DOH-BROWARD HEALTH EQUITY PLAN

July 1, 2022 – June 30, 2025

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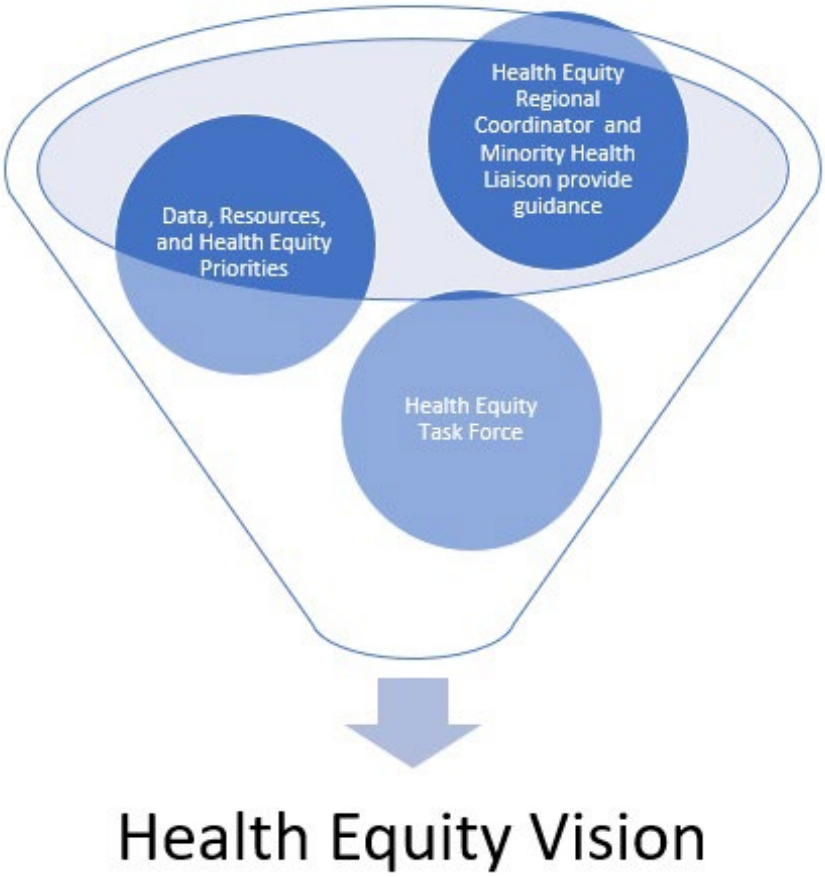
I. VISION

"All Broward County residents achieve and sustain a fair and just opportunity for health and well-being"

In Broward County, we agree that everyone deserves an opportunity to be healthy. To advance health equity and eliminate health disparities, multiple collaborative practices have been implemented to address vulnerable populations. The Florida Department of Health in Broward County (DOH-Broward) engaged community partners and stakeholders to form the Health Equity Coalition and Health Equity Taskforce to address the health needs of underserved communities, prioritize health disparities, and devise a strategic action plan. DOH-Broward, the Health Equity Coalition and Health Equity Taskforce continually work to promote and protect the health of racial and ethnic minorities and tribal populations through evidence-based strategies that address health disparities. Health equity is the attainment of the highest level of health for all people. However, several barriers have been identified through county-wide planning and assessment processes which include access to care, communicable and infectious diseases, maternal, infant, and child health, and preventive care.

Broward County successfully was awarded the Robert Wood Johnson Foundation (RWJF) Culture of Health Prize in 2019. The RWJF Culture of Health Prize honors and elevates U.S. communities that are making great strides in their journey toward better health for all. The seven prize criteria are:

1) Defining health in the broadest possible terms
2) Committing to sustainable systems changes and policy-oriented long-term solutions
3) Creating conditions that give everyone a fair and just opportunity to reach their best possible health
4) Harnessing the collective power of leaders, partners, and community members
5) Securing and making the most of available resources
6) Measuring and sharing progress and results


Health Equity Regional Coordinator and Minority Health Liaison provide guidance
Data, Resources, and Health Equity Priorities
Health Equity Task Force
Health Equity Vision

II. PURPOSE OF THE HEALTH EQUITY PLAN

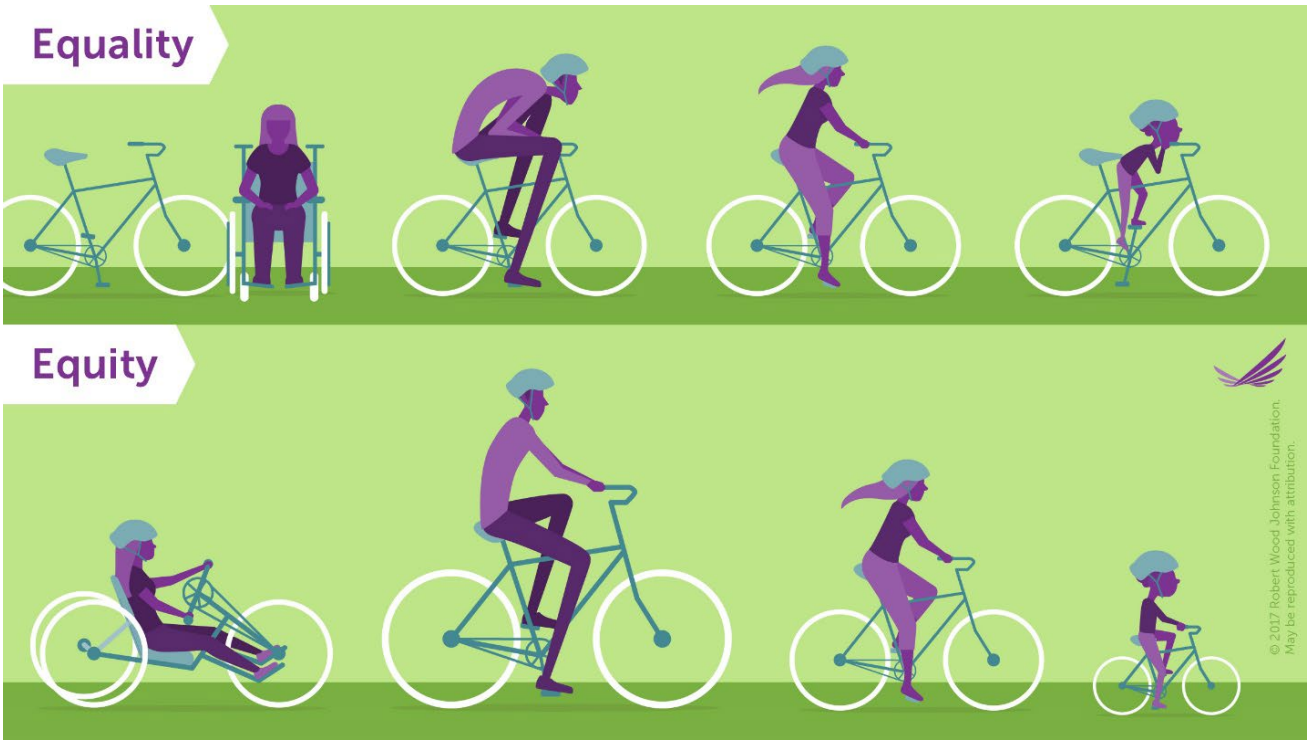
Health Equity is achieved when everyone can attain optimal health.

The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with government agencies and community organizations to address the barriers inhibiting populations from reaching optimal health. A focus on health equity means recognizing and eliminating the systemic barriers that have produced disparities in achieving wellness. In response to Chapter 2021-117 of the Florida Statute, effective July 1, 2021, each county health department (CHD) has been provided resources to create a Health Equity Plan to address health disparities in their communities.

The Health Equity Plan should guide counties in their efforts to create and improve systems and opportunities to achieve optimal health for all residents, especially vulnerable populations. County organizations have a critical role in addressing the social determinants of health (SDOHs) by fostering multi-sector and multi-level partnerships, conducting surveillance, and integrating data from multiple sources, and leading approaches to develop upstream policies and solutions. This plan acknowledges that collaborative initiatives to address the SDOHs are the most effective at reducing health disparities.

The purpose of the Health Equity Plan is to increase health equity within Broward County. To develop this plan, DOH-Broward followed the Florida Department of Health's approach of multi-sector engagement to analyze data and resources, coordinate existing efforts, and establish collaborative initiatives. This plan addresses key SDOH indicators affecting health disparities within Broward County. This Health Equity Plan is not a county health department plan; it is a county-wide Health Equity Plan through which the Health Equity Taskforce, including a variety of government, non-profit, and other community organizations, align to address the SDOH impact health and well-being in the county.

III. DEFINITIONS



Health equity is achieved when everyone can attain optimal health

Health inequities are systematic differences in the opportunity's groups must achieve optimal health, leading to avoidable differences in health outcomes.

Health disparities are the quantifiable differences, when comparing two groups, on a particular measure of health. Health disparities are typically reported as rate, proportion, mean, or some other measure.

Equality each individual or group of people is given the same resources or opportunities.

Social determinants of health are the conditions in which people are born, grow, learn, work, live, worship, and age that influence the health of people and communities.

IV. PARTICIPATION

Cross-sector collaborations and partnerships are essential components of improving health and well-being. Cross-sector collaboration uncovers the impact of education, health care access and quality, economic stability, social and community context, neighborhood and built environment and other factors influencing the well-being of populations. Cross-sector partners provide the range of expertise necessary to develop and implement the Health Equity Plan.

Above: Community Partners meeting to discuss Health Equity in Broward County.

Broward County has a long history of collaborative planning to improve health outcomes where partners share priorities, monitor progress based on data and continuously improve. Mobilizing for Action through Planning and Partnerships

(MAPP) is a community-driven strategic planning tool developed by the National Association of County & City Health Officials (NACCHO) for improving community health. This tool provides guidance for communities in each of the six MAPP phases: Organize for Success; Visioning; The Assessments; Strategic Issues; Goals/Strategies; and Action Cycle. MAPP is a strategic approach to community health improvement planning, includes four separate assessments: Community Health Status, Community Themes and Strengths, Local Public Health System, and Forces of Change. In 2012, 2015, 2018 and 2021, the Florida Department of Health in Broward County (DOH-Broward) engaged the community in the MAPP process to develop its Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Oversight of these plans and their implementation is led by DOH-Broward with oversight by the Healthcare Access Committee (HCA). Over 113 agencies participated in these processes. The 2021 CHA identified four areas of opportunity for improvement. In the CHIP, each strategic issue area has multiple objectives with corresponding activities and action steps. Each action step is owned by a community partner along with associated deliverables and timeframes. The objectives have annual and three- year targets by which we measure our success. Where racial and ethnic disparities exist, CHIP objectives address decreasing those disparities. All CHIP priority areas and their corresponding objectives and action plans are approved by the HCA. Additionally, the HCA monitors progress of the CHIP via presentations and quarterly and annual reports. The plan is updated annually, and the MAPP assessments are repeated on a three-year cycle.

In addition to the MAPP process, Broward County uses Results Based Accountability (RBA) as a framework for sharing priorities and measuring success. Since 2010, each of the Children's Strategic Plan Committees and over 80 non-profit agencies use RBA for reporting performance measures and for showing their programs' impact on community indicators and well-being. Specifically, CSC and United Way of Broward County require their contracted agencies to report on the three simple, plain language RBA questions: How Much Did We Do? How Well Did We Do It? And Is Anyone Better Off? to show the value of their work and to identify what is not working. The shared RBA approach allows funders and system partners to see gaps and opportunities more quickly across funded agencies, in zip codes and across racial and ethnic lines. In addition to using RBA to facilitate communication about funding and programs, RBA's Turn the Curve Report is a one to two-page report that supports community collaborations to come together and define shared results, collect and analyze data, identify and implement best practices and share

accomplishments. Broward partners use RBA to generate improvements organically and weave the opportunities and successes across systems.

There are many innovative, strategic, systems-oriented, and data-informed ways that Broward is working towards sustaining a vibrant culture of health in our diverse county. Broward County is widely known as “collaboration county” due to the multitude of coalitions and task forces that work together in a non-competitive way to improve the health and quality of life of residents. These coalitions are mobilized in strategic ways that address key health challenges based on community needs assessments. In 1995, a United Way of Broward County Needs Assessment revealed that a coordinated community effort was needed to solve persistent problems in the effective delivery of services to residents and visitors. These findings convinced Broward leadership and policymakers that a formal, long-term, and intensive collaboration would provide significant and sustainable solutions. This led to the establishment of the Coordinating Council of Broward (CCB), with accomplishments related to affordable housing and long-term disaster recovery. Additionally, in 2021 through the Broward County Community Health Assessment, the Priorities identified for the Community Health Improvement Plan, include: 1) Access to Care, 2) Communicable and Infectious Diseases, 3) Maternal, Infant, and Child Health, and 4) Preventative Care. Significant challenges for Broward County include access to primary care, discrimination and health equity, safe and affordable housing, and our senior population. Our cultural diversity is both a strength and a challenge. To address these issues, we partner across the public and private sector to improve our community and view challenges and solutions through a health equity lens. Understanding the role of Social Determinants of Health from the HHS Healthy People 2020 initiative, and the role of institutional discrimination in creating and perpetuating health disparities has allowed us to develop a more comprehensive approach to building a culture of health. As a result, we are in the process of reframing existing county-wide plans to incorporate a broader and more inclusive health equity approach. To this end, 1,173 adults, 220 youth and staff of 119 agencies have participated in our racial and health equity training programs which will be discussed in our achievements. In Broward County, we look at the preventable differences that are experienced by socially disadvantaged populations in the burden of disease, violence, or lack of opportunities to achieve optimal health for all. We strive to value all individuals and populations equally, recognize and rectify historical injustices and provide resources according to need. We implement, evaluate, and then refine our actions to address the social determinants of health and work across a broad spectrum of policy connected

and resident-coordinated actions with a goal to ultimately eliminate health disparities in Broward County.

DOH-Broward engaged the local community in its assessment and strategic planning activities to develop a plan "Ending the HIV Epidemic" (EHE). During the community engagement period, COVID-19 impacted traditional outreach and engagement efforts due to the general restrictions for group gatherings. As a precautionary measure amidst the COVID-19 pandemic, DOH-Broward adjusted outreach and community engagement efforts by using social media, virtual listening sessions and town hall meetings, surveys, and virtual key informant interviews with priority populations. With social distancing measures imposed, collaboration from community partners and agencies increased the opportunities to build communities and secure invested stakeholders to support engagement, activities, and strategies for alleviating the burden from populations at high risk for HIV/AIDS.

From October 2019 to October 2020, EHE community engagement efforts in Broward County involved community presentations, listening sessions, focus groups, key informant interviews, a student survey, a community survey in four languages and social media advertising using community partners. Collectively, these activities were essential to discuss both the strengths within the county that will aid in the successful implementation of EHE activities and the barriers that will need to be addressed in the local EHE plan.

During the accelerated planning process, two needs-based surveys were designed and administered by FDOH-Broward from November 2019 through December 2019. One survey was conducted with service providers and the other with the community-at-large. A student survey was created November 2019 to incorporate youth voices on developing innovative strategies for future EHE planning activities. To date, over 2,300 survey responses have been submitted: nearly 1,800 from community members, over 400 from providers and CBOs and over 130 from students in public high schools. The needs-based surveys successfully reached a wide array of people and viewpoints that are reflective of the community.

FDOH-Broward hosted 40 key informant interviews between October 2019 and December 2019. Interviews were conducted with community members, stakeholders, and community-based HIV service providers. To further engage the community in conversation, in-person (pre-COVID) and focus group sessions

and 28 community presentations were facilitated throughout February 2020 and March 2020 by FDOH-Broward staff and representatives of priority populations (e.g., transgender, youth LGBTQ, Hispanic women, Black cisgender women, MSM). FDOH-Broward received input from planning council members; PWH; HIV service providers; community groups; HIV testing site supervisors; RWHA Program Part A, C and D partners; community partners; and local advocates. Feedback was analyzed to identify common themes for inclusion in the EHE plan. FDOH-Broward engaged over 150 new and existing partners, including community leaders and local organizations, that do not directly provide HIV prevention/care services but serve high-risk populations (e.g., providers, FQHCs, health providers and Broward County Public Schools).

Overall, connections with the community were strengthened even more. FDOH-Broward intends to continue engagement efforts with members of the population as well as with Native American tribes, a priority population that was under-represented, to ensure inclusion and eliminate the burden of HIV/AIDS.

A. Minority Health Liaison

The Minority Health Liaison supports the Office of Minority Health and Health Equity in advancing health equity and improving health outcomes of racial and ethnic minorities and other vulnerable populations through partnership engagement, health equity planning, and implementation of health equity projects to improve social determinants of health. The Minority Health Liaison facilitates health equity discussions, initiatives, and collaborations related to elevating the shared efforts of the county.

Minority Health Liaison: candidate selected 07/07/22; Terri Sudden is interim and will be the supervisor once onboarding is complete
Minority Health Liaison Backup: Latonya Delaughter
Regional Minority Health Coordinator: Pascale Edouard, start date 07/08/22

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the CHD. The Health Equity Team explores opportunities to improve health equity efforts within the county health department. Members of the Health Equity Team assess the current understanding of health equity within their program and strategize ways to improve it. The Health Equity Team also relays information and data concerning key health disparities and SDOH in

(County) to the Health Equity Taskforce. The Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below. Due to the COVID-19 response, the Health Equity Team first met in March 2022, and will continue to meet quarterly.

Name	Title	Program
Terri Sudden	HE Supervisor/Director	Public Health Preparedness
Ederick Johnson	MSM Coordinator	HIV/AIDS
Cramita Goss	Minority AIDS Coordinator	HIV/AIDS
Scott DiMarzo	Regional Care Coordinator	Florida Breast and Cervical Cancer
Renée Podolsky	Director	Community Health
Joshua Rodriguez	HIV/AIDS and Pharmacy Services Administrator	HIV/AIDS
Vanice Rolle	Operations Management Consultant	Outreach Coordinator/ In-School COVID-19 testing
Esther March Singleton	Breastfeeding Coordinator	WIC
Latonya Delaughter	Operations Director	Community Health
Paula Thaqi, MD	Director	DOH-Broward

The Health Equity Team met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Team has continued to meet at least quarterly to track progress.

Meeting Date	Organizations	Topic/Purpose
March 17, 2022	Entire HE Team	Discuss HE Plan, SDOH, and priorities related to approved Health Disparity.
June 10, 2022	HE Team	Reviewed and finalized Health Equity Plan

C. Health Equity Taskforce

The Health Equity Taskforce utilizes the existing Health Care Access Committee which includes CHD staff and representatives from various organizations that provide services to address various SDOH. Members of this Taskforce brought their knowledge about community needs and SDOH. Collaboration within this group addresses upstream factors to achieve health equity. The Health Equity Taskforce developed the (County) Health Equity Plan and led the design and implementation of projects. Health Equity Taskforce members are listed below.

The Taskforce meets monthly and provides oversight and direction to the HE Plan.

