NACCHO
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2020 Model Practices

Applicant Information

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Size

Select a size: *

- ☐ Small (0-50,000)
- ☐ Medium (50,000-499,999)
- ☑ Large (500,000+)

Application Information

Local Health Department/Organization Name: *

Florida Department of Health in Broward County

Title of Practice: *

Decreasing Community Viral Load Through Innovative Test and Treat Program

Submitter Name: *

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Submitter Title: *

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Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select the most relevant category that applies most to your practice: : *

- [ ] Access to Care
- [ ] Advocacy and Policy Making
- [ ] Animal Control
- [ ] Coalitions and Partnerships
- [ ] Communications/Public Relations
- [ ] Community Involvement
- [ ] Cultural Competence
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Food Safety
- [ ] Global Climate Change
- [ ] Health Equity
- [x] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [ ] Organizational Practices
- [ ] Other
- [ ] Primary Care
- [ ] Quality Improvement
- [ ] Research and Evaluation
- [ ] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce

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- [ ] Research and Evaluation
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- [ ] Vector Control
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Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community.
- Describe public health issue.
- Goals and objectives of the proposed practice.
- How was the practice implemented/activities.
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
- Were all of the objectives met?
- What specific factors led to the success of this practice?
- Public Health impact of practice.
- Website for your program, or LHD.

Please use this portion to respond to the questions in the overview section. : *

Overview: Provide a brief summary of the practice in this section

Broward County is the second most populous county in Florida, 17th most populous in the United States with over 1.9 million people and 10% of Florida's residents. Broward County is home to an international airport that is ranked 19th in the U.S. in total passenger traffic and a sea port which is the cruise ship capital of the world. 15.4 million tourists visit our beaches each year. We are a majority/minority community with a population of 37% White, 28% Black, and 30% Hispanic of any race (U.S. Census) with one-third residents being foreign born. Nearly 15% of the residents are living below the poverty level and 20 % of children under age 18 are living in poverty. South Florida continues to be the most cost-burdened metro region in the nation with over half of Broward residents spending more than 30% of their monthly income on housing expenses. Fort Lauderdale ranks 10th nationwide as one of the most cost-burden communities. Broward County Public Schools is the sixth largest public-school system in the United States. Students are from 204 different countries and speak 191 languages.

According to the Centers for Disease Control and Prevention (CDC), the Fort Lauderdale Division of the Miami Metropolitan Statistical Area (MSA) has the highest rate of new HIV infections (40.1/100,000 persons) and the third highest AIDS case rates in the United States (18.9/100,000 persons). In 2018 Broward County had an estimated 21,048 people living with HIV/AIDS. Prior to April 30, 2017, individuals newly diagnosed with HIV in Broward County needed to wait for laboratory results, eligibility and medical appointments before starting anti-retroviral (ART) medication. This practice resulted in clients lost in the process and not engaging in care.

To improve linkage to care and decrease the rate of new HIV infections, the Florida Department of Health in Broward County (DOH-Broward) implemented a Test and Treat (T&T) program. The goals and objectives of the program are aligned with measures/indicators and targets set forth by the CDC and include:

- Increase linkage and retention in HIV medical care among people living with HIV (PLWH).
- Increase the percentage of persons linked to care and on ART medications
- Increase the percentage retained in care and percentage with suppressed viral load

DOH Broward's T&T program was implemented in partnership with the Broward County Ryan White Part A Grantee Office. The evidence base for the program was the successful projects in San Diego, New York, and San Francisco. The Broward Test and Treat Program is unique because it strives to provide HIV same day primary care appointments and ART initiation and provides 30 days of ART. Additionally, the program was implemented in partnership with all 5 Ryan White Part A HIV primary care providers, and accepts clients regardless of how long they have been non-adherent to ART. In addition, Test and Treat Linkage and Re-engagement Specialists (LRS) help clients overcome barriers to retention in care and medication adherence. They ensure clients make and attend eligibility determination, medical and case management appointments, provide transportation, and make referrals to other services.

DOH-Broward developed a T&T Action Plan to address the high rates of HIV in Broward County and utilized an Incident Command System to provide organizational structure, meeting formats and After Action and Improvement Planning to manage a non-emergency response across multiple internal and external programs.

Key Processes that were monitored on a weekly basis include 1.) Training/Outreach, 2.) Social Marketing, 3.) Data Monitoring and Evaluation, 4.) Ryan White Part A Provider Engagement, 5.) T&T Implementation and 6.) Pharmacy

DOH-Broward has the largest T&T program in Florida. Since May 1, 2017 through April 30, 2019, 1,696 clients have enrolled in the program, 39% being newly diagnosed and 61% previously diagnosed who were lost to care. The one-year evaluation showed a viral suppression rate at 12 months of 87%, compared to 64% for the continuum of care in Broward County. 93% of newly diagnosed clients are virally suppressed, whereas, 79% of clients who have fallen out of care and enrolled are virally suppressed.

The specific factors that led to the success of T&T were the following: 1.) utilization of incident command system, 2.) ongoing engagement in training of stakeholders, 3.) intensive linkage and client engagement.

By increasing the percentage of persons linked to care and on ART medications, percentage retained in care and percentage with suppressed viral load, the long-term outcome will be a reduction in community viral load; therefore, decreasing transmission of the virus and rates of new HIV infection in Broward County.

Website www.broward.floridahealth.gov

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be -

1. new to the field of public health (and not just new to your health department) OR
2. a creative use of an existing tool or practice, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

Please state the Responsiveness and Innovation of your practice : *

Responsiveness and Innovation

Statement of the problem/public health issue

According to the Centers for Disease Control and Prevention (CDC), the Fort Lauderdale Division of the Miami Metropolitan Statistical Area (MSA) has the highest rate of new HIV infections (40.1/100,000 persons) and the third highest AIDS case rates in the United States (18.9/100,000 persons). In 2017, Broward County had an estimated 20,871 people living with HIV/AIDS. In 2018, the number of people living with HIV/AIDS was 21,048. Prior to April 30, 2017, individuals newly diagnosed with HIV in Broward County needed to wait for laboratory results, eligibility and medical appointments before starting anti-retroviral (ART) medication. This resulted in clients lost in the process and not engaging in care as many did not return for their follow up appointments.

