

Palm Beach County Integrated Prevention and Patient Care Plan

Introduction

The Palm Beach County Coordinated Services Network (CSN) is a partnership of state and federal funding sources, planning authorities, medical and social support agencies, and people living with HIV/AIDS (PLWHA) that provides the continuum of patient care for PLWHA in Palm Beach County. The CSN has partnered with the local Community Prevention Partnership (CPP) to develop the integrated plan for Palm Beach County that follows. Both the CSN and CPP are actively engaged with the development of the Statewide Coordinated Statement of Need (Needs Assessment) through representation on the statewide Prevention Planning Group and Patient Care Planning Group.

The development of the local Palm Beach County integrated plan built on previous comprehensive plans: the 2012-15 Palm Beach County Eligible Metropolitan Area (EMA) Comprehensive Plan, and the Palm Beach County 2014-2016 Jurisdictional HIV Prevention Plan. In addition, the 2013-2016 Ryan White Part A Needs Assessment evaluated available resources, gaps in services, and needed services for PLWHA. The CPP and CSN have begun the process of integrating local planning processes, and have developed the integrated plan to guide these efforts. This will involve the implementation of a local integrated needs assessment in 2016 that addresses both prevention and patient care needs. The Area 9 (Palm Beach County) CPP served as an integral part of the Integrated HIV Planning Group (HPG) that helped inform the development of this Plan.

Patient Care Programs

The Palm Beach County, Florida, Eligible Metropolitan Area (EMA) has been providing medical and support services for people living with HIV/AIDS (PLWHA) under the Ryan White Part A program since 1994. With the adoption of the National HIV/AIDS Strategy (NHAS) in 2010, the EMA has developed a coordinated approach to reducing new HIV infections, increasing access to care for PLWHA, and reducing HIV-related health disparities. By focusing on the local HIV Care Continuum, the EMA will assure that adequate treatment and support services are accessible to our most vulnerable populations. As implementation of the Affordable Care Act improves access to these services, the EMA can assure that PLWHA receive quality, culturally-competent care. Services for the affected population vary and are primarily provided by community-based organizations located in the heavily impacted areas throughout the county. The local EMA utilizes the HIV Care Continuum as a model to identify areas of improvement and reduce community viral load.

HIV Prevention Programs

The mission of the Palm Beach County HIV CPP is to promote community participation and involvement in HIV prevention services and activities, and provide required planning documents as requested by the Florida Department of Health, Bureau of HIV/AIDS (BHA).¹ CPP membership includes individuals from: Florida Department of Health in Palm Beach County, community-based organizations (CBOs), AIDS service organizations, the faith-based community, the school district, community health centers, state and local government, mental

¹ Bylaws of the Palm Beach County HIV Community Prevention Partnership; 4/11/12 revision

health and substance abuse providers, businesses, as well as representation from minority and ethnic groups, youth, persons living with HIV/AIDS and underserved populations.²

The Community Planning Partnership:

- *Strives to reduce the duplication of prevention services and improve coordination within the county for service implementation.*
- *Strengthens local collaborative efforts between public and private partnerships in the fight against HIV disease.*
- *Collaborates with the Palm Beach County HIV Care Council to promote community planning for HIV prevention/education, early intervention and patient care.*
- *Promotes community mobilization.*³

Moving forward and toward the implementation, monitoring and evaluation phases, the CPP members, specifically those identified as ‘Plan liaisons’ will play a critical role in ensuring that the Integrated Plan is utilized to effectively address gaps in HIV prevention and to further improve HIV prevention efforts throughout the community.

Development of the Integrated Plan

The development of the Palm Beach County chapter of the statewide integrated plan occurred through an inclusive process that brought together prevention providers, patient care providers, consumers, and other stakeholders to identify key goals, objectives, and strategies to guide efforts over the next five years. The Part A Health Planner guided early discussions in the CARE Council’s Planning Committee to orient members to the guidance documents published by CDC and HRSA. Members of the Planning Committee and CPP developed an initial framework of goals and objectives for the plan based on the NHAS and other integrated plan resources. In February 2016, the CARE Council held its annual retreat, which was a working meeting to identify specific strategies under each objective. Participants included representatives from patient care, prevention, Disease Intervention Specialists, staff from the Housing Opportunities for People with AIDS (HOPWA) program, and consumers. Each table of participants was seated based on area of interest, and consumers were represented in each discussion. Participants reported back to the larger group with initial strategy recommendations. Staff from the Health Council of Southeast Florida (HCSEF) collated responses and facilitated a number of meetings to prioritize and categorize strategies. This information was then brought forward through two cycles of both CPP and CARE Council meetings for further discussion and approval.

This process was also supported by the completion of a local epidemiological study conducted by HCSEF. This study, *RARE 2015*, was a mixed-methods study that updated a 2001 report detailing the nature of the epidemic in Palm Beach County. This new report contained both qualitative and quantitative data on the current state of the epidemic, and provided recommendations regarding how HIV prevention and treatment programs might effectively address the epidemic utilizing an enhanced model of the HIV Care Continuum (these

² Bylaws of the Palm Beach County HIV Community Prevention Partnership; 4/11/12 revision

³ Bylaws of the Palm Beach County HIV Community Prevention Partnership; 4/11/12 revision

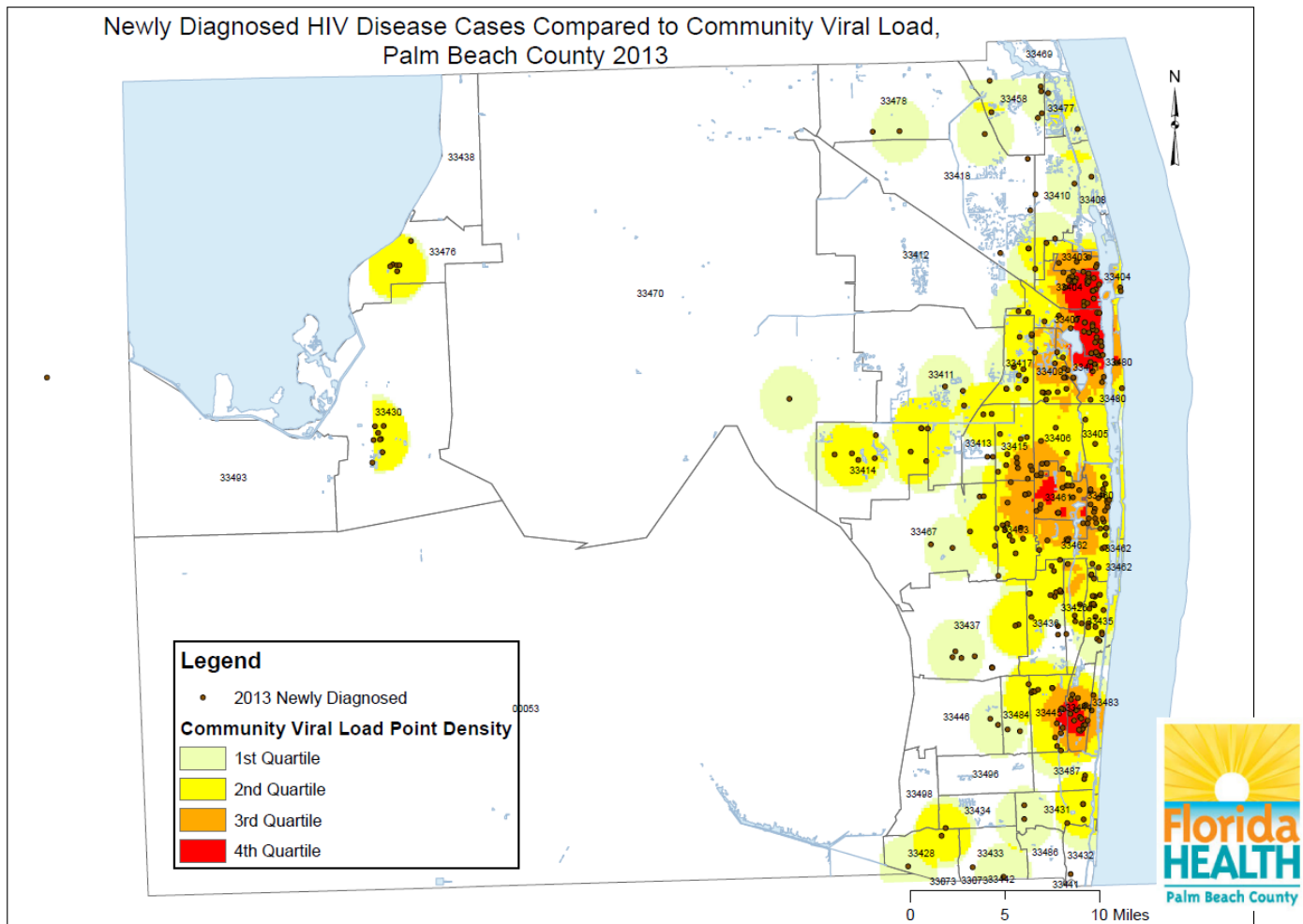
recommendations are discussed below). The RARE 2015 report was presented at the CARE Council annual retreat, and the recommendations were incorporated into this document.

Palm Beach County HIV/AIDS (Area 9) Epidemiological Profile

Jurisdictional Description of HIV Infection by Geographical Region

HIV infection in Palm Beach County, FL varies by geography. The county covers approximately 2,200 square miles and is comprised of 38 cities. With the use of geographic information systems (GIS) and spatial data analysis, the map below identifies areas with high viral load concentrations. Laboratory results for persons diagnosed with HIV infection in Palm Beach County in 2013 were combined with viral load data of persons living with HIV disease. The data was geo-coded to provide a spatial density map of community viral load. The following Newly Diagnosed HIV Disease Cases Compared to Community Viral Load density map for 2013 in Palm Beach County displays significant areas of both low and high community viral loads in a number of cities throughout the county.

Using the most recent year for which complete data sets were available, the map details three distinct coastal areas of high HIV concentration stemming from the following cities: Riviera Beach, West Palm Beach, and Delray Beach. These urban parts of the county have emerged as the areas with communities heavily affected by HIV infection. These cities dominate both the



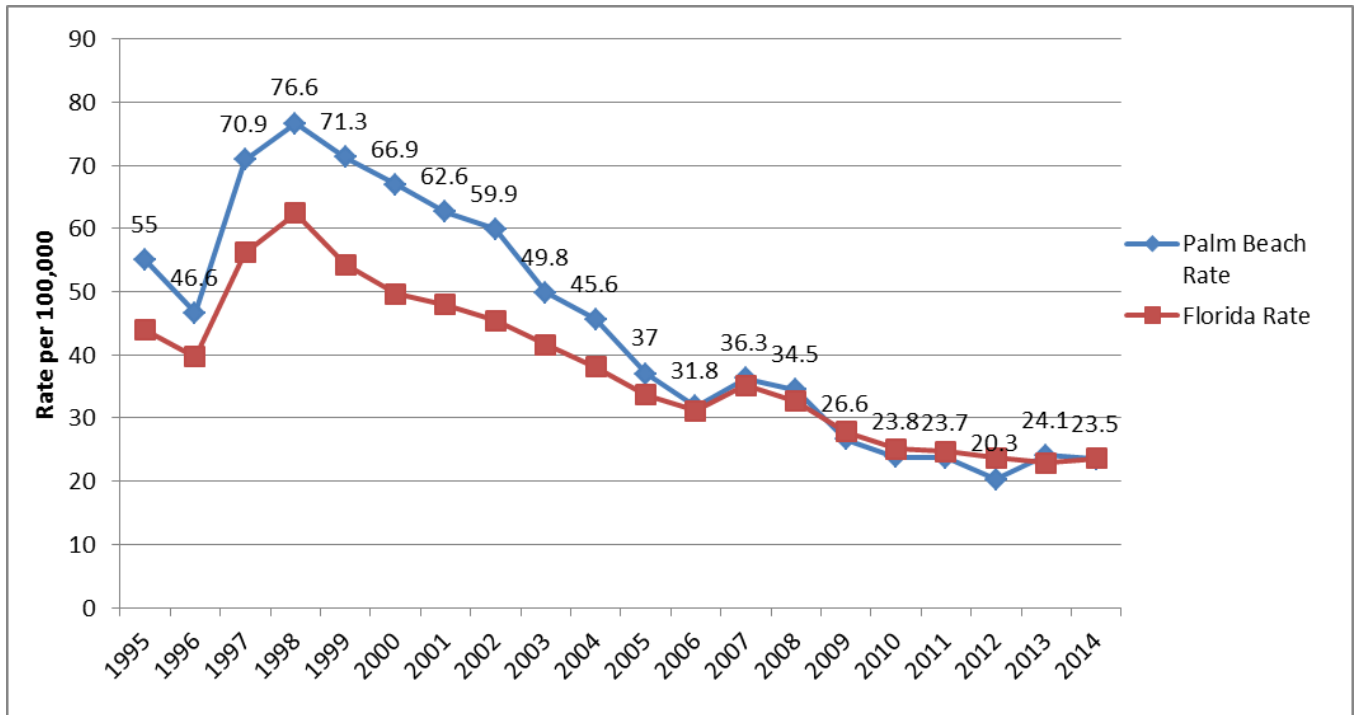
northern and southern coastal area of the county, with surrounding areas demonstrating lower areas of HIV infection. The western side of the county demonstrates areas with a moderate concentration of HIV infection and includes the rural cities of Belle Glade, Pahokee, South Bay and Canal Point.

