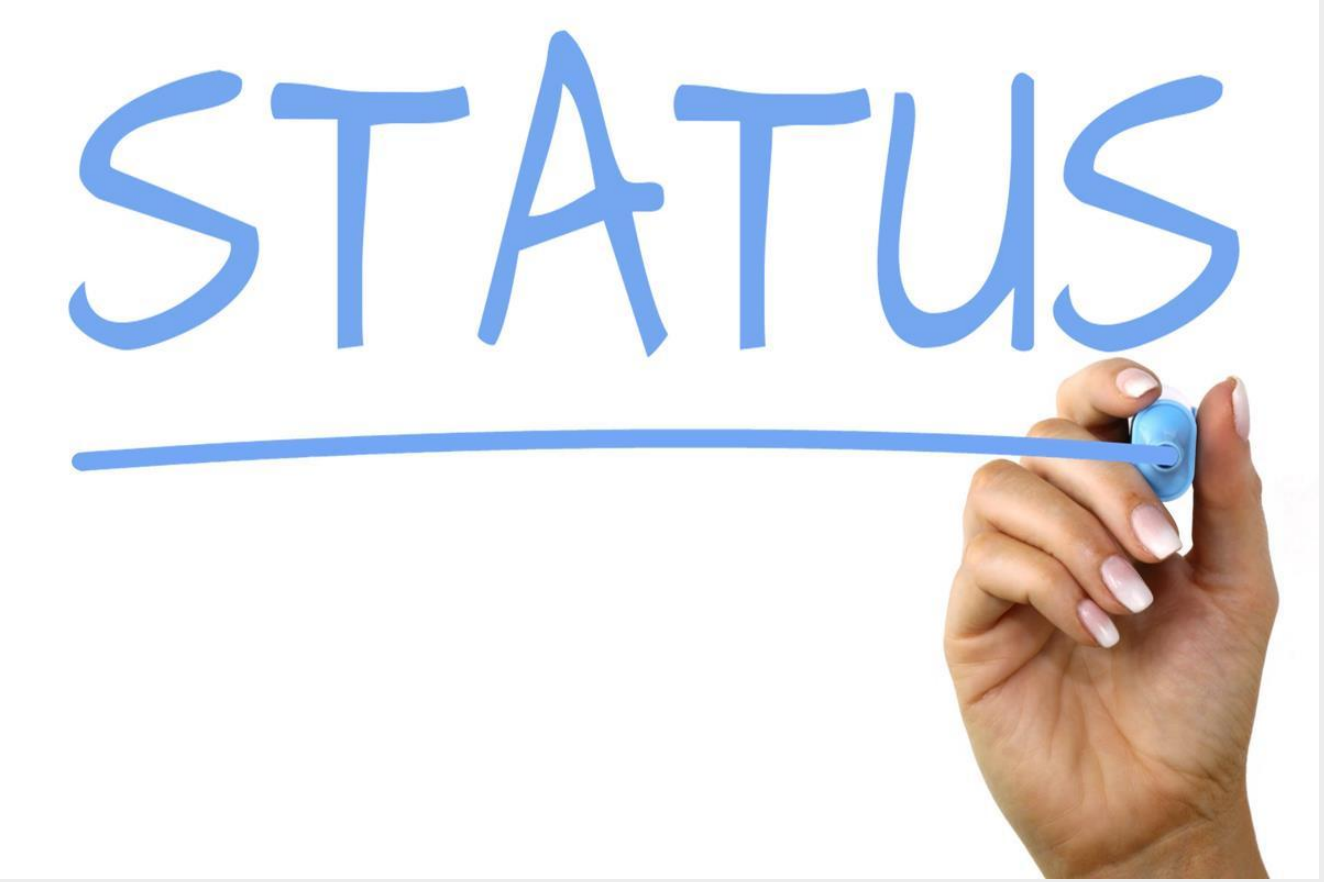
- A community where individuals who live with HIV/AIDS do so without prejudice, abandonment, or social stigma.
- A community where people living with HIV/AIDS are afforded a comprehensive range of medical and support services assuring the person's wellness, independence, and self sufficiency.
- A community where HIV medical and supportive services are eligibility accessed based upon need, and approved CARE Council guidelines.

Red Ribbon Activity
Remembrance, Awareness or Feelings

Livingwell
by Gilead Sciences



Thank you Bolivar Nieto…
now please welcome Dr. Casey Messer



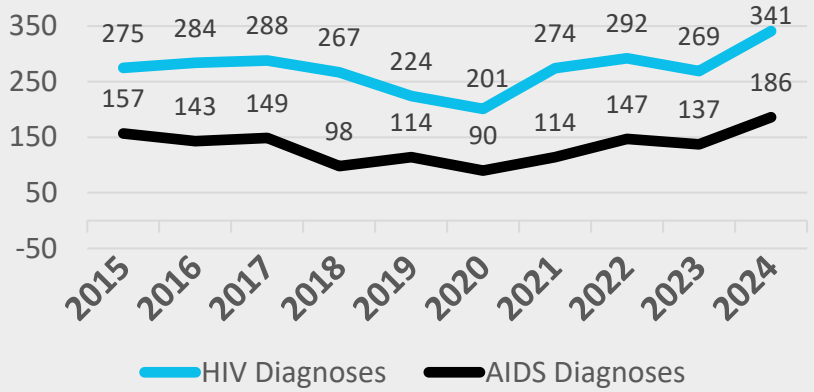
THE STATUS OF HIV IN PALM BEACH COUNTY

CASEY MESSER, DHSc, PA-C, AAHIVS
PROGRAM MANAGER, HIV ELIMINATION SERVICES

JULY 17, 2026

THE STATUS OF HIV IN PALM BEACH COUNTY BY THE NUMBERS

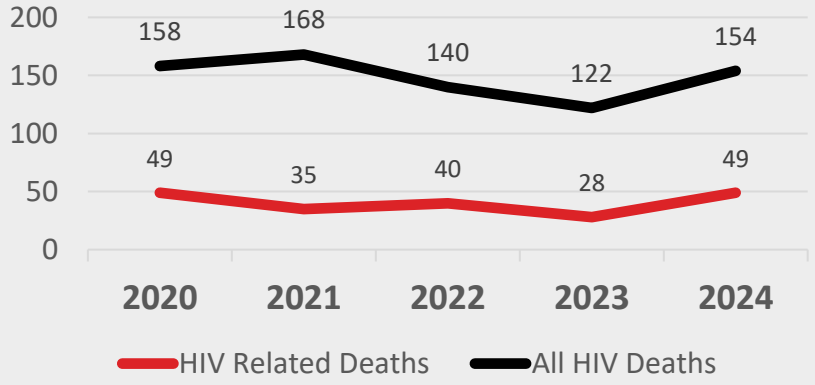
Diagnoses of HIV/AIDS, 2015-2024



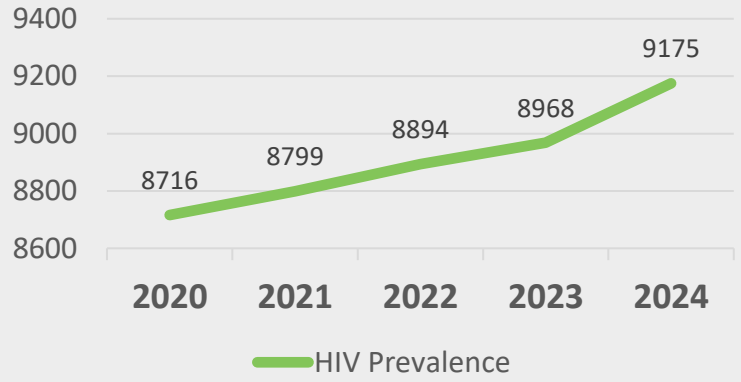
New HIV diagnoses have risen steadily following COVID-19

Number of HIV-related deaths have increased in the last year

HIV-Related Deaths, 2020-2024



Number of People with HIV, 2020-2024



Number of people with HIV has reached its highest level in 5 years

THE STATUS OF HIV IN PALM BEACH COUNTY CONSOLIDATED FUNDING

Program	Funding Amount (GY25)	Funding Amount (GY26)	Contracts
Ryan White Part A (RW)	$7,028,623	$7,115,011	10
Minority AIDS Initiative (MAI)	$683,207	$615,898	2
Ending the HIV Epidemic (EHE)	$3,676,308	$2,438,682	11
Syringe Services Program (SSP)	$0	$0	1
NASTAD Relink HIV (Relink)	$0	$200,000	0
Total	$11,388,138	$10,369,591	24

FDOH AIDS DRUG ASSISTANCE PROGRAM (ADAP) CHALLENGES

February 2026

- FDOH publishes an Emergency Rule, effective immediately

March 2026

- March 1st, ADAP clients not meeting new Emergency Rule criteria are terminated
  - Income reduced: 400% to 130% FPL ($20,748 annually)
  - Elimination of health insurance premium assistance (Direct dispense only)
  - Removal of Biktarvy (single tablet complete regimen)
  - Descovy restricted (CrCl <60 mL/min)
  - No reciprocal eligibility between State & Counties

More than 87.5% of current Palm Beach County ADAP clients affected by the rule change

FDOH AIDS DRUG ASSISTANCE PROGRAM (ADAP) CHALLENGES

July 2026

- July 1, state budget bill included $75M in funding for ADAP
  - One-time funding for current year
  - Income restored to 400% FPL
  - Biktarvy and Descovy restored to formulary
  - Reciprocal eligibility between State & Counties restored
  - Health insurance premium assistance not restored
  - Enrollment cap of 21,000 persons

Palm Beach County fiscal impact estimated at $8.6M annually

FDOH AIDS DRUG ASSISTANCE PROGRAM (ADAP) LOCAL RESPONSE

1) HIV CARE Council sponsored a resolution through PBC BCC to request the state legislature to fully restore ADAP
2) HIV CARE Council is considering budget reallocations to support projected deficit in health insurance assistance funding
3) County launching 340B Program to support cost-savings that will be reinvested into health insurance assistance
4) County will recommend specific health insurance plans that are cost effective for ACA Open Enrollment 2027
5) County pursuing new grant funding opportunities to support health insurance assistance
6) Community Partners/Agencies have been requested to utilize discretionary funding and program income to support health insurance assistance

Thank you Dr. Casey Messer…
now please welcome Esteban Wood

Thank you Estaban Wood…
Let’s Take a Break and Network

It’s now time for
Team Building
with Dr. Sandra Anderson and Vicki Tuci Krussel

Thank you Dr. Sandra Anderson and Vicki Tuci Krussel…
now please welcome Geneve Simeus

FROM DATA TO DIRECTION: COMPREHENSIVE HIV NEEDS ASSESSMENT 2025-2026

GENÈVE SIMEUS, MPH
HEALTH PLANNER II
RYAN WHITE PART A PROGRAM
HIV ELIMINATION SERVICES
PALM BEACH COUNTY
COMMUNITY SERVICES DEPARTMENT
JULY 17TH, 2026

Data

Decisions

Actions

Agenda

- Needs Assessment Purpose and Components
- Palm Beach County HIV Snapshot
- Priority Populations
- System Strengths and Successes
- Unmet Needs, Gaps, and Access Barriers
- Client and Provider Perspectives
- Resource Inventory
- Key Needs
- Recommendations

Purpose

- The Needs Assessment identifies where our system is working well, where gaps remain, and where resources may have the greatest impact.
- The Needs Assessment helps the CARE Council:
  - Understand current trends among people living with HIV in Palm Beach County
  - Identify gaps, barriers, and unmet service needs
  - Elevate client and provider experiences
  - Recognize system strengths to build upon
  - Inform priority setting, resource allocation, and service improvement efforts

Needs Assessment Components

01 Epidemiologic Profile

02 Estimate of Unmet Need and PWH Who are Unaware of their Status

03 Assessment of Service Needs and Barriers- HIV Client Survey and Focus Groups

04 Resource Inventory

05 Provider Capacity and Capability

06 Assessment of Service Needs and Gaps

Palm Beach County HIV Snapshot

9,175

People living with HIV in 2024

Persistent HIV burden

341

New HIV diagnoses in 2024. **28,402** HIV tests completed

Ongoing transmission

27% ↑

Increase in new HIV diagnoses from 2023 to 2024

Testing and prevention remain critical

2,251

People with diagnosed HIV not in care. **76%** in care, **24.5%** out of care

Re-engagement opportunity

68%

People with HIV retained in care

Retention remains central

67%

People with HIV virally suppressed

Viral suppression remains a priority

Who is Most Impacted?