Name	Title	Organization	Social Determinant of Health
Jennifer Tobon		American Cancer Society	Access to care
Rosalyn Frazier	Chief Executive Officer	Broward Community and Family Health Center	Access to care
Monica King	Chief Executive Officer	Broward Healthy Start Coalition	Access to care
Carrisa Sookoo	Health Planner	Broward Regional Health Planning Council, Inc.	
Gritell Martinez	Director, Planning and Quality Managemant	Broward Regional Health Planning Council, Inc.	Access to HIV Care
Jasmin Shirley	Project Director, COVID-19 Vaccine Outreach	Broward Regional Health Planning Council, Inc.	Access to COVID vaccine Discrimination
Jasmine Rohoman	Clinical Quality Management Health Planner	Broward Regional Health Planning Council, Inc.	
Maxine Pink	Nurse Family Partnership	Broward Regional Health Planning Council, Inc.	Access to Maternal Health
Michele Rosiere	Vice President of Programs	Broward Regional Health Planning Council, Inc.	
Michael De Lucca	President & CEO	Broward Regional Health Planning Council, Inc.	
Nicole Cohen	Public Information Officer	Broward Regional Health Planning Council, Inc.	
Shawn Tinsley	Enrollment Coordinator	Broward Regional Health Planning Council, Inc.	
Tijee Williams	HIV Health Services Planning Council Health Planner	Broward Regional Health Planning Council, Inc.	
Whitney Rolle	HIV Health Services Planning Council Health Planner	Broward Regional Health Planning Council, Inc.	
Yolanda Falcone	Manger of Administrative Services	Broward Regional Health Planning Council, Inc.	
Adrian Parker	Executive Director, Strategic Initiatives	Broward Schools	Education
Audaly Bartley	Coordinated Student Health Services	Broward Schools	Education
Nichole Anderson	Undersheriff	Broward Sheriff's Office	Public Safety
Tim Ludwig	Manager, In-Custody Behavioral Services Division	Broward Sheriff's Office	Behavioral Health Substance Abuse

Amy Pont	Director, Population Health	Community Care Plan Cares	
Keisha Grey	Strategy Manager	Children's Services Council	Behavioral Health Education Food Security Discrimination
Angelica Rosas	Director of Community Impact	Community Foundation of Broward	Education Access to care
Sherry Brown	Vice President, Community Impact	Community Foundation of Broward	Education Access to care
Caroline Bartha	Director Performance Excellence	DOH-Broward	
Renee Podolsky	Community Health Director	DOH-Broward	
Latonya Delaughter	Community Health Operations Director	DOH-Broward	
Terri Sudden	Director Public Health Preparedness	DOH-Broward	
Lynne Kunins	CEO	Flipany	Built Environment
Doug Bartel	Market Leader	Florida Blue	Access to care
Fernanda Kuchkarian	Director of Programs	Health Foundation of South Florida	Access to care
Kim Saiswick	VP, Community Health & Well-Being	Holy Cross Hospital	Access to care
Melissa Blum	Strategic Consultant	Humana	Access to care
Anne Meoli	Director, Health Initiatives	Jack and Jill Center	Access to Care Education
Sandy Lozano	Executive Director	Light of the World Clinic	Access to care Discrimination
Laura London	Director of Quality and Patient Safety	Memorial Healthcare System	Access to care
Melida Akiti	Vice President	Memorial Healthcare System	Access to care
Tim Curtin	Administrative Director of Community Services	Memorial Healthcare System	Access to care
Akiva Turner	Chair and Professor of Health Care Sciences Department	Nova Southeastern University	Access to care
Farzanna Haffizulla	Chair, Department of Internal Medicine	Nova Southeastern University	Access to care
Nicole Cook	Assistant Professor of Public Health	Nova Southeastern University	Access to care
Peter Gorski		Nova Southeastern University	Access to care
Sandra Einhorn		NPO Broward	Access to care Discrimination

Janine Ribeiro	Vice President Health Initiatives	United Way of Broward County	Substance abuse Financial Prosperity/ Economic Stability
Jessica Abou	Program Officer-Health	United Way of Broward County	Access to care Affordable housing

Meeting Date	Organizations	Topic/Purpose
4th Monday of each month July 25, 2022	Entire HE Task Force	Discuss HE Plan, SDOH, and priorities related to approved Health Disparity.
August 22, 2022	Entire HE Task Force	Discuss HE Plan, SDOH, and priorities related to approved Health Disparity.
September 26, 2022	Entire HE Task Force	Discuss HE Plan, SDOH, and priorities related to approved Health Disparity.
October 24, 2022	Entire HE Task Force	Discuss HE Plan, SDOH, and priorities related to approved Health Disparity.
November 28, 2022	Entire HE Task Force	Discuss HE Plan, SDOH, and priorities related to approved Health Disparity.

D. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on the social determinants of health: education access and quality, health care access and quality, economic stability, social and community context, and neighborhood and built environment. Membership includes community leaders working to address each SDOH, as well as any relevant sub-SDOHs. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility. See Appendix 1 for a list of Additional Community Coalitions and groups that provide oversight and input to planning activities.

Name	Title	Organization	Social Determinant of Health
Camila Romero Gil	Executive Assistant	Children's Services Council of Broward County	Discrimination

Chantale Bossous		Broward Sheriff's Office	Public safety Discrimination
Leonard Jones	Director of External Programs and Services	Broward Health	Access to health care
Adamma DuCille	Director of Equity and Organizational Development	Children's Services Council of Broward County	Discrimination
Sara Roffe		Broward Sheriff's Office	Public safety Discrimination
Nadia Clarke	Assistant Director	Broward County Public Schools	Education
Monica King	Chief Executive Officer	Broward Healthy Start Coalition	Access to care
Martha Ruiz	Vice President	United Way of Broward County	Substance abuse Affordable housing
Maria Hernandez	Community Impact Chief Program Officer	United Way of Broward County	Substance abuse Affordable housing
Sharetta Remikie, Ed. D	Chief Equity and Community Engagement Officer	Children's Services Council of Broward County	Behavioral health Education Food Security Dismantling discrimination

E. Regional Health Equity Coordinators

There are eight Regional Health Equity Coordinators. These coordinators provide the Minority Health Liaison, Health Equity Team, and Health Equity Taskforce with technical assistance, training, and project coordination.

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Technical assistance, training, and project coordination
Quincy Wimberly	Capitol	Technical assistance, training, and project coordination
Diane Padilla	North Central	Technical assistance, training, and project coordination
Ida Wright	Northeast	Technical assistance, training, and project coordination
Rafik Brooks	West	Technical assistance, training, and project coordination

Lesli Ahonkhai	Central	Technical assistance, training, and project coordination
Frank Diaz	Southwest	Technical assistance, training, and project coordination
Paola Edouard	Southeast	Technical assistance, training, and project coordination

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

To improve health outcomes in Florida, it is critical to assess the knowledge, skills, organizational practices, and infrastructure necessary to health inequities. Health equity assessments are needed to achieve the following:

- Establish a baseline measure of capacity, skills, and areas for improvement to support health equity-focused activities
- Meet Public Health Administration Board (PHAB) Standards and Measures 11.1.4A which states, "The health department must provide an assessment of cultural and linguistic competence."
- Provide ongoing measures to assess progress towards identified goals developed to address health inequities
- Guide CHD strategic, health improvement, and workforce development planning
- Support training to advance health equity as a workforce and organizational practice

DOH-Broward completes a CLAS assessment every five years and is accredited as part of the integrated Florida Department of Health. See Appendix 2 for the completed 2022 CLAS assessment.

Broward County has a unique health and human service system in which extensive and continuous collaboration occurs between agencies and coalitions in an informal and formal manner. Much of this collaboration occurs organically due to a long- standing history of agency leaders making decisions based on the good of the community rather than their individual agency and directing resources to the most expert and best positioned organizations. Agency leaders and subject matter experts prioritize participation in Broward County's multiple coalitions working to give all residents the chance to live their healthiest life possible. This shared expertise and communication across committees provides the opportunity to leverage resources and avoid duplication of effort. Some of these coalitions include: Healthy Start Community Action Group, Breast

Feeding Taskforce, Perinatal Provider Network, Early Leaning Coalition, KidCare Taskforce, Comprehensive School Health Advisory Committee, Healthcare Coalition, Nutrition and Fitness Taskforce, Drowning Prevention Taskforce, HIV Prevention Planning Council, Commission on Substance Abuse, Dignity in Agency Taskforce, Funders Forum, Association of Non-profit Executives, League of Cities, Smart Growth Partnership, Local Coordinating Board (Transportation Disadvantaged) Complete Streets Advisory Committee, and the Broward Alliance. Regarding formal collaboration, there are three overarching structures: Coordinating Council of Broward (CCB), Health Care Access (HCA) Committee and the Children's Strategic Plan (CSP) Leadership Coalition.

The CCB, operating for almost 25 years, is comprised of the top executives of state and county entities from the public, private and business sectors, who are responsible for funding and implementing a broad array of health, public safety, education, economic and human services in Broward County. In addition to discussing CCB priorities of transportation and affordable housing, monthly meetings provide an opportunity for members to share information about activities and initiatives of their agencies as well those of the coalitions, taskforces, and committees on which they serve. When CCB initiatives require extensive time and resources, separate committees are created under the CCB structure, such as the Long-Term Recovery Coalition and the Dignity in Aging Taskforce.

The HCA of Broward County has been in existence since 1991. The members of the committee represent hospitals, Broward Regional Health Planning Council, Universities, Broward County Public Schools, Federally Qualified Health Center, volunteer clinics, Children's Services Council, DOH-Broward, Broward Sheriff's Office, community members and community-based organizations. The original purpose of this committee was to improve access to primary health care for the residents of Broward County. In 2013, the committee expanded its scope to include oversight of the Community Health Assessment and Community Health Improvement Planning Process. Specifically, the HCA Committee reviews the data gather through the Mobilizing for Actions through Planning and Partnerships Process (MAPP), identifies, and prioritizes the opportunities for improvement and monitors the progress of the action plans to address these issues.

The Children's Strategic Plan (CSP) Leadership Coalition oversees the work of the 40 Children's Strategic Plan Committees in implementing the Children's Strategic Plan. The Plan brings together government, non-profits, the private sector, and community members to improve the lives of Broward's children and families by achieving 5 desired results. These are: children living in stable and nurturing families, children are mentally and physically healthy, children are ready to succeed in school, children live in safe and supportive communities and young people successfully transition to adulthood. Partners work collectively in committees on a common agenda, to share data and strategies, maximize resources and hold each other accountable. Reports and recommendations from the Committees are brought to the Leadership Coalition.

The group has been instrumental in advancing initiatives including specialized aftercare and summer programs, efficiencies in early identification of developmental delays, expedited medical responses for medically complex children and braided funding partnerships to expand service capacity. Most notably the committee has been successful in: Developing an annual (since 2010) Transitioning to Life Resource fair and workshop series for youth with disabilities and their families, the passage of Early Steps budget request, creating a Special Needs and Behavioral Health Hotline, creating a Supported Training Employment Program for Special Needs (STEPS), creating a resource guide for parents of school-aged children with an Individual Education Plan and initiating the Special Needs System of Care Assessment RFQ to complete a community needs assessment focusing on special needs and behavioral health using a racial equity lens.

Broward County conducted an HIV specific health equity assessment to examine the capacity and knowledge of DOH-Broward staff and county partners to address social determinants of health which is included in the SDOH section of this report. Below are the dates assessments were distributed and the partners who participated.

Date	Assessment Name	Organizations Assessed
April 14, 2022	HIV Town Hall Focus Group	Various Broward County HIV providers and advocacy groups; HIV Planning Council; Broward Regional Health Planning Council

B. County Health Equity Training

Broward's racial equity initiative is an unprecedented cross-agency, community-wide commitment to interrupt the functions and manifestations of institutional discrimination negatively impacting people we serve in ways that are reflected in their disparate outcomes. Bringing a racial equity educational platform to Broward was a partnership decision between the Broward County Human Services Department (BCHSD) and Children's Services Council of Broward (CSC) in the fall of 2016. Two years of monthly educational workshops has created the basis for this movement for racial equity in Broward. The partnership acknowledged that understanding the origins and construct of race and institutional discrimination is essential; technically defining what these are enable us to have a common understanding and allow us to all be on the same page when discussing, identifying, strategizing, and working to dismantle it.

The Florida Department of Health in Broward County (DOH Broward) joined the partnership in FY18. Additional organizations have joined the anchor institution collaborative including the Broward Sheriff's Office Child Protection Investigation Section and the local child welfare organization, ChildNet. To date, over 1,500 people have received this transformative training. In addition, CSC staff have trained nearly 200 additional community partners in the local history of discrimination and the research on implicit bias including the management team at the Public Defender's Office.

Once individuals have completed the two-day racial equity training, they are invited to participate in the People of Color Caucus or White Caucus meetings. The Caucuses work to identify institutional discrimination in policies and practices and to organize themselves around dismantling institutional and structural discrimination. Meetings are held monthly and include a quarterly Joint Caucus to bring the participants together for cross race conversations and the development of strategic approaches.

Broward anchor institutions are sharing and conducting internal racial equity audits to improve staff racial equity knowledge and skills to co-create equitable customer service, identify policies and practices that disproportionately hurt children and families of color and increase the engagement of community members. For example, CSC has added

community voices to procurement process including the development and rating of proposals. BCHSD has revised the multi-million-dollar full procurement process using a racial equity lens and community voice.

The Discrimination Initiative's facilitator staffs the monthly Anchor Institutions collaborative as well as numerous community groups including the Child Welfare Racial Equity Workgroup, the Justice Task Force, the DJJ RED (Racial and Ethnic Disparities) Committee and the Greater Fort Lauderdale Alliance "Distressed Areas" subcommittee to center racial equity in the discussions and workplans and to build relationships across public and private institutions. Partners for this initiative include Broward County Public Schools, Broward County Department of Human Services, Children's Services Council of Broward County, Florida Department of Health in Broward County, United Way of Broward County, Broward Healthy Start, Broward Behavioral Health Coalition, Early Learning Coalition of Broward County, Smith Community Mental Health and Broward Sheriff's Office Child Protection Investigation Section are current partners.

C. County Health Department Health Equity Training

The Florida Department of Health in Broward County recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH – Broward County staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training. In addition, the Health Equity Team provides regular training to staff on health equity and cultural competency. The training is recorded in the following chart.

Date	Topics	Number of Staff in Attendance
Ongoing	SDOH, Health Equity, Health Disparities, Cultural Competency.	All staff receive training during New Employee Orientation.

D. Minority Health Liaison Training

The Office of Minority Health and Health Equity and the Health Equity Regional Coordinator provide training and technical support to the Minority Health Liaison on topics such as: the health equity planning process and goals, facilitation, and prioritization techniques, reporting requirements, and taking a systems approach to address health disparities. The Minority Health Liaison training is recorded below.

Date	Topics
9/16/21	Minority Health Liaison Technical Assistance Training on HE Scope of work; HE and Health Disparities funding; grant writing and project scope
10/21/21	Minority Health Liaison Technical Assistance Training on the HE project management tool, Social Ecological Model; and Health Disparities Workplan
5/24/22	Minority Health Liaison Technical Assistance Training on use of the HE Assessment standards tool and the review and feedback process

E. National Minority Health Month Promotion

DOH-Broward sponsored 1 event during National Minority Health Month. The “Spring Into Health” Health Fair provides an opportunity for the community to speak one-on-one with community based providers and learn about resources that may be available to assist them. Vendors with informational booths included: Community Care Plan, DOH-Broward COVID-19, Guardian Ad Litem, Hispanic Unity of Florida, Ambetter from Sunshine Health, Urban League of Broward, Broward Health Start Coalition, Light of the World Clinic, Blue Soleil LLC, Children Services Council of Broward, Sickle Cell Disease Association, Dental Team of Lauderhill, Broward Community and Family Health Center, Drowning Prevention, HIV Prevention, Feeding South Florida, Florida Breast and Cervical Cancer, Epilepsy Florida, Tobacco Prevention, Broward Regional Health Planning Council, Holy Cross Hospital, Broward Health, and Florida KidCare Outreach. More than 620 individuals attended the event, which was advertised on agency websites and social media as well as paid Minority Media advertisements in the Westside Gazette and Caribbean National Weekly Newspaper. Feeding South Florida provided fresh produce and food items, access to care vendors included the DOH-Broward’s KidCare program, that provided application assistance, Breast and Cervical Cancer Education about how to access the program, HIV testing and prevention and PrEP education, as well as information about the development of our Health Equity Plan—who it will help, what it will do, how and when that will happen, etc. and to provide awareness and education about the existing health equity initiatives already in progress. The event was held in a local community Mall with vendors positioned throughout the mall. This mall is located in one of our underserved communities and we are a trusted provider in that community. Members of the community that participated include Blacks, Caribbean Islanders, and individuals living with or at risk for HIV.

SPRING INTO HEALTH

HEALTH FAIR

SATURDAY, APRIL 2ND, 2022
10:00AM - 2:00PM

FREE SPRING BASKETS !!!
(First 500 Children)

Florida KidCare Application Assistance

Free Safety Tips

Breast and Cervical Cancer Education

HIV Testing

Health Education

Face Painting, Pony rides, Petting Zoo

Games, Entertainment & Prizes

Inside The Lauderhill Mall
1267 N. State Road 7
Lauderhill, FL 33313

For information, scan barcode. more

Florida KidCare

Florida HEALTH Broward County

LAUDERHILL MALL

20th Children's Services Council of Broward County

Or call us at
(954)467-8737

DOH-Broward participated in two additional events for National Minority Health Month. On Friday, April 1, 2022, DOH-Broward participated in the "Finally Friday" event hosted by the City of Fort Lauderdale at Provident Park, 1412 NW 6th Street, Fort Lauderdale, Florida 33311. This local family-friendly event is held in the priority area of Sistrunk. The event features presentations about the CRA, food trucks, vendors, art, music, live entertainment, and interactive kids' activities. At the event, DOH-Broward provided tabling to increase awareness of HIV prevention activities, including PrEP. A **total of 150 individuals** were provided with condoms, PrEP education, and marketing materials.

On Friday, April 15, 2022, DOH-Broward participated at the Carter Park *Jamz.* Joseph C. Carter Park, 1450 W. Sunrise Blvd., Fort Lauderdale, Florida is located in a priority area of Broward County. The event features, food trucks, vendors, music, and live entertainment, At the event, The Florida Department of Health in Broward County provided tabling to increase awareness of HIV prevention activities, including PrEP. A **total of 96 individuals** were provided with condoms, PrEP education, and marketing materials.

VI. PRIORITIZING A HEALTH DISPARITY

The Community Health Assessment Advisory Council began meeting on December 13, 2018. During these meetings, the council reviewed health rankings and quantitative community health data, and qualitative data sets which included key informant interviews, community conversations, a community health survey, and provider and community focus groups. These primary and secondary data sets were analyzed and discussed to identify and prioritize the following community health needs areas: Access to Care; Social Determinants of Health; Preventive Care; Community Education; Quality of Care; and Substance Abuse/ Mental Health focusing on Broward Health strategic planning. The table below outlines the agenda topics for each of the meeting dates.

Meeting Dates	Agenda Topics
December 18, 2018	Introduction: Planning and Process Broward County Quantitative Data Presentation – Part 1 Stakeholder Discussion Identify Needs and Gaps
January 10, 2019	Broward County Quantitative Date Presentation – Part 2 Stakeholder Discussion Identify Needs and Gaps
February 14, 2019	Broward Health Quantitative Data Presentation – Part 1 Stakeholder Discussion Identify Needs and Gaps
March 14, 2019	Broward Health Quantitative Data Presentation – Part 2 Broward Health Community Services Presentation Stakeholder Discussion Identify Needs and Gaps
March 28, 2019	Qualitative Data Presentation Stakeholder Discussion Identify Needs and Gaps

A copy of the 2019 Broward Health CHNA can be accessed at: https://www.browardhealth.org/-/media/Broward-Health/Pages/Other-PDFs/2019-Broward-Health-CHNA.pdf?la=en. Page 7 shows the results of the deliberation by the Broward Health Community Health Needs Assessment Advisory Council. The Council prioritized the needs as:

- Access to Care
- Community Education
- Preventive Care
- Quality of Care
- Social Determinants of Health
- Substance Abuse/Mental Health

These priorities were then ranked using qualitative and quantitative data sources. The results of this ranking were:

1. Access to Care
2. Social Determinants of Health
3. Preventive Care
4. Community Education
5. Quality of Care
6. Substance Abuse/Mental Health

The **Forces of Change Assessment** focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. A total of 15 areas were identified with 4 identified as local in scope. These were: 1) Community Collaboration; 2) Diversity; 3) Social/Emotional Learning and ACES; 4) Transportation. Hurricanes was added to the list due to the need for response and protecting citizens and visitors.