HIV Incidence

HIV incidence is the number of newly reported HIV cases during a time period.

Figure 1 shows HIV incidence in Palm Beach County and in Florida from 1995 to 2014. Data labels are shown for Palm Beach County rates. In both the county and the state, the rate of new HIV cases decreased considerably. In 2014, there were 320 new HIV cases reported in Palm Beach County. In 2014, the rate in Palm Beach County (23.5 per 100,000) was the same as the state’s rate (23.6 per 100,000).

Figure 1: HIV Incidence, Palm Beach, Florida, 1995-2014



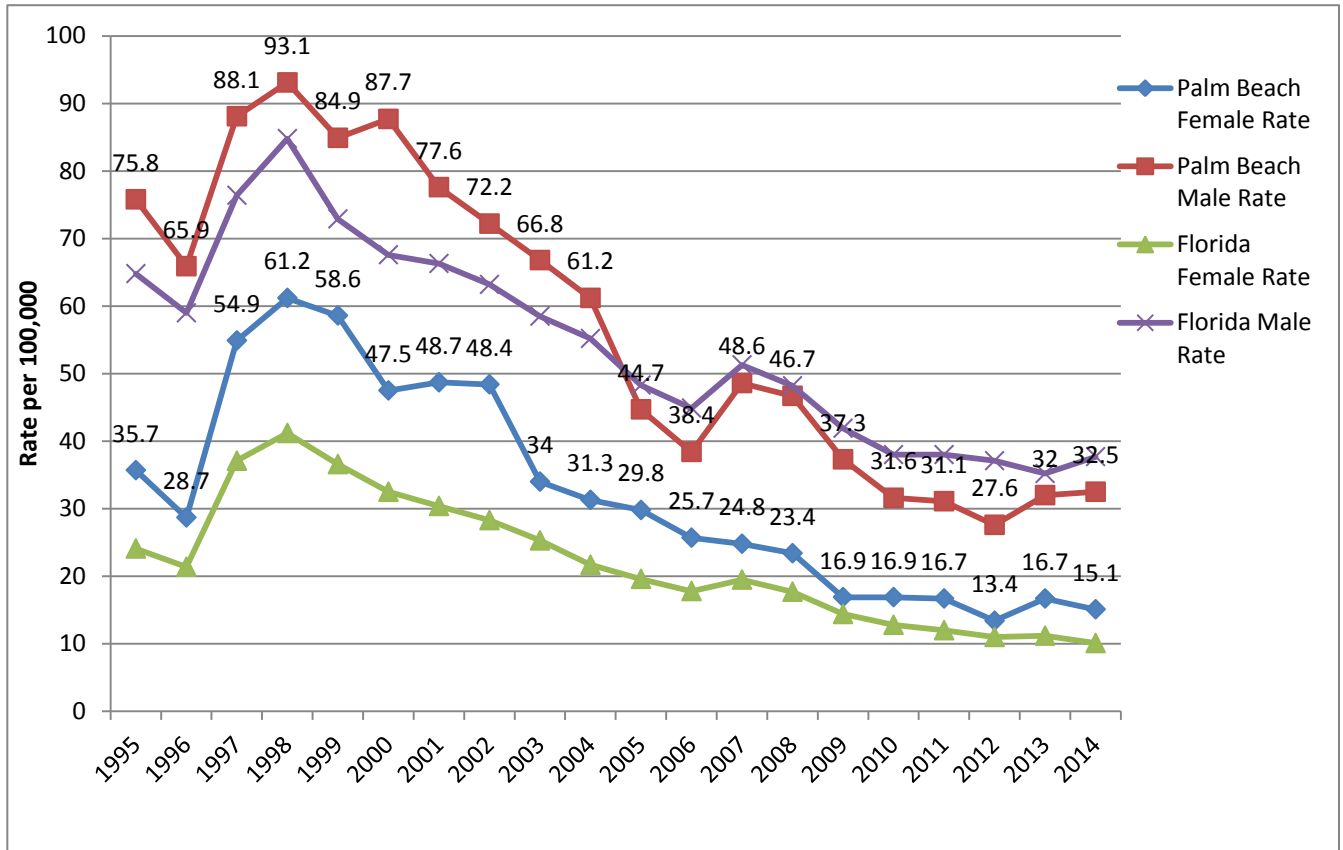
Data Source: FloridaCHARTS, Florida Department of Health, HIV/AIDS Section

Data Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. These data represent reported new cases of HIV. No data available prior to 1998. The increased number of cases for 2007 is partially attributable to changes in HIV case definitions for HIV reporting.

Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Figure 2 shows HIV incidence rates in Palm Beach County and Florida by gender from 1995 to 2014. Data labels are shown for Palm Beach County rates. In 2014, the rate of new cases of HIV was higher in males than in females in both the county and the state. The rate of new HIV cases in males was lower in the county (32.5 per 100,000) than in the state (37.7 per 100,000), however the rate of new HIV cases in females was higher in the county (15.1 per 100,000) than in the state (10.1 per 100,000).

Figure 2: HIV Incidence Rates, by Gender, Palm Beach County and Florida 1995-2014



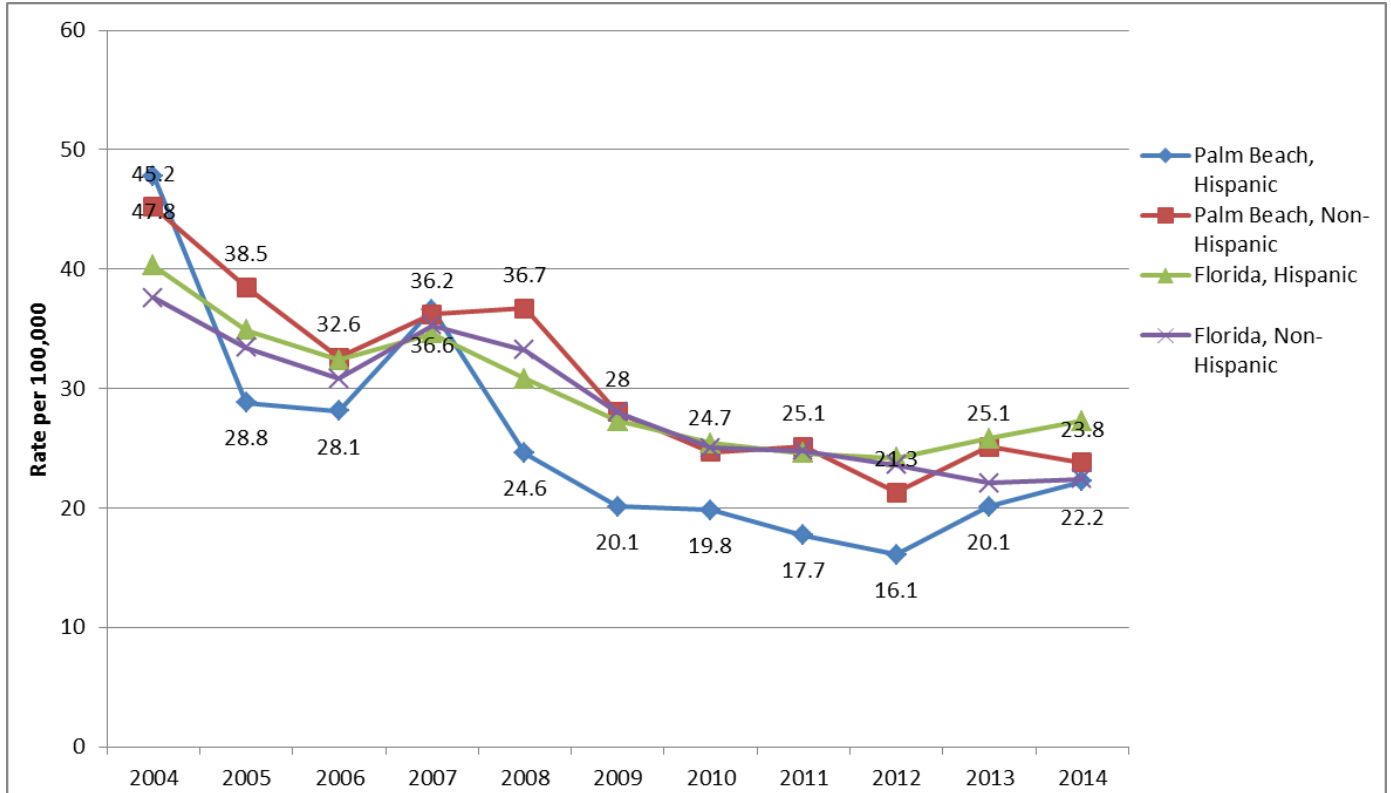
Data Source: FloridaCHARTS, Florida Department of Health, HIV/AIDS Section

Data Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. These data represent reported new cases of HIV. No data available prior to 1998. The increased number of cases for 2007 is partially attributable to changes in HIV case definitions for HIV reporting.

Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Figure 3 shows HIV incidence rates in Palm Beach County and Florida by ethnicity from 2004 to 2014. Data labels are shown for Palm Beach County rates. In 2014, the rate of new HIV in Palm Beach County was slightly higher in non-Hispanic individuals (23.8 per 100,000) than in Hispanic individuals (22.2 per 100,000). Furthermore, the disparity between ethnicities was not as great in Florida either with the rate of Hispanic individuals being only slightly greater than Non-Hispanic individuals (27.3 vs. 22.4 per 100,000).

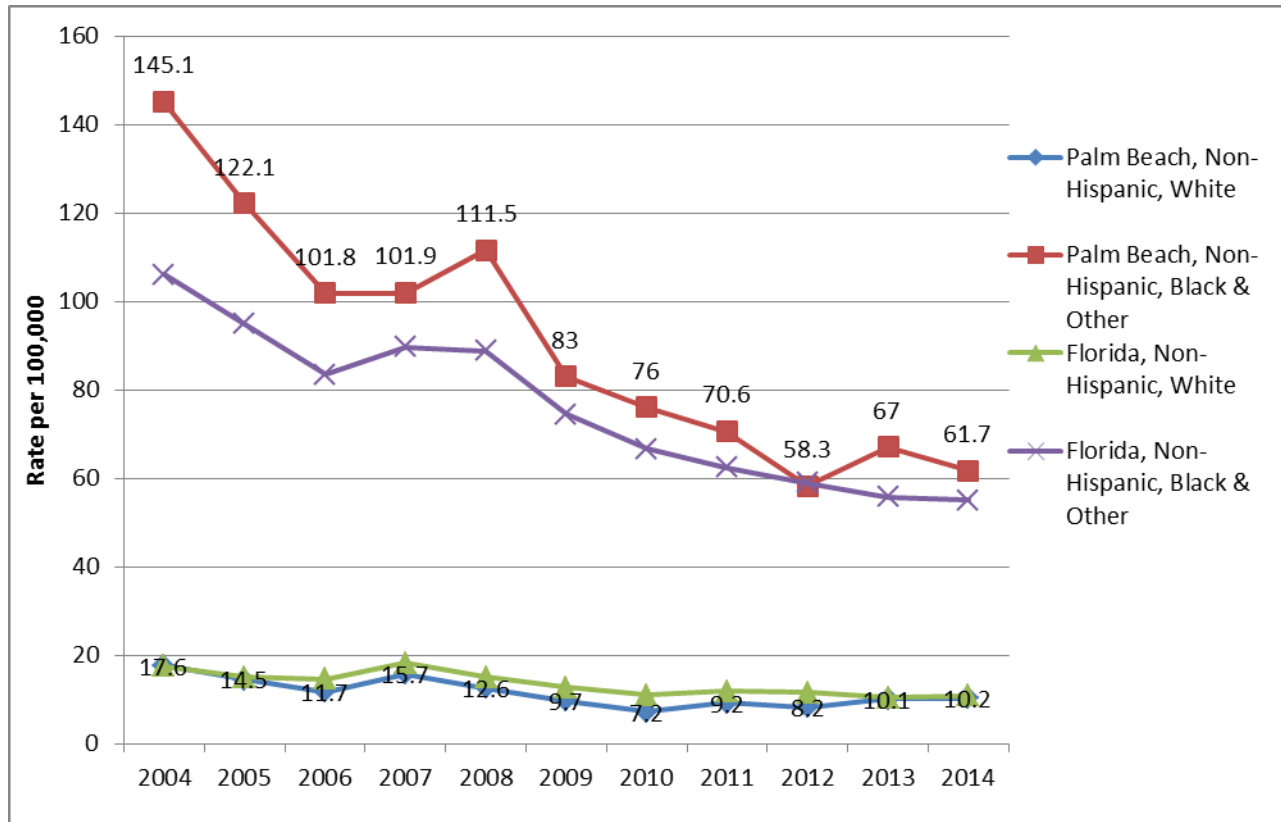
Figure 3: HIV Incidence Rates, by Ethnicity, Palm Beach County and Florida 2004 - 2014



Data Source: FloridaCHARTS, Florida Department of Health, HIV/AIDS Section
 Data Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. These data represent reported new cases of HIV. No data available prior to 1998. The increased number of cases for 2007 is partially attributable to changes in HIV case definitions for HIV reporting.
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Figure 4 shows HIV incidence rates in Palm Beach County and Florida by race from 2004 to 2014. Data labels are shown for Palm Beach county rates. Considerable racial disparity was seen in both the county and the state between non-Hispanic white and non-Hispanic black individuals. In 2014, the rate of new HIV cases in non-Hispanic black individuals in Palm Beach County was 145.1 per 100,000 over 8 times the rate in non-Hispanic white individuals 17.6 per 100,000. Palm Beach County rates of new HIV cases in non-Hispanic black individuals was greater than in the state however, the rate in non-Hispanic white individuals was lower in the county than in the state.