	Priority Populations	Key Data Points
1	Black/African American residents	71% of new diagnoses
2	Younger residents ages 13-29	31% of new diagnoses
3	Heterosexual transmission category	64% of new diagnoses
4	Older adults living with HIV	61% of PWH are age 50+
5	People out of care	2,251 PWH out of care, 24.5% out of care
6	High burden areas	West Palm Beach, Boynton, Delray, Lake Worth, Riviera Beach, Belle Glade

Planning Takeaway: Priority populations should guide outreach, linkage, retention, support services, and culturally responsive strategies.

What Is Working: System Strengths to Build Upon

Strong Medical Care Engagement

Most respondents reported regular HIV medical visits.

High Medication Access

Nearly all respondents reported currently taking HIV medication.

Strong Provider Communication

Clients reported clear explanations of lab results and treatment plans.

Core Services Are Being Used

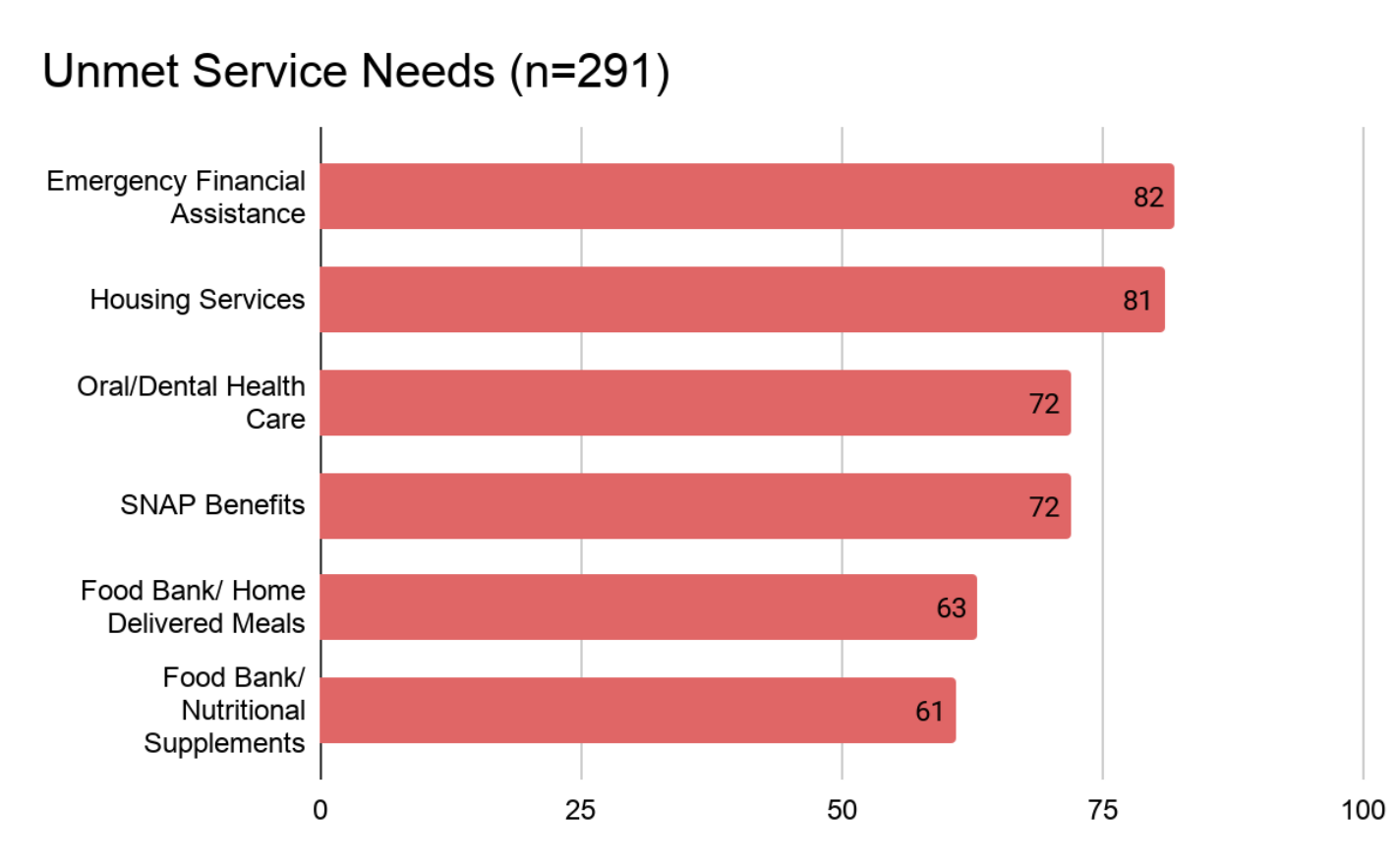
High use of lab testing, case management, medication assistance, outpatient care, and insurance assistance.

Responsive Provider Network

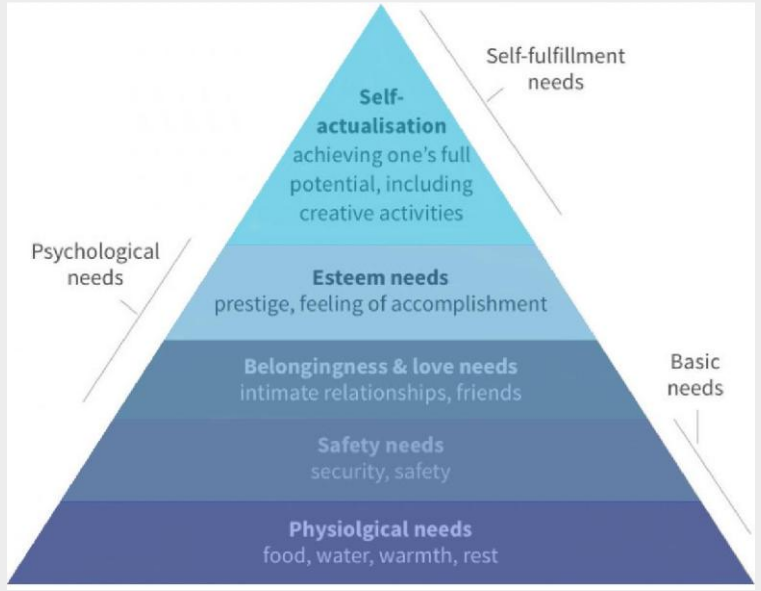
Providers reported multilingual capacity, timely appointments, telehealth use, and culturally responsive practices.

Planning Takeaway: Protect core HIV medical services while strengthening supports that help clients remain stable, engaged, and virally suppressed.

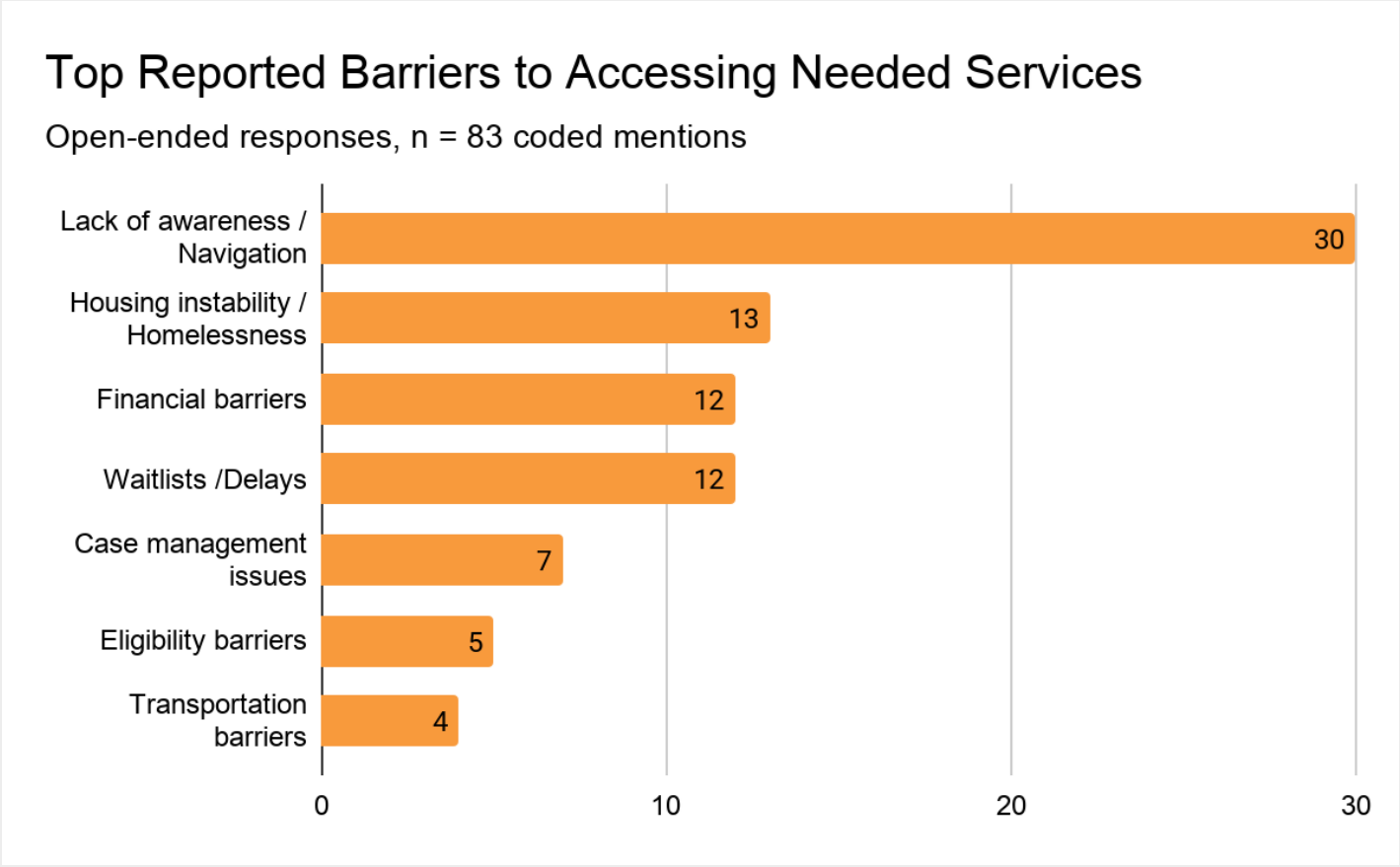
Where the Gaps Are: Highest Unmet Needs



Planning Takeaway: The highest unmet needs are concentrated in **supportive services** that help clients meet basic needs, remain engaged in care, adherent to medication, and virally suppressed.



Barriers Behind the Gaps



Planning Takeaway: Improving navigation, communication, and timely follow-up may reduce unmet need even when services are available. Services may exist, but clients still need help accessing them.

What Clients Told Us: Lived Experience Behind the Data

Client Voice: *"When you're trying to figure out where you're sleeping that night, going to a doctor's appointment becomes the last thing on your mind."*

Client Voice: *"When people hear HIV, they think they can catch it just by sitting next to you."*

Planning Takeaway: Client experiences reinforce the need for services that address stability, trust, communication, stigma, and whole-person care.