The following table provides an overview.

Identified Areas	Category (Social, Economic, Political, Technological, Environmental, Scientific, Legal, Ethical)	Scope (local, regional, national, global)	Type of Force (trend, event, factor)
Access to Technology	Technological, Economic, Social	Global	Trend
Affordable Healthcare	Economic, Political	National	Trend
Community Collaboration	Political, Economic, Social	Local	Factor
Diversity	Social, Political, Ethical, Legal	Local	Factor
Election	Political	National	Event
Gun Violence/ Psychological Trauma	Social, Political, Economic, Legal	National	Trend
HIV/AIDS Epidemic	Social, Scientific, Economic, Political, Legal, Ethical	Global	Trend
Hurricanes	Environmental, Economic	Regional	Event
Lack of Affordable Housing	Economic, Political, Social, Ethical	National	Trend
Opioid Overdose	Social, Legal, Political	Global	Trend
Pandemic	Environmental, Scientific, Economic, Political, Ethical, Legal, Technological, Economic, Social	Global	Event
Racial Equity	Social, Legal, Ethical, Political, Economic	National	Trend
Social/Emotional Learning and ACES	Social, Economic, Political	Local	Trend
Suicide	Social	National	Trend
Transportation	Economic, Political	Local	Factor

DOH-Broward reviewed and analyzed information from the four assessment assessments to identify potential focus areas/strategies as part of their continued participation in the Community Health Assessment Advisory Council.

1. Increase Access to Care
   a. Health insurance for children ages 0-18
2. Reduce the Incidence of Communicable and Infectious Diseases
   a. HIV Testing and Treatment
3. Improve maternal, infant and child health
   a. Perinatal transmission of HIV
   b. Syphilis cases/incidence
   c. Cervical Cancer
   d. Infant Mortality (Blacks)
4. Enhance Preventive Care Activities
   a. Immunizations for Children (aged 2 years, Kindergarten, 7th graders
   b. Unintentional Injury and Drug Use
   c. Obesity, Black Adults

The Health Equity Team reviewed FDOH provided Analysis of the Health Disparities Among People living with Disability data (see Attachment 3) and FDOH provided Health Equity profiles in FLCharts at the county and state level (see Attachment 4) and selected HIV as the issue to focus its Health Equity Plan activities and efforts in addressing. HIV disparities in race and gender was a determining factor as well as the high incidence rates of new HIV cases disproportionally impacting communities of color.

COMMUNITY HEALTH ASSESSMENT

Broward County is located on FL's southeastern coastline, with Miami-Dade County to the south and Palm Beach County to the north. The US Census estimates that in CY2018, Broward had a population of over 1.9 million- a 12% increase over CY2010. It is the second most populous FL county. Broward's population has high rates of racial/ethnic diversity. The CY2018 Census reports that among 1.9 million Broward residents, 36% were White non-Hispanic, 30% Black non-Hispanic, and 30% Hispanic. Thus, Broward has a "majority of minorities," with rates of racial/ethnic minorities exceeding White non-Hispanics. Shifts in Broward's demographics are driven by immigration of foreign-born minorities and includes residents representing over 200 different countries and speaking over 130 languages. Diverse linguistic proficiency is common among residents, with 40% speaking a language at home other than English.

U.S. Census Bureau Population Estimates for Broward County, 2021 indicate a total population of 1,930,983. Race and Hispanic Origin percentages are as follows: White alone (63.1%), Black or African American alone (30.2%), American Indian and Alaska Native alone (0.4%), Asian alone (3.9%), Native Hawaiian and Other Pacific Islander alone (0.1%), Two or More Races (2.3%), Hispanic or Latino (31.1%) and White alone, not Hispanic or Latino (34.8%).

Due to the small number of individuals living with HIV belonging to race/ethnicity other than White, Black, and Hispanic, data is presented using White/Black and Hispanic and in some cases includes "other" as available.

U.S. Census Bureau QuickFacts for Broward County, Florida 2021

All Topics	Broward County, Florida
Households with a computer, percent, 2016-2020	94.3%
PEOPLE	
Population	
Population Estimates, July 1 2021, (V2021)	1,930,983
Population estimates base, April 1, 2020, (V2021)	1,944,375
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	-0.7%
Population, Census, April 1, 2020	1,944,375
Population, Census, April 1, 2010	1,748,066
Age and Sex	
Persons under 5 years, percent	5.7%
Persons under 18 years, percent	21.0%
Persons 65 years and over, percent	17.1%
Female persons, percent	51.3%
Race and Hispanic Origin	
White alone, percent	63.1%
Black or African American alone, percent (a)	30.2%
American Indian and Alaska Native alone, percent (a)	0.4%
Asian alone, percent (a)	3.9%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.1%
Two or More Races, percent	2.3%
Hispanic or Latino, percent (b)	31.1%
White alone, not Hispanic or Latino, percent	34.8%

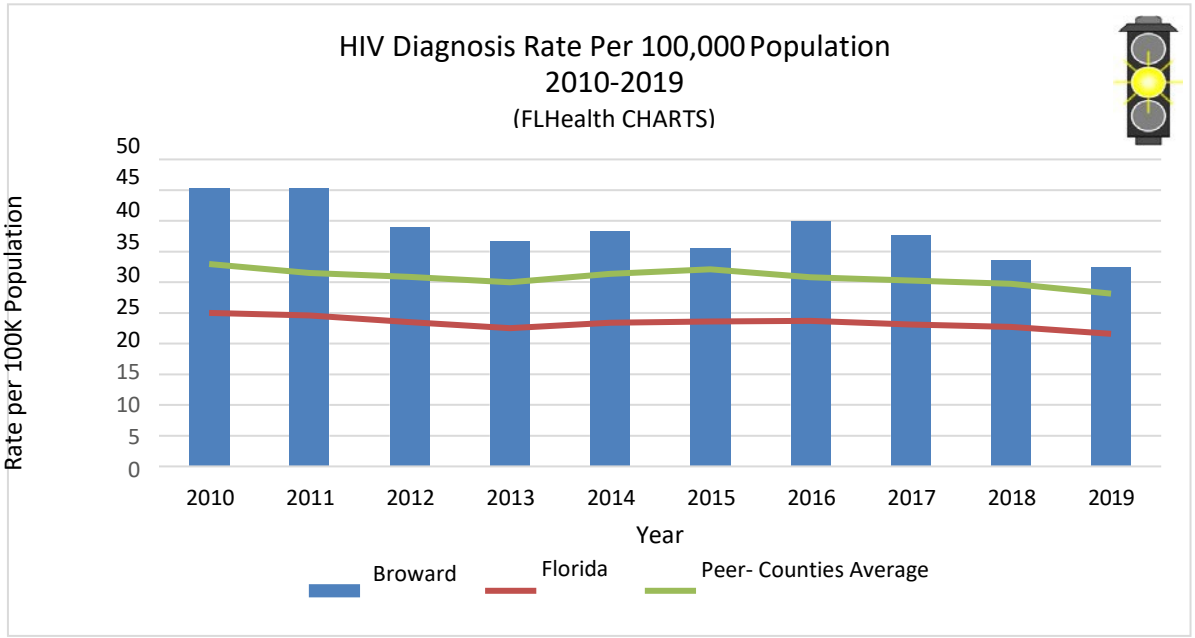
Infectious Diseases

Sexually transmitted infections (STIs) are preventable and there are estimated more than 20 million cases in United States each year. HIV (Human Immunodeficiency Virus) which is an STI can weaken a person's immune system that fights disease and infection. HIV can be controlled with proper medical care. Certain groups of people are more likely to have HIV due varying factors including sex partners, their risk behaviors and where they live.

HIV/AIDS

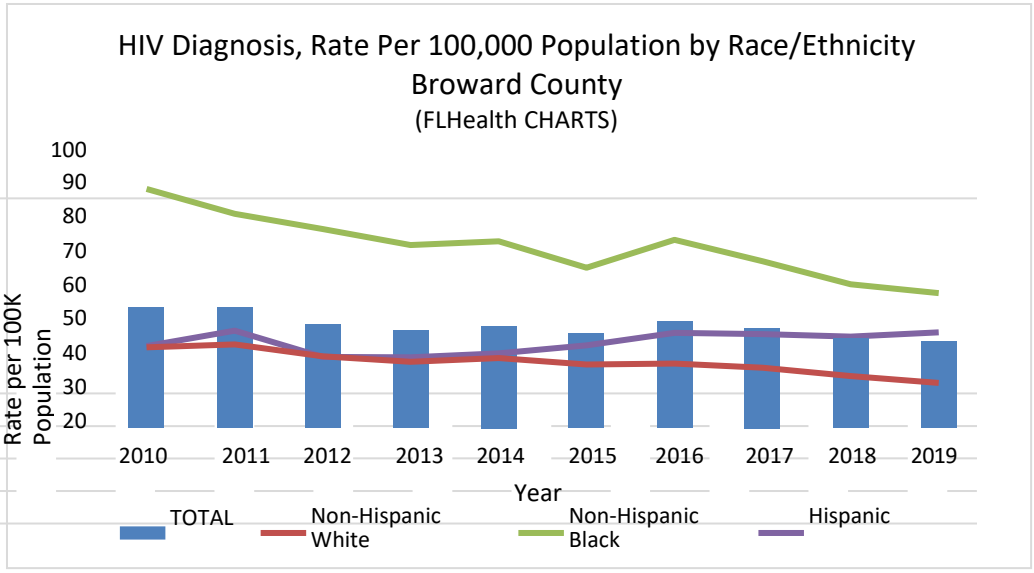
Broward County consistently ranks in the top 2-3 for newly diagnosed HIV cases in the entire United States. The rates of STIs have increased since 2001 in both Broward County and the State. Broward County's infectious syphilis and congenital syphilis rates are amongst the highest in the State. Reductions in the rate of new HIV infections per 100,000 and in cases of congenital syphilis were seen in 2019.

Broward County's **HIV Diagnosis Rate Per 100,000 Population** has trended favorably since 2016. Broward County's rate is unfavorable when compared to Florida and the Peer-Counties Average since 2010.

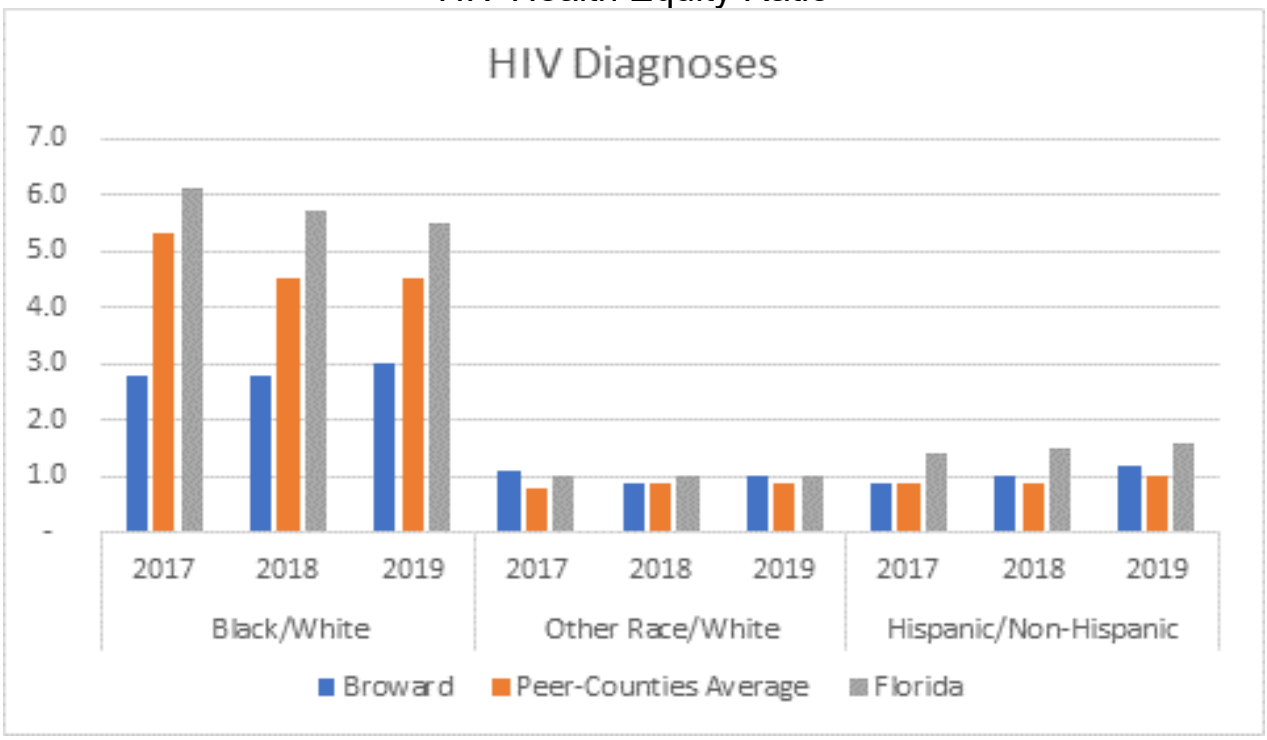


Source: FLHealth Charts

The **HIV Diagnosis Rate Per 100,000 Population by Race/Ethnicity** is trending favorably for Blacks and Whites but not Hispanics. However, Blacks are disproportionately impacted with the rate for Blacks more than 2.5 time the White rate.

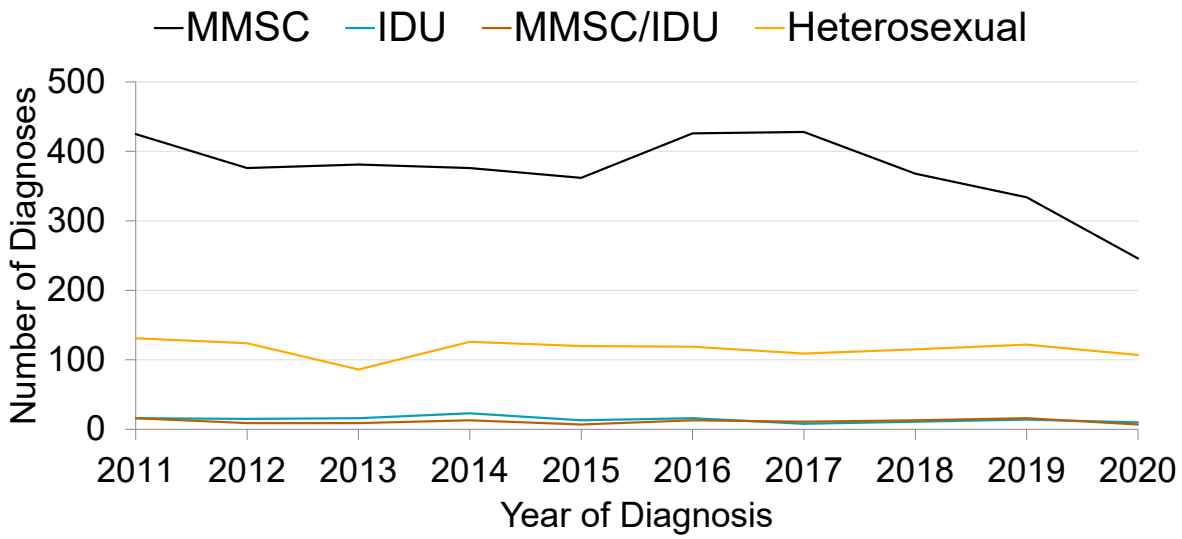


HIV Health Equity Ratio



The HIV epidemic reflects the uniquely large lesbian, gay, bisexual, transgender, and questioning (LGBTQ) communities in Broward. Fort Lauderdale ranks first among mid-sized cities for population-adjusted rates of same-sex couples per 1,000 households, while Hollywood, FL ranks 24th. Among small cities with populations <100,000, Wilton Manors ranks 2nd and Oakland Park ranks 10th for population-adjusted rates of same-sex couples per 1,000 households. Broward has an estimated 9,125 same-sex households or 1% of households. Over 12.8 million tourists visit Broward annually, including 1.5 million LGBTQ visitors.

Adult Male HIV Diagnoses by Mode of Exposure, 2011–2020, Broward County



Adults with HIV, 2020, Living in Broward County

		Male #	%	Female #	%	Total #	%
Race/ Ethnicity	White	5,988	38.9%	420	8.2%	6,408	31.2%
	Black	5,495	35.7%	4,048	79.0%	9,543	46.5%
	Hispanic/ Latino/a	3,534	22.9%	538	10.5%	4,072	19.8%
	Other	389	2.5%	116	2.3%	505	2.5%
Age Group	13-19	33	0.2%	22	0.4%	55	0.3%
	20-29	934	6.1%	251	4.9%	1,185	5.8%
	30-39	2,268	14.7%	779	15.2%	3,047	14.8%
	40-49	2,639	17.1%	1,234	24.1%	3,873	18.9%
	50+	9,532	61.9%	2,836	55.4%	12,368	60.2%
Mode of Exposure	MMSC	11,036	71.6%	0	0.0%	11,036	53.8%
	IDU	576	3.7%	435	8.5%	1,011	4.9%
	MMSC/IDU	599	3.9%	0	0.0%	599	2.9%
	Heterosexual Contact	3,026	19.6%	4,531	88.5%	7,558	36.8%
	Transgender Sexual Contact	63	0.4%	3	0.1%	66	0.3%
	Other risk	106	0.7%	153	3.0%	259	1.3%

Persons Newly Diagnosed with HIV: The CDC reports that Miami/Dade and Broward Counties had population-adjusted HIV incidence rates that were consistently higher than other US MSAs in the last two decades. Broward's HIV population-adjusted incidence rates ranked first or second among MSAs nationally for CY2008-2017, the most recent data available.

Drops in HIV incidence rates disproportionately occurred among Broward White non-Hispanic residents, but not among racial/ethnic minorities. Between CY2016-2018, the rates of HIV new cases dropped for White non-Hispanics,

while rising for all non-White groups. Adjusting for population size demonstrates the dramatic racial/ethnicity disparities in HIV incident rates. In CY2018, Black non-Hispanics had a 55.9 per 100,000 population new HIV case rate, compared to Hispanics with rate of 35.9 and White non-Hispanics with a rate of 20.3 Despite a systemwide effort to prevent HIV perinatal infection, two children were diagnosed with HIV in CY2017 and one child in CY2018. Among adolescents and adults, new HIV cases dropped for all age groups except individuals 25-29 years of age (3%), 30-44 years of age (3%), and 55-59 years of age (6%). Among new adolescent/adult HIV cases in CY2018, 72% were reported infected via male-to-male exposure, 23% heterosexual exposure, and 5% other factors. Among new HIV cases among adolescent/adult women, 96% were reported to have been HIV-infected through heterosexual exposure, 3% intravenous drug use (IDU), and 1% other factors. Between CY2016-2018, rates of new HIV cases among adolescent/adult males dropped among exposure groups except for heterosexual exposure among males (2%).