Figure 4: HIV Incidence Rates, by Race, Palm Beach County and Florida 2004 – 2014



Data Source: FloridaCHARTS, Florida Department of Health, HIV/AIDS Section
 Data Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. These data represent reported new cases of HIV. No data available prior to 1998. The increased number of cases for 2007 is partially attributable to changes in HIV case definitions for HIV reporting.
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

HIV Prevalence

HIV prevalence refers to the total number of individuals living with HIV at a given point in time. This differs from HIV incidence which is the number of newly diagnosed HIV cases during a period of time. Table 9 shows HIV prevalence in Palm Beach County through 2014 by race and ethnicity. There were 3198 individuals living with HIV at the end of 2014. Racial disparity is evident as black, non-Hispanic individuals represented 57.3% of living HIV cases even though Blacks, non-Hispanics only represent 17% of Palm Beach County's total population.

Table 1: HIV Prevalence by Race and Ethnicity, Palm Beach County, through 2014

	Number	% of Total
White, Non-Hispanic	862	27%
Black, Non-Hispanic	1,833	57.3%
Hispanic	460	14.4%
Asian/Pacific Islander	14	0.4%
American Indian/Alaskan Native	2	0.1%
Not specified/Other	27	0.8%
Total:	3,198	100.0%

Data Source: FLORIDA Department of Health, HIV/AIDS Section, data run 10/06/2015
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 10 shows HIV prevalence by exposure category in adult males through 2014. Nearly 62% of male HIV cases in Palm Beach County (1,234) were men who have sex with men (MSM), and an additional 86 cases were MSM/injection drug users. Males represented nearly 60% of individuals living with HIV in Palm Beach County.

Table 2: HIV Prevalence by exposure category, Adult Males, Palm Beach County through 2014

	Number	% of Total
MSM (Men who have sex with men)	1,234	62.5%
IDU (Injection drug user)	86	4.4%
MSM/IDU	62	3.1%
Heterosexual	575	29.1%
Other	18	0.9%
Total:	1,975	100.0%

Data Source: FLORIDA Department of Health, HIV/AIDS Section, data run 10/06/2015
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 11 shows HIV prevalence by exposure category in Adult females through 2014. Females represented nearly 40% of individuals living with HIV in the county (1,186). The majority of females with HIV in the county were in the heterosexual exposure category.

Table 3: HIV Prevalence by exposure category, Adult Females, Palm Beach County, through 2014

	Number	% of Total
IDU	74	6.1%
Heterosexual	1,113	92.1%
Other	22	1.8%
Total:	1,209	100.0%

Data Source: FLORIDA Department of Health, HIV/AIDS Section, data run 10/06/2015
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 12 shows HIV prevalence by exposure category in the pediatric population in Palm Beach County through 2014. The 14 cases of pediatric HIV in Palm Beach County were infected via maternal exposure.

Table 4: HIV Prevalence by exposure category, Pediatric, Palm Beach County, through 2014

	Number	% Total
Mother with/at risk for HIV infection	14	100%
Risk not reported/Other	0	0%
Total:	14	100%

Data Source: FLORIDA Department of Health, HIV/AIDS Section, data run 10/06/2015
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 13 shows HIV prevalence in Palm Beach County by age group through 2014. Individuals 50-59 represented 24.0% of HIV cases, the highest percentage among a ten-year age group, followed by the 40-49 age group with 21.3%. It is important to recognize that these are not necessarily newly diagnosed cases, but people living with HIV.

Table 5: HIV Prevalence by age group, Palm Beach County, by Age, 2014

	Number	% of Total
0-2 years	1	0.1%
3-12 years	13	0.6%
13-19 years	32	1.2%
20-24 years	129	4.9%
25-29 years	248	7.0%
30-39 years	624	21.3%
40-44 years	407	13.8%
45-49 years	443	14.8%
50-59 years	824	24.0%
60+ years	477	12.3%
Total:	3,198	100.0%

Data Source: FLORIDA Department of Health, HIV/AIDS Section, data run 10/06/2015
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 14 shows HIV prevalence by special populations in Palm Beach County through 2014. The greatest number of individuals in the county living with HIV are white MSM (625), followed by black women of child-bearing age (456) and then by black MSM (398).

Table 6: HIV Prevalence by special populations, Palm Beach County, through 2014

	Number		Number
White MSM	625	Male Haitian Born	222
Black MSM	398	Female Haitian Born	257
Hispanic MSM	253		
		White Male Youth (current ages 13-24)	12
White Male IDU	56	Black Male Youth (current ages 13-24)	73
Black Male IDU	62	Hispanic Male Youth (current ages 13-24)	18
Hispanic Male IDU	27	White Female Youth (current ages 13-24)	11
White Female IDU	39	Black Female Youth (current ages 13-24)	42
Black Female IDU	26	Hispanic Female Youth (current ages 13-24)	5
Hispanic Female IDU	6	White WCBA (current ages 15-44)	78
		Black WCBA (current ages 15-44)	456
White Male Homeless	0	Hispanic WCBA (current ages 15-44)	64
Black Male Homeless	2	White Pediatric Cases (current ages 0-12)	2
Hispanic Male Homeless	0	Black Pediatric Cases (current ages 0-12)	9
White Female Homeless	1	Hispanic Pediatric Cases (current ages 0-12)	3
Black Female Homeless	2		
Hispanic Female Homeless	0	DOC Cases	46

Data Source: FLORIDA Department of Health, HIV/AIDS Section, data run 10/06/2015

Data Notes: MSM includes MSM & MSM/IDU; Male IDU includes IDU and MSM/IDU; WMCA – women of child bearing age

Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

AIDS Incidence

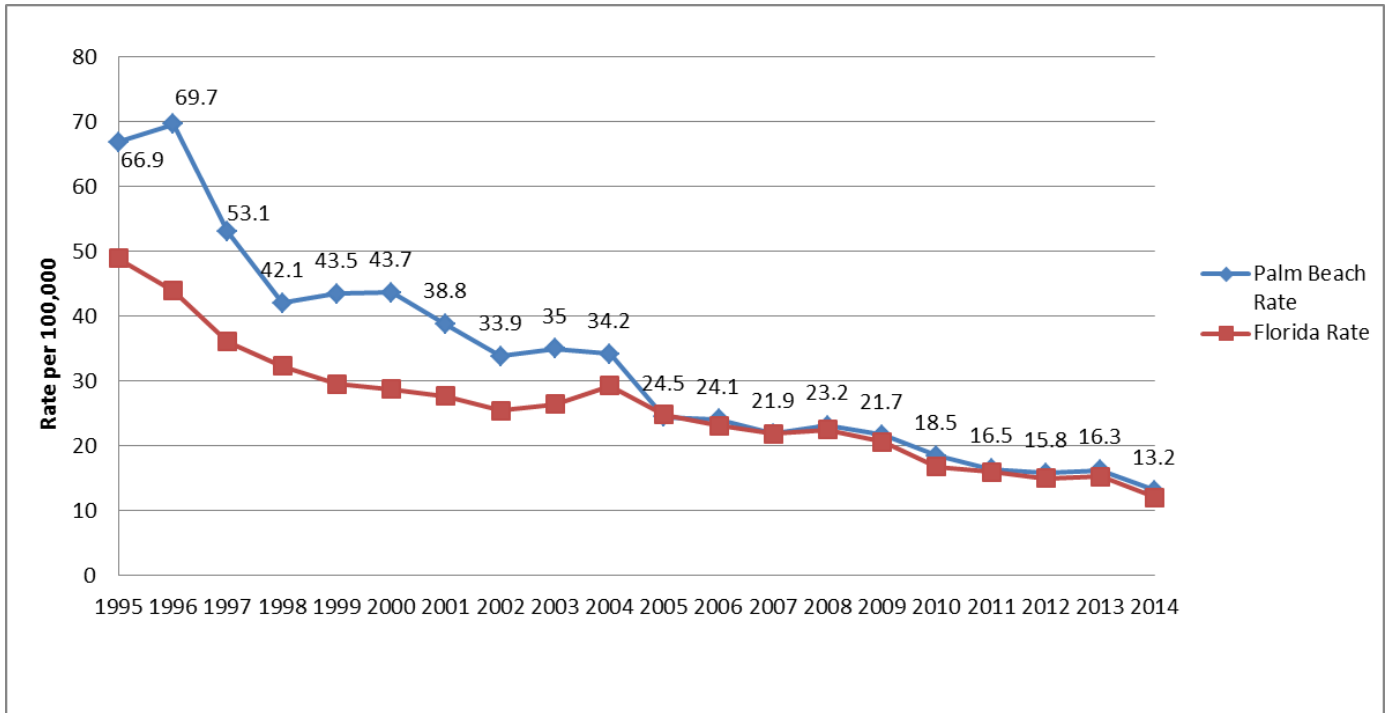
AIDS incidence is the number of newly diagnosed AIDS cases during a period of time. Table 15 and Figure 5 show the AIDS incidence in Palm Beach County and Florida from 1995 to 2014. Data labels are shown for Palm Beach County rates. The rate in both areas decreased considerably during the time period shown. In 2014, there were 180 newly diagnosed AIDS cases in Palm Beach County resulting in a rate of 13.2 per 100,000, which was slightly higher than the state’s rate of 12.1 per 100,000.

Table 7: AIDS Incidence, Palm Beach County, Florida, 1993 – 2014

	Palm Beach		Florida
	Number	Rate per 100,000	Rate per 100,000
1995	666	66.9	49.0
1996	712	69.7	44.0
1997	558	53.1	36.1
1998	454	42.1	32.4
1999	482	43.5	29.6
2000	497	43.7	28.8
2001	451	38.8	27.7
2002	404	33.9	25.5
2003	428	35	26.5
2004	430	34.2	29.3
2005	313	24.5	24.9
2006	312	24.1	23.2
2007	286	21.9	21.9
2008	304	23.2	22.5
2009	285	21.7	20.7
2010	244	18.5	16.8
2011	219	16.5	16.0
2012	210	15.8	15.0
2013	220	16.3	15.3
2014	180	13.2	12.1

Data Source: FloridaCHARTS, Florida Department of Health, Bureau of HIV/AIDS
 Date Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. Many 2007 cases were not reported until 2008 because of the change from paper to electronic lab reporting (ELR). This results in an artificially low count of AIDS cases in 2007.
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Figure 5: AIDS Incidence Rates, Palm Beach and Florida 1995-2014



Data Source: FloridaCHARTS, Florida Department of Health, Bureau of HIV/AIDS
 Date Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. Many 2007 cases were not reported until 2008 because of the change from paper to electronic lab reporting (ELR). This results in an artificially low count of AIDS cases in 2007.
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Figures 6a and 6b shows AIDS incidence in Palm Beach County and Florida by gender from 1995 to 2014. Data labels are shown for Palm Beach County rates. In 2014, the incidence of AIDS was greater in males (16.2 per 100,000) than in females (10.4 per 100,000) in the county. However, the gender disparity in the rate of individuals diagnosed with AIDS in Palm Beach County narrowed considerably during the time period shown.

Figure 6a: AIDS Incidence Rates by Gender (female), Palm Beach County and Florida 1995 – 2014