What Providers Told Us: System Capacity and Service Delivery

System Strengths

- Multilingual capacity and culturally responsive practices
- Timely appointment scheduling, often within 72 hours
- Telehealth availability across parts of the system
- Strong provider commitment to serving people with HIV
- Inter-agency referral network and service coordination

Capacity Gaps

- Housing remains a major service gap and barrier
- Workforce strain, including caseloads and documentation burden
- Waitlists reported for some supportive services
- Peer support access is not universal across providers
- Funding limitations affect service and staffing capacity

Planning Takeaway: Provider feedback reinforces the need to protect system strengths while addressing housing, workforce capacity, peer support, and supportive service access.

Key Differences in Client and Provider Perspectives

Topic	Client Perspective	Provider Perspective
Timely Access	Reported waitlists, appointment delays, and access challenges.	Reported timely scheduling, often within 72 hours.
Service Navigation	Reported lack of awareness and difficulty knowing where to go or how to access services.	Reported referral networks and service coordination.
Case Management / Follow-Up	Most had case management, but some reported communication concerns.	Reported workforce strain, caseload variation, and documentation burden.
Mental Health Access	Reported anxiety, depression, PTSD, stress, trauma, and need for counseling and support.	Most reported no difficulty linking clients to mental health services, though some cited insurance or provider availability barriers.

Planning Takeaway: Provider capacity may exist, but clients may still experience barriers related to awareness, communication, eligibility, timing, and perceived accessibility. Strengthening navigation, warm referrals, follow-up, and behavioral health supports can help close the gap between system capacity and client experience.

Resource Inventory: Strong Network & Targeted Gaps

System Infrastructure

Ryan White, MAI, EHE, CDC prevention, HOPWA, FQHCs, DOH, and community-based providers

Service Network

management, medication assistance, oral health, mental health, transportation, food support, housing support, prevention, PrEP, testing, and linkage

Pressure Points

Housing, emergency financial assistance, food access, oral health, navigation, behavioral health support, and workforce capacity

Planning Takeaway: Palm Beach County has a strong HIV service network, but resource planning should continue to focus on the gaps that affect stability, access, retention, and viral suppression.

Key Gaps and Needs:
Major themes from Needs Assessment data

Housing and Basic Needs Stabilization

Housing, emergency financial assistance, food access, transportation, and basic needs affect care engagement.

Service Navigation and Communication

Clients need clearer information, warm referrals, timely follow-up, and support navigating eligibility and services.

Behavioral Health, Stigma, and Social Support

Mental health needs, stigma, misinformation, confidentiality concerns, and isolation affect quality of life and engagement.

Workforce and Provider Capacity

Provider feedback points to caseloads, documentation burden, funding limits, peer support gaps, and service capacity constraints.

Targeted Outreach and Re-Engagement

Priority populations, high-burden areas, and people out of care should guide testing, linkage, retention, and viral suppression strategies.

Planning Takeaway: The strongest opportunities are not only in expanding services, but in improving stability, access, coordination, and targeted support for the populations most affected.

From Data to Action: Recommendations for CARE Council

Prioritize & Allocate Resources

Use PSRA to align funding with high-need services, including **housing supports**, **emergency financial assistance, food access, transportation, oral health, behavioral health, insurance assistance, and medication access.**

Set Direction Through Standards & Directives

Use service standards, directives, and planning guidance to strengthen service navigation, warm referrals, case manager training, follow-up, and completed service connections.

Monitor Equity, Access & Outcomes

Use data, community input, and Integrated Plan monitoring to focus strategies on priority populations most impacted, high-burden areas, people out of care, culturally responsive services, and re-engagement.

Planning Takeaway: Use the Needs Assessment to guide priorities, allocations, directives, service standards, and monitoring toward services most connected to stability, access, retention, and viral suppression.

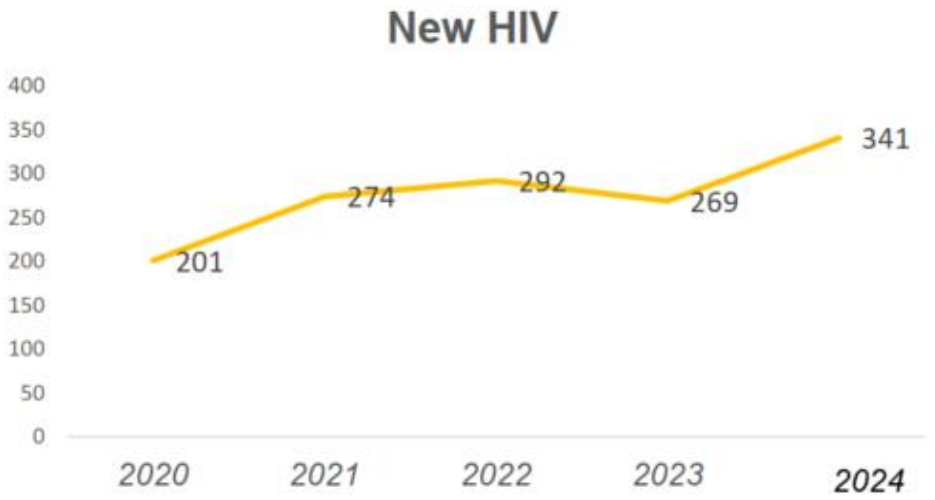
Thank you Geneve Simeus...
now please welcome Dr. Daisy Wiebe

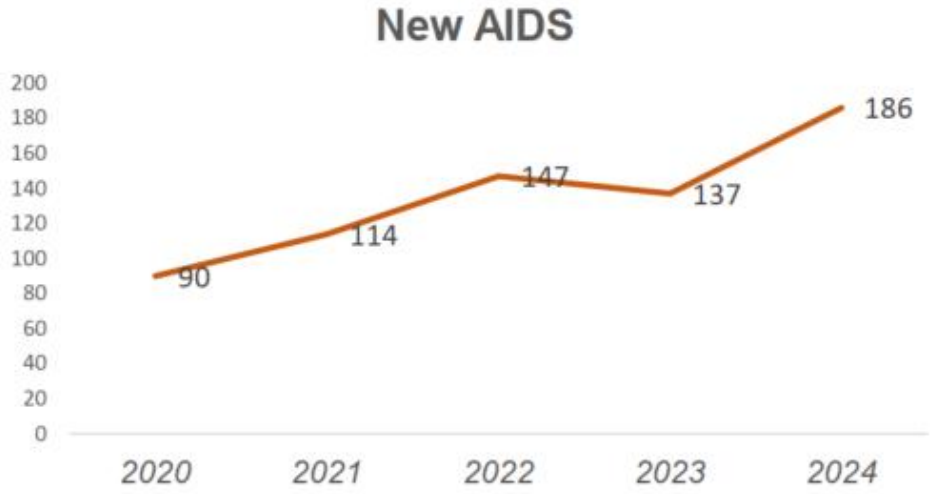
PALM BEACH COUNTY HIV EPIDEMIOLOGY AND PERFORMANCE MEASURES

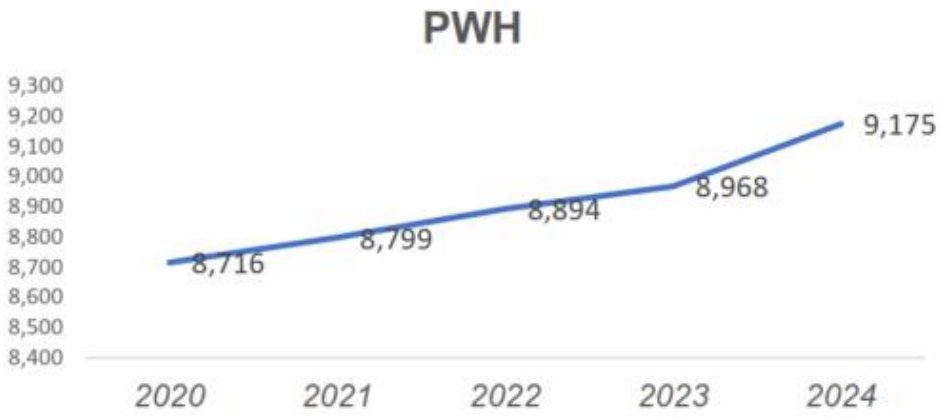
DAISY WIEBE, PHD, MPH

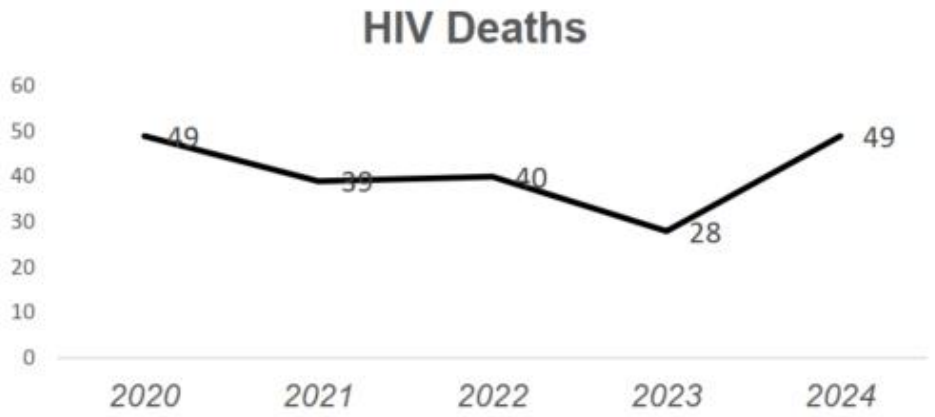
QUALITY MANAGEMENT CLINICIAN

New HIV / AIDS diagnoses, PWH, HIV deaths: 2020-2024 Palm Beach

- 







Florida HEALTH

Source: Integrated Epidemiological Profile, Florida 2024, as of 6/30/25.

New HIV Diagnoses - Demographic data 2024 Palm Beach

- In 2024, **341 persons** in Palm Beach County were **newly diagnosed with HIV**.
  - This is a 27% increase from 2023 (269) and a 17% increase from 2022 (292)

- 64% were males.
- 36% were females.

- 71% were Black
- 10% were White
- 18% were Hispanic

- 31% were between the ages of 13–29.
- 48% were aged 30–49.
- 22% were over the age of 50.

- 33% were MSM
- 64% were Heterosexual
- 2% were PWID

Refers to Risk:
- **IDU**: Injection Drug Use
- **MMSC**: Male-to-Male Sexual Contact

Refers to Persons with those Risks:
- **MSM**: Men Who Have Sex with Men
- **PWID**: Persons Who Inject Drugs

Persons living with HIV: Demographic data 2024 Palm Beach

- In 2024, there were **9,175 persons living with HIV** in Palm Beach County .
  - This is a 2.3% increase from 2023 (8,968) and a 3.2% increase from 2022 (8,894)

- 66% were males.
- 34% were females.

- 58% were Black
- 22% were White
- 19% were Hispanic

- 6% were between the ages of 13–29.
- 33% were aged 30–49.
- 61% were over the age of 50.