Persons Newly Diagnosed with AIDS: The CDC reports that Broward ranked third in population-adjusted AIDS cases in CY2017, the most recent data available. A total of 261 Broward residents were diagnosed with AIDS in CY2018, or 13.7 cases per 100,000 population. New AIDS case rates rose 3% between CY2016-2018. AIDS case rates varied by demographic and HIV epidemiologic group. Increases in AIDS case rates are concerning as they reflect new HIV cases presenting with low CD4 counts and/or opportunistic infections (OIs) and inadequate access or adherence ARVs and OI prophylaxis drugs.

Persons Living with HIV (PWH): The CDC reports that Broward's HIV prevalence case rate ranked first or second among MSAs nationally for much of CY2008-2017, the most recent data available. Broward had 21,048 prevalent HIV cases in CY2018, with HIV prevalent cases increasing 2% between CY2016-2018. The prevalence rate represents PWH through the end of the CY (regardless of where they were diagnosed).

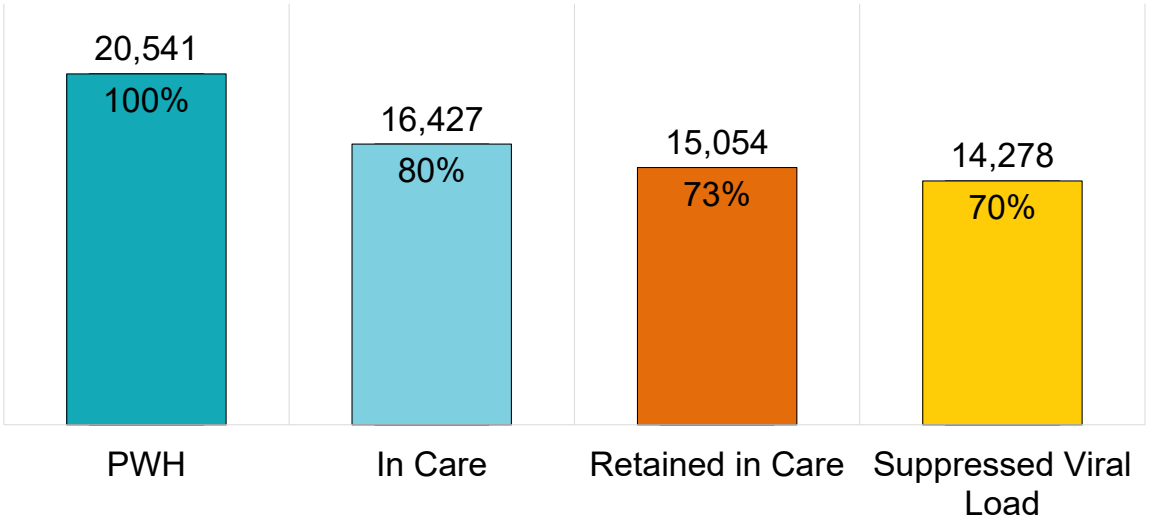
Broward's HIV epidemic, as reflected in Broward PWH, is increasingly highly diverse. The number of PWH rose 2% among males and < 1% among females between CY2016-2018. Black non-Hispanics were 47% of PWH, compared to 33% White non-Hispanic and 18% Hispanic. The number of

White non-Hispanic PWH decreased 3% between FY2016-2018, compared to a 3% increase among Black non-Hispanic PWH and 8% among Hispanics. The number of Broward PWH may not be fully accounted for due to in-migration. DOH measured the number of PWH migrating to and within FL jurisdictions between CY2014-2017. Broward consistently had the largest share of in-migrating PWH among FL Part A jurisdictions in that period. Due to lags in HIV reporting, DOH may be unaware of in-migrating PWH for months or years unless they are engaged by the healthcare system and tested for HIV. Thus, assessing the extent of the Broward HIV epidemic and scale-up required to increase the rate of virally suppressed PWH may be underestimated.

Broward HIV Care Continuum: Examining the Continuum is vitally important in identifying barriers to engagement and retention in HIV care, assessing effectiveness of the HIV care and treatment system, and improving all stages of the Continuum. The following chart depicts the number and percentage of PWH along the HIV care continuum living in Broward in 2020, as estimated by DOH. Definitions for the categories in the figure are:

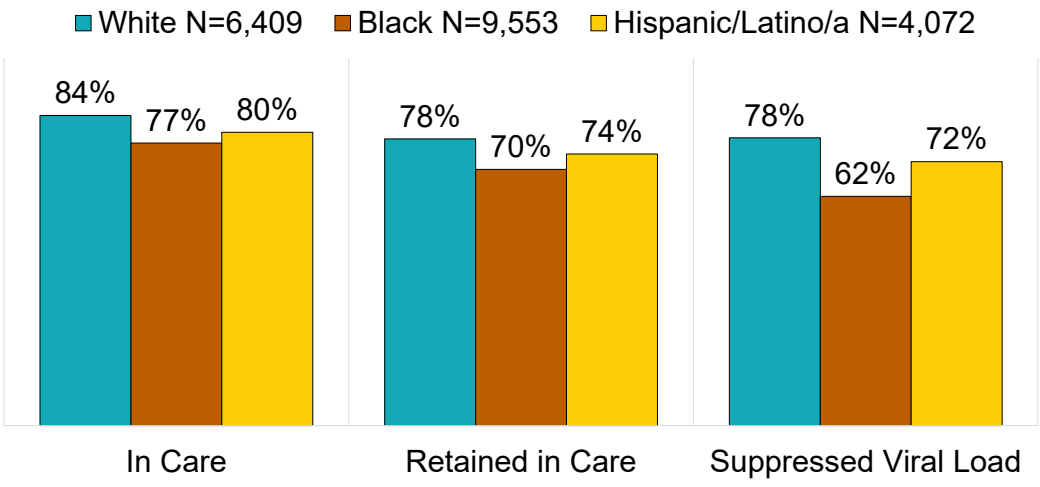
- **PWH:** Persons with HIV living in Broward at the end of 2020.
- **In Care:** PWH with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2020 through 3/31/2021.
- **Retained in Care:** PWH with two or more documented VL or CD4 labs, medical visits, or prescriptions at least three months apart from 1/1/2020 through 6/30/2021.
- **Suppressed VL:** PWH with a suppressed VL (<200 copies/mL) on their last VL lab from 1/1/2020 through 3/31/2021.
- **Not in Care:** PWH with no documented VL or CD4 lab, medical visit, or prescription from 1/1/2020 through 3/31/2021.
- **Linked to Care:** PWH with at least one documented VL or CD4 lab, medical visit or prescription following their first HIV diagnosis date.

PWH Along the HIV Care Continuum in 2020, Living in Broward County



It is noteworthy that PWH in the Broward RWHAP Continuum had much higher viral suppression rates than the PWH population. For example, 93% of RWHAP clients in FY2018 were in care, 75% were retained in care, 95% were on ARVs, and 85% were virally suppressed. The challenge is expanding access to the RWHAP Continuum, particularly among newly identified, in-migration, or out of care PWH.

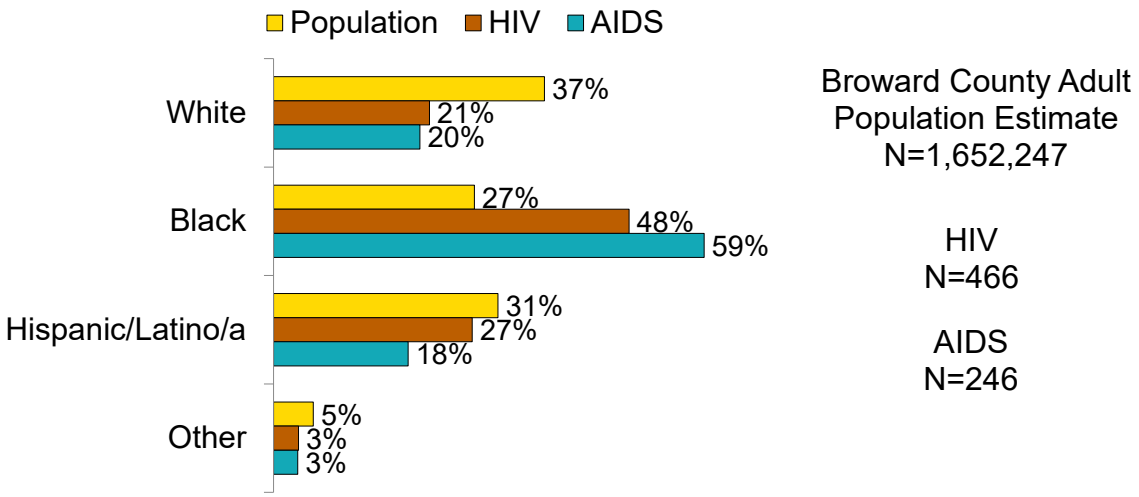
PWH by Race or Ethnicity Along the HIV Care Continuum in 2020, Living in Broward County



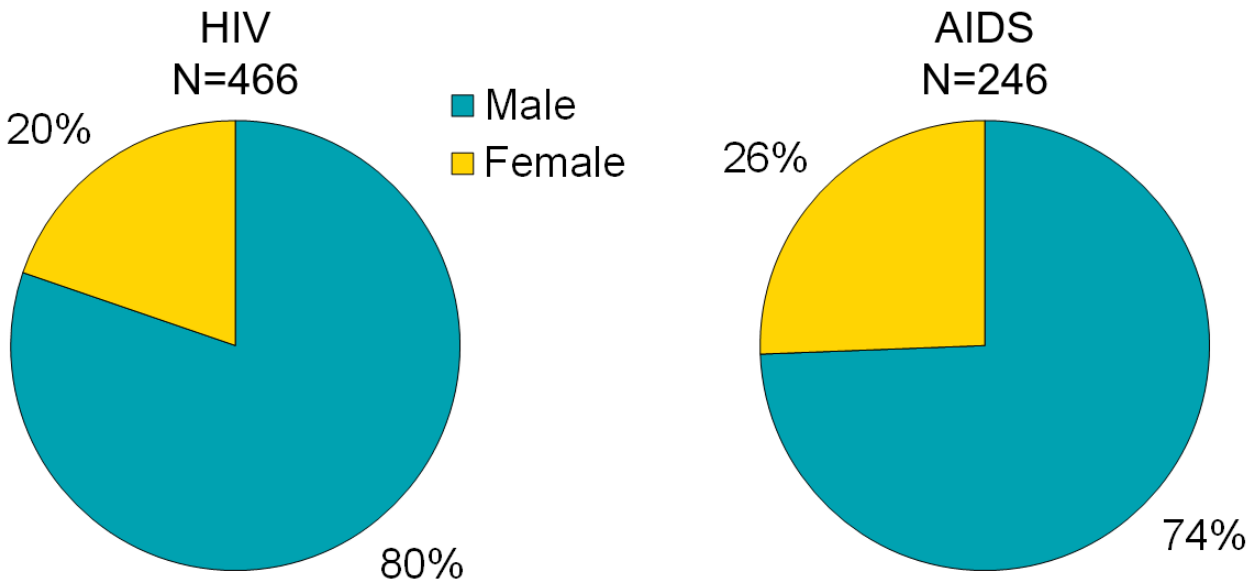
Scale Up Needed to Improve Viral Suppression Rates: Viral suppression rates increased slightly among Broward PWH between CY2016-2018, rising from 63% in CY2016 to 64% in CY2017 and 66% in CY2018. To achieve the Initiative goals, rapid scale-up of cost-effective linkage, care, treatment, and retention interventions will have to be launched for 4,727 Broward PWH with detectable VL either in or not in care.

Overarching disparities in viral suppression rates in CY2018 must be addressed to ensure equity among all PWH. For example, white non-Hispanic and Hispanic PWH had viral suppression rates of 72% and 71%, compared to 60% for Black non-Hispanic PWH. Males had a viral suppression rate of 68% versus 62% for females. Adult males with an MSM HIV exposure category had a 71% viral suppression rate, compared to 59% of males with a heterosexual exposure category and 59% of males with an IDU exposure category.

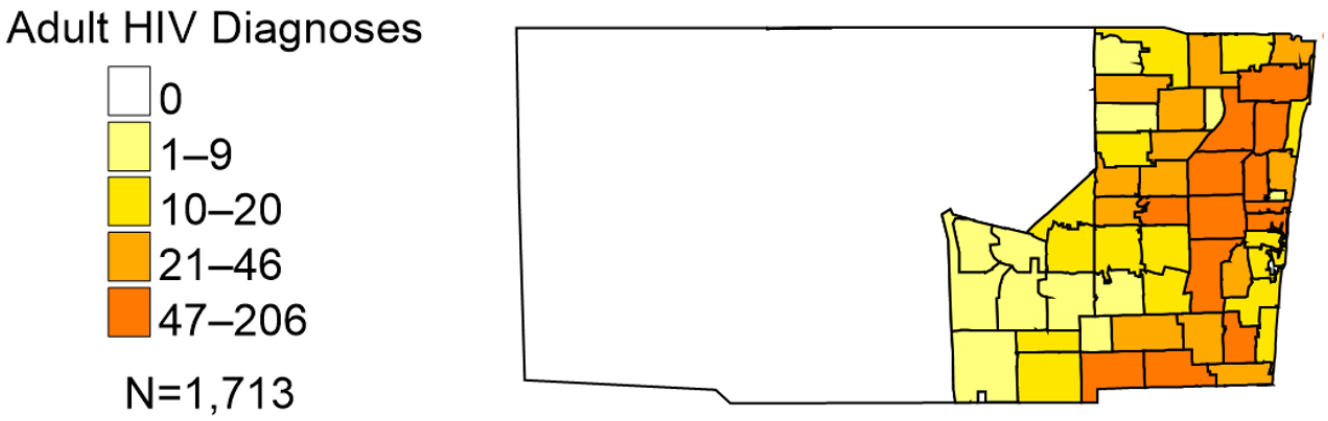
Adult HIV and AIDS Diagnoses and Population by Race or Ethnicity, 2020, Broward County



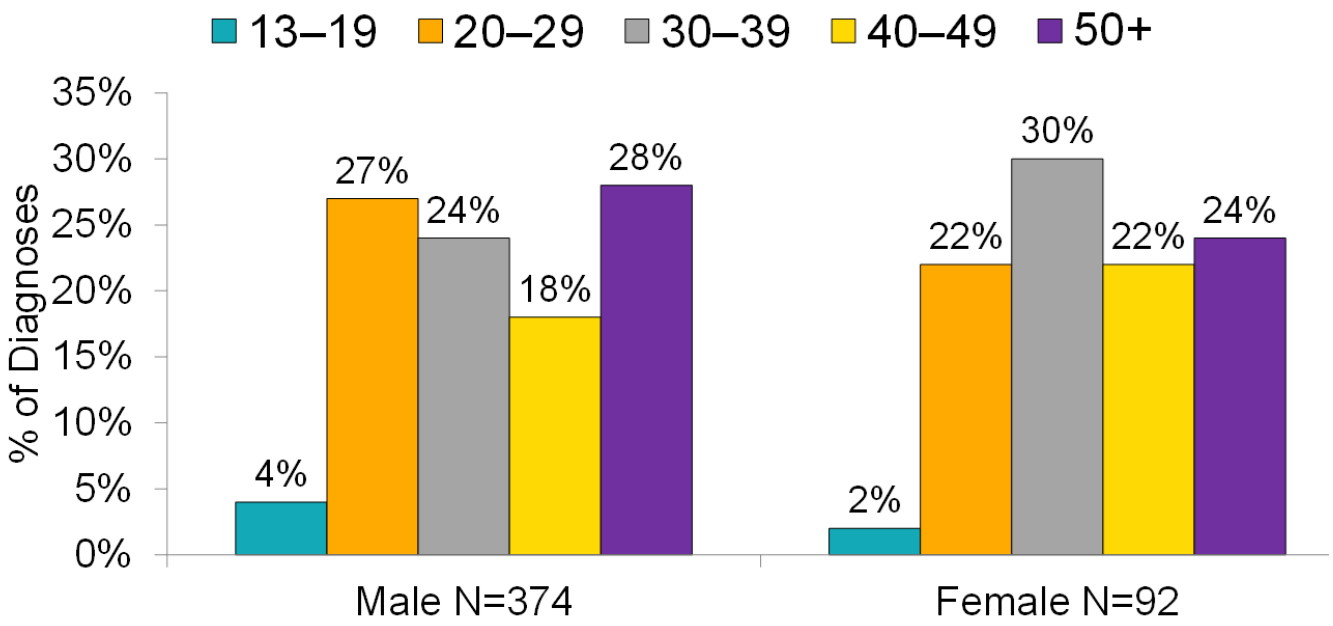
Adult HIV and AIDS Diagnoses
By Sex at Birth, 2020, Broward County



Adult HIV Diagnoses by ZIP Code of Residence
at Diagnosis, 2018–2020, Broward County

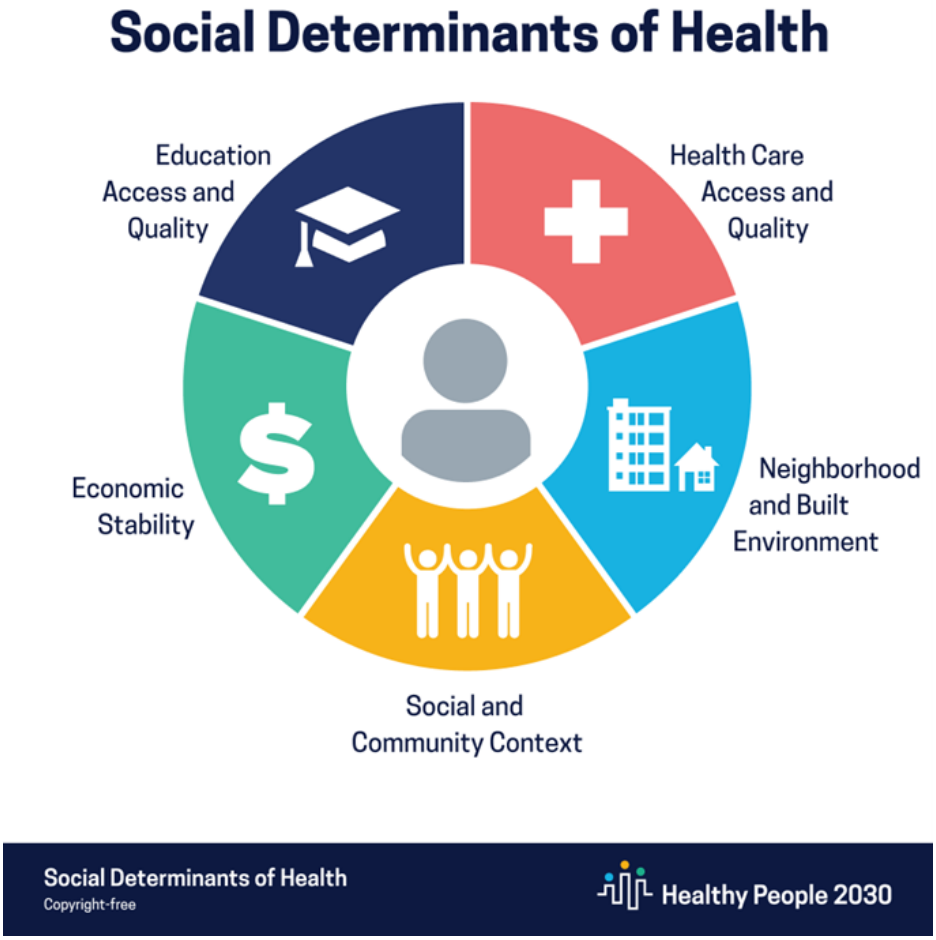


Adult HIV Diagnoses By Sex and Age at Diagnosis, 2020, Broward County



VII. SDOH DATA

Social Determinants of Health (SDOHs) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The SDOHs can be broken into the following categories: education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability.