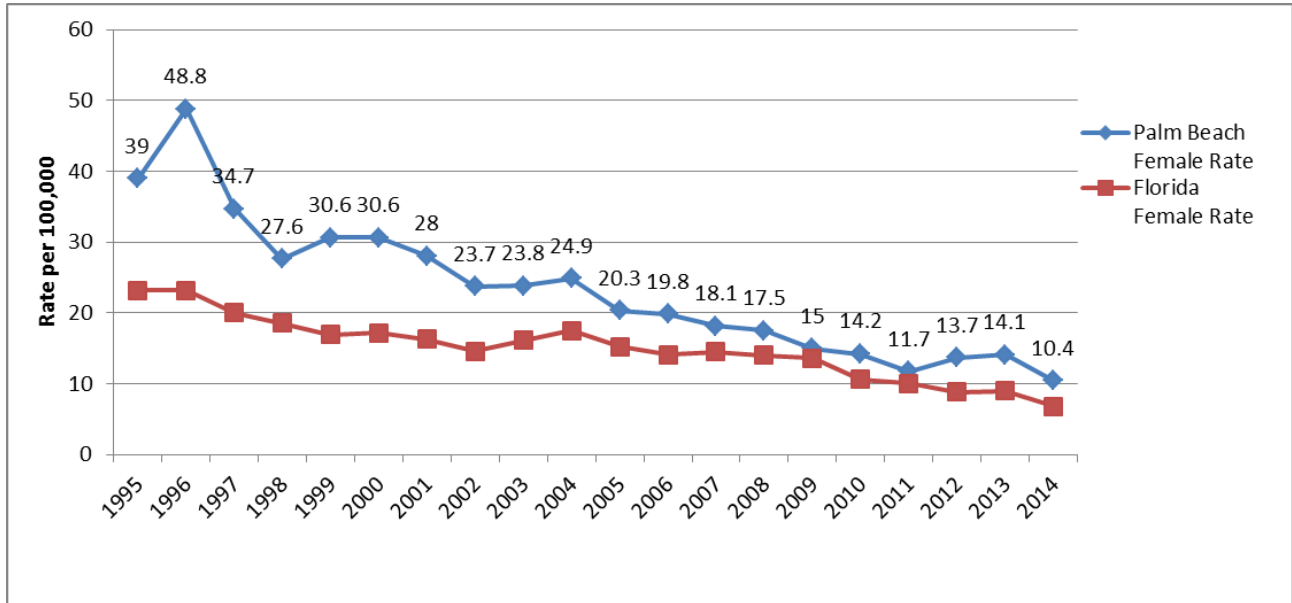
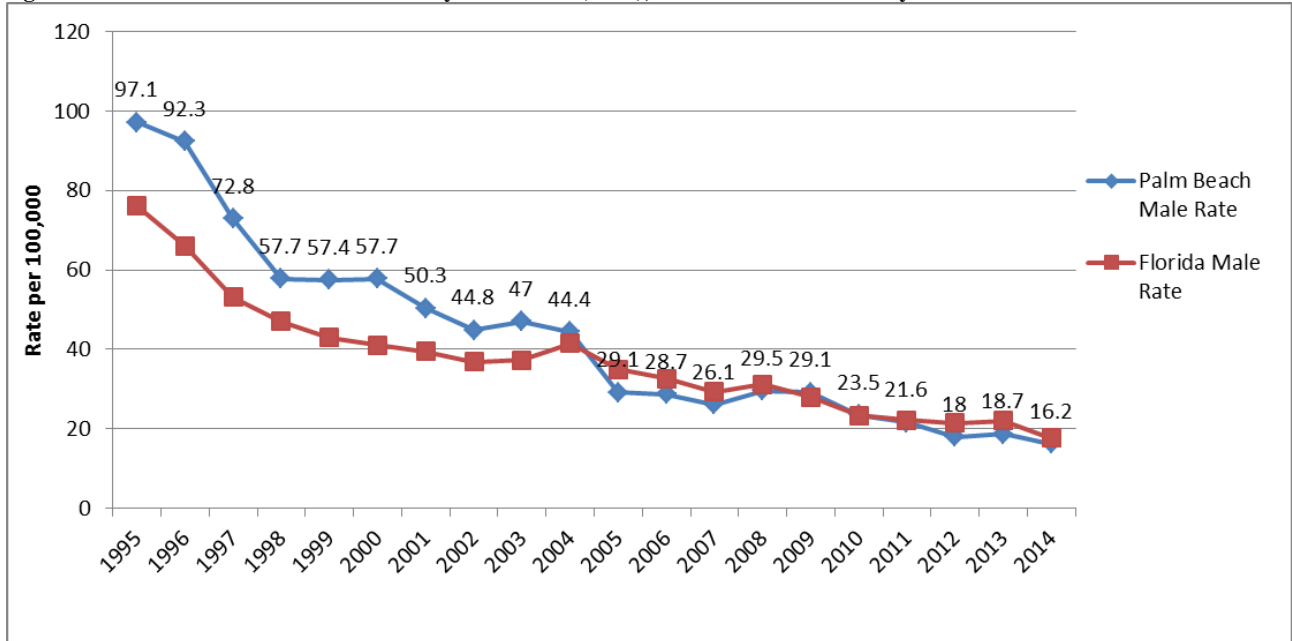


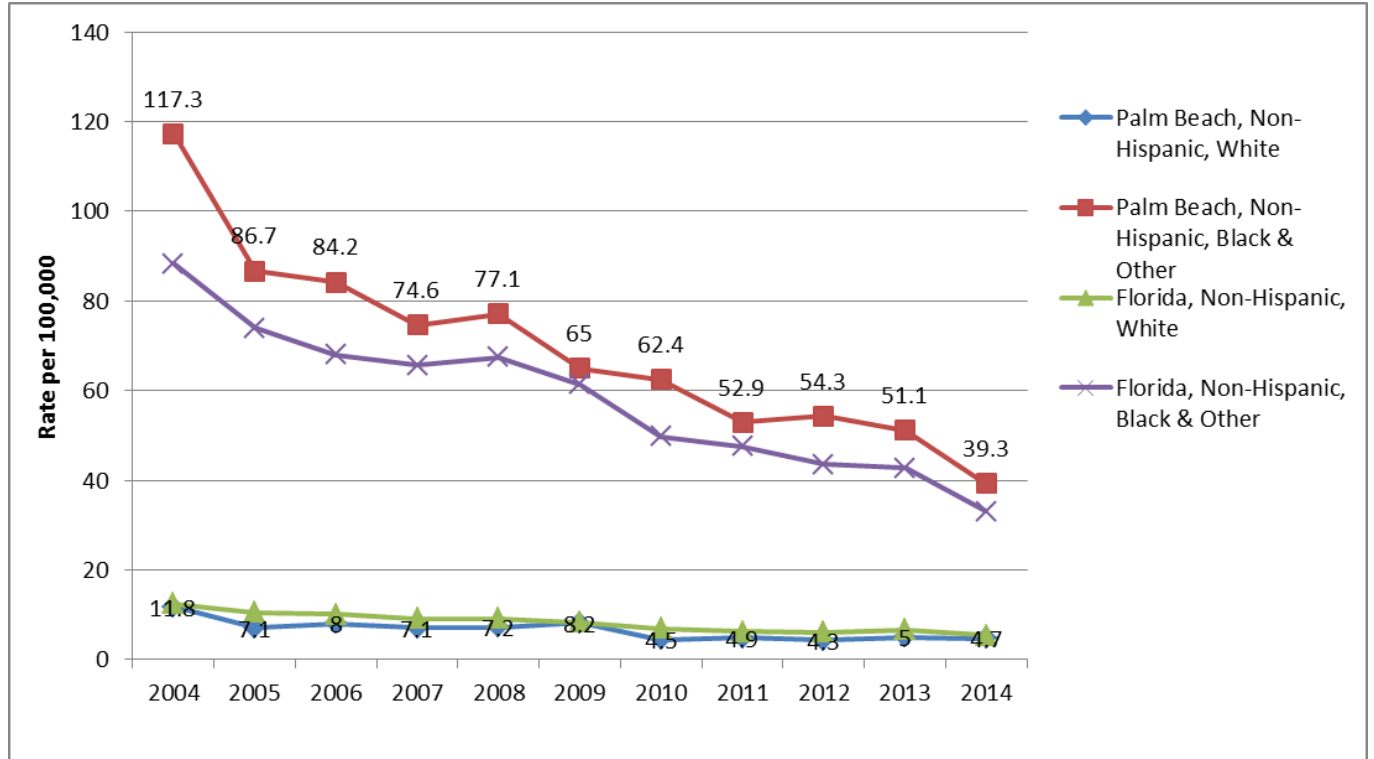
Figure 7b: AIDS Incidence Rates by Gender (male), Palm Beach County and Florida 1995 – 2014



Data Source: FloridaCHARTS, Florida Department of Health, Bureau of HIV/AIDS
 Date Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. Many 2007 cases were not reported until 2008 because of the change from paper to electronic lab reporting (ELR). This results in an artificially low count of AIDS cases in 2007.
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Figure 7 shows AIDS incidence in Palm Beach County and Florida by race from 2004 to 2014. Data labels are shown for Palm Beach County rates. Considerable disparity is present between the rates of AIDS in non-Hispanic white individuals and non-Hispanic black individuals in both the county and the state. In 2014, the rate of newly diagnosed AIDS cases in black non-Hispanic individuals (39.3 per 100,000) was over eight times the rate in non-Hispanic white individuals (4.7 per 100,000) in Palm Beach County.

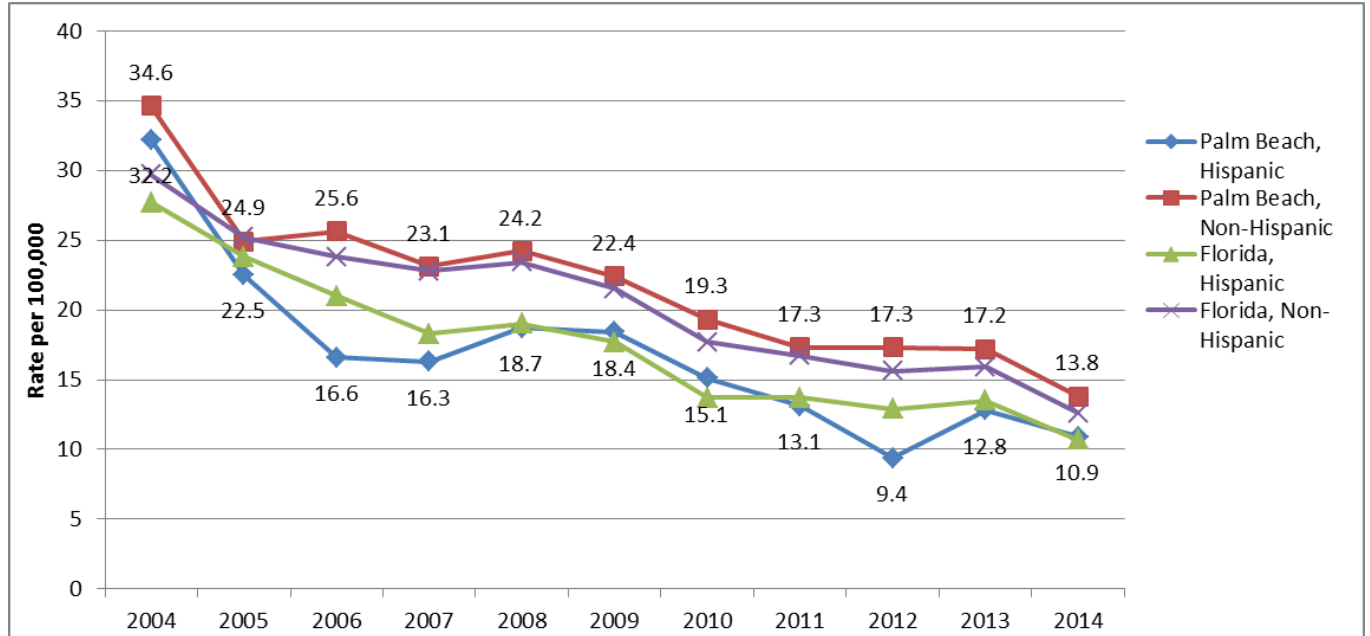
Figure 8: AIDS Incidence Rates, by Race, Palm Beach County and Florida 2004 – 2014



Data Source: FloridaCHARTS, Florida Department of Health, Bureau of HIV/AIDS
 Date Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. Many 2007 cases were not reported until 2008 because of the change from paper to electronic lab reporting (ELR). This results in an artificially low count of AIDS cases in 2007.
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Figure 8 shows AIDS incidence in Palm Beach County and Florida by ethnicity from 2004 to 2014. Data labels are shown for Palm Beach County rates. In 2014, Palm Beach County incidence of AIDS in non-Hispanic individuals (13.8 per 100,000) was slightly higher than the rate in Hispanic individuals (10.9 per 100,000).

Figure 9: AIDS Incidence Rates by Ethnicity, Palm Beach County and Florida 2004 – 2014



Data Source: FloridaCHARTS, Florida Department of Health, Bureau of HIV/AIDS
 Date Notes: HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. Many 2007 cases were not reported until 2008 because of the change from paper to electronic lab reporting (ELR). This results in an artificially low count of AIDS cases in 2007.
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

AIDS Prevalence

AIDS prevalence is the number of individuals living with AIDS at a given time. This differs from AIDS incidence which is the number of newly diagnosed AIDS cases during a period of time.

Table 16 shows AIDS prevalence in Palm Beach County through 2014 by Special Populations. The greatest number of individuals living with AIDS were white MSM (719), followed by Haitian born males (624) and then by Black MSM (503).

Table 8: AIDS Prevalence by special populations, Palm Beach County, through 2014

	Number		Number
White MSM	719	Male Haitian Born	624
Black MSM	503	Female Haitian Born	395
Hispanic MSM	304		
		White Male Youth (current ages 13-24)	3
White Male IDU	78	Black Male Youth (current ages 13-24)	34
Black Male IDU	164	Hispanic Male Youth (current ages 13-24)	3
Hispanic Male IDU	62	White Female Youth (current ages 13-24)	1
White Female IDU	53	Black Female Youth (current ages 13-24)	41
Black Female IDU	101	Hispanic Female Youth (current ages 13-24)	3
Hispanic Female IDU	27	White WCBA (current ages 15-44)	61
		Black WCBA (current ages 15-44)	468
White Male Homeless	1	Hispanic WCBA (current ages 15-44)	72
Black Male Homeless	5	White Ped Cases (current ages 0-12)	0
Hispanic Male Homeless	2	Black Ped Cases (current ages 0-12)	2
White Female Homeless	0	Hispanic Ped Cases (current ages 0-12)	0
Black Female Homeless	1		
Hispanic Female Homeless	0	DOC Cases	99

Data Source: FLORIDA Department of Health, HIV/AIDS Section, data run 10/06/2015

Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Data Notes: MSM includes MSM & MSM/IDU; Male IDU includes IDU and MSM/IDU; WMCA – women of child bearing age

Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Comorbidities and Other Infections

Populations disproportionately affected by HIV are also affected by other infections including tuberculosis and STDS. The risk of acquiring these diseases is associated with similar behaviors and environmental conditions that put individuals at risk of becoming infected with HIV or they can put individuals at risk for reciprocal or interdependent effects.⁴

Infectious Syphilis

Infectious syphilis is “a sexually transmitted disease (STD) caused by the bacterium *Treponema pallidum*.”⁵ STDs such as syphilis share common modes of transmission and increase the risk for HIV infections.⁶

Table 17 shows the number of infectious syphilis cases in Palm Beach in 2013 and 2014 by gender. In 2014, 89.6% of the 67 infectious syphilis cases were males. The number of cases in 2013, 84, decreased to 67 cases in 2014.