- 39% were MSM
- 52% were Heterosexual
- 8% were PWID

Refers to Risk:
- **IDU**: Injection Drug Use
- **MMSC**: Male-to-Male Sexual Contact

Refers to Persons with those Risks:
- **MSM**: Men Who Have Sex with Men
- **PWID**: Persons Who Inject Drugs

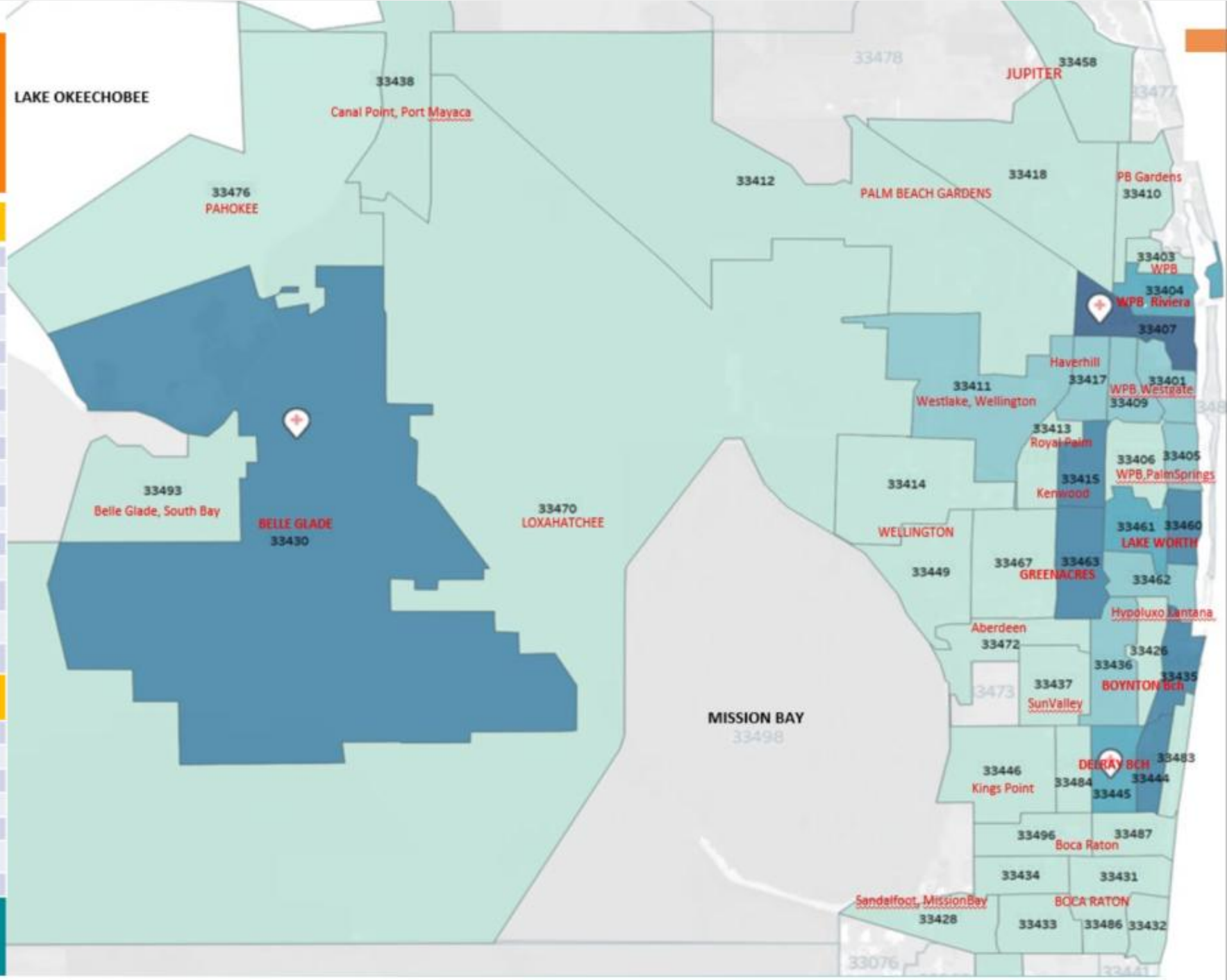
2024 Palm Beach
Total PWH – 9,175

EASTERN Palm Beach County	Count, % (Eastern PBC)	
West Palm Beach	1,478	16.1%
Riviera Beach, North Palm Beach	770	8.4%
Palm Beach, Juno Beach	66	0.7%
Palm Springs, Cloud Lake	223	2.4%
Palm Beach Gardens	256	2.8%
Royal Palm, Royal Palm Beach	398	4.3%
Haverhill	567	6.2%
Greenacres	561	6.1%
Boynton Beach	1,171	12.7%
Boca Raton	561	6.1%
Delray Beach	1,037	11.3%
Wellington	158	1.7%
Jupiter	130	1.4%
Lake Worth	790	8.6%
Lantana, Hypoluxo	289	3.1%
TOTAL Eastern PBC	8,455	(92.3%)

WESTERN Palm Beach County	Count, % (Western PBC)	
Belle Glade	446	4.9%
Bryant, Port Mayaca	7	.07%
Loxahatchee	77	0.8%
Pahokee	82	0.9%
South Bay	90	1.0%
TOTAL Western PBC	702	(7.6%)

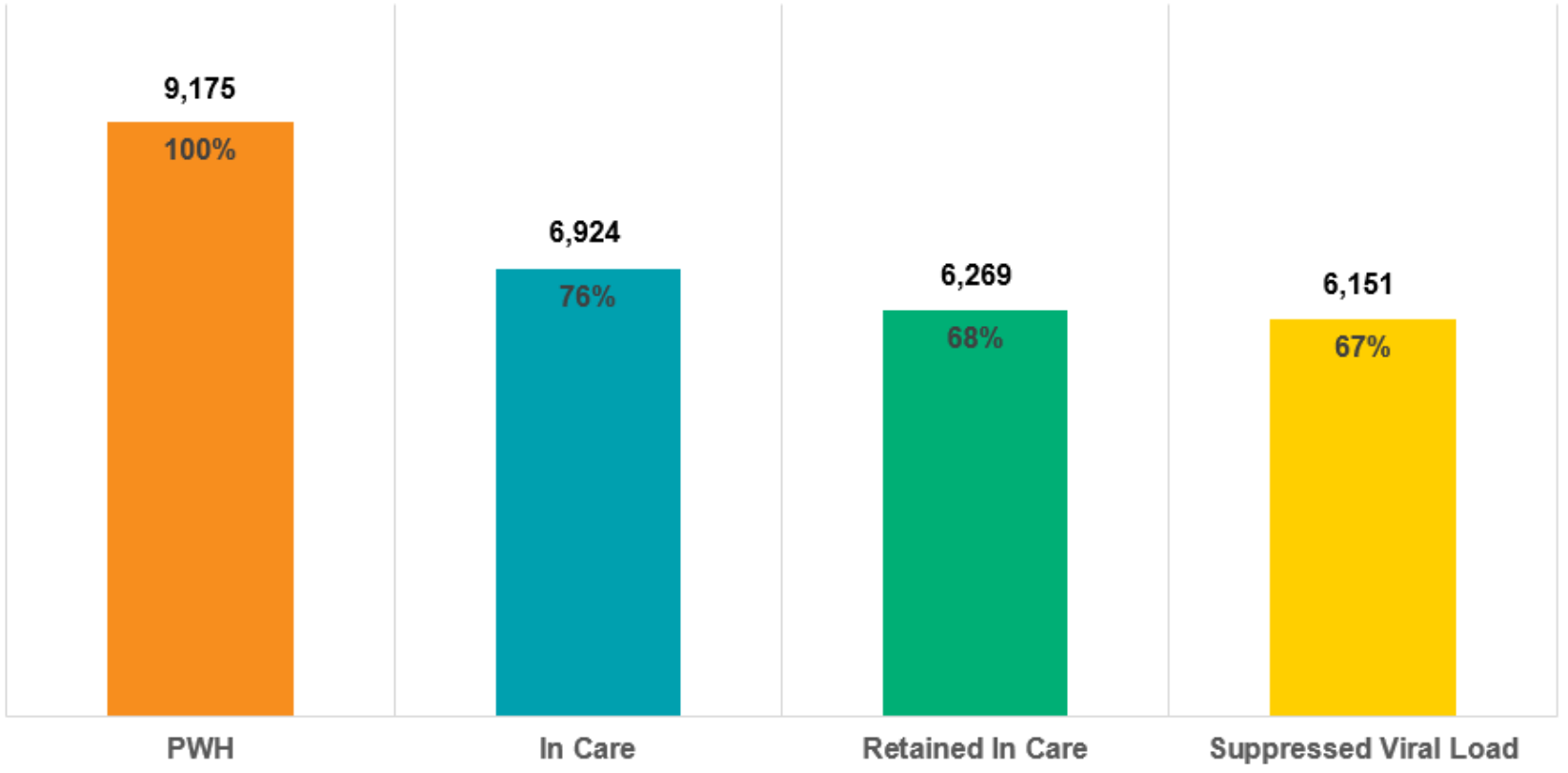
Florida HEALTH

18 = Unknown Zip Codes



HIV STATE OF THE EPIDEMIC IN FLORIDA

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



Note: 91% of individuals retained in care have a suppressed viral load.

Source: Integrated Epidemiological Profile, Florida 2024, as of 6/30/25.

Care Continuum Definitions

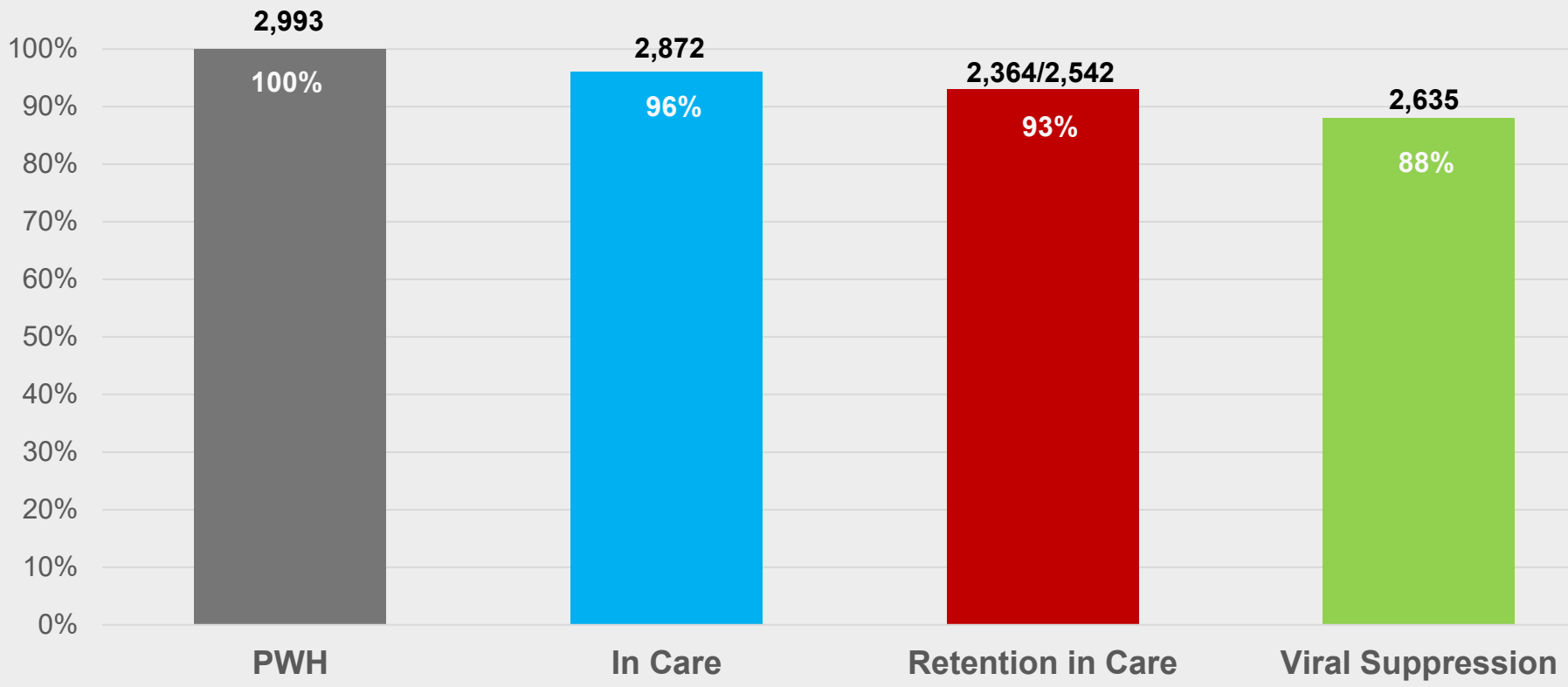
PWH: The number of persons with an HIV diagnosis living in Florida at the end of 2024.