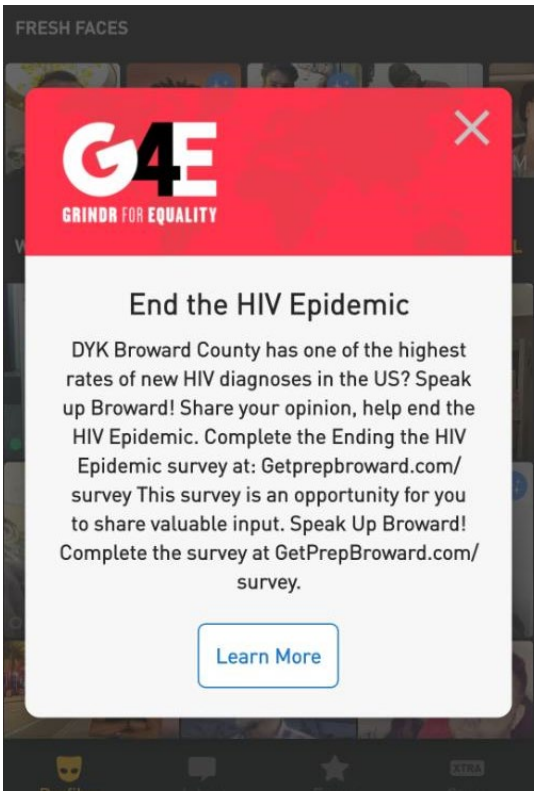
Broward County has a unique health and human service system in which extensive and continuous collaboration occurs between agencies and coalitions in an informal and formal manner. Much of this collaboration occurs organically due to a long- standing history of agency leaders making decisions based on the good of the community rather than their individual agency and directing resources to the most expert and best positioned organizations. Agency leaders and subject matter experts prioritize participation in Broward County's multiple coalitions working to give all residents the chance to live their healthiest life possible. This shared expertise and communication across committees provides the opportunity to leverage resources and avoid duplication of effort. Some of these coalitions include: Healthy Start Community Action Group, Breast Feeding Taskforce, Perinatal Provider Network, Early Leaning Coalition, KidCare Taskforce, Comprehensive School Health Advisory Committee, Healthcare Coalition, Nutrition and Fitness Taskforce, Drowning Prevention Taskforce, HIV Prevention Planning Council, Commission on Substance Abuse, Dignity in Aging Taskforce, Funders Forum, Association of Non-profit Executives, League of Cities, Smart Growth Partnership, Local Coordinating Board (Transportation Disadvantaged) Complete Streets Advisory Committee, and the Broward Alliance. Regarding formal collaboration, there are three overarching structures: Coordinating Council of Broward (CCB), Health Care Access Committee (HCA) and the Children's Strategic Plan (CSP) Leadership Coalition.

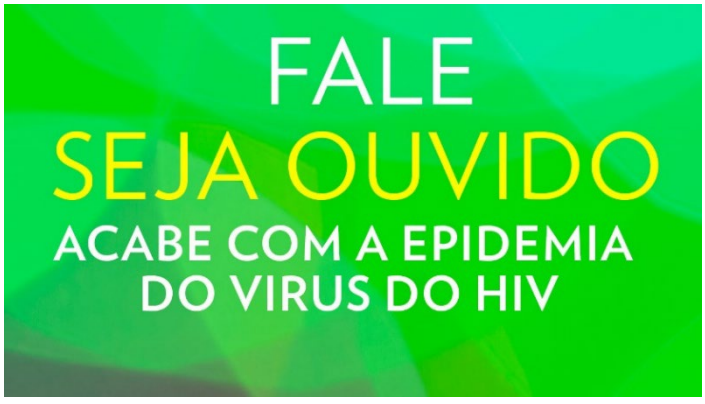
A. Community Engagement

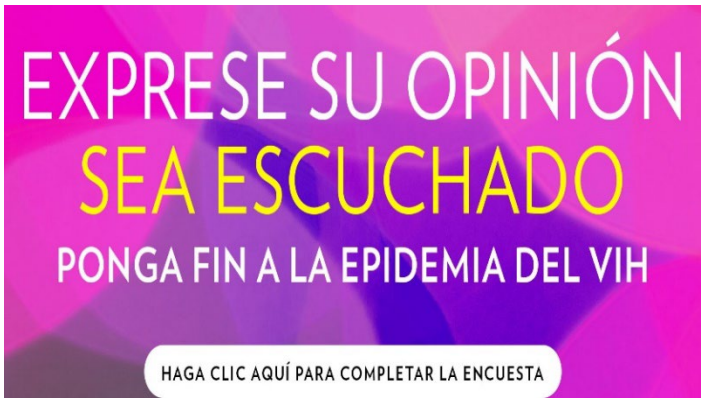
Community Engagement activities began in the fall of 2019. Community and provider surveys were developed with input from the community coalitions. The surveys were field tested with ADAP clients, BCHPPC members and the community. Revisions were made based on input gathered from the field testing. Surveys were then translated into English, Spanish, Creole, and Portuguese. The survey implementation occurred from October 18, 2019, through October 2, 2020.

- www.getprepbroward.com
- Listserv promo
- Posters/flyers w/QR code
- Surveys distributed through community outreach by DOH-Broward Staff on tablets or paper copies in four languages
- Survey link posted on DOH-Broward contracted providers' websites

Survey Marketing	
Media Campaign	Sources: to reach priority populations and broader audiences
Newspapers (full-page color ads)	Sun-Sentinel, El Sentinel, South Florida Gay News, Westside Gazette, AcheiUSA Brazilian News, Caribbean National Weekly, Gazeta Brazilian News
Radio	WHYI-FM (Y100), WEDR-FM/WHQT-FM (Black/Caribbean), WZTU-FM (Spanish), WLQY 1320/WSRF 1580 (Creole)
Social Media	Twitter, Facebook, NextDoor
Phone Apps	Grindr (11/13): Grindr for Equality created a free ad pop-up link for 24 hours *(data/results pending)*
Press Release	*The Florida Department of Health in Miami-Dade and Broward Counties Seek Community Involvement on "Ending the HIV Epidemic: A Plan for America" Initiative (10/21)*







Business Outreach:

The Business Responds to AIDS (BRTA) Initiative engages and supports the private sector in promoting HIV education, awareness, and policies in the workplace. The program has evolved over the years into a public/private partnership that promotes both the involvement of businesses in HIV prevention & treatment. DOH Broward BRTA partners and their customers participated in the survey and the BRTA partners are visited on a quarterly bases to assist with the distribution of condoms and educational materials. BRTA partners are recruited based upon their business location and population.

Zip Code	Number of Businesses
33311	118
33023	51
33024	32
33025	29
33029	1
33313	92
33319	7
33305	12
33304	35
33316	4
33315	1
33312	2
33314	5

Zip Code	Number of Businesses
33317	7
33328	1
33321	1
33020	21
33334	19
33308	3
33062	3
33060	18
33069	18
33068	1
33065	3
33351	3
33309	28
TOTAL	**515**

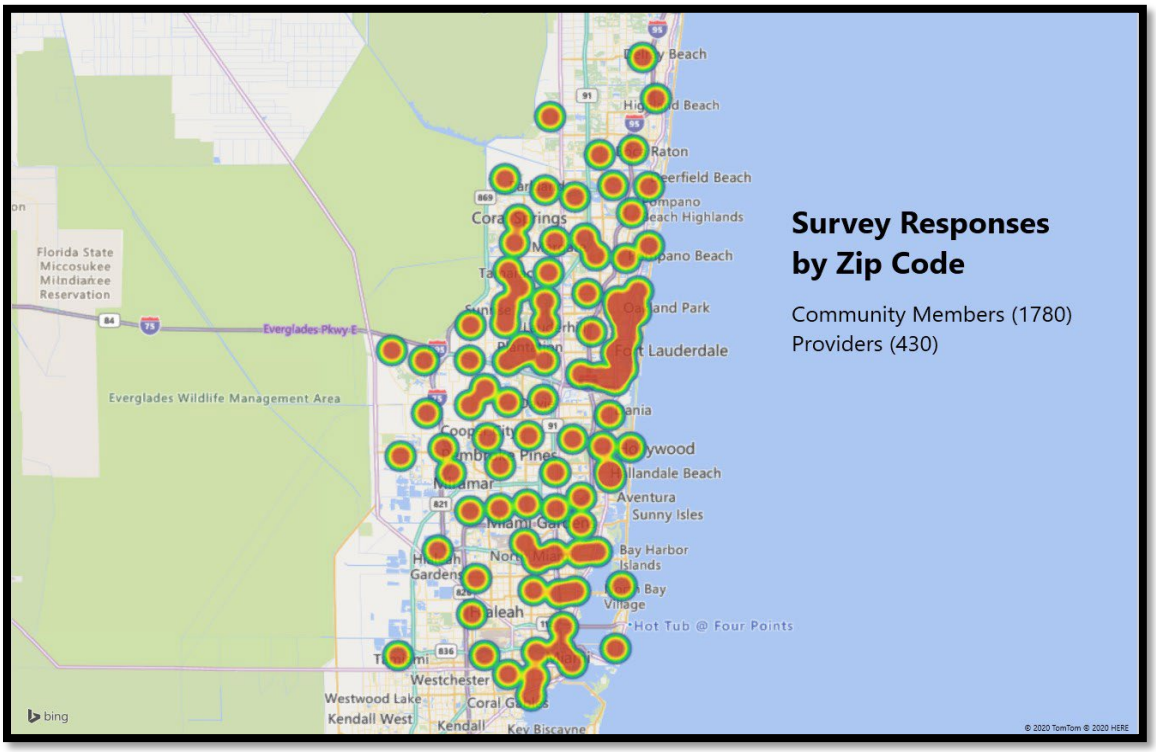
Street Outreach:

The HIV prevention program conducted street outreach from 10/18/2019-10/02/2020 to distribute the surveys in four languages. The Public locations that was selected for outreach was based upon HIV priority zip codes and public locations that had a large gathering of Broward residents.

Street outreach locations:

Bus Stations
Homeless Shelters
Train Stations
Lauderhill Mall and other malls
Sistrunk Blvd.
Oakland Park Flea Market
Fort Lauderdale Beach
Hollywood Boardwalk
Wilton Drive
Other Neighborhoods
Faith Based Institutions
Venues where substance users congregate

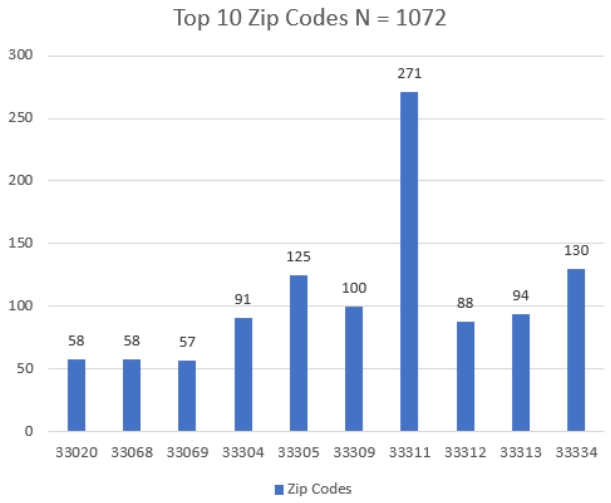
The total number of surveys collected is 2,210. The geographical map shows the frequency of responses from each zip code. The map also shows that responses came from throughout the East Coast of Florida, from Palm Beach County to Monroe County. Responses were also seen on the West Coast of Florida, Central Florida, North Florida, and out of state as well (Georgia, California, New York, Virginia, etc.) but they are not being displayed on this map. The chart below shows the top 10 zip codes of where the survey respondents reside. the bulk of the surveys collected were from community members (1780). With 1780 surveys coming from community members, a total of 430 surveys came from providers. Most of the providers were from Community-Based Organizations/Non-Profits (226).



Survey Distribution by Top 10 Zip Codes

Zip Code	Total
33020	577
33068	428
33069	713
33304	983
33305	1057
33309	1159
33311	2851
33312	785
33313	1046
33334	1340

Survey Distribution by Top 10 Zip Codes



As of 6/30/20 data provided by HIV Section – Surveillance Unit

Survey Respondent Type

Community Respondent		
	N	%Total
Community Member	1780	100.00%

Provider Respondent		
Type of Provider	N	% Total
Community-Based Organization/Non-Profit	226	52.6%
Other	98	22.8%
Department of Health (DOH) Employee	86	20.0%
Planning Council Member/Advisory Board Member	20	4.7%
Total	430	100.0%

Survey Respondent Demographics:

Provider Survey:

Provider Demographic Summary		
Age	N	%Total
13-19	13	3.0%
20-29	50	11.6%
30-39	103	24.0%
40-49	85	19.8%
50-59	100	23.3%
60+	79	18.4%
Total	430	100.0%

Provider Demographic Summary		
	N	%Total
Gender		
Male	209	48.6%
Female	209	48.6%
Transgender (M to F)	7	1.6%
Transgender (F to M)	1	0.2%
Non-Binary	1	0.2%
Non-Conforming	1	0.2%
Other*	2	0.5%
Race/Ethnicity		
Non-Hispanic White	153	35.6%
Non-Hispanic Black	127	29.5%
Hispanic	125	29.1%
Asian	4	0.9%
American Indian/Alaskan Native	0	0.0%
Native Hawaiian/Pacific Islander	0	0.0%
Mixed/More than one race	17	4.0%
Other*	4	0.9%

The provider demographic summary table shows the demographic data of 430 providers. There was an even number of male and female providers (48.6%). Majority of the providers were Non-Hispanic White (35.6%) between ages 30-39 (24.0%) and 50-59 (23.3%).

Community Survey:

Community Demographic Respondent		
	N	%Total
Age		
13-19	186	10.4%
20-29	288	16.2%
30-39	360	20.2%
40-49	313	17.6%
50-59	363	20.4%
60+	270	15.2%
Total	1780	100.0%

Community Demographic Respondent		
	N	%Total
Gender		
Male	1034	58.1%
Female	702	39.4%
Transgender (M to F)	8	0.4%
Transgender (F to M)	10	0.6%
Non-Binary	11	0.6%
Non-Conforming	9	0.5%
Other*	6	0.3%
Race/Ethnicity		
Non-Hispanic White	505	28.4%
Non-Hispanic Black	706	39.7%
Hispanic	439	24.7%
Asian	14	0.8%
American Indian/Alaskan Native	7	0.4%
Native Hawaiian/Pacific Islander	1	0.1%
Mixed/More than one race	44	2.5%
Other*	25	1.4%

*Other includes community members who identify their ethnicity as Haitian, Jamaican, Middle Eastern, or West Indian.

In comparison to the provider demographic summary table, the community demographic survey table shows that most community members were male (58.1%), Non-Hispanic Black (39.7%), between the ages of 30-39 (20.2%) and 50-59 (20.4%.

Top 5 issues (barriers) that affect the community/you the most:

Provider Response	N = 430	Community Response	N = 1,780
Affordable Housing	48.4%	**Affordable Health Care**	40.4%
Mental Health	44.7%	**Affordable Housing**	40.4%
Affordable Health Care	39.5%	**Mental Health**	30.0%
Substance Use	36.5%	**Discrimination**	27.5%
Transportation	35.6%	**No Job/Low Pay**	24.8%

Affordable Housing, Affordable Health Care & Mental Health were in the top 3 for both Community Members & Providers.

Key Findings/Themes include:

- Access to **housing**, **health care**, **mental health** care, and **employment** are clearly needed in the community and would greatly improve the quality of life for priority populations.

Most common themes:

- Improving **access to care**
- Addressing **stigma**
- Lack of **education** about HIV in the community and among providers

- Promoting the **availability of resources**, including HIV testing, care and treatment, and prevention (PrEP)

Student Survey:

Broward County Public Schools conducted a survey of High School students visiting sexual health services offices from November 5 – 22, 2019.

135 students in 7 public high schools were asked:

- *Q12: Do you think that HIV transmission is a big issue among students and youth in Broward?* ***93% reported YES, 7% reported NO***
- *Q13: What ideas do you have for how to better educate students and youth about HIV risk behaviors and the virus?* ***Themes: increase education, increase condom access, increase HIV/STI testing***

Key Findings/Themes include:

- **Expand HIV education** and awareness for youth and students
- Common suggestions: improve sex ed/health classes, presentations, guest speakers, assemblies, summits, posters, peer education, social media, teen talks, etc.
- Increase **access to condoms and HIV/STI testing**
- Build upon current BCPS comprehensive sexual health curriculum
- Involving youth and students is vital to developing new and innovative strategies for future EHE planning activities

Key Informant Interviews:

Forty (40) interviews were conducted with individuals representing the following:

• Law enforcement	• HIV Care & Treatment Continuum Services
• Pharmacies	• CBOs
• Food/nutritional services	• Case management
• Racial equity and social justice	• Legal services
• Substance use	• Public schools
• Mental health treatment	• Hospitals
• Medical care	• Current/former DOH staff
• LGBTQ & transgender programs/services	• Planning/advisory board members
• Latinx organizations	• Community members (youth, seniors, PWH, or PrEP, Latinx, Black
• Ryan White Part A	
• Department of Children & Family Services	

Key Findings/Themes include:

- Provide basic **HIV education** and awareness (community and providers)
- Eliminate **barriers to health care** (including affordability, mobile)
- Implement effective **community education** campaigns
- Eliminate **HIV stigma** and discrimination (U=U messaging)
- Implement harm reduction programs (SEPs, innovation)
- Increase **access to PrEP**

Common concerns raised:

- Need safe, affordable **housing** (especially for priority populations)
- Increase HIV **education in schools**/with youth
- Increase support for transgender programs & community
- Opportunities to improve communication & collaboration with DOH (HIV/AIDS Program)
- Expand access to **routine HIV testing**
- Dismantle institutional discrimination and increase racial equity

Listening Session:

One (1) community event with twenty-one (21) participants consisting of:

- HIV care and treatment continuum provider staff
- Community stakeholders
- Planning body groups membership
- Staff from CBOs
- HIV care orgs
- MSM & transgender programs
- Staff from CBOs
- HIV care orgs
- MSM & transgender programs
- Latinx programs
- Local healthcare facilities

Small brainstorm sessions/rounds at each table on priorities, strengths, challenges, strategies, and next steps to report back for larger group discussion

Key Findings/Themes include:

- Increase **access points for PrEP** and make it accessible (PrEP-AP)
- Address **HIV stigma**
  - Adopt Undetectable=Untransmittable messaging
  - Advocacy to protect PWH (disclosure/criminalization laws)
- Increase **HIV education** in community and with providers
- Expand **routine HIV testing**
- Enhance **Test & Treat** model for rapid HIV care and treatment
- Implement harm reduction programs (SEPs)

Common concerns raised:

- Need for more community involvement
- Grassroots/homegrown programs need to be funded
- Opportunities to improve communication & collaboration with DOH (HIV/AIDS Program)
- Not enough people were involved – conduct more sessions & forums

Focus Groups:

Five (5) focus groups were conducted with Fifty (50) participants from priority populations:

- Transgender Focus Group
- LatinX Focus Group
- MSM Focus Group
- Black Heterosexual Females Focus Group
- Children's Diagnostic & Treatment Center (CDTC) staff Focus Group

Key Findings/Themes include:

- Address **HIV stigma**
  - Adopt Undetectable=Untransmittable messaging
- Increase **HIV education** in community and with providers
- Expand **routine HIV testing**
- Enhance **Test & Treat** model for rapid HIV care and treatment
- Expand **access to PrEP**

Common concerns raised:

- Need for more community involvement
- Grassroots/homegrown programs need to be funded

- Conduct more focus groups to reach priority populations throughout the community

Community Presentations:

Twenty-eight (28) community presentations were conducted by DOH-Broward and/or EHE Consultant.