Table 9: Infectious Syphilis, Palm Beach County, by Gender, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
Male	73	86.9%	11.2	60	89.6%	9.1
Female	11	13.1%	1.6	7	10.4%	1.0
Other/Unknown	0	0.0%	N/A	0	0.0%	N/A
Total	84	100.0%	6.3	67	100.0%	4.9

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

⁴ HIV Planning Guidance, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, July 2012

⁵ FloridaCHARTS, Accessed 3/12/14

⁶ HIV Planning Guidance, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, July 2012

Table 18 shows the number of infectious syphilis cases in Palm Beach in 2011 and 2012 by age. In 2012, the 20-29 year old age group represented 42.9% (33 diagnosed cases) of the 77 diagnosed cases.

Table 10: Infectious Syphilis, Palm Beach County, by Age, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
0-12	0	0.0%	0.0	0	0.0%	0.0
13-19	13	15.5%	12.0	6	9.0%	5.5
20-24	29	34.5%	36.7	19	28.4%	23.4
25-29	14	16.7%	18.0	12	17.9%	15.1
30-39	11	13.1%	7.3	8	11.9%	5.2
40-49	11	13.1%	6.5	13	19.4%	7.7
50-59	6	7.1%	3.3	5	7.5%	2.6
60+	0	0.0%	0.0	64	6.0%	1.0
Other/Unknown	0	0.0%	N/A	0	0.0%	N/A
Total	84	100.0%	6.3	67	100.0%	4.9

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 19 shows diagnosed infectious syphilis cases in Palm Beach County in 2013 and 2014 by race. In 2013, Black non-Hispanic individuals represented 60.7% of the total diagnosed cases and their rate of infectious syphilis diagnosis was over four times the rate in white non-Hispanic individuals.

Table 11: Infectious Syphilis, Palm Beach County, by Race and Ethnicity, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
White, Non-Hispanic	21	25.0%	2.7	29	43.3%	3.6
Black, Non-Hispanic	51	60.7%	22.2	26	38.8%	11.0
Hispanic	7	8.3%	2.6	12	17.9%	4.3
Asian/Pacific Islander	0	0.0%	N/A	0	0.0%	N/A
Amer. Indian/Alaskan	0	0.0%	N/A	0	0.0%	N/A
Other/Unknown	5	6.0%	N/A	0	0.0%	N/A
Total	84	100.0%	6.3	67	100.0%	4.9

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Gonorrhea

Gonorrhea is a “common sexually transmitted infection (STI). Gonorrhea is caused by the bacteria *Neisseria gonorrhoea*.”⁷ STDs such as gonorrhea share common modes of transmission and increase the risk for HIV infections.⁸

Table 20 shows gonorrhea cases in Palm Beach County in 2013 and 2014 by gender. In 2014, there were 1125 cases of gonorrhea in the county, an increase from 1050 in 2013. Males represented over 50 % of the total cases in 2013 and 2014.

Table 12: Gonorrhea, Palm Beach County, by Gender, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
Male	568	54.1%	87.3	623	55.4%	94.3
Female	482	45.9%	69.6	499	44.4%	70.9
Other/Unknown	0	0.0%	N/A	3	0.0%	N/A
Total	1050	100%	78.1	1125	100%	82.4

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 21 shows gonorrhea cases in Palm Beach County in 2013 and 2014 by age. Individuals 20-29 years old represented over half (51.7%) of the 1125 total cases in 2014.

Table 13: Gonorrhea, Palm Beach County, by Age, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
0-12	0	0.0%	0.0	0	0.0%	0.0
13-19	188	17.9%	173.5	150	13.3%	137.9
20-24	346	33.0%	437.5	343	30.5%	421.6
25-29	197	18.8%	253.0	239	21.2%	300.8
30-39	175	16.7%	115.7	199	17.7%	130.2
40-49	83	7.9%	49.0	106	9.4%	63.2
50-59	39	3.7%	21.2	65	5.8%	34.3
60+	22	2.1%	5.7	23	2.0%	5.9
Other/Unknown	0	0.0%	N/A	0	0.0%	N/A
Total	1050	100%	78.1	1125	100%	82.4

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

⁷ FloridaCHARTS, Accessed 3/12/14

⁸ HIV Planning Guidance, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, July 2012

Table 22 shows gonorrhea cases in Palm Beach County in 2013 and 2014 by race and ethnicity. Considerable racial disparity was present as the rate in non-Hispanic black individuals was nearly ten times the rate in non-Hispanic white individuals.

Table 14: Gonorrhea, Palm Beach County, by Race and Ethnicity, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
White, Non-Hispanic	219	20.9%	27.7	227	20.2%	28.6
Black, Non-Hispanic	446	42.5%	194.4	504	44.8%	214.1
Hispanic	100	9.5%	36.8	98	8.7%	34.9
Asian/Pacific Islander	3	0.5%	N/A	5	0.4%	N/A
Amer. Indian/Alaskan	0	0.0%	N/A	0	0.0%	N/A
Other/Unknown	282	26.94%	N/A	291	25.9%	N/A
Total	1050	100%	78.1	1125	100%	82.4

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Tuberculosis

Tuberculosis is an AIDS-defining opportunistic condition and the disease accelerates HIV disease progression.⁹

Table 23 shows tuberculosis cases in Palm Beach County in 2013 and 2014 by gender. The number of cases decreased from 37 to 31 cases from 2013 to 2014.

Table 15: Tuberculosis, Palm Beach County, by Gender, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
Male	37	67.3%	5.7	31	62.0%	4.7
Female	18	32.7%	2.6	19	38.0%	2.7
Other/Unknown	0	0.0%	N/A	0	0.0%	N/A
Total	55	100.0%	4.1	50	100%	3.7

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 24 shows tuberculosis cases in Palm Beach County in 2013 and 2014 by age. In 2013, the rate was highest in the 50-59 year old age group at 6.3 per 100,000. In 2014, the rate was highest in the 20-24 year old age group at 9.8.

Table 16: Tuberculosis, Palm Beach County, by Age, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
0-12	4	7.3%	2.1	2	4.0%	1.0
13-19	2	3.6%	1.0	0	0.0%	0.0
20-24	5	9.1%	2.6	8	16.0%	9.8
25-29	6	10.9%	3.1	3	6.0%	3.8
30-39	7	12.7%	3.7	9	18.0%	5.9
40-49	9	16.4%	4.7	6	12.0%	3.6
50-59	12	21.8%	6.3	9	18.0%	4.8
60+	10	18.2%	5.2	13	26.0%	3.3
Other/Unknown	0	0.0%	N/A	0	0.0%	N/A
Total	55	100.0%	4.1	50	100.0%	3.7

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

⁹ HIV Planning Guidance, Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, July 2012

Table 25 shows tuberculosis cases in Palm Beach County in 2013 and 2014 by race and ethnicity. In 2014, Black non-Hispanic individuals had the highest rate (8.5 per 100,000) of Tuberculosis cases and represented 40% of the 50 total cases in 2014.

Table 17: Tuberculosis, Palm Beach County, by Race and Ethnicity, 2013, 2014

	2013			2014		
	Cases	% Total	Rate	Cases	% Total	Rate
White, Non-Hispanic	9	16.0%	1.1	8	16.0%	1.0
Black, Non-Hispanic	31	56.4%	13.5	20	40.0%	8.5
Hispanic	11	20.0%	4.0	21	42.0%	7.5
Asian/Pacific Islander	4	7.3%	N/A	1	2.0%	N/A
Amer. Indian/Alaskan	0	0.0%	N/A	0	0.0%	N/A
Other/Unknown	0	0.0%	N/A	0	0.0%	N/A
Total	55	100%	4.1	50	100%	3.7

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

HIV Counseling and Testing

Table 26 shows HIV counseling and testing data from 2013 and 2014 in Palm Beach County by gender. In 2014, there were 25,209 tests administered in the county of which 11,008 were males, 13,417 were females and 784 were unknown. The overall percent positive was .7%. The percent positive in males was 0.9%, 0.4% in females and 0.6% in cases where the gender was unknown.

Table 18: HIV Counseling and Testing, Palm Beach County, by Gender, 2011, 2012

	Number of Tests		Number Positive		% Positive	
	2013	2014	2013	2014	2013	2014
Male	13,046	11,008	154	104	1.2%	0.9%
Female	20,313	13,417	85	58	0.4%	0.4%
Unknown	1,363	784	9	5	0.7%	0.6%
Total	34,722	25,209	248	167	0.7%	0.7%

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 27 shows HIV counseling and testing data from 2013 and 2014 in Palm Beach County by race and ethnicity. In 2014, the greatest number of tests were administered to black individuals (10,177), followed by Hispanic individuals (8,312). The percent positive was 0.8% in black individuals, 0.8 % in white individuals and 0.4% in Hispanic individuals.

Table 19: HIV Counseling and Testing, Palm Beach County, by Race and Ethnicity, 2013, 2014

	Number of Tests		Number Positive		% Positive	
	2013	2014	2013	2014	2013	2014
White	7,156	5,262	40	41	0.6%	0.8%
Black	14,401	10,177	149	86	1.0%	0.8%
Hispanic	10,988	8,312	44	31	0.4%	0.4%
Asian	358	223	0	0	0.0%	0.0%
Am. Native	50	19	0	0	0.0%	0.0%
Other	196	141	2	2	1.0%	1.4%
Unknown	1,573	1,075	13	7	0.8%	0.7%
Total	34,722	25,209	248	167	0.7%	0.7%

Source: FLORIDA Department of Health, HIV/AIDS Section, 2016
Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

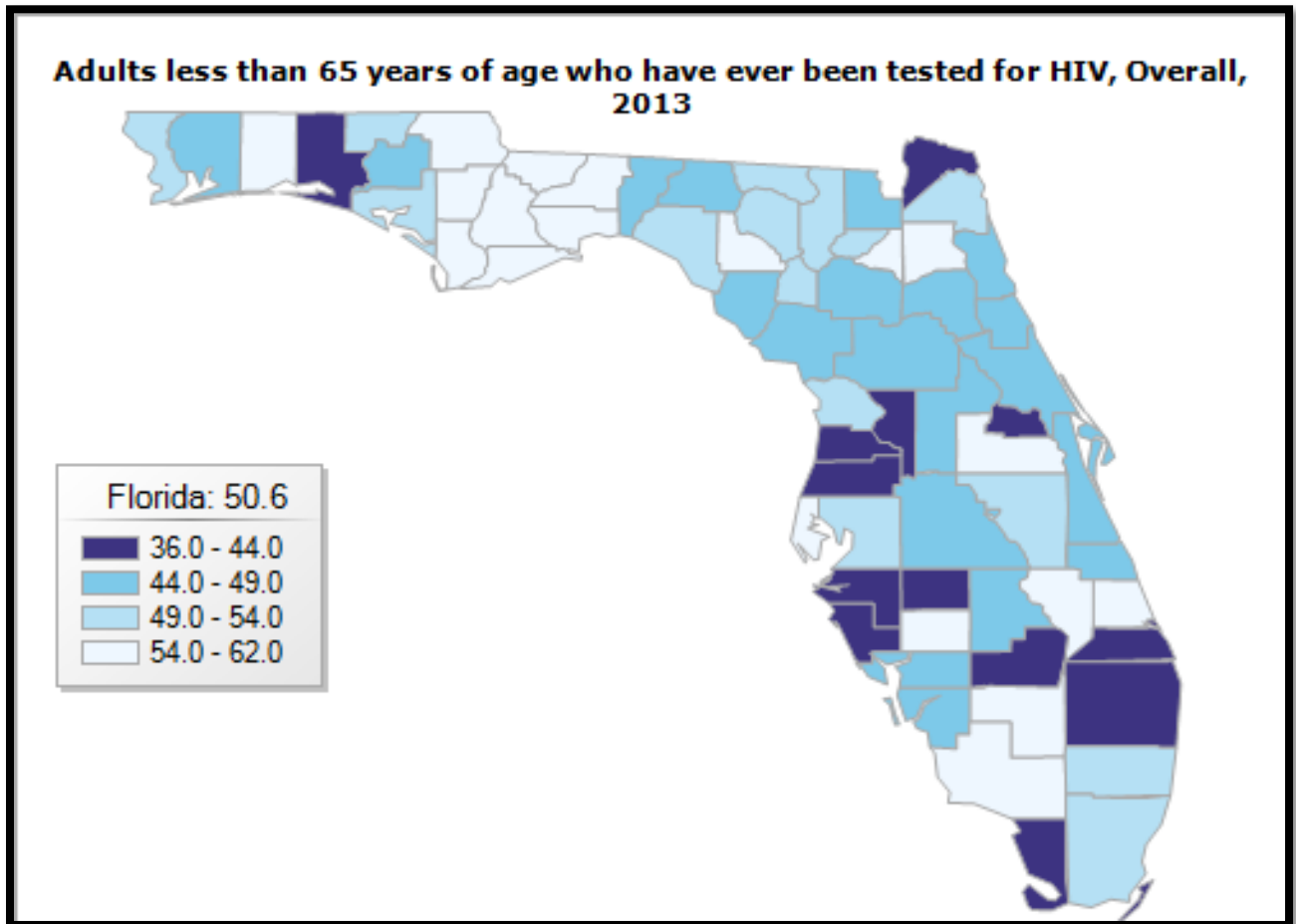
Table 28 and Figure 9 show adults under age 65 in Palm Beach County and in Florida who reported ever having been tested for HIV. In 2013, the percentage in Palm Beach County 42.8% was slightly lower than Florida, 50.6%.