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

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

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

PBC RYAN WHITE PART A/MAI CONTINUUM OF CARE



In Care
Percentage of PWH who had at least one medical care service in the reporting period (12 months):
Client has a “Kept” medical appointment OR
Client had a CD4 or Viral Load test result OR
Client has a Payment Request “Paid” (Co/pay or Deductible)
OR Client had a prescription dispensed

Retention in Care
Percentage of PWH who had two or more medical care services at least 90 days 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)

Viral Load Suppression
PWH clients whose most recent viral load test result record is less than 200 and the test result is from the reporting period (13 months).

PBC Ryan White Program, PM Quartely Metrics

Service Category	Grant Year 2025-2026									
	Baseline		Q1		Q2		Q3		Q4	
	Thru Date 2/28/2025		Thru Date 5/31/2025		Thru Date 8/31/2025		Thru Date 11/30/2025		Thru Date 2/28/2026	
	N/D	Metric	N/D	Metric	N/D	Metric	N/D	Metric	N/D	Metric
In Care	**2850/2993**	95%	**2885/3006**	96%	**2903/3018**	96%	**2935/3028**	97%	**2872/2992**	**96%**
Early Intervention Services	865/939	92%	904/941	96%	929/965	96%	602/664	91%	840/874	96%
Early Intervention Services - MAI	311/349	89%	517/548	94%	649/683	95%	610/649	94%	670/694	97%
Retention in Medical Care	**2349/2556**	92%	**2371/2545**	93%	**2355/2607**	90%	**2447/2623**	93%	**2364/2542**	**93%**
Emergency Financial Assistance	24/25	96%	21/22	95%	24/24	100%	33/33	100%	23/24	96%
Food Bank - Nutritional Supplements	4/4*	100%	3/3*	100%	5/5*	100%	4/5*	80%	6/6*	100%
Food Bank/Home Delivered Meals	756/798	95%	761/789	96%	752/797	94%	714/741	96%	687/724	95%
Health Insurance Premium & Cost-Sharing Assistance	395/415	95%	412/425	97%	437/457	96%	447/462	97%	518/538	96%
Legal Services	228/244	93%	241/246	98%	238/257	93%	256/274	93%	271/285	95%
Medical Case Management	1384/1453	95%	1387/1449	96%	1334/1437	93%	1308/1375	95%	1508/1560	97%
Medical Case Management - MAI	526/544	97%	603/613	98%	627/646	97%	660/678	97%	636/655	97%
Medical Transportation	323/340	95%	346/361	96%	338/367	92%	350/362	97%	341/360	95%
Mental Health Services	81/85	95%	77/81	95%	60/65	92%	53/56	95%	51/52	98%
Non-Medical Case Management	1997/2135	94%	1999/2116	94%	2023/2217	91%	2116/2250	94%	2083/2201	95%
Non-Medical Case Management - MAI	631/660	96%	736/765	96%	698/729	96%	690/715	97%	592/618	96%
Oral Health Care	130/131	99%	88/88	100%	76/77	99%	76/76	100%	53/55	96%
Psychosocial Support Services - MAI	365/377	97%	418/426	98%	419/431	97%	425/433	98%	244/254	96%

PBC Ryan White Program, PM Quartely Metrics

	Grant Year 2025-2026									
	Baseline		Q1		Q2		Q3		Q4	
	Thru Date 2/28/2025		Thru Date 5/31/2025		Thru Date 8/31/2025		Thru Date 11/30/2025		Thru Date 2/28/2026	
	N/D	Metric	N/D	Metric	N/D	Metric	N/D	Metric	N/D	Metric
Viral Load Suppression	**2540/2993**	85%	**2578/3006**	86%	**2600/3018**	86%	**2664/3028**	88%	**2635/2992**	**88%**
AIDS Pharmaceutical Assistance	7/7*	100%	7/7*	100%	7/7*	100%	3/4*	75%	1/1*	100%
Emergency Financial Assistance - Emergency Medication	5/5*	100%	2/2*	100%	x	x	x	x	x	x
Laboratory Diagnostic Testing	464/517	90%	329/360	91%	493/528	93%	441/467	94%	450/484	93%
Medical Case Management	1438/1574	91%	1436/1556	92%	1411/1541	92%	1373/1496	92%	1579/1726	91%
Medical Case Management - MAI	519/571	91%	589/635	93%	617/675	91%	654/707	93%	634/683	93%
Non-Medical Case Management	2133/2441	87%	2151/2341	92%	2227/2501	89%	2302/2556	90%	2296/2549	90%
Non-Medical Case Management - MAI	632/726	87%	742/845	88%	693/782	89%	678/752	90%	601/654	92%
Specialty Outpatient Medical Care	146/158	92%	118/129	91%	115/120	96%	124/130	95%	114/123	93%
Outpatient/Ambulatory Health Services	843/932	90%	599/643	93%	895/956	94%	860/914	94%	770/826	93%

≥ 90%	
80% - 89%	
≤ 79%	

	Missing Viral Loads Q4		Confirmed Non-VLS Q4	
	N/D	%	N/D	%
Overall	**164/2992**	5%	**193/2992**	6%
APA	0/1	0%	0/1	0%
EFA-Meds	x	x	x	x
Labs	0/484	0%	34/484	7%
MCM	49/1726	3%	98/1726	6%
MCM MAI	11/683	2%	38/683	6%
NMCM	108/2549	4%	145/2549	6%
NMCM MAI	13/654	2%	40/654	6%
Specialty	2/123	2%	7/123	6%
OAHS	6/826	1%	50/826	6%

< 5%	
5% - 9%	
≥ 10%	

KEY TAKEAWAYS

- **96%** of clients are In Care
- **93%** of clients are Retained in Care
  - Of service categories serving more than 100 clients,
    Medical Case Management (Part A & MAI) has the highest rate of retention at **97%**
  - Clients receiving health insurance support through Ryan White and EHE have a retention rate of **96%**
- **88%** of clients are Virally Suppressed
  - Elevated viral loads and missing/outdated viral loads which includes clients missing lab appointments are both about equal as the reason for non-suppression
  - Medical Case Management (MAI), Outpatient Ambulatory, Laboratory Diagnostic Testing and Specialty Medical have the highest rate of viral suppression at **93%**
  - Clients receiving health insurance support through Ryan White Part A is **92%**

KEY TAKEAWAYS CONTINUED

- **EIS is serving many clients:** *more than 850 clients*
  - The intent for EIS is just for linkage and for a short period of time: to serve those newly diagnosed, returning to care, moving to the area or switching providers
- EIS may be overfunded
  - The total number of clients who are out of care in Palm Beach County has been overstated by nearly 50%
    - Once PWH are on the list, they are never removed if the last known location is PBC
      - While there are good efforts to locate individuals in the United States, when PWH leave the country, there is no way to track them
    - Ending the HIV Epidemic Community Outreach, Response and Engagement Teams re-engage out of care clients through investigation and field work through the Florida Department of Health (FDOH) surveillance system
    - Many newly diagnosed clients are linked with FDOH EIS through their surveillance system

Thank you Dr. Daisy Wiebe…
It’s now time for lunch!

As we are relaxed and full…
we welcome Jeffrey Lesanti to liven us up

PBC RWHAP SERVICE UTILIZATION & COST ANALYSIS

JEFFREY J. LESANTI JR., MBA

FINANCIAL ANALYST II | PBC RYAN WHITE HIV/AIDS PROGRAM

JLESANTI@PBCGOV.ORG | 561-355-1945

GRANT YEAR 2025 FISCAL REVIEW

GY25 ALLOCATION & EXPENDITURE SUMMARY

Award Category	Allocated	Expended	Balance
Part A	$7,082,623	$6,825,482	$203,141
MAI	$683,207	$668,955	$14,252
EHE	$1,487,550	$1,487,550	$0
Total	**$9,253,380**	**$8,981,987**	**$217,393**

Source: FY2025 Part A & MAI Service Category Plan Tables. EHE reflects Ending the HIV Epidemic health insurance premium assistance.

GY25 CORE MEDICAL SERVICES EXPENDITURES BY SERVICE CATEGORY

Core Medical Service Category	Amount	Percent
AIDS Pharmaceutical Assistance (LPAP)	$32	<0.01%
Early Intervention Services	$534,492	6.65%
Early Intervention Services – MAI	$220,534	2.75%
Health Insurance Premium & Cost Sharing Assistance*	$3,940,523	49.05%
Medical Case Management	$1,081,563	13.46%
Medical Case Management – MAI	$245,303	3.05%
Mental Health Services	$109,821	1.37%
Oral Health Care	$65,666	0.82%
Outpatient/Ambulatory Health Services	$387,427	4.82%

*Includes EHE premium assistance of $1,487,550. Percent of combined Part A + MAI + EHE service expenditures ($8,981,987).

GY25 SUPPORT SERVICES EXPENDITURES BY SERVICE CATEGORY

Support Service Category	Amount	Percent
Emergency Financial Assistance	$31,420	0.39%
Food Bank/Home Delivered Meals	$426,077	5.30%
Medical Transportation	$90,729	1.13%
Non-Medical Case Management	$527,691	6.57%
Non-Medical Case Management – MAI	$60,641	0.75%
Other Professional Services (Legal)	$246,787	3.07%
Psychosocial Support Services – MAI	$64,445	0.80%

Percent of combined Part A + MAI + EHE service expenditures ($8,981,987).

SERVICE CATEGORY ORDERED BY EXPENDITURE

Service Category	Percent of Expenditures
Health Insurance Premium & Cost Sharing Assistance	49.05%
Medical Case Management	13.46%
Early Intervention Services	6.65%
Non-Medical Case Management	6.57%
Food Bank/Home Delivered Meals	5.30%
Outpatient/Ambulatory Health Services	4.82%
Other Professional Services (Legal)	3.07%
Medical Case Management – MAI	3.05%
Early Intervention Services – MAI	2.75%
Mental Health Services	1.37%
All other service categories	**3.89%**

SERVICE CATEGORY COST PER UNIT – PART A CORE MEDICAL

Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
AIDS Pharmaceutical Assistance (LPAP)	$32	1	$32	1	$32
Early Intervention Services	$534,492	1,084	$493	8,610	$62
Health Insurance Premium & Cost Sharing*	$3,940,523	572	$6,889	3,290	$1,198
Medical Case Management	$1,081,563	1,711	$632	38,210	$28
Mental Health Services	$109,821	54	$2,034	459	$239
Oral Health Care	$65,666	50	$1,313	94	$699
Outpatient/Ambulatory Health Services	$387,427	498	$778	9,940	$39

*Includes EHE premium assistance of $1,487,550.