- Broward County HIV Prevention Planning Council (BCHPPC)
- Biomedical Advisory Group
- Men Who have Sex with Men Advisory Group
- Black Treatment Advocates Network (BTAN)
- Latinos en Acción Advisory Group
- Broward County Public Schools Student Advisory Meeting
- Perinatal Advisory Group
- Medical/Disease Case Management Network Meeting
- Integrated HIV Prevention & Care Workgroup
- HIV Health Services Planning Council (HIVPC)
- South Florida AIDS Network (SFAN)
- HIV Prevention Contracts Provider Meeting
- Coordinating Council of Broward
- Homeless Continuum of Care Advisory Board
- Healthcare Access Committee

Key Findings/Themes include:

- Eliminate HIV stigma
- Provide broad community & provider education
- Expansion of PrEP access
- Expansion of Test & Treat to ensure immediate linkage to care
- Addressing barriers to care, including health coverage, housing, mental health
- Expansion of HIV testing in healthcare and non-traditional settings
- Addressing structural discrimination and promoting racial equity
- Build resources and support on a local level to support grassroots programs

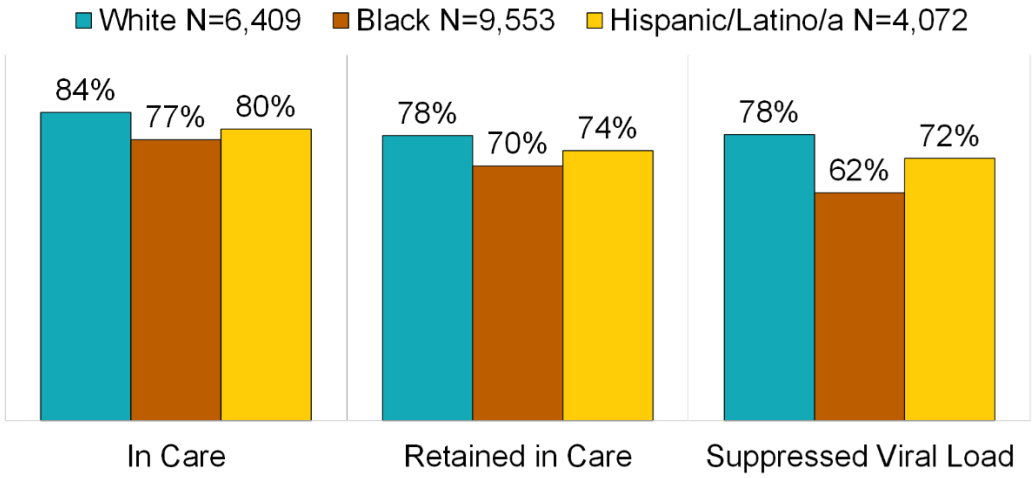
Broward County in partnership with DOH-Broward held a town hall meeting to assess the capacity and knowledge of health equity. The information garnered through this meeting assisted the Minority Health Liaison identify

knowledge gaps and create training plans for the Health Equity Taskforce, the Coalition, and other county partners.

Social Determinants Negatively Impact Broward PWH and Impede Efforts to Increase Viral Suppression: Low income, low educational attainment, unemployment, and lack of insurance negatively impact PWH. The US Census reports that the Broward median household income was $54,395 in CY2017 dollars, the most recent data available. Socioeconomic data for PWH are unavailable from DOH. Part A household income data were assessed as a substitute. Among one-tenth (13%) of Broward households had an annual income < 100% federal poverty level (FPL), compared to 53% of Part A clients. Most (88%) Broward adult residents 25 years or older had earned a high school diploma or higher, compared to 62% of Part A clients. In August 2019, Broward's unemployment rate was 3% versus 29% of Part A clients. About 17% of Broward residents < 65 years of age were uninsured versus 42% of Part A clients. An additional 25% of Part A clients had private insurance, 20% Medicare, 9% Medicaid, and < 1% other public insurance.

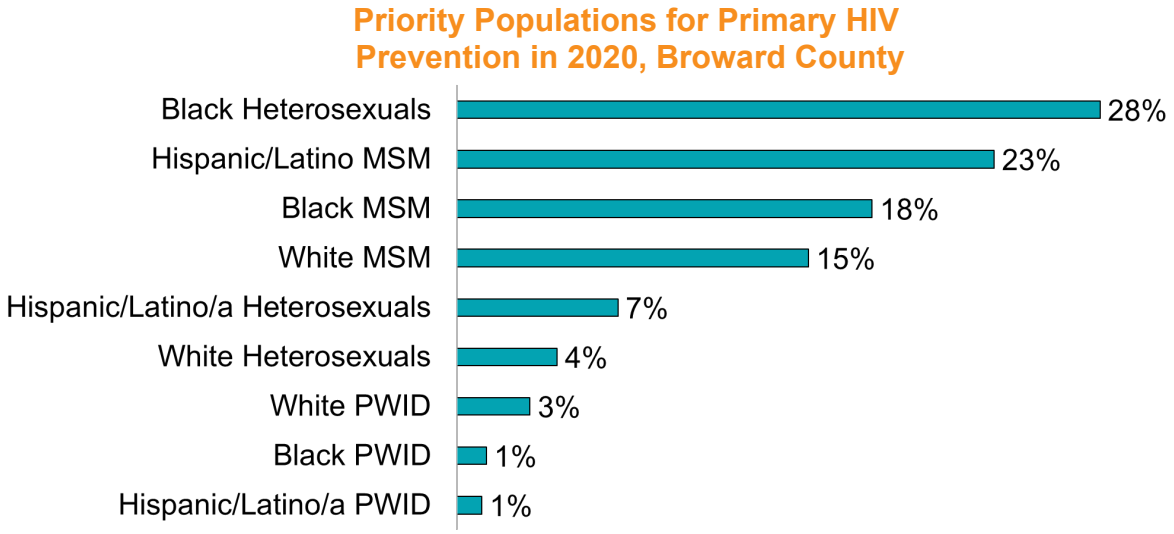
Efforts to increase viral suppression among Broward Hispanic PWH must reflect their significant diversity, with highly variable educational attainment, health literacy, acculturation, English proficiency, and income levels.

PWH by Race or Ethnicity Along the HIV Care Continuum
In 2020, Living in Broward County



Priority Populations for Primary HIV Prevention

These data were calculated from HIV diagnoses 2018–2020 and represent the proportion of each race or mode of exposure group to the total diagnoses. These data are used to identify and prioritize testing, PrEP, and other HIV prevention services to those at greatest risk for acquiring HIV in Florida.



Additionally, some Broward Hispanics immigrated to the US legally, while others have unresolved immigration issues. Unlike other EMAs, a large portion of Hispanic PWH identify as gay and settled in Broward due to its gay friendly culture. Due to these diverse social determinants, strategies for improving engagement and retention in care, ARV adherence, and viral suppression rates must be tailored to the requirements of PWH.

FDOH provided data for individuals living with disabilities with segmentation for individuals living with HIV. Across all measures, people living with HIV were not statistically significantly represented in any category. The disability data is in Appendix 3.

HIV/AIDS Social Determinants of Health Impacted Populations and Health Disparities		
SDOH	**Vulnerable Populations Impacted**	**How the SDOH Impacts HIV/AIDS (Health Disparity)**
Neighborhood and the Built Environment	Minority and immigrant populations (Black, Hispanic, Haitian), transgender men and women, veterans, and people experiencing homelessness.	Clients may face discriminatory housing/rental practices related to race, sexual orientation, etc.; frustration with processes related to housing programs, vouchers, lack of affordable housing, etc. *75% of Part A clients reported having stable/permanent housing, 20% were in temporary housing arrangements, and < 1% had unstable housing. While 2% of clients were reported to be homeless, with 7% of clients with $0 income homeless. Almost one-third (30%) of Part A clients are non-permanently housed, commonly with short periods of homelessness, living with friends or family, or exchanging sex for a place to stay. Stable housing was significantly more common for women (78%) than men (74%) and transgender people (68%). Black non-Hispanics had a lower rate of stable housing (73%) than White non-Hispanics (79%) and Hispanics (77%). Employed clients had a higher rate of stable housing (94%) versus non-employed clients (73%). Homelessness was found to be under-reported, with 5% of clients reported in PE to be homeless versus 12% documented in EHRs.*
Economic Stability	Non-Hispanic Black heterosexual women, veterans, transgender women of color, people experiencing homelessness, adolescent youth, and young adults (ages 13-30).	Frustration with navigating life around HIV diagnosis, or with navigating health care services, transportation challenges and the associated costs; Unemployment or under-employment. *The US Census reports that the Broward median household income was $60,922 (2016-2020). Socioeconomic data for PLWH are unavailable from DOH. Part A household income data were assessed as a substitute. Among one-tenth (13%) of Broward households had an annual income < 100% federal poverty level (FPL), compared to 53% of Part A clients.*

Health Care Access and Quality - Access to Mental Health Services	Minority and immigrant populations (Black, Hispanic, Haitian), veterans, adolescents and young adults, transgender men and women, and people experiencing homelessness.	Stigma associated with diagnosis, causing fear in seeking care, or leaving care; greater need for peer support and case management and other wrap-around services for clients; issues with medication adherence due to prioritizing housing expenses over medications or treatment; frustration with navigating life around HIV diagnosis, or navigating mental health services; lack of local providers make access difficult for clients with transportation challenges. *Almost half (46%) of clients were reported to have one or more behavioral health diagnosis, including chronic depression (29%) and anxiety (8%). Severe chronic mental illness was also common among this group, including schizophrenia, bipolar disorder, and psychosis. Substance abuse and addiction were also common among the clients. Alcohol abuse/addiction was reported among 7% of clients, compared to cocaine (6%), opioids 6%), methamphetamines (3%), and 18% other substances. It was common that clients were reported to abuse or be addicted to several substances. It is noteworthy that clients tended to volunteer information about their behavioral issues, rather than a thorough behavioral assessment documented in the EHR.* *HIV and comorbid medical conditions were common. Over two-thirds (69%) of clients met the CDC criteria for AIDS, with 72% of clients diagnosed with candidiasis, hyperlipidemia, peripheral neuropathy, anal cancer, or pneumonia. Other common chronic medical conditions include hypertension, diabetes, chronic hepatitis C virus (HCV), obesity, seizure disorder, arthritis, and tuberculosis (TB).*
Education Access and Quality	Minority and immigrant populations (Black, Hispanic, Haitian), veterans, people with HIV, transgender men and women, young adults	Lack of comprehensive and inclusive sex education for adolescents and young adults; discussing gender, sexuality, consent, and relationship wellness. Lack of tailored HIV/AIDS education for sub-populations – Caribbean, Black (non-Hispanic), Hispanic/LatinX, etc. *Most (88%) Broward adult residents 25 years or older had earned a high school diploma or higher, compared to 62% of Part A clients.*

		Broward's long-term average unemployment rate was 5.77% versus 29% of Part A clients.
Social and Community Context	Minority and immigrant populations (Black, Hispanic, Haitian), veterans, young adults and adolescents, transgender men, women	Stigma associated with diagnosis, causing fear in seeking care, or leaving care; Greater need for peer support and case management and other wrap-around services for clients; Frustration with navigating life around HIV diagnosis *The student survey, provider and community survey, key informant interviews, and transgender/gender non-conforming, Spanish-speaking, MSM, black heterosexual women and children's provider all included stigma as a top five issue. A large portion of Black, non-Hispanic PLWH were born in Haiti. A large portion of Haitian-born RW clients speak only Creole or prefer to speak in Creole to their healthcare providers. Some Haitian-born clients are reported by HIV clinic staff to be reluctant to engage in HIV care due to HIV stigma and concern about disclosure of their HIV status to other Haitian community members.*
Please note: Due to the small number of individuals living with HIV belonging to race/ethnicity other than White, Black, and Hispanic, data is presented using White/Black and Hispanic and in some cases includes "other" as available.		

VIII. SDOH PROJECTS

The Minority Health Liaison recruited and engaged members across the county, including government agencies, nonprofits, private businesses, and community organizations, to join the Health Equity Taskforce. The Minority Health Liaison took into consideration the prioritized health disparity and the impactful SDOHs identified by the Health Equity Team during recruitment.

A. Data Review

The Health Equity Taskforce reviewed FDOH provided Analysis of the Health Disparities Among People living with Disability data (see Appendix 3) and FDOH provided Health Equity profiles in FLCharts at the county and state level (see Appendix 4). The Health Equity Taskforce also reviewed health disparities and SDOHs provided by the Health Equity Team as it relates to HIV. The Health Equity Taskforce researched evidence-based and promising approaches to improve the identified SDOHs. The Health Equity Taskforce considered the policies, systems and environments that lead to inequities. Data from the 2019 Community Health Assessment and Community Health Improvement Plan were also foundational documents used in the development of this plan.

B. Barrier Identification

Members of the Health Equity Taskforce worked collaboratively to identify their organizations' barriers to fully addressing the SDOHs relevant to their organization's mission. Common themes were explored as well as collaborative strategies to overcome barriers.

1. Housing

The highest HIV diagnosis rates were among those who lived in zip code 33311, where of the 26,989 housing units in 2020, 13,504 or slightly more than 50% were rentals and of these 7,701 and 57% of these units utilized more than 35% of their gross income towards rent. This compares to the county where of the 826,382 housing units in 2020, 255,427 or 30.9% of units are rented and of these rentals 50.9% or 129,827 pay 35% or more of their gross income for rent.

In South Florida, landlords are raising rents **by as much as 40% percent**, and wages have only increased about 6%, according to new statistics from the U.S. Bureau of Labor. More than 1,000 new apartments will be built across Broward to help low-income families — with rents expected to range from $700 to $1,850 a month.

Housing Insecurity Presents a Serious Challenge for PWH: Broward County was one of the last jurisdictions to recover from the US housing finance crisis in the early 2000s. PWH and other Broward residents experienced high rates of foreclosures and were forced into the rental market. That market now experiences high demand for affordable rental units. Simultaneously, Broward's reputation as a sunny, welcoming destination for homeless individuals has grown.

In FY2018, 75% of Part A clients reported having stable/permanent housing, 20% were in temporary housing arrangements, and < 1% had unstable housing. While 2% of clients were reported to be homeless, with 7% of clients with $0 income homeless. Almost one-third (30%) of Part A clients are non-permanently housed, commonly with short periods of homelessness, living with friends or family, or exchanging sex for a place to stay. Stable housing was significantly more common for women (78%) than men (74%) and transgender people (68%). Black non-Hispanics had a lower rate of stable housing (73%) than White non-Hispanics (79%) and Hispanics (77%). Employed clients had a higher rate of stable housing (94%) versus non-employed clients (73%).

In many states, HOPWA funds have expanded access to affordable, stable housing. In Broward, however, being eligible for HOPWA funds is unlikely to result in housing stability. Among the 1,727 PWH enrolled in HOPWA in FY2018, 33% received financial subsidies and 67% received housing case management. Barriers to providing HOPWA financial assistance included constrained affordable housing, as well as a requirement that HOPWA applicants live in Broward for at least six months before receiving housing assistance. We propose increasing the percent of PWH that are stably housed by funding HIP, which is funded by the Housing and Urban Development (HUD) Department and other federal agencies. HIP has an extensive network of housing options for indigent Broward residents, including those with behavioral health problems and chronic diseases. HIP

also offers an array of housing support services designed to address the underlying causes of unstable housing.

2. Health Care Access and Quality

Access to Health Services

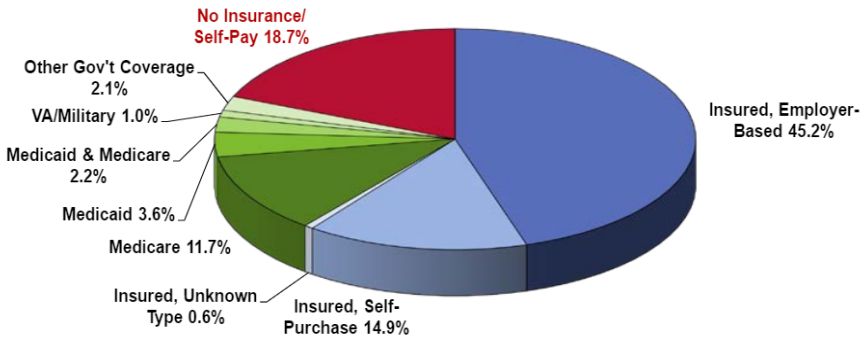
Health Insurance Coverage

Type of Healthcare Coverage

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

A total of 60.7% of Broward County adults age 18 to 64 report having healthcare coverage through private insurance. Another 20.6% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Healthcare Insurance Coverage
(Adults Age 18-64; Broward County, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 169]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 18.7% report having no insurance coverage for healthcare expenses.

- **BENCHMARK**: The Healthy People 2020 objective is universal coverage.
- **TREND**: Higher than when first measured in 1994.
- **DISPARITY**: Lack of coverage is more than twice as high in North Broward than South Broward. The proportion is also notably high among young adults, low-income residents (especially), and in communities of color.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

— Healthy People 2020 (www.healthypeople.gov)

Barriers to Healthcare Access

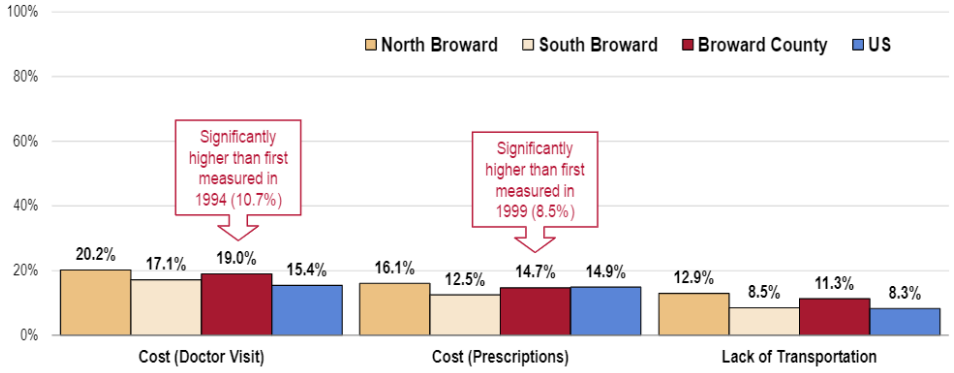
To better understand healthcare access barriers, survey participants were asked whether any of three types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

These percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, cost of a physician visit (19.0%) impacted the greatest share of Broward County adults, followed by cost of prescriptions (14.7%) and lack of transportation (11.3%).