In 2016, Broward County met the National HIV/AIDS Strategy target for the metrics associated with the percentage linked to Continuum of Care. Specifically, the percentage of HIV Diagnoses linked to care was 85.7% (target is 85%), the percentage of HIV Diagnoses retained in care was 76.9% (target is 90%), percentage of HIV Diagnoses with suppressed viral load was 66.1% (target is 80%).The percentages of HIV Diagnoses linked to the Continuum of Care for 2017 shows an increase, specifically in the percentage linked to care and retained in care. The percentage of HIV Diagnoses linked to care increased to 89.4%, the percentage of HIV Diagnoses retained in care increased to 81.1%, the percentage of HIV Diagnoses with suppressed viral load also increased to 73.8%. According to the Continuum of Care for 2018, 91.1% were linked to care. The percentage of HIV Diagnoses for those retained in care is at 78.5%. HIV Diagnoses with a suppressed viral load for 2018 is at 70.8%.

US Department of Health and Human Services (DHHS) guidelines currently recommend universal Antiretroviral Therapy (ART) for all people living with HIV regardless of CD4 count immediately after HIV diagnosis. There are few documented programs in the US that support this recommendation. Even with the current recommendations, only three US cities have published on immediate ART after HIV diagnosis; they include San Francisco, San Diego, and New York.

What target population is affected by problem (please include relevant demographics)

The top priority populations based on persons living with HIV disease (HIV prevalence surveillance data) are the following:

1. Black Heterosexual men and women
2. White Men who have Sex with Men (MSM)
3. Black MSM
4. Hispanic MSM
5. Hispanic Heterosexual men and women
6. Black Injection Drug Use (IDU)
7. White heterosexual men and women
8. White IDU
9. Hispanic IDU

What is the target population size? What percentage did you reach?

Per the Florida Department of Health (DOH) 2017 Broward County surveillance data, there were an estimated 20,871 individuals living with HIV/AIDS, accounting for 3,100 (15%) who are unaware of their HIV status. Of the 20,871 people living with HIV/AIDS who were aware of their diagnosis, the percentage linked to care was 94.2%, the percentage retained in care was 70.3%, and the percentage with a suppressed viral load was 64.4%. 2018 surveillance data indicates 94.1% were linked to care, the percentage of those retained in care increased to 70.9%, and the percentage of those with a suppressed viral load also increased to 66%.

DOH-Broward has the largest Test and Treat program in Florida. Since the program's inception on May 1st, 2017 through April 30th, 2019, a total of 2,016 individuals diagnosed with HIV and currently not on ART medication were referred to the T&T program. Of the total referred, 1,696 (84%) were eligible for the program, meaning they were confirmed HIV positive and 320 were ineligible. Of the total eligible for the program, 1,696 (84%) were successfully enrolled in the T&T Program which is determined by receipt of ART medications and 72 refused participation. Of the 1,696 enrolled, 665 (39%) were newly diagnosed and 1031 (61%) lost to care.

The one-year evaluation showed a viral suppression rate of those retained at 12 months of 87%, compared to an estimated 64% for the continuum of care in Broward County. Of those clients enrolled in Broward's Test & Treat program for the first two years, 50.8% were virally suppressed within 90 days of enrollment, whereas, 36.8% of enrolled clients acquired viral suppression in more than 90 days. 93% of newly diagnosed clients enrolled in the program are virally suppressed, whereas, 79% of clients who have fallen out of care and enrolled are virally suppressed. Continually decreasing viral load will reduce the number of new infections in the County.

T&T enrollment is the best measure of linkage to care because it ensures clients receipt of ART medications. The specific factors that led to the success of T&T were the following: 1.) utilization of incident command system, 2.) ongoing engagement in training of stakeholders, 3.) intensive linkage and client engagement.

What has been done in the past to address the problem?

In the past, the standards for initiation of ART after HIV diagnosis have varied and often were determined by CD4 count levels and physician discretion.

https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf

Why is the current/proposed practice better?

DOH-Broward's strategy is unique because it addresses both newly diagnosed HIV positive and previous HIV positive individuals who are re-engaged in care. In addition, DOH-Broward's T&T program is designed to focus on re-engagement in HIV care and the delivery of comprehensive essential support services through partnerships with community providers that therefore ensure people living with HIV/AIDS continue to receive ART medications.

Is it a creative use of existing tool and practice?

The HIV care continuum is a tool supported by the DHHS and consists of several steps required to achieve viral suppression. This tool measures the effectiveness of the practice of linkage and retention to HIV care and will be used to measure improvements in these measures as a result of T&T program implementation.

Specifically, CDC tracks:

1. HIV Diagnosed
2. Linked to care (at least 1 CD4 or VL), meaning they visited a health care provider within–1 month (30 days) after learning they were HIV positive
3. Received or were retained in care (at least 2 CD4 or VL at least 3 months apart), meaning they received medical care for HIV infection
4. Viral suppression, meaning that their HIV "VL" – the amount of HIV in the blood – was at a very low level (<200 copies/ml)

Using both incidence and prevalence-based HIV continuum of care methodologies, we can evaluate and monitor T&T Implementation.

Source: https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf

Is the current practice evidence-based?

Recently, there has been increased evidence that demonstrates better health outcomes and reduction of infectiousness, the sooner an individual initiates ART after HIV diagnosis. The latest updated National Institute of Health (NIH) Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents living with HIV, recommends ART for all individuals with HIV regardless of CD4 cell counts. This is determined to reduce morbidity and mortality associated with HIV infection.

Source: https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/10/initiation-of-antiretroviral-therapy

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broadbased involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice were other stakeholders involved?
- What was their role in the planning and implementation process?
    - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

Enter the LHD and Community Collaboration related to your practice : *

LHD and Community Collaboration

Goal(s) and objectives of practice

The goals and objectives of DOH-Broward's Test and Treat (T&T) Program are aligned with measures/indicators and targets set forth by the CDC. The CDC's most recent PS-18-1802 Integrated HIV Surveillance and Prevention Programs for Health Departments Evaluation and Performance Measurement Plan is to:

- Increase linkage and retention in HIV medical care among people living with HIV (PLWH).