SERVICE CATEGORY COST PER UNIT – PART A SUPPORT SERVICES

Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Emergency Financial Assistance	$31,420	25	$1,257	37	$849
Food Bank/Home Delivered Meals	$426,077	771	$553	12,813	$33
Medical Transportation	$90,729	393	$231	5,660	$16
Non-Medical Case Management	$527,691	2,494	$212	56,918	$9
Other Professional Services (Legal)	$246,787	313	$788	2,542	$97

SERVICE CATEGORY COST PER UNIT – MAI

Service Category	Amount	Persons Served	Cost/Person	Units of Service	Cost/Unit
Early Intervention Services – MAI	$220,534	698	$316	5,931	$37
Medical Case Management – MAI	$245,303	680	$361	22,132	$11
Non-Medical Case Management – MAI	$60,641	644	$94	8,271	$7
Psychosocial Support Services – MAI	$64,445	265	$243	3,711	$17

SERVICE CATEGORY ORDERED BY PERSONS SERVED

Service Category	Persons Served
Non-Medical Case Management	2,494
Medical Case Management	1,711
Early Intervention Services	1,084
Food Bank/Home Delivered Meals	771
Early Intervention Services – MAI	698
Medical Case Management – MAI	680
Non-Medical Case Management – MAI	644
Health Insurance Premium & Cost Sharing	572

Service Category	Persons Served
Outpatient/Ambulatory Health Services	498
Medical Transportation	393
Other Professional Services (Legal)	313
Psychosocial Support Services – MAI	265
Mental Health Services	54
Oral Health Care	50
Emergency Financial Assistance	25
AIDS Pharmaceutical Assistance (LPAP)	1

SERVICE CATEGORY ORDERED BY COST/PERSON – TOP 10

Rank	Service Category	Cost Per Person	Annual Expense
1	Health Insurance Premium & Cost Sharing	$6,889	$3,940,523
2	Mental Health Services	$2,034	$109,821
3	Oral Health Care	$1,313	$65,666
4	Emergency Financial Assistance	$1,257	$31,420
5	Other Professional Services (Legal)	$788	$246,787
6	Outpatient/Ambulatory Health Services	$778	$387,427
7	Medical Case Management	$632	$1,081,563
8	Food Bank/Home Delivered Meals	$553	$426,077
9	Early Intervention Services	$493	$534,492
10	Medical Case Management – MAI	$361	$245,303

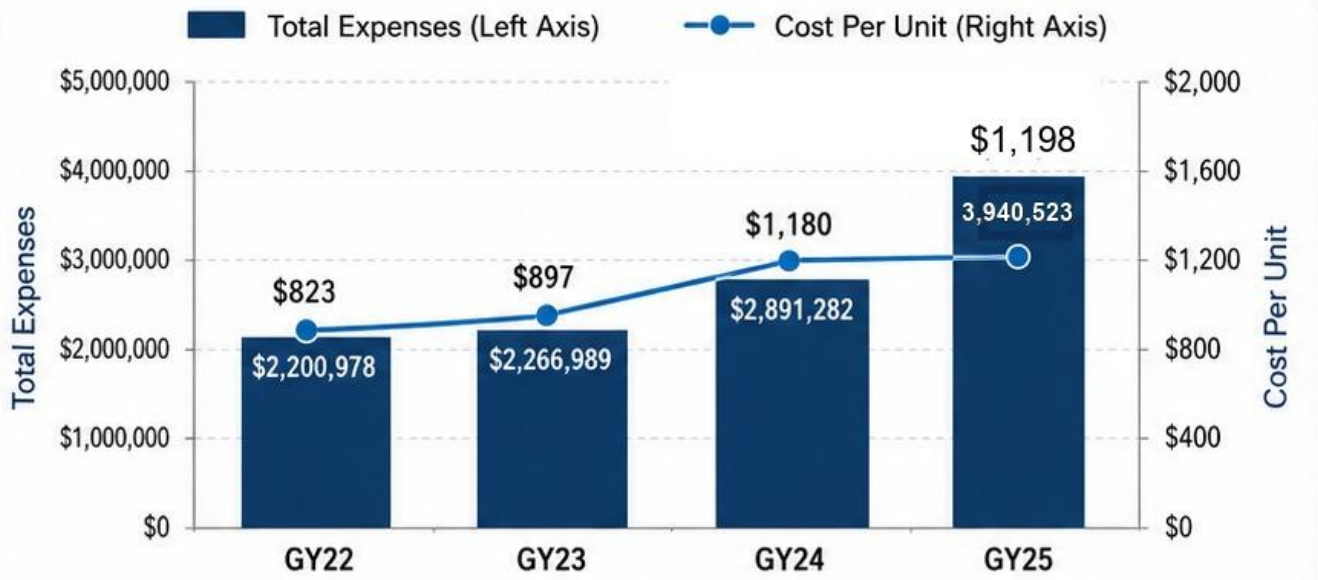
SERVICE CATEGORY ORDERED BY COST/UNIT – TOP 10

Rank	Service Category	Cost Per Unit	Annual Expense
1	Health Insurance Premium & Cost Sharing	$1,198	$3,940,523
2	Emergency Financial Assistance	$849	$31,420
3	Oral Health Care	$699	$65,666
4	Mental Health Services	$239	$109,821
5	Other Professional Services (Legal)	$97	$246,787
6	Early Intervention Services	$62	$534,492
7	Outpatient/Ambulatory Health Services	$39	$387,427
8	Early Intervention Services – MAI	$37	$220,534
9	Food Bank/Home Delivered Meals	$33	$426,077
10	AIDS Pharmaceutical Assistance (LPAP)	$32	$32

Health Insurance Assistance: Fiscal Pressure Overview

Prepared for Care Council discussion

1. EXPENSES AND COST PRESSURE TREND



2. GY26 FUNDING GAP

4. EXPENSE SUMMARY BY GRANT YEAR

Grant Year	Total Expenses	Total Units	Cost Per Unit*	Total Clients
GY22	$2,220,978	2,700	$823	492
GY23	$2,266,989	2,526	$897	481
GY24	$2,891,282	2,450	$1,180	441
GY25	$3,940,523	3,290	$1,198	572

**Co-payments may skew cost per unit lower.*

3. KEY TAKEAWAYS

- Cost per unit increased from $823 in GY22 to $1,198 in GY25.
- GY26 projected need exceeds available budget by $667,671.
- Rising health insurance costs are placing pressure on available program resources.

Thank you Jeffrey Lesanti…
now please welcome back Geneve Simeus

INTEGRATED PLAN DATA UPDATES (GY 25–26) AND 2027–2031 PLAN INTRODUCTION

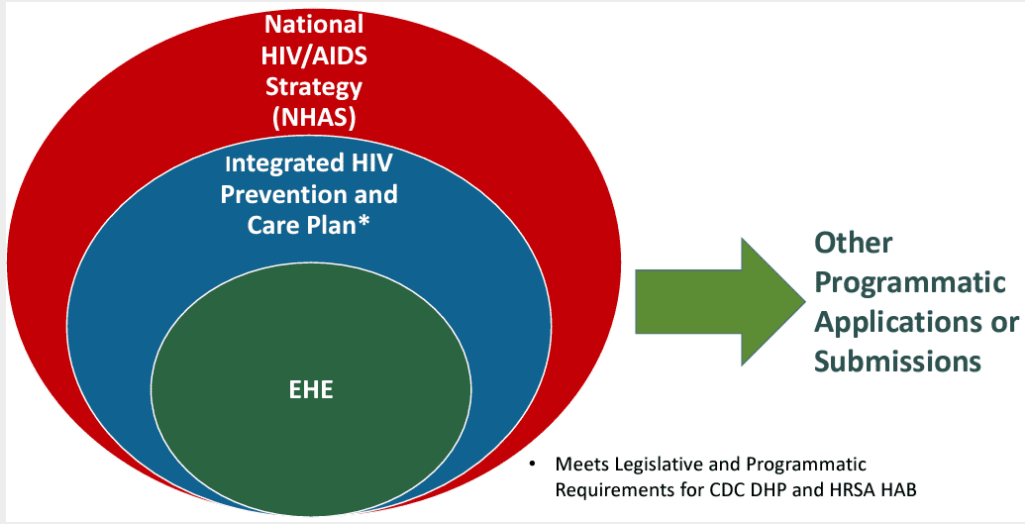
GENÈVE SIMEUS, MPH
HEALTH PLANNER II
RYAN WHITE PART A PROGRAM
HIV ELIMINATION SERVICES
PALM BEACH COUNTY
COMMUNITY SERVICES DEPARTMENT
JULY 17TH, 2026

Agenda

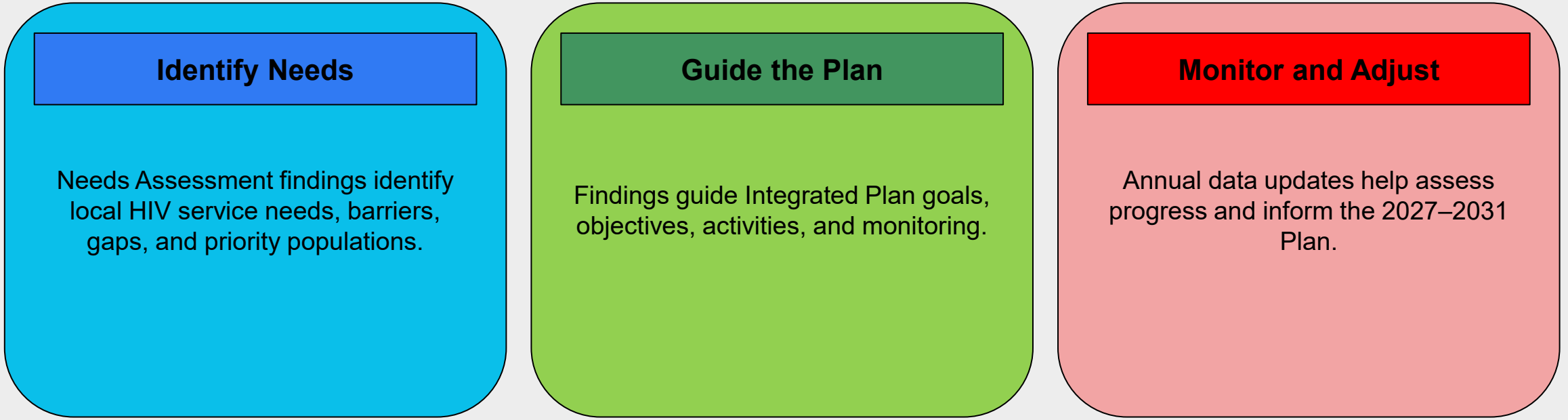
- Integrated Planning Overview
- Needs Assessment Connection
- 2022–2026 Pillar Highlights and GY 25–26 Data Updates
- Data Takeaways and Lessons Learned
- 2027–2031 Integrated Plan Introduction
- Implementation and Community Call to Action
- Closing and Questions

What is Integrated Planning?

- Five-year strategic roadmap for local HIV prevention, care, treatment, and response
- Connects community needs, service gaps, data findings, and partner activities
- Required by CDC and HRSA for HIV prevention and Ryan White HIV/AIDS Program planning
- Aligns local activities with NHAS and Ending the HIV Epidemic goals
- Reinforces that HIV prevention and care are connected across the service system

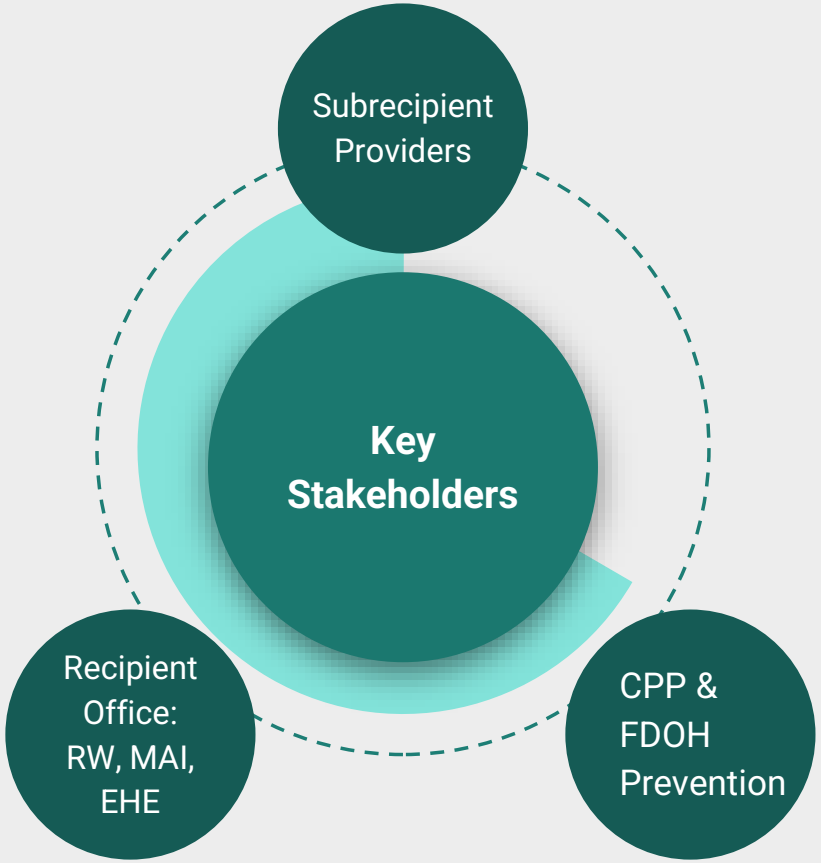


Connection to Needs Assessment



Takeaway: The Needs Assessment connects community input and data to Integrated Plan activities and ongoing monitoring.