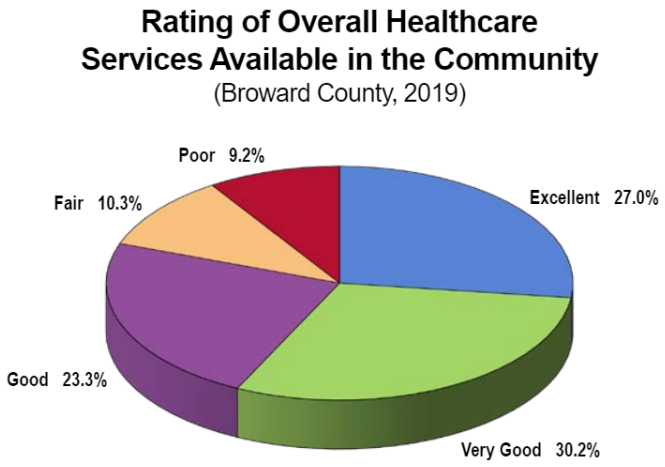
- **TREND**: A significant increase over time for barriers related to cost (doctor visits and prescriptions).

Barriers to Access Have Prevented Medical Care in the Past Year



Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 7-13]
- 2017 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.



Increasing educational opportunities about HIV to reduce new infections: According to HIV.gov, About **13% of people with HIV in the U.S. don't know it and so need testing**. Early HIV diagnosis is crucial. Everyone aged 13-64 should be tested at least once. People at higher risk of acquiring (or exposure to) HIV should be tested at least annually. Sexually active gay and bisexual men may benefit from more frequent testing (e.g., every 3-6 months).

Strengthening Linkage and Engagement Services: Test and Treat (TTP) services were initiated in May 2017 as a joint DOH and Part A service, with 1,866 TTP clients served through July 2019. The Recipient evaluated TTP effectiveness in linking and engaging newly identified and returning PWH, as well as short to moderate-term viral suppression rates.

The TTP model includes identification of the PWH in the community by DOH staff, rapid linkage by DOH to a RWHAP-funded HIV clinic, rapid assessment by clinic staff, same day medical appointment, and same day ARV initiation. The sequencing of the service dates of DOH activities and clinic TTP assessments were evaluated. Most DOH contact activities occurred after the first TTP assessment. About one-third (35%) of post-assessment DOH contact activities occurred within 30 days of assessment

and 47% received DOH contact activities greater than 30 days after the assessment.

The most common method used by DOH staff for contacting TTP clients was by telephone (53%), face to face contacts (31%), voicemail message, and field visit (12%). Infrequent contacts were made by mail, email, or texting. Most common methods were reported to be unsuccessful in contacting clients. For example, 25% of attempted contacts with TTP clients were unsuccessful during clinic visits.

Part A requires that TTP clients receive at least presumptive rapid RWHAP intake or reassessment by Centralized Intake and Eligibility Program (CIED). Only 39% of clients had a PE CIED intake and or reassessment record. Most but not all TTP clients (84%) received OAHS, while 89% received one or more VLs. Among clients receiving a VL, 27% were undetectable at initial lab assessment, 7% suppressed, 47% detectable, and 18% highly detectable. Among clients who were undetectable at their first VL test, 84% remained undetectable, 7% became suppressed, 8% detectable, and < 1% highly detectable. Conversely, among detectable clients at first VL test, 53% became undetectable, 11% suppressed, 34% detectable, and 2% highly detectable. Of greatest concern were clients who did not attain undetectable status. While 46% became undetectable, 21% were suppressed, 15% detectable, and 18% highly detectable. Evaluation results indicate that strengthening linkage and engagement services are needed to achieve sustained undetectable VL. Improved coordination between DOH, HIV clinic, and CIED staff is also needed.

HIV and comorbid medical conditions were common. Over two-thirds (69%) of clients met the CDC criteria for AIDS, with 72% of clients diagnosed with candidiasis, hyperlipidemia, peripheral neuropathy, anal cancer, or pneumonia. Other common chronic medical conditions include hypertension, diabetes, chronic hepatitis C virus (HCV), obesity, seizure disorder, arthritis, and tuberculosis (TB). Homelessness was found to be under-reported, with 5% of clients reported in PE to be homeless versus 12% documented in EHRs.

Hospitalization was reported among 15% of the clients, ER use among 5%, incarceration among 5%, and residential drug treatment among 8%. ARVs were commonly discontinued those events. Treatment interruptions were

associated with significant increases in VL among clients who had previously achieved undetectable or suppressed VL.

The assessment of clients with highly detectable VL identified a series of challenges to achieving and sustaining undetectable VL. Missed opportunities related to low rates of ARV resistance testing to inform prescribing, patient treatment education and adherence counseling, and re-engagement of clients. Unanticipated consequences resulting in detectable VL were associated with interventions such as hospitalizations. Lessons learned through the assessment will be integrated into several components of the Initiative including improved clinical processes, expanded behavioral assessments, clinical and non-clinical interventions, and new re-engagement strategies.

Low Health Insurance Rates Impede Access to ARVs and Lower Rates of Viral Suppression: In FY2018, 42% of RWHAP clients were uninsured, versus 25% with private insurance, 20% Medicare, and 9% Medicaid. In CY2018, 54% of Part A clients would have been Medicaid eligible if they resided in states with expanded Medicaid enrollment. Despite the need Medicaid expansion and the loss of federal funds to support expansion, the FL Governor and Legislature refuse to expand Medicaid. While clients might access insurance via the ACA Marketplace, <1% of clients have household incomes <400% FPL required to receive financial subsidies. Some RWHAP clients cannot enroll in publicly funded insurance, including the ACA, due to legal status. While the Recipient and HIVPC have been strategic in maximizing resources by funding Health Insurance Continuation Program (HICP), that strategy is limited by the large number of HIV+ who are not enrolled in private insurance.

Capacity of Broward's RWHAP Clinical Infrastructure is Inadequate: Despite the scale and complexity of Broward's HIV epidemic, clinical infrastructure is surprisingly lean. Five OAHS subrecipients serve Parts A and C clients. Two tax district hospitals have three HIV outpatient department clinics in community settings, two CHCs operate four HIV community clinic sites, and one ASO has three community clinic sites. The tax district clinics can only accept patients that reside in their service areas. All clinic sites are relatively small, with clinical, administrative, case management, support service, and CIED staff sharing the space. The physical limitations of most of the sites impede the subrecipients' capacity to

efficiently move patients through registration, exam room, lab station, and other stops in a medical visit. While several clinics operate until the early evening, no clinic offers weekend hours. Other indicators of capacity are also constrained at most sites including waiting room and parking lot size.

Clinical staff capacity is relatively limited compared to other RWHAP EMAs. The number of full-time equivalent (FTE) clinicians supported by Part A funds is relatively small, with about 6.5 FTEs. Only two subrecipients employ physician assistants (PA) or advanced practice nurses, with physicians managing most RWHAP clients. The Parts C and D recipient funds an additional two FTE physicians who serve pediatric, adolescent, and adult female patients. While the five subrecipients employ 21 clinicians in total, most of them are part-time or serve private or publicly funded patients not enrolled in RWHAP.

Unlike other US counties with similar size HIV epidemics, Broward has no medical school or teaching hospital with faculty, clinical fellows, or students that can expand clinical capacity. The only two CHCs in Broward are RWHAP-funded. While there is a small group of community physicians that treat PWH, they are do not participate as RWHAP subrecipients.

3. Behavioral Health

- Broward's public behavioral health system is managed by the Broward Behavioral Health Coalition (BBHC). BBHC provides a comprehensive system of care for substance use, mental health, and co-occurring disorders
- After the Marjorie Stoneman Douglas mass shooting, there has been recognition in Broward County on the pervasive experience of trauma because of violence and focus on trauma informed care
- The Broward Suicide Prevention Coalition was founded in 2019 and is implementing a strategic plan focusing on youth

Barriers to Achieving Undetectable VL: Broward County commissioned a series of assessments to improve understanding of trends in VL testing, the extent to which Part A clients can sustain undetectable VL, and characteristics of clients with highly detectable VL. For the 89 clients with persistent highly detectable VL in CY2017-2018, electronic health records

(EHRs) were reviewed through August 2019. While 75% of the clients' first VL was highly detectable, 84% of last VLs were highly detectable.

Personal factors likely to have contributed to highly detectable VLs were identified. Over one-third (36%) of clients were reported to have poor OAHS appointment adherence, with broken, rescheduled, or canceled appointments common in the observation period. Similarly, clients' EHRs documented refusal of ARVs contributed to highly detectable VLs. While all clients were offered ARVs, 5% did not want to start ARVs or no longer wanted to take them. Among clients refusing ARVs, clinicians counseled them about the benefits of ARVs. Over one-half (55%) of clients had documented ARV treatment adherence issues, with 37% of clients reported having poor ARV adherence. Other issues included ARV side effects, complexity of the regimen, dislike for ARVs, inability to take ARVs due to other medical conditions, forgetting to take ARVs, and ARV treatment interruptions varying from short term "drug holidays" to being off ARVs for long periods.

Almost half (46%) of clients were reported to have one or more behavioral health diagnosis, including chronic depression (29%) and anxiety (8%). Severe chronic mental illness was also common among this group, including schizophrenia, bipolar disorder, and psychosis. Substance abuse and addiction were also common among the clients. Alcohol abuse/ addiction was reported among 7% of clients, compared to cocaine (6%), opioids (6%), methamphetamines (3%), and 18% other substances. It was common that clients were reported to abuse or be addicted to several substances. It is noteworthy that clients tended to volunteer information about their behavioral issues, rather than a thorough behavioral assessment documented in the EHR.

Strengthening Behavioral Health Screening and Treatment: Like the findings of the highly detectable client evaluation, the Recipient has identified the needed for greatly expanded and thorough behavioral health screening and treatment. Although some OAHS clinicians conduct behavioral health screening, tends to focus on identification of depression and anxiety. Results of Part A program monitoring and CQM site visits indicate substantial improvement should be made. Initiative funds are requested to significantly increase the rate of behavioral health screening by trained and experienced clinicians.

C. Projects

1. Neighborhoods and the Built Environment

Broward County is maximizing resources, promoting sustainability, and investing equitably though ballot initiatives to secure funding, policy change, planning and a commitment to racial equity. In November 2018, voters approved a local one cent, 30-year surtax to increase mobility and address transportation challenges in Broward County. The detailed plan is designed to reduce traffic congestion, improve roads and bridges, enhance traffic light timing, develop safe sidewalks, and bike paths, expand mass transit, fully fund special needs/on-demand services and community shuttles, connect greenways, enhance school safety zones, and fund a variety of transportation projects. Also, with over 73% of the vote, voters supported the creation of the Broward County Affordable Housing Trust Fund. This solidified the CCB's effort to address stigmas related to affordable housing and helping municipalities, business owners and residents better understand the need for affordable housing and the negative health and economic impacts of the lack of clean, quality affordable housing stock. Another housing policy advancement was the update and expansion of the impact fee waiver program by Broward County Public Schools based on feedback received through the CCB. Additionally, the City of Hollywood and BC entered an Inter Local Agreement which appropriates a total of 50 million dollars for neighborhood revitalization in low to moderate income areas. Current projects underway include:

- Broward County Transit (BCT) implemented 70,000 new annual hours of service since September 2019
- BCT increased the per trip subsidy to $18, further increasing the convenience and value of the program for Broward's disabled or elderly customers
- A new agreement for funding of municipal operated Community Shuttles
- Installed 160 new bus shelters
- Installing free Wi-Fi throughout the entire bus fleet
- Will add 147 new buses to expand services and replace aging buses
- Will add 146 new Paratransit vehicles
- Complete Streets, to make street safe for all users, including those who walk, ride bikes, and use public transportation

- Improving the resiliency of roadway infrastructure to sea-level rise
- Road expansion
- School Safety Zone Improvements
- Upgrading existing traffic communications and Adaptive Traffic Controls Systems

In partnership with Rebuilding Together Broward County, the Broward County Board of County Commissioners approved a Minor Home Repair Pilot Program to assist elderly, veteran, and disabled homeowners in the Broward Municipal Services District. Public/ private partnerships between the Broward County Board of County Commissioners and ten local non-profits resulted in the development of forty new single-family homes completed in mid-2019.

Project:

DOH-Broward HE and EHE will work with the Broward County Affordable Housing Trust Fund, Coordinating Council of Broward, City of Hollywood, Children's Services Council, Broward Behavioral Health Coalition and HOPWA to coordinate the development of informational resources regarding housing options for people living with HIV in Broward County that includes contact information, eligibility requirements, slide fee scales, vouchers, etc. that may assist clients in accessing stable housing.

2. Education Access and Quality

Broward County Public Schools (BCPS) and community partners have had a successful long- term collaboration to improve graduation rates of Black and Hispanic students and close the gap between Black and White student graduation rates. In 2010, Broward County was identified by the Schott Foundation for Public Education as the nation's third worst district for graduating black male students. In response, the Black Male Success Task Force, with over 100 members, was founded in 2012 as a committee of the CSP and has evolved and been institutionalized at Broward County Public School in the Office of Equity and Academic Achievement. Local Universities assisted the taskforce by analyzing data and identifying effective interventions. BCPS's plan has included individualized Turning the Curve strategies for each high school and feeder schools, increased teacher training, mentoring and social services. These data driven efforts

have resulted in improved graduation rates of Black students from 66% in 2013 to 79% in 2018 and for Hispanic students from 80% to 86%. The disparity in graduation rates between Black and White Students has also decreased from 17% in 2013 to 11% in 2018.

In 2018 Broward County Public Schools launched the Equity Liaison program to help teachers and school leaders across the district understand and examine the impact of race on student achievement and the role that discrimination plays in institutionalized racial disparities. 300 Equity Liaisons developed comprehensive equity plans for their schools outlining the goals and benchmarks that guide their work. Equity plans include data analysis of student performance and behavioral incidents based upon race, ethnicity and gender and strategies to ensure equal opportunities for students regarding elective course offerings, advanced academic courses, access to STEM related courses, fair discipline, and equal access to technology. Through developing a common language around discrimination, effective cross sector collaboration, policy changes, securing resources through partnership and ballot initiatives and measurement and monitoring of progress, Broward County is eliminating health disparities, achieving health equity, and building a Culture of Health.

In 2014, voters reauthorized the CSC which funds $80 million dollars in programs, leadership, and advocacy to improve life and health outcomes for children and youth. This reauthorization secured the sustainability of prevention programs including afterschool, summer youth employment, family strengthening, diversion, and life coaches for youth aging out of foster care or who are LGBT or involved with the juvenile justice system. Additionally, CSC Broward has begun implementing racial equity practices in procurements, contracting and collaborations.

The new L.A. LEE YMCA/MIZELL COMMUNITY CENTER located in the Historic Sistrunk community, will impact more than 18,000 people per year and includes a preservation of the history of the community and previous L.A. Lee YMCA. The building is 65,000 square feet, and of that, YMCA traditional programs will be run in about 25,000 square feet. The rest will be Broward College, retail space, community meeting space, and other features available to the community. It will be a Community Center that has a Y in it, along with other programs and offerings the community told us they wanted. The new Y/Community Center will provide:

Traditional Y program offerings – exercise and wellness options, youth programs and activities, family, **Health & wellness programs** – diabetes and cardiovascular disease prevention, **Meeting Space** that supports events from community – family reunions, group meetings, HOAs, a place to gather
Retail space – drive economic development in the corridor and give business owners affordable space to grow business, **Preschool** – to serve the community and continue the legacy of Mrs. Irma Wesley, **Shared Work Space** – Heard many businesses looking for space to set up until the can get on their feet, **Black Box Theater** – opportunity to bring cultural arts to the community and offer programming that the community wants to see, **Swimming Pool** – #1 Priority – teach kids to swim, provide low-impact exercise options.

Project:

DOH-Broward HE and EHE will develop a partnership with the Community Center, CSC, and BCPS to provide inclusive education for young adults and the community regarding HIV awareness (to include testing opportunities and PrEP) and prevention education. Educational opportunities will be provided for minority populations (Black, Hispanic, Haitian), people with HIV, transgender men and women, and young adults.

3. Economic Stability

The Broward Municipal Services District HCZ is comprised of seven of the most marginalized communities in Broward County's most racially segregated, highest poverty neighborhoods. The Broward County Board of Commissioners (BOCC) is the governing body of the Broward Municipal Services District. In 2012, the Central County Community Advisory Board (CCCAB) was established to represent the residents of four of these neighborhoods in identifying and addressing issues affecting their community. CCCAB members represent homeowners and civic associations and are a conduit for feedback from and communication with residents. In 2016, the Broward Municipal Services District was designated as an HCZ, increasing the opportunity for community engagement and participation in decision making. Utilizing walking audits and community engagement meetings, residents within the Broward Municipal Services District identified the following barriers: economic development, unemployment, affordable housing, and lack of opportunities for physical

activity and have worked with the Broward County Board of County Commissioners, non-profit organizations, and foundations to make sustainable changes. Broward Municipal Services District works with Broward County's Office of Economic and Small Business Development and has engaged 24 businesses in the Economic Development Program. The Broward County Board of County Commissioners implemented the Transit Transitional Employment Pilot to provide specialized job readiness classes, vocational and job skills training, and employment opportunities to residents over 18 who reside in the target areas and are experiencing a high unemployment rate, low income, disabilities or returning from incarceration.

An investment by the Health Foundation of South Florida, and other Broward County Agencies provides an opportunity for residents in the Delevoe Park area to have access to an outdoor gym to improve their health at no cost, known as Destination Fitness. Destination Fitness ties in with the rich history of the corridor and is part of a triplex with the Urban League and the African American Research Library and Cultural Center.

DOH-Broward HE and EHE will work with the CSC, Broward County Government, CCB to continue to approve and implement policies that provide economic security to individuals living with HIV and Broward County residents.

4. Healthcare Access and Quality

Strategies for improving viral suppression among Broward Black, non-Hispanics must also be tailored to their cultural, linguistic, and health seeking experiences. For example, a large portion of Black, non-Hispanic PWH were born in Haiti. A large portion of Haitian-born RWHAP clients speak only Creole or prefer to speak in Creole to their healthcare providers. Some Haitian-born clients are reported by HIV clinic staff to be reluctant to engage in HIV care due to HIV stigma and concern about disclosure of their HIV status to other Haitian community members. For these reasons, initiative-funded services will be designed and undertaken to account for the cultural and linguistic requirements of clients serviced. Consistent with Broward Part A requirements, services will be undertaken that are culturally competent and recognize the impact of discrimination, homophobia, gender

bias, poverty, and HIV stigma on the diverse clients served. To this end, Initiative-funded services will be client-centered and aim to assist clients to achieve viral suppression by addressing social determinants and other barriers to care.

Project:

DOH-Broward and EHE will work with the Broward County Transportation Options (TOPS) program for individuals diagnosed Mental Health issues to enroll eligible residents in the program. In addition, bus passes and uber gift cards will be implemented to assist individuals living with HIV to access transportation to needed medical appointments.

DOH-Broward HE and EHE will enhance access to HIV testing and PrEP via opportunities for testing and education about PrEP at community events and in underserved communities.

DOH-Broward HE and EHE will provide oversight and subject matter expertise to funded service providers to ensure services are client-centered and aim to assist clients to achieve viral suppression through provision of culturally and linguistically competent client services.

5. Social and Community Context

The Broward County Planning Council incorporated equity into the Broward County Comprehensive Land Use Plan through an “Environmental Justice” policy adopted in 2017. The policy reads “For local and regional land use policy and public infrastructure and services decisions, local governments and agencies should ensure environmental justice when considering the impacts to vulnerable populations, including but not limited to, the economically-disadvantaged, racial and ethnic minorities, the uninsured, low-income children, the elderly, the homeless and those with chronic health conditions, including severe mental illness.”

Broward County uses the Healthy Community Zone (HCZ) model to foster a sense of security, belonging and trust among residents, including marginalized groups. Through the HCZ process, residents are involved in identifying barriers to good health and are included in decision making, while resources are leveraged from community partners to address these barriers.