- Increase the percentage of persons linked to care and on ART medications
- Increase the percentage retained in care and percentage with suppressed viral load

The long-term outcome will be a reduction in community viral load; therefore, decreasing transmission of the virus and rates of new HIV infection in Broward County.

What did you do to achieve the goals and objectives?

DOH-Broward utilized an Incident Command System (ICS) to provide organizational structure, meeting formats and After Action and Improvement Planning to manage a non-emergency response across multiple internal and external programs. The Federal Emergency Management Agency defines ICS as "a management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. Under the ICS structure, ICS Chiefs first met daily beginning 2/5/16 where situation reports were prepared to document meeting outcomes. A T&T Action Plan was developed to address the high rates of HIV in Broward County. The Action Plan was championed by the DOH-Broward Communicable Disease Director using the approach laid out in the Program Collaboration Service Integration Model (PCSI). In February 2017, the Incident Action Plan was reviewed and updated weekly to monitor key processes that included 1.) Training/Outreach, 2.) Social Marketing, 3.) Data Monitoring and Evaluation, 4.) Ryan White Part A Provider Engagement, 5.) T&T Implementation and 6.) Pharmacy.

Steps taken to implement the program

Step 1: Referral for Newly Diagnosed Clients

A. Newly Diagnosed Client Identified at a Testing Site that does not Provide HIV Primary Care Under the Ryan White Part A Program:

1. Each site where HIV testing is conducted will designate a T&T Key Contact who will servie as the primary point of contact with DOH-Broward.
2. T&T Key Contact will immediately inform the DOH-Broward Disease Intervention Program (DIP) Manager or designee about the newly diagnosed client.
3. The testing counselor will introduce the concept of T&T to the client and determine the most appropriate T&T provider. If the client's insurance will not cover a visit to a Ryan White Part A T&T provider due to being out of network, deductible, copays etc., the DIP Linkage Retention Specialist (LRS) will attempt to make a T&T appointment with an in-network HIV primary care physician for the client.
4. The DOH-Broward DIP STD Program Manager will determine if a HIV positive client is newly diagnosed or lost to care using databases including: PSTARS, Linkage to Care module, Axiom Pro, eHARS and/or Provide Enterprise (PE).
5. If the client is newly diagnosed, the testing counselor will do an oral confirmatory test as an additional mechanism.
6. If the client is newly diagnosed, the DIP STD Manager or designee will send a DIP Disease Intervention Specialist (DIS) to the client's location. DIP DIS will arrive onsite to initiate partner services and complete the T&T discussion.
7. The DIP LRS will select a T&T provider based on the client's insurance status.
8. The DIP LRS will accompany the client to the appointment. The testing counselor/linkage staff may also accompany the client. Transportation will be provided.

B. DIP LRS Newly Diagnosed Client who is Identified at a Testing Site that Provides HIV Primary Care Under the Ryan White Part A Program:

1. Each Ryan White Part A primary care provider site where HIV testing is conducted will designate a T&T Champion.
2. The T&T Champion will inform the DOH-Broward DIP Manager or designee about the newly diagnosed client immediately during normal business hours or the next business day ensuring client confidentiality with HIPAA.
3. The testing counselor will introduce the concept of T&T to the client and determine the preferred T&T provider.
4. The DOH-Broward DIP Manager will determine if the HIV positive client is newly diagnosed or was lost to care using databases STARS, Linkage to Care Module, Axiom Pro, eHARS and/or PE and will inform the provider.
5. If the client is newly diagnosed, the testing counselor will do an oral confirmatory test as an additional mechanism.
6. The T&T Champion will make a T&T appointment for the client on the day they are meeting with the client and the testing counselor/linkage staff will accompany the client to the appointment.
7. The DIP DIS will follow up with the client to determine the need for partner services.

C. DIP LRS Newly Diagnosed Client Identified at a Private Physician's Office:

1. DOH-Broward DIP staff will be notified about the positive HIV test as part of routine surveillance and usually before the physician is aware.
2. The DOH-Broward DIP Manager will determine if HIV positive client is newly identified or lost to care.
3. The DIP DIS staff will contact private physician to determine who will notify the client of their HIV positive diagnosis.
4. Once client is aware of their HIV positive diagnosis, DIP DIS will initiate partner services and introduce the T&T Program to the client.
5. The DIP LRS will select a T&T provider based on the client's insurance status.
6. If the client's insurance will not cover a visit to a Ryan White Part A T&T provider due to out of network, deductible etc., DIP LRS

will attempt to make a T&T appointment with an in-network HIV primary care physician on behalf of client.

DIP LRS Step 1: Referral for Lost to Care Clients

1. Lost to care clients may be identified in various ways, including but not limited to:

- Reactive rapid test at a testing site that provides Ryan White Part A primary care or one that does not
- Contact with an HIV community-based organization
- Referral to the T&T Program by Part A providers, DOH-Broward Pharmacy, DOH-Broward AIDS Drug Assistance Program (ADAP). ADAP is administered by States and authorized under Part B of the Ryan White Treatment Modernization Act and provides FDA-approved medications to low-income individuals with HIV diagnosis who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured Ryan White HIV/AIDS Program clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program match those offered through ADAP, private physicians, and ERs etc.
- Identified by Data to Care Project data analysis

- T&T Key Contact/Champion will inform the DIP Manager or key contact about the lost to care client
- DIP LRS will conduct the appropriate research in the available data systems
- If client is onsite, DIP LRS will arrive onsite and conduct T&T referral as described above.
- If client is not onsite, DIP LRS will locate the client and conduct T&T referral as described above

Step 1: Referral for Newly Diagnosed or Lost to Care Client Identified while Hospitalized