Key Stakeholders in Integrated Plan Implementation



- Subrecipients: Direct client services, service navigation, linkage to care, outreach, encourage peer support
- Recipient Office: Supports system coordination, provider/case management training, data sharing agreements, stigma reduction education, faith-based engagement, care/treatment resource education, and mobile unit planning.
- CPP: Prevention activities, HIV/STI testing, PrEP and PEP education, prevention messaging

Takeaway: Integrated Plan implementation is a shared effort, with each stakeholder group helping move activities from planning into action across the four pillars.

2022–2026 Pillars & Key Activities

Diagnose	Treat	Prevent	Respond
• Increase HIV testing access • Promote HIV testing awareness • Support early diagnosis	• Link and retain PWH in care • Improve access to treatment and support services • Promote viral suppression	• Implement prevention services and education • Reduce stigma, barriers, disparities, and SDOH • Improve HIV-related communication	• Support cluster detection and response • Use data to inform outreach and strategies • Strengthen coordinated response efforts

Diagnose Highlights

Goal: Diagnose all people with HIV as early as possible

Objective 1: Testing Access & Community Awareness

Community outreach, awareness, and partner collaboration in priority communities

- 117+ partner connections/referrals to prevention services
- 72 U=U awareness campaigns

Objective 2: Knowledge of HIV Status

Rapid HIV testing, nontraditional hours, and PrEP/nPEP linkage

- 4,520 rapid HIV tests
- 11/15 providers offered nontraditional hours
- 15 /15 offer PrEP/nPEP linkage

Objective 3: Prevention Interventions

PrEP promotion, multilingual messaging, and social service partnerships

- 13/15 providers promoted PrEP hotlines/contact info
- 16/16 providers delivered multilingual messaging
- 12/15 providers partnered with social service orgs

Objective 4: System Capacity

Inclusive sexual health services, peers, private partnerships, and staff capacity

- 21 peers in prevention system
- 9/16 providers fostered private partnerships
- 39 inclusive sexual health service providers

Treatment Highlights

Goal: Treat people with HIV rapidly and effectively to reach sustained viral suppression

Objective 1: Rapid Linkage to Care

Same-day/walk-in appointment capacity for newly diagnosed or re-engaging clients

- 8 same-day/walk-in providers
- 2,930 same-day/walk-in slots
- 5 agencies with 72-hour capacity

Objective 2: Re-engagement/ Out of Care

Data-to-care and linkage module activities for out-of-care or newly diagnosed clients

- 53 re-engaged via data-to-care
- 194/396 linkage module clients re-engaged
- 8/10 providers offer HIV care navigation

Objective 3: Treatment Adherence & Retention

Adherence, viral suppression, and virtual care support

- 76 clients improved adherence/viral suppression through PL Cares
- 8/10 agencies offered virtual/phone care options (CM, mental health)

Objectives 4 & 5: Provider Capacity & Aging PWH

Provider training, care education, and HIV aging outreach

- Annual training for case managers/providers
- 5 senior center HIV education events
- 13 HIV care/treatment PSAs

Prevention Highlights

Goal: Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

Objective 1: Stigma Reduction & Outreach

HIV stigma training, education, and outreach in priority communities

- AETC training offered twice/year
- 514 outreach/education events
- 10/10 agencies reported priority population outreach

Objective 2: Disparities & Data Sharing

Data reports, multilingual materials, and disparity-focused communication

- 6 agencies used easy-read materials
- 5 offered materials in English, Spanish, Creole
- 8 agencies used data to inform outreach

Objective 4: SDOH & Co-Occurring Conditions

Mobile services, trauma-informed care, and supportive access

- 77 mobile unit events
- 6/10 have trauma-informed care policy
- 10/10 reported outreach in priority settings

Objective 6: HIV Communication

Social media, prevention messaging, and health literacy

- Continued social media prevention messaging
- PrEP/nPEP/U=U materials available
- Prevention resources shared in multiple formats

Respond Highlights

Goal: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Objective 1: Integrated Response to Syndemics

HIV, STI, substance use, mental health, and harm reduction coordination

- 35 tested through SSP partnership
- HIV testing initiative with syringe exchange
- Continued syndemic-focused coordination

Objective 2: Coordination & Cluster Response

Coordination with FDOH and partners to support linkage and response

- RW Part A/FDOH coordination continued
- Data sharing agreement in place
- Supports response to active transmission

Objective 3: Data Sharing & Client Communication

EMR portals and electronic communication with clients

- 5 clinical agencies using EMR portals
- Supports client-provider communication
- Helps strengthen care coordination

Objective 4: Monitoring & Technical Support

Integrated Plan monitoring, data review, and partner support

- 20 Integrated Plan workgroup meetings
- Data reviewed with prevention/care partners
- Supports ongoing plan monitoring

GY 25–26 Data Takeaways

Success & System Strengths

- Outreach, testing, linkage, and education continued across all four pillars
- Strong data points for testing, re-engagement, mobile services, and provider capacity
- Multilingual and culturally responsive practices reported
- Telehealth/phone options available across parts of the system
- Continued referrals, coordination, and partner participation

Implementation / Monitoring Gaps

- Some activities were harder to measure consistently
- Formal MOUs, data sharing, and cross-agency agreements require long-term coordination
- Research/clinical trial and academic partnerships were harder to advance
- Employment/leadership activities for PWH lacked shared reporting measures
- Technology and data system improvements require more infrastructure

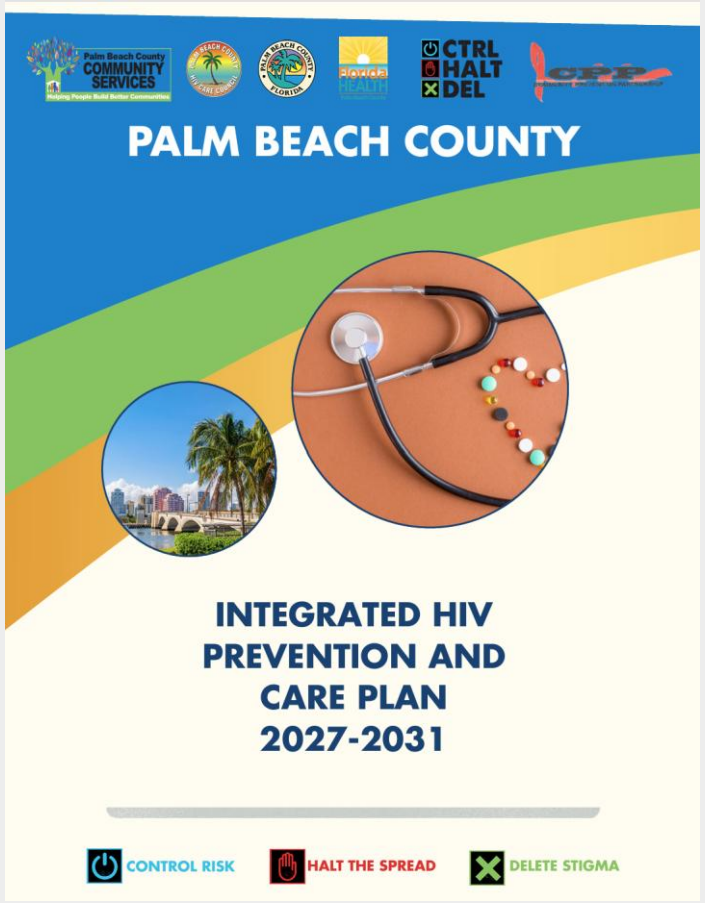
Takeaway: Strong implementation across the system, with clearer ownership and data collection needed for 2027–2031.

From GY 25–26 Lessons to the 2027–2031 Plan

GY 25-26 Lessons	2027-2031 Plan Response
■ Some activities were difficult to measure consistently ■ Ownership was not always clear across partners ■ Some activities were broad, duplicative, or hard to place ■ Needs Assessment alignment needed to be stronger	■ Activities revised with clearer indicators and measurable outcomes ■ Responsible parties clarified across key partners ■ Activities simplified, combined, or moved to the most appropriate pillar ■ Activities more directly connected to barriers, priority populations, and service gaps

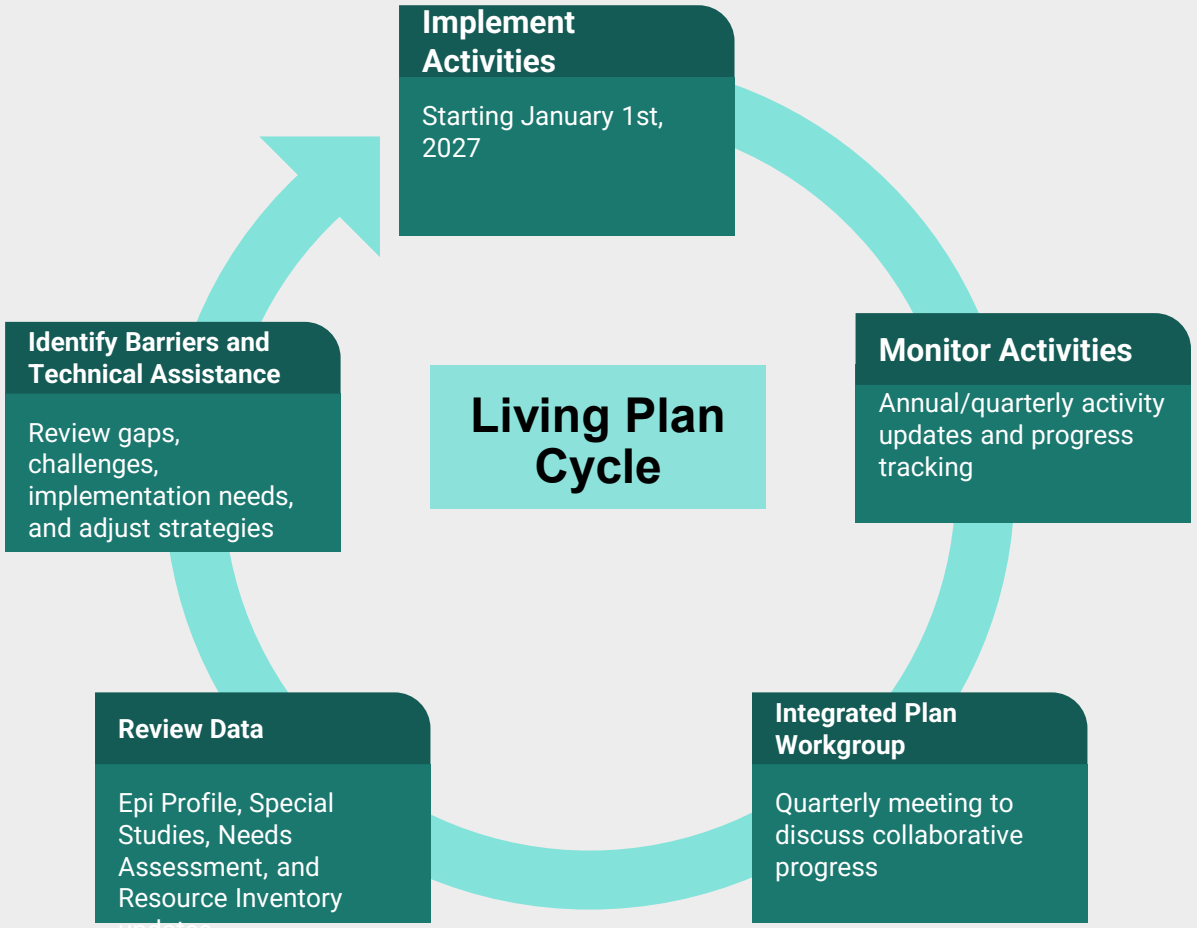
Takeaway: GY 25–26 lessons helped strengthen the focus, accountability, and data collection approach for the 2027–2031 Plan.