Table 20: Adults <65 who have ever been tested for HIV, Palm Beach County and Florida, 2002, 2007, 2010, 2013

	Palm Beach County	Florida
2002	46.0%	47.7%
2007	52.2%	49.1%
2010	45.5%	48.4%
2013	42.8%	50.6%

Data Source: FloridaCHARTS, Florida County-level Behavioral Risk Factors Surveillance Telephone Survey conducted by the Florida Department of Health, Bureau of Epidemiology
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

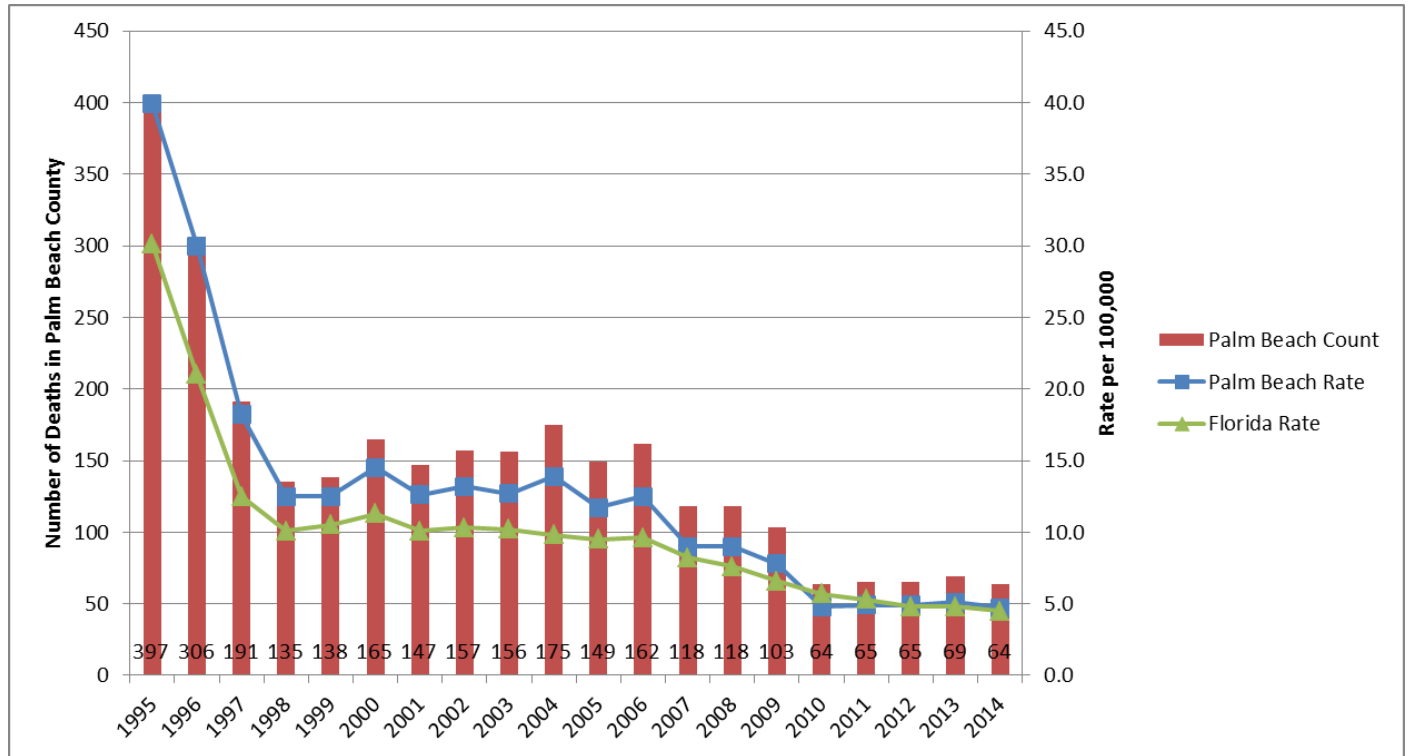
Figure 10: Adults <65 who have ever been tested for HIV, Palm Beach County and Florida, 2010



HIV Death Rates and Counts

Figure 10 shows the death rates and counts HIV/AIDS in Palm Beach County and Florida from 1995-2014. The blue and green trend lines show the rate per 100,000 for the county and state and correspond with the right axis. The red bars show the number of deaths in Palm Beach County and corresponds with the left axis. The death rate and count for Palm Beach continues to decrease considerably for the time period shown. In 2014, the Palm Beach County death rate was slightly higher (4.7 per 100,000) than in the state (4.5 per 100,000).

Figure 11: HIV/AIDS Crude Death Rates and Count, Palm Beach County and Florida, 1993 - 2014



Data Source: FloridaCHARTS, Florida Department of Health, Bureau of Vital Statistics
 Data Notes: ICD-10 Code(s): B20-B24
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 29 shows deaths from HIV and AIDS in Palm Beach County and in Florida in 2012, 2013 and 2014 by gender. In 2014, the Palm Beach County rate of death in males was higher in both the county (6.4 vs. 3.1 per 100,000) and the state (6.2 vs. 2.8 per 100,000) than in females.

Table 21: Deaths from HIV/AIDS, Palm Beach County and Florida, by Gender 2012, 2013, 2014

	Palm Beach County						Florida					
	2012		2013		2014		2012		2013		2014	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
Male	39	6.0	45	6.9	42	6.4	597	6.4	631	6.7	595	6.2
Female	26	3.8	24	3.4	22	3.1	326	3.3	304	3.1	283	2.8

Data Source: FloridaCHARTS, Florida Department of Health, Bureau of Vital Statistics
 Data Note: Rates per 100,000
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 30 shows deaths from HIV and AIDS in Palm Beach County and in Florida in 2012, 2013 and 2014 by race. In 2014, the Palm Beach County rate of death from HIV/AIDS of individuals who are black or other races (15.7 per 100,000) was over 12 times the rate in white individuals (1.3 per 100,000). The rate of death in blacks and other race individuals increased during the time period shown.

Table 22: Deaths from HIV/AIDS, Palm Beach County and Florida, by Race 2012, 2013, 2014

	Palm Beach County						Florida					
	2012		2013		2014		2012		2013		2014	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
White	26	2.5	24	2.3	14	1.3	322	2.2	365	2.4	343	2.2
Black & Other Races	39	12.9	44	14.2	49	15.7	601	14.6	568	13.5	534	12.5

Data Source: FloridaCHARTS, Florida Department of Health, Bureau of Vital Statistics
 Data Note: Rates per 100,000
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

Table 31 shows deaths from HIV and AIDS in Palm Beach County and in Florida in 2012, 2013 and 2014 by ethnicity. In 2014, the rates of death in non-Hispanic individuals were higher in both the county (5.2 vs. 3.8 per 100,000) and the state (5.5 vs. 2.6 per 100,000) than in Hispanic individuals.

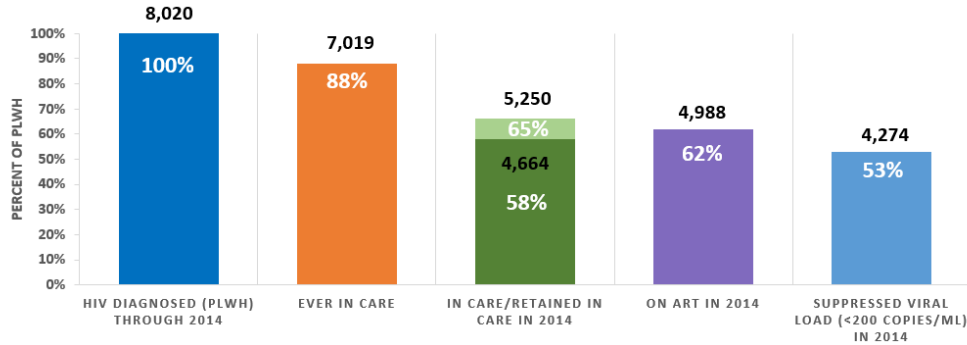
Table 23: Deaths from HIV/AIDS, Palm Beach County and Florida, by Ethnicity 2010, 2011, 2012

	Palm Beach County						Florida					
	2012		2013		2014		2012		2013		2014	
	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate
Hispanic	10	3.8	4	1.5	7	2.5	113	2.6	116	2.6	108	2.3
Non-Hispanic	55	5.2	64	5.9	57	5.3	801	5.5	803	5.4	757	5.1

Data Source: FloridaCHARTS, Florida Department of Health, Bureau of Vital Statistics
 Data Note: Rates per 100,000
 Compiled by: FDOH-Palm Beach County, HIV Surveillance, 2016

HIV CARE Continuum

Number and Percentage of Persons Diagnosed and Living with HIV (PLWH) Engaged in Selected Stages of the Continuum of HIV Care West Palm Beach EMA (excl. DOC), 2014



- 80% of those diagnosed with HIV in 2014 had documented HIV-related care within 3 months of diagnosis
- 81% of PLWH in care had a suppressed viral load in 2014

- (1) **HIV Diagnosed:** Persons diagnosed and living with HIV (PLWH) in Florida through the end of 2014.
- (2) **Ever in Care:** PLWH with at least 1 documented viral load (VL) or CD4 lab, medical visit or prescription since HIV diagnosis.
- (3) **In Care:** PLWH with at least 1 documented VL or CD4 lab, medical visit or prescription in 2014.
- Retained in Care:** PLWH with 2 or more documented VL or CD4 labs, medical visits or prescriptions (at least 3 months apart) in 2014.
- (4) **On ART:** Estimated PLWH on antiretroviral therapy (ART) in 2014 (estimated from 2013 FL MMP data).
- (5) **Suppressed Viral Load:** PLWH with a suppressed VL (<200 copies/mL) on last VL in 2014.



The HIV Care Continuum for the EMA illustrates the HIV epidemic in West Palm Beach, and reflects both the number and percentage of HIV-infected persons engaged in each stage of the continuum. The West Palm Beach EMA is currently using the data from the HIV Care Continuum for two specific purposes: (1) planning and resource allocation, and (2) improving health outcomes across care continuum stages. In planning and resource allocation, the EMA in collaboration with the Florida Department of Health has developed Geographic Information System (GIS) density maps to locate hot spots of disease throughout Palm Beach County. The use of GIS and spatial data analysis has allowed the EMA to document changes in both the geographical concentration and the distribution of HIV disease in Palm Beach County. The result of the GIS density maps revealed three areas of HIV concentration within the county. The identification of these areas has allowed the EMA to determine existing disparities within the HIV-infected population. Moreover, the detection of the hot spot areas has encouraged the EMA to target dollars for culturally appropriate care, HIV prevention strategies, and testing events. As the EMA develops overlays for HIV testing sites, Ryan White providers, and hospitals, HIV viral density maps will provide further insight regarding the distribution of risk factors among various demographic groups. The goal is to continue the development of novel prevention strategies, encourage more testing, and create targeted social marketing and community outreach, with a focus on condom distribution sites for the Florida Department of Health. The use of GIS will continue to guide planning, resource allocation and the delivery of HIV/AIDS medical and support services in Palm Beach County.

To address health outcomes at each care continuum stage, data from the care continuum has allowed the EMA to decipher which stage of the continuum impacts the most number of HIV-infected persons. The tracking of stages has encouraged the EMA to support programs that will increase the number of HIV-Infected persons in each stage of the continuum; ultimately increasing the number of individuals with suppressed viral loads. For example, with the EMA

noting the number of individuals linked to care in the HIV Care Continuum, funding allocations went to support an additional three Early Intervention Services (EIS) programs in West Palm Beach in an effort to identify, educate, and link more people living with HIV into care for the area. In addition, the EMA has compared the HIV Care Continuum data from funded agencies to encourage better treatment adherence for the HIV-Infected persons of West Palm Beach. Constant monitoring and observations of both medical and support service utilization has also highlighted areas of improvement within the HIV Care Continuum. In supporting HIV-infected persons as they move from one stage in the continuum to the next, the West Palm Beach EMA has made a number of improvements within the area to address emerging gaps along the continuum:

Linkage to Care Stage: The EMA has moved from funding one EIS program to funding a total of four EIS programs in the area. Not only does the latter ensure greater efforts to identifying newly diagnosed individuals who are positive in the area, it also works to find individuals who are known positives and are lost to care with additional staff on the ground in high risk behavior areas. The EMA is striving to adhere to the National HIV/AIDS Strategy update 2020 with the collaboration of a network of EIS provider within the area. The four providers meet monthly in an EIS work group to discuss their efforts and ensure there are resolutions to challenges with finding positive individuals in West Palm Beach who are newly diagnosed or lost to care.

Retention in Care Stage: The EMA has strived to support programs that will encourage HIV positive individuals to stay in care. Funding allocations for Peer Mentors have encouraged positive individuals to adhere to treatment, seek those support services that eliminate barriers to care, and trust in a growing relationship that someone “just like them” as gone through the process and are living a life that is completely willing to embrace medical care. Moreover, the EMA has developed, in collaboration with Florida Department of Health, GIS density maps to define HIV hot spots and create a provider overlay in an effort to see where there is the need for additional services to retain positive individuals in care.

On ART Stage: The EMA funds a Local Pharmacy Assistance Program (LPAP) to assure the availability of both HIV and supplemental medications for persons waiting for ADAP or Medicaid enrollment to be completed. In addition, the Health Insurance Continuation Program supports clients to enroll in health insurance plans under the Affordable Care Act (ACA). The EMA pays for premiums, copays, deductibles and ADAP wrap-around costs. The support of clients in health insurance increases the accessibility of medications and other medical services.