1. Social worker/designated T&T key contact contacts the Centralized Intake and Eligibility Determination (CIED) Program to complete eligibility. CIED collects and enters client's eligibility information including proof of residence, proof of income, HIV positive test and enters this information into the PE database.
2. Social worker/designated T&T key contact informs the DOH-Broward DIP Manager or designee about the newly diagnosed client immediately.
3. The DOH-Broward DIP Program Manager will determine if the HIV positive client is newly diagnosed or has been lost to care by researching STARS, Linkage to Care module, Axiom Pro, eHARS and/or PE.
4. If the client is newly diagnosed:
5. A DIP DIS will initiate partner services.
6. If the client is discharged with a prescription for ART, the DIP LRS will assist the client in filling the prescription as described in Step 2 below based on the client's insurance status.
7. The DIP LRS will also link the client to HIV primary care at a Ryan White Part A provider or in network HIV primary care physician.
8. If the client is not discharged with a prescription, the DIP LRS will select a T&T provider based on the client's insurance status. If the client's insurance will not cover a visit to a Ryan White Part A T& T provider, the STD DIS will attempt to make a T&T appointment with an in-network HIV primary care physician.
9. If the client is lost to care, a DIP LRS will be assigned to the client and complete the steps described above.

DIP LRS Step 1: Referral for Newly Diagnosed or Lost to Care Clients who are identified while in the ED

1. T&T Key Contact informs the DOH-Broward DIP Manager or designee about the newly diagnosed client immediately during normal business hours or the next business day.
2. The DOH-Broward DIP Manager will determine if HIV positive client is newly diagnosed or lost to care by researching in STARS, Linkage to Care module, Axiom Pro, eHARS and/or PE.
3. If the client is newly diagnosed:
4. A DIP DIS will initiate partner services.
5. If the client is discharged with a prescription for ART, the STD DIS will assist the client in filling the prescription as described in Step 2 below based on the client's insurance status. The DIP LRS will also link the client to HIV primary care at a Ryan White Part A provider or in network HIV primary care physician.
6. If the client is not discharged with a prescription, the DIP LRS will select a T&T provider based on the client's insurance status. If the client's insurance will not cover a visit to a Ryan White Part A T&T provider, the STD DIS will attempt to make a T&T appointment with an in-network HIV primary care physician.
7. If the client is lost to care, the DIP Manager or designee will send a DIP LRS who will arrive onsite if the client is present, or if not, contact the client to complete the steps describes above.

DIP LRS Step 2: T&T Visit with ART Initiation

A. Recommended ART Regimens for T&T Program

1. Dolutegravir 50 mg once daily (Tivicay®) + tenofovir alafenamide/emtricitabine (Descovy®) one (1) tab once daily or
2. Darunavir/cobicistat (Prezcobix®) once daily + tenofovir alafenamide/emtricitabine (Descovy®) one (1) tab once daily or
3. Tenofovir alafenamide/emtricitabine/elvitegravir/cobicistat (Genvoya®) one (1) tab once daily with food.
4. (BIKTARVY ®) one (1) tab once daily with food.
5. (ODEFSEY ®) one (1) tab once daily with food.

6. (COMPLERA ®) is a combination of emtricitabine, rilpivirine, and tenofovir disoproxil fumarate. One (1) tab once daily with food.
7. SYMTUZA (darunavir, cobicistat, emtricitabine, and tenofovir alafenamide) one tablet taken daily with food.
8. DOVATO (dolutegravir and lamivudine) one tablet taken orally once daily with or without food.

B. ART Availability - ART will be available on-site at all Ryan White Part A offices that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV/AIDS epidemic. This includes outpatient medical care, AIDS Pharmaceuticals Assistance, Oral Care, Health Insurance premiums and cost sharing assistance, mental health services, Medical Case Management, Outpatient Substance Abuse, Food Bank/home delivered meals, legal services, and primary care providers.

1. Uninsured clients
    - Community providers, Broward Health or the AIDS Healthcare Foundation, will fill initial 30-day ART prescriptions at their on-site pharmacies and bill Ryan White Part A under Tier 2 of the Ryan White Part A Formulary.
    - Community providers, Memorial Healthcare Systems, Care Resource, Broward Community and Family Health Centers, and Children's Diagnostic & Treatment Center, will be provided with a bulk purchase of drugs on their shelves by DOH-Broward and no billing is necessary. DOH-Broward will develop and deploy an inventory tracking system for the drugs they provide.
2. Insured clients
    - If the client has insurance and is having a T&T visit at a Ryan White Part A provider, the pharmacy should attempt to get a 30-day ART prescription filled. If insurance will not approve immediate fulfillment of ART prescription, Ryan White Part A will cover the cost. Client must provide proof that insurance denied ART prescription (insurance statement, prior authorization, or denial of fill).
    - If the client has a T&T visit at a private physician's office and receives a prescription, the client should attempt to fill the prescription at a pharmacy that accepts their insurance. If insurance will not approve immediate fulfillment of the ART prescription, the client can fill the prescription at the DOH-Broward pharmacy. Ryan White Part A will cover the cost if the client provides proof of insurance denial.

C. T&T Visit Process at a Ryan White Part A Primary Care Provider Site

1. An expedited eligibility process will be conducted. The site's designated T&T Champion (Designated T&T Champion: A dedicated T&T Program Staff member located at each community testing site that provides HIV Primary Care) will collect and enter client's eligibility information (proof of residence, proof of income (may be self-declaration), HIV+ test) into Provide Enterprise (PE), ensure the client completes the "Authorization to Treat" form, and contact CIED to schedule client's appointment within two weeks to complete eligibility.

2. Client will see the on-site HIV Primary Care physician who will perform a history and physical examination, order the necessary laboratory tests, select a T&T regimen, as deemed appropriate by the physician and acceptable by the client, and provide a 30-day ART prescription. The physician may choose from one of the three recommended ART regimens or prescribe a different regimen based on client history and clinical judgment. The ART will be prescribed with laboratory results pending.