Introducing the 2027–2031 Integrated Plan



- Submitted to HRSA and CDC on June 30, 2026
- More focused structure: one goal and 3–5 objectives per pillar
- Activities realigned to best-fit pillars and reduced duplication
- Prevention and Response pillars revised to better reflect PrEP, PEP/nPEP, cluster detection, and information sharing
- Stronger alignment with Needs Assessment findings, gaps, barriers, and priority populations
- Clearer roles for CARE Council, CPP, FDOH, providers, and recipient office
- Living document supported by ongoing partner collaboration

2027–2031 Integrated Plan Implementation



Community Call to Action: Moving the Plan Forward

Choose one pillar and share one action, idea, or reminder that can help **move the plan forward**.

Thank you Geneve Simeus...
now please welcome Anna Bala

RYAN WHITE HIV/AIDS PROGRAM SUMMARY OF ANNUAL MONITORING FINDINGS GRANT YEAR 2025

Anna Balla

Grant Compliance Specialist II

PURPOSE OF THE SUMMARY

The Health Resources & Services Administration (HRSA) recommends that the Ryan White HIV/AIDS Program (RWHAP) provide an annual summary of monitoring findings to the HIV CARE Council. This summary highlights systemic issues and patterns observed across multiple sub-recipients and details how the Recipient (RWHAP) is addressing these findings.

GOALS OF MONITORING

The overarching goals of this monitoring cycle are to:

- Obtain a better understanding of the sub-recipient program within Palm Beach County.
- Ensure compliance with legislative mandates, program requirements, and internal fiscal controls.
- Assess the system of care, including community and consumer involvement.
- Identify targeted technical assistance (TA) needs.

MONITORING PROCESS OVERVIEW

All Ryan White Program sub-recipients undergo a mandatory annual monitoring site visit to ensure compliance with HRSA Monitoring Standards, programmatic guidelines, and fiscal management.

The Contracts, Compliance and Program Performance (CCPP) section manages the scheduling and final reporting using a comprehensive tool divided into four core areas:

- Program Operations Review
- Fiscal Review
- Service Delivery Standards Review
- Continuous Quality Management (CQM)

SITE VISIT TIMELINE

- **Preparation:** The Grant Compliance Specialist (GCS) establishes a draft schedule at the start of the grant year, coordinates dates with sub-recipients, and sends a confirmation email detailing the agenda, required staff, and monitoring tools.
- **Chart Selection:** prior to the visit, the GCS provides a Client ID list for chart audits.
- **Entrance Conference:** An introductory meeting to outline the review process and allow the sub-recipient to present their program.
- **Exit Conference:** A concluding meeting to discuss preliminary monitoring results.

CORRECTIVE ACTION PLAN (CAP) PROCESS

When site visits reveal findings, sub-recipients must address them through a formal Corrective Action Plan (CAP):

- **Timeline:** The sub-recipient must submit a CAP within **30 calendar days** of receiving the site visit report.
- **Requirements:** The CAP must outline specific steps to rectify and prevent the issue, a timeline for completion, and designated responsible parties.
- **Approval & Follow-up:** The Recipient must approve the CAP in writing. Unapproved plans must be revised and resubmitted. The Recipient provides technical assistance and conducts follow-up tracking to ensure all findings are fully resolved.

ANNUAL MONITORING FINDINGS

Review Category	Subrecipient Impact	Core Findings
Program Operations	1 of 9 Agencies	Issues with eligibility documentation (insurance, proof of residency).
Fiscal Review	3 of 9 Agencies	Tracking program income, late reimbursement submissions, lacking documentation, and incorrect/incomplete paperwork.
Service Delivery	5 of 9 Agencies	Service Delivery Standards *(detailed by category below)*.
Clinical Quality Management	0 of 9 Agencies	No findings.

SERVICE DELIVERY FINDINGS BY CATEGORY

- **MCM vs. NMCM Distinction:** 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 (MCM):** Missing annual assessments, updated action plan and goals, progress notes, and referral follow-ups.
- **Non-Medical Case Management (NMCM):** Missing annual assessments, progress notes, and action plan goals; insufficient communication and updates regarding additional client needs.
- **Early Intervention Services (EIS):** Insufficient documentation proving education was provided to clients designed to help navigate and understand the HIV system of care. Lack of documentation of provisions of all four required EIS components (testing/referral/linkage/education and training).
- **Food Bank/Home Delivered Meals:** Outdated food stamp data within the Provide Enterprise (PE) system.
- **Psychosocial Support Services:** Client documentation failed to support "counseling" services as defined by the service category (documented as support needs, general activities). Files lacked documentation of nutritional counseling discussions with clients.
- **Legal Services:** No documentation of progress/resolution of the open legal matter. Insufficient documentation showing that referring agencies were notified of case resolutions.
- **Health Insurance**: Missing Summary of Benefits page –representst medical and medication coverages

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 Training 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, webinars, and conferences.
- HIV Resources Hub -This interim website provides agencies funded by the Ryan White HIV/AIDS Program with resources, information, and tools to provide care to people with HIV.

QUALITY IMPROVEMENT OPPORTUNITIES

- Quality improvement processes are now recommended in monitoring reports if there are findings
  - Recipient staff available to assist

- There are 3 current Quality Improvement Projects (QIPs) in response to monitoring findings
  - Service categories for Ryan White Part A: EIS, Medical and Non-medical Case Management, and Outpatient Ambulatory Health Services

- The other current QIP is Assuring Continuity of Care to Enable Sustained Suppression (ACCESS) in response to the ADAP changes and clients losing health insurance

QUALITY IMPROVEMENT OUTCOMES

- Quality Improvement Project (QIP) outcomes are highlighted in the annual Quality Improvement Showcase in February right before the HIV CARE Council meeting
- Four sub-recipients were worked on improving primary care screenings and vaccines (in response to monitoring findings) and all were able to exceed their goals
- One sub-recipient had completed an additional project the previous year in regards to a food bank service delivery finding and was able to address the issue well in advance of the next monitoring cycle
- Other Ryan White Part A/MAI QIPs focused on supportive services and were also able to improve upon their baseline outcomes

QUESTIONS?

For HIV Services in Palm Beach County,

1-833-PBC-HIV1 (1-833-722-4481)

Control Risks. Halt the Spread. Delete Stigma

#ENDHIVPBC

Facebook.com/endhivpalmbeachcounty

Palm Beach County COMMUNITY SERVICES
Helping People Build Better Communities

Instagram.com/endhivpbc

Thank you Gilead Sciences

Need a moment….
Let’s unwind

Resources for OUR Palm Beach County

Interactive Team Building
Chair Yoga
With Dr. Sandra Anderson

A Time to Be Thankful –
We appreciate each and everyone of you!

The Guiding Hand Award

- Presented in recognition of her continued support, encouragement, and willingness to always lend a helping hand to the HIV CARE Council.

The Tireless Efforts Award

- Presented in recognition of her commitment, positive contributions, and growing impact on the HIV CARE Council and the community.

The Tireless Efforts Award

- Presented in recognition of his dedication, leadership, and commitment to strengthening the community through service.

The Western Community Award

- Presented in recognition of her outstanding commitment to keeping the western community connected, informed and engaged.

The Outstanding Impact Award

- Presented in recognition of his exceptional contribution, resourceful efforts, and dedication that helped save the Palm Beach County HIV CARE Council resources.

The Above and Beyond Award

- Presented in recognition of consistently going above and beyond to support the Palm Beach County HIV CARE Council, its members, and the community.

The Dedication and Diligence Award

- Presented in recognition of her dedication, diligence, and valuable work in advancing the Integrated Plan.

The Leadership and Guidance Award

- Presented in recognition of his continued guidance, education, and support to the Palm Beach County HIV CARE Council and its members.

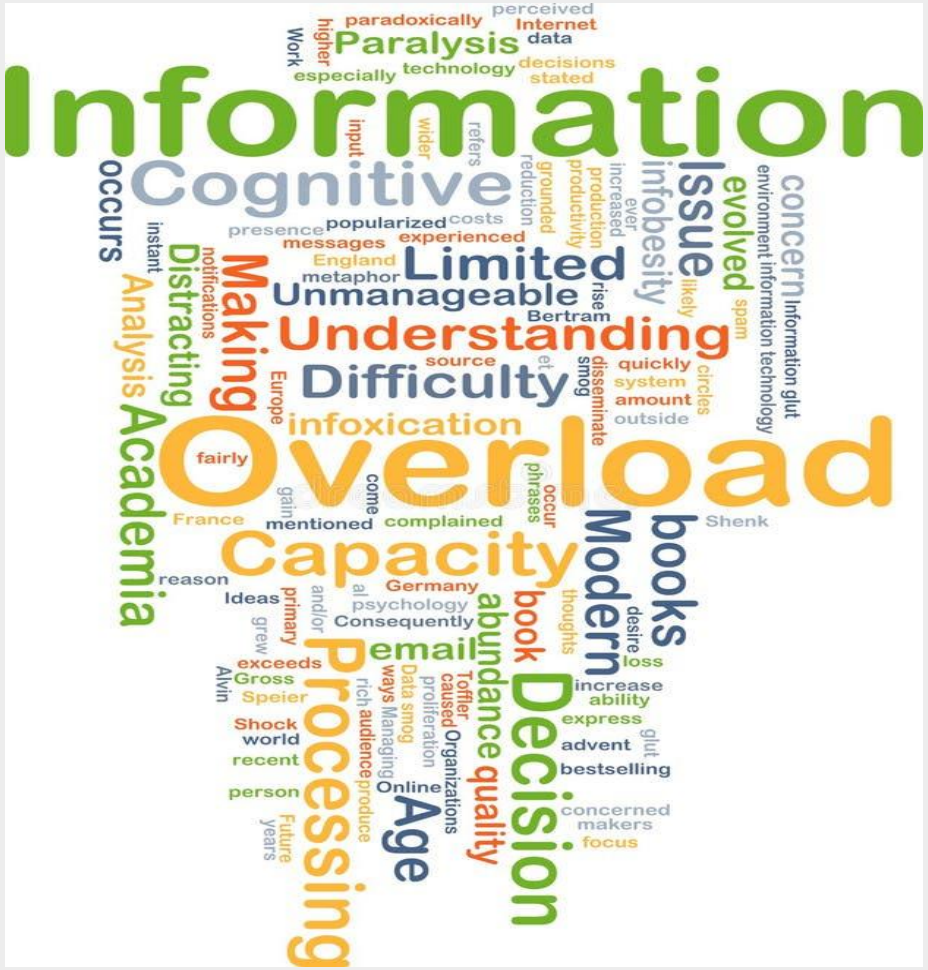
The Priority and Allocations Excellence Award

- Presented in recognition of his excellent service, expertise, and commitment to the Priority and Allocation process.

The Excellence in Leadership Award

- Presented in recognition of her exceptional leadership, strategic vision, organization, and unwavering commitment to excellence, which contributed to a successful clean (no findings) HRSA audit.

What is Next?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HELP
SUPPORT
ADVICE
CARE

Events Coming Up

Time for a Raffle
Do You Have Your Ticket?

- $50.00 gift card (Wawa)
- $50.00 gift card (Amazon)
- $100.00 gift card (Visa)
- $100.00 gift card (AMEX)

Thank you for Joining Us…
Have a great weekend!

On behalf of the Palm Beach County HIV CARE Council, we thank you for being with us today and supporting our endeavors . We are all here to support individuals living with HIV/AIDS and those who are at risk.