Viral Load Suppression Stage: The EMA has worked to keep programs that encourage HIV treatment adherence through the continued allocations for support services and intense focus on low income populations. Moreover the EMA has ensured psychosocial and substance abuse services are in existence in the area to retain positive individuals, in medical care which can ultimately contribute to viral suppression of the disease.

The West Palm Beach EMA has recognized the need for additional data in order to measure health disparities in relation to race, gender, sexual orientation, and age along the HIV Care Continuum. The EMA has invested in a new data management system (Provide Enterprise, PE), which can determine by agency and individual provider who is initiating ART treatments, what

really happens to the “dropouts” along the HIV Care Continuum, and differences in access to care across subpopulations. As reporting in PE is further developed, the EMA will have an increased capacity to use care continuum data in health planning, prioritization of services and monitoring of health outcomes. Care Continuum data, stratified by agency, provider, risk category, and sub-population type will be the key information source for the monitoring and evaluation strategies discussed below.

Financial and Human Resources Inventory

The tables below detail the financial and human resources inventory for the West Palm Beach EMA:

Palm Beach County, Patient Care 2015

Local Grantee Resources (Health Department , Part A, B, C , D)								
Area Counties	Total HIV Funds	Early Intervention Services	ARTAS (or ARTAS Hybrid)	Peer or Near Peer Subset	Outreach	Funded Linkage Specialist (FTE)	Funded Peer Program (FTE)	Other Retention Services
Part A	6,564,184	294,111		177,357		5.1	4.07	1,549,085
Part B	703,131		150,000					180,911
STATE Network	617,205							
STATE Patient Care	815,480							229,652

Community Resources

Agency	Funding Type	Target Population Served	Category of Linkage or Retention Service
Medicaid	119,626/Federal Fund	PLWHA	Home & Community Based Services, Medic
VA*	32,040,000/Federal F	PLWHA Veterans	Outpatient/Ambulatory Medical Care
SAMHSA	283,875/Federal Fund	PLWHA	Mental Health Services, Substance Abuse S
HOPWA	2,945,747/Federal Fu	PLWHA	Home & Community Bases Services, Housir
Health Care District	159,094/State Tax Fu	PLWHA	Outpatient/Ambulatory Medical Care, Hom

Notes:

* The VA has 356 active HIV patients, and budgets \$90,000 for each patient. The \$90,000 per patient is a special budgetary allotment for “high-expense patients”, a category which includes HIV patients.

Local Grantee Resources (Health Department , Part A, B, C , D)								
Area Counties	Total HIV Funds	Funded PTC (yes or no)	Total HD Condom Sites	Total Test Sites	Funded HIV DIS (FTE)	Funded Linkage Specialist (FTE)	Funded Peer Program (FTE)	Perinatal Nurse (FTE)
Health Department	1,755,044	Yes	36**	31*	1	0.33	5.5	1

Community Resources

Agency	Funding Type	Target Population Served	Category of Service
Compass	\$100,000/MSM	MSM	Prevention
FoundCare	\$235,000/High-Impact	PLWHA, Minority, Gay	Prevention
Compass	\$175,000/High-Impact	PLWHA, Minority, Gay	Prevention
Families First	\$150,000/TOPWA	Pregnant Women	Prevention
Genesis Community H	\$75,000/Expanded Tes	Minority, Gay/MSM, T	Prevention
Caridad Center	\$75,000/ETI	Minority, Gay/MSM, T	Prevention
Community Health Ce	\$75,000/ETI	Minority, Gay/MSM, T	Prevention
Florida Atlantic Unive	\$50,000/ETI	Minority, Gay/MSM, T	Prevention

Notes:

* There are 31 State Registered HIV Test Sites that perform HIV testing in 151 additional locations

** There are 36 agencies that receive condoms for distribution; in turn they then distribute to an additional 343 outreach locations

The Palm Beach EMA receives Part A funds to provide core medical and support services, with at least 75 percent of grant funds allocated for services on core medical services and no more than 25 percent on support services. Prevention programs are managed primarily through the Florida Department of Health through its local office in Palm Beach County. For example, medications for Hepatitis C infection are provided through a pilot project paid for by FDOH. The Part A program in Palm Beach County is a key partner in planning for the project and assuring that needed medical services such as labs and physician services are covered.

The local Part B consortia (Area 9) works to ensure that there is adequate collaboration between Ryan White Parts A and B, through their use of the Part A Prioritization and Allocation Committee. This committee is responsible for developing recommendations for the funding prioritization and allocation process. The Part B consortia members also participate in the local needs assessment process. They also closely monitor Part A spending in order to ensure that necessary adjustments can be made to Part B spending so that needed services are provided. The Part A and Part B programs also closely coordinate enrollment of shared clients in the ACA insurance marketplace. In 2015, 92 clients were enrolled under Part A, and 246 clients were enrolled under Part B. Both Parts participated in joint planning and implementation of enrollment, which also involved CMS-funded Navigators.

The 2015 Prevention Funding Snapshot represents funding from the CDC Prevention Cooperative Agreement, PS12-1201 and the CDC Partnerships for Care (P4C) Demonstration Project grant, PS14-1410. Prevention funding in Palm Beach County includes both Category A:

Core Prevention, and Category B: Expanded Testing Initiative (ETI). P4C demonstration project funds from CDC are also allocated to Palm Beach County. These funds are used to support personnel in local CHDs, contracts with prevention providers, condoms for statewide distribution and HIV test kits for CHDs and CBOs.

Needed Resources

According to the American Academy of HIV Medicine (AAHIVM), the current U.S. HIV medical workforce is largely composed of the first generation of HIV medical providers who entered the field more than 20 years ago. As a result, the HIV care system faces a serious crisis in care capacity as these clinicians retire without qualified recruits to take their place. In Florida, EMAs work to mitigate this issue by enlisting the help of the HRSA-funded AIDS Education and Training Centers (AETCs) to build capacity for medical providers through education, consultation, and mentoring. The efforts alone, however, will not solve the workforce shortage. The Palm Beach EMA will need to assess local needs and assure that resources are delivered based on those criteria. As service delivery data becomes more available, local areas use this information to eliminate redundant services, prioritize core service over support services, and address short-falls.

Assessing Needs, Gaps, and Barriers

The Part A EMA completed a patient care needs assessment in 2012 for the 2013-16 Comprehensive Plan. The CPP and EMA are planning to conduct an integrated needs assessment that will address both prevention and patient care programs in 2016. The first year of the integrated plan period will utilize the 2013-2016 Part A needs assessment. The findings in the Comprehensive Needs Assessment 2013-2016 were used by the planning council to help identify the needs and service priorities of PLWHA residing in Palm Beach County. Information was gathered from respondents who both were in primary medical care, as well as out of primary medical care. In this study, the definition of “in care” or “in primary care” was the definition adopted by the Health Resources and Services Administration (HRSA) for being “in primary medical care”:

...if the patient has been in receipt of one of the following HIV-related primary medical care services within the past 12 months:

- HIV/AIDS medical care
- Lab work for CD4 count
- Lab work for viral load count

The Comprehensive Needs Assessment 2013-2016 utilized three data collection strategies including surveys of PLWHA, focus groups of PLWHA, and surveys of HIV service providers. The PLWHA survey and focus group script were similar to those which were used in the 2000, 2003, 2007 and 2010 Comprehensive Needs Assessments. Throughout the surveying process, sampling was monitored to ensure that the demographic and social characteristics of survey respondents represented the diversity of the PLWHA population in Palm Beach County. Using this stratified sampling methodology resulted in a survey sample similar to the profile of PLWHA in the Palm Beach County EMA. Likewise, survey respondents were recruited from all areas of the county and from populations of special concern to ensure representation of the

geographic diversity of PLWHA in the county and the voices of selected populations of special concern.

Key Findings

A total of 366 survey respondents participated in the Comprehensive Needs Assessment 2013-2016. Of these, 211 indicated they were currently in primary medical care. When asked where they received their HIV/AIDS medical care, 197 of the 211 indicated a response. Of the 197 in care respondent who indicated one source, 54.8% said Public Clinic/Health Department and 36.6% said Doctor's Office.

Out of the total 211 respondents that indicated they were currently in care, 33 responded that during the previous five years there had been a period of at least 12 months where they had not gone to the doctor. When asked what prevented them from receiving HIV/AIDS medical care, the three most frequently identified reasons were "I did not have medical insurance," "I could not afford care," and "I was using drugs or alcohol" (33.3%). 155 out of 366 survey respondents indicated they were out of care. When asked about the reasons for not being in care, the three most frequently mentioned reasons include; I did not feel sick (57.4%, 89), I was depressed (38.7%, 60), and I did not want people to know that I have HIV (37.4%, 58).

Eleven providers in Palm Beach County completed a 22-item on-line survey in regards to addressing disparities, improving services, mitigating barriers, and improving or expanding HIV service delivery. When providers were asked, "what is the single most important change you would suggest to improve services for individuals of families infected with HIV?" The responses included themes in increasing service capacity and availability, promoting client empowerment, and improving systematic approaches to change.

Data analyses for each year's needs assessment were conducted to identify trends from 2000 through 2013. Examination of service category utilization, gaps, and barriers has varied slightly in the five needs assessments throughout the 13 years. Utilization has remained high (by more than 50% of respondents) from 2000 through 2013 in laboratory diagnostic testing, primary medical care, and case management services. Gaps in care that generally remained somewhat consistent over time are in the service categories of case management and transportation. Barriers to services have remained low and fairly consistent except for a few notable exceptions in 2013, health insurance food bank, and transportation. In addition to focusing on PLWHA who are in care and those who are out of care, the Needs Assessment also identified specific populations of special concern:

Homelessness

In 2015 the rate of homelessness among PLWHA in Palm Beach County was 0.3% compared to 0.1% among the general population. Thus the PLWHA rate is 3 times that of the general population rate. In Palm Beach County, homelessness and HIV are not limited to urban populations. The prevalence of HIV appears to be more likely in the coastal metropolitan areas; however, there is evidence that both problems are widespread throughout rural areas, yet do not get reported in the same manner. In fact, homelessness is not even defined the same way in rural areas as it is in urban areas. One of the complexities of tracking this vulnerable population is that they are transient.

In the Needs Assessment conducted in 2013, the most frequently cited problems in getting housing were not having enough money for a deposit (18%); inability to find affordable housing (15%); bad credit (14%); being put on a waiting list (14%); and having a criminal record (13%). Additionally, the Needs Assessment revealed that there is a relationship between incarceration and homelessness; among those who were incarcerated during the prior 12 months, 47% were homeless at the time of the survey.¹⁰ Many homeless PLWHA are not being treated and are not being identified for services since they are difficult to target. A higher cost for case managers, and disease intervention specialists is incurred because these are problem cases that require a great deal of time and resources. Living with HIV spectrum disease and being homeless is a complicated situation. Maintenance of physical and emotional health is frequently ignored when food, clothing and shelter are of primary concern. Medical appointments are difficult to meet and maintaining complicated HIV drug therapies is a major challenge. Shelters, food kitchens, and health clinics are model centers for HIV prevention; however, insufficient resources in Palm Beach County limit health education to the homeless and other interventions that others receive. Individuals who are homeless have limited access to health care. Such individuals are vulnerable to increased morbidity and mortality since they lack the care they need. Some barriers to access HIV-related health care in Palm Beach County for the homeless are lack of health insurance, absence of financial resources, and lack of transportation.

Recently Released Former Prisoners

A total of 117 PLWHA in Palm Beach County have been released from state corrections facilities within the past 3 years (36 in 2012, 47 in 2013, and 34 in 2014). This accounts for 1.5% of the PLWHA population, compared to 0.3% of the county's general population. Thus, the rate of recent state incarceration among the PLWHA population is 5 times the rate in the general population.

The Florida corrections system has two types of incarceration facilities: prisons, which are funded and operated by the state Department of Corrections, and jails, which are operated and funded by local county governments.¹¹ The above figures pertain to the prisons; analogous data for jails and for Federal facilities are not available at this time.

The average length of stay in prisons is three to five years, and the prisons are mandated to test each inmate for HIV within 60 days of release. The average length of stay in jails is 23 to 46 days and the jails are not required to test inmates for HIV unless they have been convicted of a sex crime.¹²

The Florida Department of Health (DOH) contracts with the Department of Corrections (DOC) to provide pre-release planning (PRPP) services to HIV-infected inmates preparing to return to their communities. The PRPP includes all correctional facilities and some transitional programs, such as work camps. Funded through Ryan White Part B, the PRPP is responsible for offering pre-release services to all known HIV-infected prisoners in Florida Department of Corrections facilities. The DOC employs five pre-release planners who are divided among three regions in

¹⁰ Palm Beach County Department of Community Services (2013). *Needs Assessment 2013-2016*.

¹¹ Florida Department of Health, Bureau of HIV/AIDS (2015). *Florida DOH Corrections Programs*.