3. Client will receive a 30-day ART regimen either through the provider onsite pharmacy or physician dispensing.

4. Ideally, the client will take the first dose of medication in the physician's office.

5. The physician will document the visit in PE.

D. T&T Process for Clients who are Identified at a Private Physician's Office and May be Newly Diagnosed or Lost to Care

1. The physician should provide a 30-day ART prescription.

- If the prescription is provided, the DIP LRS will assess the client's insurance status. The client will be referred to a pharmacy that accepts their insurance and linked to HIV primary care with an in-network physician. If insurance will not approve immediate fulfillment of the ART prescription, the client can fill the prescription at the DOH-Broward pharmacy. Ryan White Part A will cover the cost if the client provides proof of insurance denial.
- If the prescription is not provided, the DIP LRS will assess the client's insurance coverage and select a T&T provider based on the client's insurance coverage and preference.
    1. If the client's insurance will allow, the DIP LRS will implement the T&T referral and visit process described above at a Ryan White Part A Primary Care Provider.
    2. If the client's insurance will not cover a visit to a Ryan White Part A T&T provider due to out of network, deductible etc., DIP LRS will attempt to make a T&T appointment with an in-network HIV primary care physician. If the patient receives a prescription from the private physician, they will be referred to a pharmacy that accepts their insurance. If insurance will not approve immediate fulfillment of the ART prescription, the client can fill the prescription at the DOH-Broward pharmacy. Ryan White Part A will cover the cost if the client provides proof of insurance denial

E. T&T Process for Clients who are Identified while Hospitalized (Newly Diagnosed or Lost to Care)

1. The hospital physician should provide a 30-day ART prescription at discharge.

- If the prescription is provided, the DIP LRS will assess the client's insurance status.
    - Insured clients will be referred to a pharmacy that accepts their insurance and linked to HIV primary care with an in-network physician. If insurance will not approve immediate fulfillment of the ART prescription, the client can fill the prescription at the

DOH-Broward pharmacy. Ryan White Part A will cover the cost if the client provides proof of insurance denial.
    - Uninsured clients will have their prescription filled at the DOH-Broward pharmacy under the Ryan White Part A Program. The client will be linked to care at a Ryan White Part A primary care provider and given a CIED appointment for full eligibility determination.

2. If the prescription is not provided, the DIP LRS will assess the client's insurance status.

- If the client is insured, the DIP LRS will select a T&T provider based on the client's insurance status. If the client's insurance will not cover a visit to a Ryan White Part A T&T provider due to out of network, deductible etc., DIP LRS will attempt to make a T&T appointment with an in-network HIV primary care physician.
- Uninsured clients will be entered into the T&T process outlined above at the Ryan White Primary Care Provider of their choice.

F. T&T Process for Clients who are identified while in the ER (Newly Diagnosed or Lost to Care)

1. The ER physician should provide a 30-day ART prescription at discharge.

- If the prescription is provided, the DIP LRS will assess the client's insurance status.
    - Insured clients will be referred to a pharmacy that accepts their insurance and linked to HIV primary care with an in-network physician. If insurance will not approve immediate fulfillment of the ART prescription, the client can fill the prescription at the DOH-Broward pharmacy. Ryan White Part A will cover the cost if the client provides proof of insurance denial.
    - Uninsured clients will have their prescription filled at the DOH-Broward pharmacy under the Ryan White Part A Program. The client will be linked to care at a Ryan White Part A primary care provider and given a CIED appointment for full eligibility determination.
- If the prescription is not provided, the DIP LRS will assess the client's insurance status.
    - If the client is insured, the DIP LRS will select a T&T provider based on the client's insurance coverage and preference.
        - If the client's insurance will allow, the DIP LRS will implement the T&T referral and visit process described above at a Ryan White Part A Primary Care Provider.
        - If the client's insurance will not cover a visit to a Ryan White Part A T&T provider due to out of network, deductible etc., DIP LRS will attempt to make a T&T appointment with an in-network HIV primary care physician. If the patient receives a prescription from the private physician, they will be referred to a pharmacy that accepts their insurance and linked to HIV primary care with an in-network physician. If insurance will not approve immediate fulfillment of the ART prescription, the client can fill the prescription at the DOH-Broward pharmacy. Ryan White Part A will cover the cost if the client provides proof of insurance denial.
- Uninsured clients will be entered into the T&T process described above at the Ryan White Part A Primary Care Provider of their choice.

Notes:

1. For all of the above scenarios, DOH-Broward will work with clients who are non-Broward and/or non-Florida residents on a case by case basis.

2. Any client who refuses the T&T appointment or the initiation of ART will be followed by the DIP LRS.

3. Any T&T client who cannot obtain medication following the completion of the initial 30-day supply because they could not complete the RW Part A and/or ADAP eligibility process or due to private insurance or other barriers should receive a second 30-day supply of medication from the T&T provider.

Linkage to Care, Re-engagement and Retention

A. Day 1 to 3 after ART initiation:

1. If the client was newly diagnosed and initially managed by the STD DIS, the STD DIS will transition the client to the DIP LRS. Lost to care clients managed by the DIP LRS will remain as part of their caseload.
2. The DIP LRS will document the information in PE.
    - If the client is in the RW Part A system of care, the information will be documented in the T&T module of PE.
    - If the client is not in the RW Part A system of care, the information will be documented in the T&T module of PE only accessible by DOH-Broward.
3. The DIP LRS will contact the client to ask about any medical symptoms or questions and convey those to the HIV primary care provider for appropriate follow up.
4. The DIP LRS will also confirm that the client has a CIED and Ryan White Part B (Ryan White Part B: The part of the Ryan White HIV/AIDS Program (formerly, Title II) that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PLWHA and their families. This includes ADAP, Health Insurance Premium and cost sharing assistance, Home and Community Based Health Services, and Medical Transportation Services) and ADAP appointment, if appropriate, and the date of their next primary care appointment. The DIP LRS will assess and address any barriers to compliance with ART or those appointments. If the client will be following up with a primary care provider other than the one that initiated T&T, the DIP LRS will assist in making the appointment. The DIP LRS will accompany the patient to those appointments if necessary and acceptable to the client.

B. Day 5 to 14 after ART initiation:

1. The client will visit with the medical provider to follow up on clinical care and laboratory tests. At that visit, lab results will be reviewed with the client. Any symptoms or medication side effects will be assessed. Treatment may be adjusted as appropriate. The client will make the necessary follow up appointments.
2. The client will complete their eligibility appointments as appropriate.
3. If the client is RW Part A and B eligible, the client will access other services as necessary and appropriate including RW Part A case management.
4. The client may be assigned a HIV Client Navigator as necessary and appropriate.

Any criteria for who was selected to receive the practice?

Eligibility for T&T

A. Newly diagnosed HIV clients defined as:

1. Acute Infection: antibody (-)/RNA (+)
2. Recent Infection: antibody (+) with last documented antibody (-) within last six months
3. The client may be identified consequently to a reactive rapid test or a routine HIV test (blood draw).

B. Previously diagnosed HIV clients lost to care defined clients who have had any interruption in their ART.

What was the timeframe for the practice?

T&T implementation began May 1st, 2017. However, additional planning milestones are as follows:

- October 2018: T&T One-year process evaluation conducted
- October 2018: Provide Enterprise was created for Test & Treat
- November 2018: T&T Protocol was updated

What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)

Training/Outreach: Training and outreach on T&T protocols have been updated and are being implemented at HIV testing sites. This includes: primary care and infectious disease providers, Hospital and Emergency Department staff, STD Disease Intervention Specialists (STD DIS), and HIV Linkage and Re-engagement Specialists (DIP LRS). T&T All STD DIS and DIP LRS are trained quarterly. To date, there are a total of 13 DIP LRS. Two supervisors have been hired as well as a Project Consultant and an Administrative Assistant. Training and outreach will be an activity that is ongoing and will be sustained throughout the implementation of the T&T program.

Ryan White Part A Provider Engagement: The engagement of the Ryan White providers in T&T involved developing a T&T training protocol, identifying insurance plans accepted by Ryan White Care providers, documenting which providers and pharmacies are in network for each insurance plan, creating a directory of insurance plans, identifying Ryan White T&T Champions, ongoing contact with Ryan White Part A providers and Infectious Disease practitioners, and monthly updates of insurance status.

T&T Implementation: Implementation encompassed finalizing the T&T protocol, presenting the protocol to Ryan White Part A, Broward County HIV Health Services Planning Council, South Florida AIDS Network, and the Broward County HIV Prevention Planning Council. The identification of insurance plans accepted by Ryan White Care providers, documentation of providers and pharmacies that are in network for each insurance plan, creation of a directory of insurance plans, and identification of Ryan White T&T Champions were completed in April 2017. All of these activities for this Key process will be ongoing and continuous.

Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/budget breakdown.

For Fiscal year (FY) 18 - 19, the allocation for Test and Treat is $2,010,452 (Below is the budget).

Employee salaries and benefits = $971,150

Prescription Drugs expenses = $1,000,000

Other expenses = $30,737

Collocated, Risk Management and HR Expenses = $8,564.88

Total for FY 18 – 19 $2,010,451.88

Total for FY 16-17 (May 2017 to June 2017) = $2,000,000 for prescription drugs.

Total = $4,010,451.88

Pharmacy: The provision of pharmaceuticals for the T&T Program required an initial bulk purchase, working with each Ryan White Provider receiving bulk purchase to determine the most effective dispensing (pharmacy versus physician) and developing a procedure

and toll for inventory monitoring and reporting. The T&T Protocol was completed in February 2017, presented to Ryan White Part A in March 2017, Broward County HIV Prevention Planning Council in April 2017, HIV Health Services Planning Council in May 2017, and South Florida AIDS Network in June 2017. Implementation of T&T in Broward County began May 1st 2017. Within the first year of T&T, the total pharmacy expenditures for medications have been $1,239,223.73.

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are process and outcome. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how? (if applicable)
    - List any secondary data sources used. (if applicable)
    - List performance measures used. Include process and outcome measures as appropriate.
    - Describe how results were analyzed.
    - Were any modifications made to the practice as a result of the data findings?

Please enter the evaluation results of your practice : *

Evaluation

What did you find out? To what extent were your objectives achieved?

During the first two years of the T&T Program implementation (May 1st, 2017 through April 30th, 2019), a total of 2,016 individuals diagnosed with HIV and currently not on ART medication were referred to the T&T program. Of the total referred, 1,696 (84%) were eligible for the program, meaning they were confirmed HIV positive, and 320 were ineligible. Of the total eligible for the program, 1,696 (84%) were successfully enrolled in the T&T Program which is determined by receipt of ART medications, and 72 refused participation. The enrolled clients consist of 665 (39%) newly diagnosed and 1,031 (61%) previously diagnosed clients who were lost to care. T&T enrollment is the best measure of linkage to care because it ensures clients receipt of ART medications. Using T&T enrollment as a best measure for linkage to care, the percent enrolled is 84% which is just below the national target (85%) for linkage to care.

The one-year evaluation showed a viral suppression rate of those retained at 12 months of 87%, compared to an estimated 64% for the continuum of care in Broward County. Of those clients enrolled in Broward's Test & Treat program for the first two years, 50.8% were virally suppressed within 90 days of enrollment, whereas, 36.8% of enrolled clients acquired viral suppression in more than 90 days. The DOH-Broward Test and Treat program assists clients newly diagnosed with HIV, in addition, the program also assists clients who have fallen out of care. 93% of newly diagnosed clients enrolled in the program are virally suppressed, whereas, 79% of clients who have fallen out of care and enrolled are virally suppressed.

The goals and objectives of Broward County's Test and Treat (T&T) Program are aligned with measures/indicators and targets set forth by the CDC. The CDC's most recent PS-18-1802 Integrated HIV Surveillance and Prevention Programs for Health Departments Evaluation and Performance Measurement Plan is to:

- Increase linkage and retention in HIV medical care among people living with HIV (PLWH).
- Increase the percentage of persons linked to care and on ART medications.
- Increase the percentage retained in care and percentage with suppressed viral load.

The long-term outcome will be a reduction in community viral load; therefore, decreasing transmission of the virus and rates of new HIV infection in Broward County.