¹² Ibid.

the state to effectively reach and serve all inmates prior to release. The pre-release planners provide services directly to the inmate within six months of their end-of-sentence date to determine the community to which the inmate is returning and what type of services he/she will need. The pre-release planner will contact at least one to two social service agencies or medical providers to connect the client to the care system prior to their release. Upon an HIV-infected inmates' release from a DOC facility, they are given a copy of their medical records (if requested) and a 30-day supply of medication. Program staff will follow up with the ex-offender and/or provider after one month to determine if the initial medical or social service appointment was kept. In 2014, approximately 33,000 inmates were tested for HIV in DOC facilities. The PRPP served 899 inmates who were HIV-positive and reported that 69% of those inmates kept their initial medical or social services appointment made by the pre-release planner.¹³

The DOH currently funds 15 county health departments to implement transitional services in their local jails, including Palm Beach County. These programs include: counseling and testing for HIV/AIDS, Tuberculosis, hepatitis, and STDs; prevention education; pre-release planning for inmates; and follow up services to ensure the releases are still in care in their respective counties. Jail linkage staff often provide STD education sessions with inmates followed by voluntary HIV testing.

In 2014, 1,960 inmates in Palm Beach County were tested for HIV and 0.05% of these tested positive.¹⁴ In 2014, the average daily population in Palm Beach County jails was 2,397.¹⁵ Applying the above HIV-positive jail rate (0.05%), it can be estimated that there is approximately 1 PLWHA in Palm Beach County jails on an average day. Since the average jail stay is less than two months, all of these individuals would be released back into the community within a year's period.

In 2010, the Palm Beach County's HIV Care Council conducted a survey of 117 PLWHAs who had been released from jail or prison within the past 12 months. 17 of these were currently out of care. The most frequently cited reasons for being out of care were lack of insurance or money to pay for care (65%); using drugs or alcohol (65%); lack of transportation (42%); not being ready to deal with one's HIV status (35%); and homelessness (29%). The recently incarcerated out of care respondents most frequently cited financial assistance (89%); food and transportation (83% each); housing (72%); and substance abuse treatment (61%) as their most needed services.¹⁶ Reportedly, some PLWHA engage in a cycle of going into jail and prison sick and coming out healthy. When they are released, they focus on looking for work and spending time with family and friends; their health is not a priority and they become sick. Doing this rotation many times creates drug resistance.

Mental Illness

¹³ Florida Department of Health, Bureau of HIV/AIDS (2015). *Florida DOH Corrections Programs*.

¹⁴ Florida Department of Health, Bureau of HIV/AIDS (2015). *Counseling and Testing Data Summary Report by Selected Variables, Palm Beach County, CY2014*.

¹⁵ Florida Department of Corrections (2014). *Jail Populations and Incarceration Rates by County* (averaged monthly data).

¹⁶ Treasure Coast Health Council (2010). *PLWHA Released from Jail/Prison in last 12 months*.

In 2014, 87 PLWHA in Palm Beach County had a history of mental illness documented in the state's electronic database, for a reported prevalence rate of 1.0%. This number very likely represents an undercount of PLWHA with mental illness, since it only includes those for whom this happened to be documented, and since the estimated prevalence of mental illness among the U.S. general population of Florida is 18.5%.

PLWHA are likely to experience a range of mental health issues, which can often accompany adverse life events. Additionally, mental health problems usually predate substance use activity, which can interfere with HIV/AIDS treatment adherence.¹⁷ Mental illness contributes to an inadequate knowledge and understanding of risk factors and difficulty navigating the health care system. Physician visits with dually-diagnosed clients frequently require increased consultation time, increased coordination of care, increased provision of treatment education, and more follow-up to ensure adherence to both psychiatric and HIV-related treatment.¹⁸

Substance Use

In 2014, 462 PLWHA in Palm Beach County had a history of substance abuse documented in the state's electronic database, for a reported prevalence rate of 5.8%. As with mental illness, this number very likely represents an undercount of PLWHA with substance abuse, since it only includes those for whom this happened to be documented, and since the estimated prevalence of substance abuse among the general population of Florida is 8.6%.

Active substance abusers are more likely to engage in risky behaviors that can have a negative effect on overall health. The interaction of illegal substances and HIV medications can diminish an individual's ability to adhere to proper HIV treatment.¹⁹ For PLWHA substance abuser, the addiction overtakes all other needs and desires. In addition, substance abuse itself is often a coping mechanism for dealing with the fear associated with the disease, and also for dealing with medication side effects. Thus, there is a vicious cycle between denial, iatrogenic symptoms, and substance abuse. The addition of substance abuse to an HIV/AIDS treatment profile significantly increases the cost of care and reflects a high likelihood of recidivism and therefore a high re-infection potential.²⁰

Hepatitis C

In 2014, 597 PLWHA in Palm Beach County were also co-infected with the Hepatitis C Virus (HCV), a prevalence rate of 7.4%, compared to a Hepatitis C prevalence rate of 0% in the county's general population. Potentially severe concurrent illnesses to HIV infection, like viral hepatitis, may increase mid- to long-range morbidity and mortality. Chronic hepatitis, especially that due to HCV is common in the HIV-infected population. Infection by hepatitis viruses in HIV-infected patients may impact health status, decrease quality of life, and increase health care costs. HCV is more serious in HIV-infected persons. It leads to liver damage more quickly. Co-

¹⁷ Florida Department of Health, Bureau of HIV/AIDS (2012). *Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan*.

¹⁸ Miami-Dade HIV/AIDS Partnership (2012). *Miami-Dade County EMA 2012-2015 Comprehensive Plan for HIV/AIDS*.

¹⁹ Florida Department of Health, Bureau of HIV/AIDS (2012). *Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan*.

²⁰ Miami-Dade HIV/AIDS Partnership (2012). *Miami-Dade County EMA 2012-2015 Comprehensive Plan for HIV/AIDS*.

infection with HCV may also affect the treatment of HIV infection. Therefore, it is important for HIV-infected persons to know whether they are also infected with HCV. Injection drug use is one of the main ways people become infected with HIV as well as with HCV. In fact 50%-90% of HIV-infected injection drug users are also co-infected with HCV. Persons who received blood products for either hemophilia or transfusion prior to 1987 commonly have HCV infection. Heterosexual sex or perinatal exposure can also pass on HCV infection, however these risks are much lower for acquiring HCV than they are for acquiring HIV. After acute HCV infection, progression to chronic hepatitis C is increased from 70%-85% in HIV negative people to more than 90% in HIV positive individuals, particularly those with advanced immunosuppression. Studies have also shown that co-infected people have higher HCV RNA levels, again correlated with degree of immune suppression.²¹

Data: Access, Sources, and Systems

In addition to the data collection activities and data systems utilized in the Statewide Coordinated Statement of Need (SCSN) process, the local EMA has a client-level database (PE) to measure health outcomes and improve performance across Part A-funded agencies. At the local level, the EMA relies on data provided by FDOH under the Unmet Need Framework to define trends across the EMA. This is combined with patient care data to present a complete local analysis. The needs assessment process also involves local data collection activities through consumer surveys, provider surveys, and community focus groups. Collectively, these data support the local jurisdiction in planning, resource allocation and outcome evaluation.

As the EMA moves forward with the integrated plan, HOPWA will merge their data system into PE, and HOPWA and Ryan White providers will share a common system for determining and maintaining client eligibility. In addition, HOPWA and Ryan White will begin to integrate planning processes, which should result in a higher level of coordination between these two programs. There have also been preliminary discussions on how to incorporate testing data into PE. This will be an additional effort that should consolidate data across HIV programs, and lead to greater integration across service providers and programs.

²¹ Bureau of HIV/AIDS Hepatitis Program & Surveillance Section (2008). *HIV/AIDS and Hepatitis C Virus (HCV) Co-Infection - Florida*

Section II: Integrated HIV Prevention and Care Plan

The following Goals, Objectives, and Strategies were formulated over a period of several months through an inclusive, comprehensive community planning process. This involved an initial full-day planning retreat of the CARE Council, and a series of listening and feedback sessions involving the CPP and the Planning Committee of the CARE Council. The following were adopted for the five-year Integrated Plan:

GOAL 1: REDUCE NEW HIV INFECTIONS

Objective 1: Increase the percentage of PLWHA who know their sero-status from 87.2% to 90%.

Strategies:

- Develop and implement a targeted, coordinated, culturally-appropriate multi-faceted social marketing campaign
- Conduct targeted outreach and testing in non-traditional venues
- Promote routine HIV testing in medical care facilities
- Increase knowledge of and access to Non-occupational Post Exposure Prophylaxis (nPEP)/Pre-Exposure Prophylaxis (PrEP) for High Risk HIV negative persons.

Objective 2: Reduce the number of new diagnoses by at least 10%

Strategies:

- Conduct coordinated, community-level interventions, in alignment with High Impact Prevention principles to address risk behaviors.
- Develop meaningful collaborations among service providers across funding sources and traditional areas of focus
- Support more comprehensive sex education in the Palm Beach County School District
- Assure opt-out testing adoption in all medical facilities

GOAL 2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PLWHA

Objective 1: Increase the percentage of homeless who are retained in care by 5%

Strategies:

- Foster meaningful partnerships among entities serving the homeless population, outside of the traditional HIV system of care.
- Address concurrent issues impacting the homeless population, such as mental health and substance abuse
- Conduct education for medical providers on the nature of homelessness and how to more effectively serve a homeless client/population

Objective 2: Increase the percentage of newly diagnosed persons linked to medical care within one month of their HIV diagnosis to at least 85%.

Strategies:

- Restructure service-related quality measures related to linkage programs
- Implement peer strategies to effectively guide newly-diagnosed individuals through critical points in their care
- Develop, implement, and support local Test to Treat Initiatives.

GOAL 3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES

Objective 1: Increase the percentage of Black, Hispanic, and Homeless individuals who are virally suppressed by 5%

Strategies:

- Enhance health outcomes monitoring for Medical Case Management services to improve care
- Employ motivational/empowerment techniques to encourage and support clients to understand and achieve viral suppression.
- Develop innovative peer mentor strategies to support clients as they work towards viral suppression.

Objective 2: Reduce disparities in the rate of new diagnoses by at least 10% among gay/bisexual men, young black gay/bisexual men, and black females.

Strategies:

- Address issues related to stigma among these populations which contribute to disparities in health outcomes
- Develop a targeted, comprehensive Minority AIDS Initiative program

Objective 3: Reduce the percentage of PLWHA who experience untreated non-HIV related chronic conditions through treatment and prevention

Strategies:

- Adopt the Expanded HIV Care Continuum model to include prevention and whole health/wellness
- Develop a health outcome monitoring plan to better track management of chronic conditions
- Incorporate strategies and efforts towards whole health, including the prevention and management of chronic conditions throughout the continuum of care

GOAL 4: MONITORING AND EVALUATION

Objective 1: Develop an integrated planning and evaluation process

Strategies:

- Identify key evaluation stakeholders
- Convene a work group representing the CPP and CARE Council to manage the evaluation plan
- Develop metrics for the Integrated Plan goals and objectives
- Identify data sources to support evaluation goals

Objective 2: Utilize evaluation findings to improve services and client-level health outcomes

Strategies:

- Identify evaluation questions
- Report evaluation findings
- Develop targeted training to implement evaluation recommendations

Collaborations, Partnerships and Stakeholder Involvement

The development of the Palm Beach County chapter of the statewide integrated plan occurred through an inclusive process that brought together prevention providers, patient care providers, consumers, and other stakeholders to identify key goals, objectives, and strategies to guide efforts over the next five years. The Part A Health Planner guided early discussions in the CARE Council's Planning Committee to orient members to the guidance documents published by CDC and HRSA. Members of the Planning Committee and CPP developed an initial framework of goals and objectives for the plan based on the NHAS and other integrated plan resources. In February 2016, the CARE Council held its annual retreat, which was a working meeting to identify specific strategies under each objective. Participants included representatives from patient care, prevention, Disease Intervention Specialists, staff from the Housing Opportunities for People with AIDS (HOPWA) program, and consumers. Each table of participants was seated based on area of interest, and consumers were represented in each discussion. Participants reported back to the larger group with initial strategy recommendations. Staff from the Health Council of Southeast Florida (HCSEF) collated responses and facilitated a number of meetings to prioritize and categorize strategies. This information was then brought forward through two cycles of both CPP and CARE Council meetings for further discussion and approval.

PLWHA and Community Engagement

As implementation of the plan moves forward, there will be a greater level of coordination between the planning processes of the Part A planning council, CPP and HOPWA. This will involve an integration of data systems, as well as planning processes. A central component to stakeholder engagement will be the continued leadership of PLWHA in the planning process. This will involve representation from subpopulations that experience disparities in health outcomes or are at higher risk. This will further inform the decision-making processes that are part of the planning process. As stakeholders participate in the monitoring and evaluation function (described below), future versions of this local chapter will have built upon these initial collaborations into a robust and integrated system of care (*see Letter of Concurrence*).

The development of this local chapter included a variety of community stakeholders, including PLWHA. The CARE Council (Part A) includes 33% of its members representing the affected community. This representation also reflects the demographics of the disease in Palm Beach County. Membership on the CARE Council Planning Committee similarly is represented by PLWHA, and it is this committee that has been the primary venue for stakeholders to participate in the development of the local chapter. In addition, the CARE Council annual retreat, which served as a forum to develop this plan, was well-represented by PLWHA. PLWHA were present at each discussion table, and continue to provide feedback and input into related discussions.

Section III: Monitoring and Improvement

The development of a comprehensive monitoring and improvement plan will be the responsibility of a newly-created, joint prevention/patient care evaluation committee. The final composition of the committee has not been finalized, but should be in place at the start of the

integrated plan cycle. It will be the responsibility of this committee to review baseline data for all plan objectives, recommend annual outcome goals, identify specific measures and data sources, and recommend priorities for quality improvement and performance management activities.