Data, Monitoring and Evaluation

Data Monitoring and Evaluation activities included the development of variables in the current Ryan White database for non-Ryan White Clients, Provide Enterprise (PE), ensuring fields match desired outcome metrics, training DOH staff in PE use, developing referrals for 'lost to care' clients in PE, ensuring undetectable viral loads are reported to DOH-Broward, and determining outcomes and metrics entered into Active Strategy (DOH-Broward's performance measurement system), and identifying a follow-up protocol. PE developed by Groupware Technologies, Inc. (GTI) is a web-based relational, integrated data system used by the Broward County Ryan White Part A program to collect client-level data on sociodemographic and epidemiologic characteristics, intake and eligibility, detailed procedure-level service units, clinical outcomes, invoices, and payments. This software is used system-wide across a network of providers to collect data that is subsequently utilized for electronic reporting as well as synchronized real time care coordination of Broward County Ryan White Part A Clients. The referral system for the lost to care in PE was completed in April 2017 along with the determination of the

follow-up protocol. In May 2017, variables were developed in the Ryan White database PE for non-Ryan White Clients, ensuring PE fields match desired outcome metrics, and DOH staff were trained in PE. T&T metrics and outcomes were added to Active Strategy in September 2017. The modules for Test and Treat client follow-up are currently being developed.

Did you evaluate your practice?

List any primary data sources, who collected the data, and how (if applicable)

Data Collection

1. Ryan White Part A clients will have their information and visits documented in PE by the primary care provider and the DIP LRS. PE may be amended to capture the required data.
2. Non- Ryan White Part A clients will have their information documented by the DIP LRS in a separate tab of PE only visible to DOH-Broward.
3. STD DIS and DIP LRS will document in PRISM (Patient Reporting Information Surveillance Manager) using their normal procedure.
4. Viral Load and CD4 data are acquired from the HIV/AIDS Surveillance Program in Tallahassee.

List any secondary data sources used (if applicable)

Not applicable

List performance measures used. Include process and outcome measures as appropriate.

A comprehensive Monitoring and Evaluation Protocol was completed for the T&T program. This protocol uses both incidence and prevalence-based HIV continuum of care methodologies, to evaluate and monitor T&T Implementation. Using Surveillance data, a final two-year evaluation was conducted. Surveillance data is collected through both passive and active forms using mandatory HIV case reporting forms and through laboratory reporting. In addition to surveillance data, monitoring of certain T&T variables are conducted on a weekly basis. These data are collected from STD DIS and DIP LRS and then filtered through an internal T&T database. STD DIS and DIP LRS collected information through STD PRISM data-base (PRISM: DOH data management system for STD surveillance and investigation), and client and provider interviews. These monitored variables are as follows:

1. Total number of people diagnosed with HIV who are referred to the T&T program
2. Total number of individuals enrolled in the T&T program (as evidenced by receipt of ART medications)
3. Total number of individuals who refused T&T and the reasons for refusal
4. Of those enrolled in T&T what percent are newly diagnosed HIV-positive or previously diagnosed HIV-positive

Metrics

1. Date of initial positive HIV test result for new HIV infections - document if Acute HIV infection
2. First date of contact for those out of care returning to care and if the client instigated the contact or who on the care team found and returned to care.
3. Date brought to T&T site
4. Date first dose of ART
5. Likert scale impression of readiness to take ART by the team at their first contact with the patient including the medical practitioner prescribing at the first clinic visit
6. Baseline CD4 and HIV viral load
7. Any patient medication side effects resulting in ART change
8. Date first undetectable HIV viral load and most recent CD4 to that date
9. Immune reconstitution inflammatory syndrome (IRIS) resulting in additional care or hospitalization
10. Whether client is retained in care at 12 months or not

Describe how results were analyzed

Active Strategy were used to monitor the process objectives above, in addition to the following monthly: 1.) The percent of clients enrolled in the T&T Program (Numerator: Total clients enrolled/denominator: Total clients referred), 2.) Percent of newly diagnosed clients in the T&T program, 3.) Percent of previously diagnosed clients enrolled in the T&T program, 4.) Percent of Clients on ART, 5.) Percent of Clients not on ART. The goals and objectives of Broward County's Test and Treat (T&T) Program are aligned with measures/indicators and targets set forth by the CDC. The CDC's most recent PS-18-1802 Integrated HIV Surveillance and Prevention Programs for Health Departments Evaluation and Performance Measurement Plan is to increase linkage and retention in HIV medical care among people living with HIV (PLWH). The states HIV Surveillance Data Analysis was used for linkage, retention, and suppressed viral load percentages.

A full year 2-year evaluation was conducted after May 1st, 2019. The following Evaluation Indicators were used for this process:

Indicator	Data Source	Numerator	Denominator
Percent of newly HIV positive		Number of newly	Number of HIV

individuals enrolled in T&T (Goal: 85%)	T&T Database	HIV positive individuals enrolled in T&T	diagnosed individuals (both New and Previous)
Percent of previous HIV positive individuals enrolled in T&T (Goal: 85%)	T&T Database	Number of previous HIV positive individuals enrolled in T&T	Number of HIV diagnosed individuals (both New and Previous)
Percent of HIV diagnosed individuals that achieve virologic suppression at 12 months	T&T Database	Number of HIV diagnosed individuals that achieve virology suppression at 12 months	Number of HIV diagnosed individuals (both New and Previous)
Percent of HIV diagnosed individuals re-enrolled in T&T	T&T Database	Number of HIV diagnosed individuals that re-enrolled in T&T	Number of HIV diagnosed individuals (both New and Previous)
Percentage of HIV diagnosed individuals screened for risk reduction intervention needs	T&T Database	Number of persons in denominator who are screened for risk reduction intervention needs	Number of HIV diagnosed individuals (both New and Previous)
Percentage of HIV diagnosed individuals, screened for risk reduction intervention needs and identified as needing an intervention	T&T Database	Number of persons in denominator identified as needing an intervention	Number of HIV diagnosed individuals (both New and Previous) screened for HIV risk reduction intervention needs
Percent of HIV diagnosed individuals identified as needing an intervention who were provided an intervention (FOA Target: 85%)	T&T Database	Number of persons in the denominator provided a risk reduction intervention	Number of HIV diagnosed individuals screened and identified as needing a risk reduction intervention
Percentage of HIV diagnosed individuals screened for other essential support services*	T&T Database	Number of persons in denominator who are screened for essential support services	Number of HIV diagnosed individuals (both New and Previous)
Percentage of HIV diagnosed individuals, who are screened and identified as needing one or more essential support services	T&T Database	Number of persons in denominator identified as needing one or more essential support services	Number of HIV diagnosed individuals screened for other essential support services
Percent of HIV diagnosed individuals, screened and		Number of persons	Number of HIV diagnosed individuals who are

identified as needing other essential support services that are actively referred to one or more of these services	T&T Database	in the denominator who are provided one or more of these services	screened and identified as needing one or more essential support services
Percentage of HIV diagnosed individuals referred to any prevention service **FOA target: 80%**	T&T Database	Number of HIV diagnosed individuals in denominator who are referred to any prevention service	Number of HIV diagnosed individuals (both New and Previous)
Percent of HIV diagnosed individuals retained in continuous medical care	T&T Database	Number of HIV diagnosed individuals in denominator with =2 tests (CD4 or VL) =3 months apart	Number of HIV diagnosed individuals (both New and Previous)

Since the program's inception on May 1, 2017 through April 30, 2019, 1,696 clients have enrolled in the program. The enrolled clients consist of 39% newly diagnosed and 61% previously diagnosed clients who were lost to care. The one-year evaluation showed a viral suppression rate of those retained at 12 months of 87%, compared to an estimated 64% for the continuum of care in Broward County.

Of those clients enrolled in Broward's Test & Treat program for the first two years, 50.8% were virally suppressed within 90 days of enrollment. Whereas, 36.8% of enrolled clients acquired viral suppression in more than 90 days. The DOH-Broward Test and Treat program assists clients newly diagnosed with HIV, in addition, the program also assists clients who have fallen out of care. 93% of newly diagnosed clients enrolled in the program are virally suppressed, whereas, 79% of clients who have fallen out of care and enrolled are virally suppressed.

Were any modifications made to the practice as a result of the data findings?

No modifications were made to the practice at this time.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation.)

- Lessons learned in relation to practice.
- Lessons learned in relation to partner collaboration. (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans.

Please enter the sustainability of your practice : *

Sustainability

Lessons learned in relation to practice

- Test & Treat in Broward County provides a great opportunity to work in tandem with various hospitals, CBOs and other counties to learn best practices and learn common challenges.
- DIP LRS/Navigators have become leaders and work well as a team.
- Understanding the diversity in our area and working well with the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex (LGBTQI) population.
- As a front runner with Test & Treat, DOH-Broward seeks opportunities to showcase our work so that other counties will have the opportunity to develop a T&T Program to include: DIP LRS, HIV client navigators and previous positive patients.
- The ability to come to an agreement on what is an acceptable level of coordination between the CBO's and the T&T Program can be extremely easy with some agencies and a difficult task with others. It is important to have a relationship with all Champions, Providers and testing sites to make the T&T process understandable for all while also giving the ability to work in harmony together.

Lessons learned in relation to partner collaboration

- Assigning a dedicated LRS to each Community Based Organization greatly speeds up the process for each client.
- Sustain quarterly CBO/Hospital/Testing Site Visits to Promote Referrals and Train Staff
- Expand utilization of the Ryan White Part A Provider Enterprise (PE) System to Support Data Collection to the Ryan White providers as well as the LRS aids with the communication between DOH-Broward and providers.
- Sustaining continuous training for providers is essential to maintain collaboration and a strengthened partnership between the CBOs and T&T.
- Expand LRS Competencies in Behavioral Health Skills.
- Understanding the collaboration between the CBOs and the DOH-Broward is a give and take, win-win situation.

Is there sufficient stakeholder commitment to sustain the practice?

Having the right stakeholders and subject matter experts from the appropriate organizations has been instrumental in establishing community ownership. In addition, ensuring the proper communication channels exist between T&T Champions and T&T Key Contacts is critical in maintaining collaboration efforts.

Describe sustainability plans

Ongoing Retention and Re-engagement:

1. The DIP LRS will work closely with each T&T client during the first three months of the program to continue with the stabilization plan, to provide ongoing support and education for coping with stigma, partners/family/friends' disclosure and other barriers. The DIP LRS will make the appropriate referrals to DOH-Broward, RW and community-based programs and services no matter if the client is newly or previously diagnosed out of care
2. Between months 6 and 12, the DIP LRS will follow up with the client by telephone before each appointment to remind the client and ensure they have viable transportation. If the client has any barriers that need to be assessed, the LRS will assist by any means possible.

For the second year of T&T, each client will be contacted by a T&T internal surveillance clerk to ensure the client does not have any new barriers or need navigational assistance. The DIP LRS will contact the client's provider to monitor adherence by whether the client has missed any HIV primary care appointments, labs or any medication pickups (if ADAP or RW pharmacy clients); if so, the LRS will conduct field visits and record searches to ensure the client does not have a break in their antiretroviral therapy.

Training/Outreach:

Training and outreach for HIV testing sites, primary care and infectious disease providers, Hospital and Emergency Department staff, STD Disease Intervention Specialists (DIS), and HIV Linkage and Engagement Specialists (DIP LRS), and HIV Navigators is ongoing and continuous.

Ongoing Monitoring and Evaluation:

A Monitoring and Evaluation Team is in place to ensure the T&T protocol is followed and the T&T Program is evaluated.

Additional Information

How did you hear about the Model Practices Program:: *

- [x] I am a previous Model Practices applicant
- [ ] At a NACCHO conference
- [ ] Colleague in my LHD
- [ ] Colleague from another public health agency
- [ ] E-Mail from NACCHO
- [ ] NACCHO Publication (Connect, Exchange, Public Health Dispatch)
- [ ] NACCHO Website

Have you applied for Model Practices before?: *

- [ ] No, this is my first time applying.
- [x] Yes, I have applied in the past.

If you answered yes to the question above, please let us know the year and award type. :

2019 Sealing and Educating All Little Smiles, Model Practice