The HCZ provides ways for those living in traditionally underserved communities to be involved in how health is defined and addressed in their communities. Residents of the HCZs, broadened their characterization of what health is, identified the barriers for healthy food, opportunities for physical activity and clinical care, and provided insights as to what they believed, would be possible solutions. They described how "health" prior to the HCZ was considered by many residents as something clinical in nature, separate from their day-to-day lives. Now, health and wellness are identified as an integral part of their daily lives and their community. Sustainability has been made possible by policies, systems, and environmental improvements that the residents helped to craft and implement along with over 30 partnering agencies. Residents attended Broward County Public Schools, City and County meetings to advocate for community plans supportive of healthy eating, active living, and smoke free outdoor places. Additionally, early wins such as the PATCH urban market gardens and neighborhood wayfinding paths, demonstrated that residents have the power to use their voices to address implicit barriers to health. The HCZs meet residents in their neighborhoods, address their concerns and prepare plans with their solutions. Residents from traditionally underserved communities were able to meet and connect with decision-makers from Broward County Public Schools and City, County and State levels. As a result, long term policy successes directly related to the work by residents in HCZs range from: adoption of Safe Routes to School by Broward County Public Schools; an “Age-Friendly Community” plan to expand elements in the HCZ Community Action Plan to the City level; changes in comprehensive land use plans to approve urban agriculture at the County level; and adoption of Complete Street Guidelines by the Metropolitan Planning Organization at the State level. Improvements that affect all 1.9 million residents of Broward County were made possible, in part, by the involvement of residents where the HCZs have been implemented. Project completed in FY 2020/21.

Building on two Asset Based Community Development (ABCD) pilots funded in FY 2021 – 2022, CSC provided additional funding to support the existing ABCD sites and expand into additional communities using authentic community engagement strategies for residents and youth who live in selected neighborhoods in Broward County in FY 22/23. The ABCD and authentic community engagement strategies should develop long-term relationships and partnerships that further unleash the potential of neighborhood residents to improve the outcomes for children and families in

Broward County. CSC affirms the value and importance of authentic community engagement, resident voice (with an interest in elevating youth voice), agency, and power building to improve community conditions necessary for all Broward County residents to thrive. CSC honors the diversity of experience and expertise necessary to co-create and produce innovative solutions to some of our community's complex problems (Hebert & Gallion, 2016). Building infrastructure to support community leadership development, connection to existing resources, systems, and collaborations, and honoring the community resident priorities are key elements for success. Specifically, research affirms the importance of building and shifting power in local contexts, of community and youth organizing, and the power of narrative to drive improvements (Hebert & Gallion, 2016). Complementary practices to ABCD include local learning partnerships, network building, cross-site learning, using data strategically, and demonstrating tolerance for pushback (Hebert & Gallion, 2016). ABCD is an approach that fosters community led listening sessions and asset mapping, trust and relationship building, and innovative solutions and strategies. These activities promote the co-production of meaningful and impactful solutions and initiatives that support long-term relationships, trust, and resident and community capacity (McKnight & Block, 2012). As a result, ABCD consultants and organizations funded under this procurement must provide the following services and or residential supports:

- Provide ABCD training for community members/youth and other relevant community stakeholders including municipal, non-profit, system, and private organizations. This training should provide a general overview of ABCD for all participants and a much deeper dive into the strategies of Authentic Community Engagement for residents selected for the Civic Design Teams.
- Facilitate the selection process for residents to serve on the Civic Design Teams. Once assembled, on board the CDT members and provide them with the support and resources needed to implement the following core ABCD elements: listening sessions/campaigns, asset mapping, administering, and releasing competitive small community grants, and the implementation of one additional Authentic Community Engagement strategy (i.e., Community Summits, Neighborhood Circles, or Door Knocking).
- Support cross-site learning among the ABCD sites funded by this procurement and share the project findings with relevant community

partners including the CSC and other community partners and collaboratives (e.g., present at the Broward County Funders Forum).

- Conduct the following Project Management Functions:
  - Compensating community members and youth as applicable. For budgeting purposes, CSC recommends a minimum of $300 per month per Civic Design Team Members and expect that there will be seven (7) residents who actively participates in each CDT/location. CDT members are anticipated to work between 10 – 15 hours per month on the ABCD initiative. The consultant will need to provide CDT members with information regarding the tax implications of receiving stipends that exceed $600 per year and require them to submit an IRS 1099 form.
  - Supporting the administration (i.e., awarding of community proposals, notification of awards, release of award funds, monitoring of the funded projects, and evidence of project implementation) for the small community grants released by the CDT via a participatory budgeting approach. For budgeting purposes, CSC requires each CDT (i.e. geographic location hosting an ABCD project) to allocate $15,000.00 for the small community grants.
  - Facilitating meetings, including scheduling, arranging meeting locations, providing materials and supplies, communicating with funders, community members, and municipalities, and entering billing information into CSC's SAMIS system.
- Evaluating and documenting the most significant learning, effects/outcomes, and recommendations to community partners supporting the ABCD efforts and the CSC. The documentation includes quarterly Formative Evaluation reports that focuses on the activities undertaken by the CDT and the experience of building long-term relationships among residents and human service systems for facilitating community led decision making and power building.

DOH-Broward HE and EHE will participate in activities to promote Health Equity in all policies and programming that includes community voices and involvement of residents.

IX. HEALTH EQUITY PLAN OBJECTIVES

Decrease the HIV rate per 100,000 from 1,055.5 to less than 500 per 100,000 by December 2030.

Project: Creating Equitable System Change to Support Priority Populations.

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve access to quality healthcare, specifically increasing transportation access for individuals living with HIV, to access culturally competent health care services.						
Objective: By July 1, 2030, increase people with HIV in care from **84% for Whites, 77% for Blacks and 80% for Hispanics to 100%.	EHE DCM Providers	Joshua Rodriguez	Client and Community Needs Assessments HIV Surveillance Data	**84% White 77% Black 80% Hispanic	100%	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Objective: By July 1, 2030, increase enrollment in behavioral health services for those in need and living with HIV from 46% to 100%.	EHE DCM Providers	Joshua Rodriguez	Client and Community Needs Assessments HIV Surveillance Data	46%	100%	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Key Activities			Key Partners		Process Measures	
DOH-Broward and EHE will work with the Broward County Transportation Options (TOPS) program for individuals diagnosed Mental Health issues to enroll eligible residents in the program. Bus passes and uber gift cards will be implemented to assist individuals living with HIV to access transportation to needed medical appointments. Implement cultural and linguistic requirements with healthcare providers to reduce stigma and increase care seeking of Haitian-born individuals.			Broward County TOPS EHE Program		Number of rides per client scheduled to health care appointments Number of rides per client scheduled to behavioral health appointments Number of clients assisted with payment Number of providers who have adopted cultural and linguistic requirements.	
**Due to the small number of individuals living with HIV belonging to race/ethnicity other than White, Black, and Hispanic, data is presented using White/Black and Hispanic and in some cases includes “other” as available.						

Medium-Term SDOH Goal: Improve access and quality of public transportation options to improve access to jobs, healthcare services, social events, and educational opportunities.						
Objective: By July 1, 2025, increase the number of public transportations by 150.	City of Hollywood and Broward County Transit	Terri Sudden	Broward County Transit	299	349	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Objective: By July 1, 2025, increase the utilization of public transportation from 94,327 daily (2020) to 100,000.	City of Hollywood and Broward County Transit	Terri Sudden	Broward County Transit	94,327 daily (2020)	100,000 daily (2025)	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Key Activities			Key Partners		Process Measures	
Replace aged and add new buses and paratransit vehicles with expanded service locations. Improve the quality of streets in prioritized areas to enhance walkability and bike riding.			City of Hollywood and Broward County MPO		Number of new buses. Number of service locations. Number of streets improved. Street walkability score.	
Medium-Term SDOH Goal: Improve the economic stability of at-risk Broward residents by improving affordable housing options and employment readiness.						
Objective: By July 1, 2025, decrease homelessness from 2561 (2021) to 2,000.	Rebuilding Together Broward County	Terri Sudden	Broward County POINT-IN-TIME HOMELESS COUNT	2,561 (2021)	2,000	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Objective: By July 1, 2025, decrease unemployment rate from 2.5% (April 2022) to 2.0%.	Broward County Board of County Commissioners	Terri Sudden	Y Charts	2.5% (2022)	2.0%	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Key Activities			Key Partners		Process Measures	
Build 1,000 new low-income homes in priority areas. Provide vocational and job skills training via the Transit Transitional Employment Pilot.			Rebuilding Together Broward County, DOH-Broward HE, EHE, Broward County Affordable Housing Trust Fund, Coordinating Council of Broward, City of Hollywood, Children's Services, Broward		The number of new low-income homes built. Number of individuals who were provided job skill training.	

			Behavior Health Coalition, and HOPWA			
Medium-Term SDOH Goal: Improve equitable education and after-school engagement opportunities for children and youth in Broward County.						
Objective: By July 1, 2025, increase grade promotion rate from 99.2% (2019/2020) to 99.4%.	Broward County Public Schools	Renee Podolsky	Broward County Public Schools	99.2% (2019/ 2020)	99.4%	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Objective: By July 1, 2025, increase the number of youths who engage in after-school activities from 553 in 2020/21 (due to staggered return to in-person school) to 2,017	Community Center, CSC, BCPS .	Renee Podolsky	Children's Service Council	553	2017	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Key Activities			Key Partners		Process Measures	
Have 5 schools adopt a teacher mentor program. Open a new community center that holds health and wellness programs, offers meeting spaces, provides a swimming pool, a Black box theater, and exercise activities.			DOH Broward, Broward County Schools, EHE, Community Center, CSC, BCPS.		The number of teachers implementation a mentor program. The opening of a new community center. Activity options for youth to engage.	
Short-Term SDOH Goal: Improve neighborhood cohesiveness and amplify the voices of priority populations.						
Objective: By July 1, 2023, increase the number of residents who identify with a ABCD project from 203 to 400	CSC	Renee Podolsky	Community Health Assessment	203	400	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Key Activities			Key Partners		Process Measures	
Hold quarterly Asset Based Community Development (ABCD) meetings in locations familiar to priority populations.			CSC City of Lauderhill City of Fort Lauderdale North Broward County Site South Broward County Site		Number of ABCD meetings	

Project: Increase access to HIV education and testing

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Increase the number of Broward County residents who get tested for HIV						
Objective: By December 31, 2024, increase the number of Broward County residents who get tested for HIV for the first time from 11,026 in 2019 to 15,134, by increasing access to testing and reducing the stigma of testing for Minority populations (Black, Hispanic, Haitian), adolescents and young adults, transgender men, and women.	PPCs, EHE DCM Providers DOH	Joshua Rodriguez	Client and Community Needs Assessments HIV Surveillance Data	11,026	15,134	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Key Activities			Key Partners		Process Measures	
Provide inclusive education for young adults and the community regarding HIV awareness (to include testing opportunities and PrEP) and prevention education. Educational opportunities will be provided for minority populations (Black, Hispanic, Haitian), transgender men and women, and young adults.			L.A. Lee YMCA/Mizell Community Center Community Services Council Broward County Public Schools		Events held Individuals Educated Groups Educated Individuals tested Individuals enrolled in Prep	
Medium-Term SDOH Goal: Increase the availability of HIV educational and testing opportunities for Broward County Residents						
Objective: By December 31, 2023, decrease the rate of new HIV Infection from 32.4 per 100,000 to 26.32 by providing HIV educational events (0-500 individuals; 0-20 groups) and testing opportunities (0-20 events) to Broward County residents via new partnerships to provide inclusive education for young adults and the community regarding HIV awareness (to include testing opportunities and PrEP education) and prevention by reducing the stigma of testing for Minority populations (Black, Hispanic, Haitian), adolescents	PPCs, EHE DCM Providers OH	Joshua Rodriguez	Client and Community Needs Assessments HIV Surveillance Data	0	500 individuals 20 groups 20 testing events	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan

and young adults, transgender men and women.						
Key Activities			Key Partners		Process Measures	
Provide inclusive education for young adults and the community regarding HIV awareness (to include testing opportunities and PrEP) and prevention education. Educational opportunities will be provided for minority populations (Black, Hispanic, Haitian), transgender men and women, and young adults. Mobile testing will be provided on site.			L.A. Lee YMCA/Mizell Community Center Community Services Council Broward County Public Schools		Events held Individuals Educated Groups Educated Individuals tested Individuals referred for Prep	
Short-Term SDOH Goal: Increase the availability of HIV educational opportunities for Broward County Residents						
Objective: By July 1, 2023, engage in 3 new partnerships to provide inclusive education for young adults and the community regarding HIV awareness (to include testing opportunities and PrEP education) and prevention by reducing the stigma of testing for Minority populations (Black, Hispanic, Haitian), adolescents and young adults, transgender men, and women.	PPCs, EHE DCM Providers DOH	Joshua Rodriguez	Client and Community Needs Assessments HIV Surveillance Data	0	3	PMQI Plan SHIP and CHIP EHE Plan Broward County Integrated HIV Prevention and Care Plan
Key Activities			Key Partners		Process Measures	
Develop partnerships to provide inclusive education for young adults and the community regarding HIV awareness (to include testing opportunities and PrEP) and prevention education. Educational opportunities will be provided for minority populations (Black, Hispanic, Haitian), transgender men and women, and young adults.			L.A. Lee YMCA/Mizell Community Center Community Services Council Broward County Public Schools		Partnerships developed Curriculum developed Curriculum approved	

X. PERFORMANCE TRACKING AND REPORTING

Ongoing communication is critical to the achievement of health equity goals and the institutionalization of a health equity focus. The successes of Health Equity Plan projects are shared with OMHHE, partners, other CHDs, CHD staff, and the Central Office through systematic information-sharing, networking, collecting, and reporting on knowledge gained, so that lessons learned can be replicated in other counties and programs. Regional Health Equity Coordinators facilitate systematic communication within their region.

The Minority Health Liaison serves as the point of contact in their county for sharing progress updates, implementation barriers, and practices associated with the Health Equity Plan. The Minority Health Liaison is responsible for gathering data and monitoring and reporting progress achieved on the goals and objectives of the Health Equity Plan. At least quarterly, the Minority Health Liaison meets with the Health Equity Taskforce to discuss progress and barriers. The Minority Health Liaison tracks and submits indicator values to the OMHHE within 15 days of the quarter end.

Annually, the Minority Health Liaison submits a Health Equity Plan Annual Report assessing progress toward reaching goals, objectives, achievements, obstacles, and revisions to the Regional Health Equity Coordinator and Coalition. The Regional Health Equity Coordinator and Coalition leaders provide feedback to the Minority Health Liaison and the Health Equity Taskforce from these annual reports. The Minority Health Liaison then submits the completed report to OMHHE by July 15th annually.

DOH-Broward developed and implemented a performance management system to continuously monitor organizational performance. To ensure alignment with public health objectives and the needs of our customer groups, DOH-Broward established metrics to manage processes and activities at all levels, down to the individual employee, using cascading scorecards. Employee metrics are linked to employee performance evaluations using Specific, Measurable, Actionable, Reasonable, Timely (SMART) goals. This ensures that DOH-Broward is aligned to the goals and objectives in the Community Health Improvement Plan, the DOH Strategic Plan, the State Health Improvement Plan, the Long-Range Program

Plan, and that DOH-Broward meets indicator targets on the CHD Administrative Snapshot, County Performance Snapshot, and CHD Dashboard.

Major industry sources of comparative data used by DOH-Broward include the state of Florida managed applications such as Florida Health Community Health Assessment Resource Tool Set (CHARTS) for health statistics, MERLIN for communicable diseases surveillance and investigations, Environmental Health Database for environmental health and engineering reporting, and Financial and Information Reporting System (FIRS) for budget and financial reporting. Additionally, DOH provides reports via email and intranet in the form of the Administrative Snapshot, CHD Snapshot, Accounts Receivable Control Report, Vaccine Accountability Report, Family Planning Quarterly Snapshot, Florida Annual Immunization Assessment Report and the EHR Meaningful Use Report. Furthermore, additional reports regarding Florida CHDs are available on the DOH Bureau of Community Health Assessment Report Center through the DOH Intranet. Finally, national public health comparative/competitive data is available from the Centers for Disease Control and Prevention (CDC) via CD Wonder Database, the Behavioral Risk Factor Surveillance Survey (BRFSS), Youth Risk Behavior Surveillance Survey (YRBSS) and the Youth Tobacco Survey. National and international data is available through the American Community Survey by the United States Census Bureau. Most of the above sources are limited to morbidity and mortality rates which are very useful for planning and resource allocation. DOH-Broward is unique in that we review process metrics segmented by site and program monthly. This level of data granularity gives us a greater level of control in the overall annual outcomes by giving us more opportunities to proactively make corrective adjustments throughout the year.

The Minority Health Liaison will be responsible for analyzing and reporting monthly progress for presentation at the DOH-Broward monthly business review meetings. These monthly business review meetings are conducted with leadership and all program managers to review programmatic metrics. Under-performing metrics are presented in a “SAG” format – “**S**ituation”, “**A**ction to be Taken” “**G**oal” for each metric. Organizational leadership and program managers provide additional input on methods to improve underperforming metrics with improvements/progress tracked from month to month.

XI. REVISIONS

Annually, the Health Equity Taskforce reviews the Health Equity Plan to identify strengths, opportunities for improvement, and lessons learned. This information is then used to revise the plan as needed.

Revision	Revised By	Revision Date	Rationale for Revision

XII. APPENDICES

Appendix 1. Coalitions

HIV PLANNING/ADVISORY GROUPS

Broward County HIV Prevention Planning Council (BCHPPC)
Biomedical Advisory Group
Men Who have Sex with Men Advisory Group
Black Treatment Advocates Network (BTAN)
Latinos en Acción Advisory Group
Broward County Public Schools Student Advisory Meeting
Perinatal Advisory Group
Medical/Disease Case Management Network Meeting
Integrated HIV Prevention & Care Workgroup
HIV Health Services Planning Council (HIVPC)
South Florida AIDS Network (SFAN)
HIV Prevention Contracts Provider Meeting
Coordinating Council of Broward
Homeless Continuum of Care Advisory Board
Healthcare Access Committee

EXISTING PARTNERS RE-ENGAGED:

- Broward House
- CenterLink LGBT Centers
- Equality Florida
- Midway Specialty Care Center
- Care Resource
- Urban League of Broward
- Midland Medical Center
- Broward County Public Schools
- Midland Medical Center
- CAN Community Center
- Latino Salud
- CAN Community Center
- Ryan White Program Office
- CVS Health
- Broward Health
- Broward College
- Broward Regional Health Planning Council
- Walgreens
- South Florida Wellness Network
- World AIDS Museum
- TranSocial
- Pride Center
- High Impacto
- AIDS Healthcare Foundation
- Poverello Live Well Center
- Legal Aid Service of Broward
- Memorial Physician Group
- Fort Lauderdale Police Department
- Broward Sherriff's Office
- Arianna's Center
- Ujima Men Collective
- Independent Medical Group
- Holy Cross Hospital Medical Group
- Broward Community & Family Health Centers
- CLEAR

NEW PARTNERS/STAKEHOLDERS ENGAGED:

- Aging and Disability Resource Center
- American Cancer Society
- Broward Behavioral Health Coalition
- Broward Workshop
- Career Source Broward
- ChildNet
- Children's Services Council
- Community Foundation of Broward
- Department of Children & Families
- Early Learning Coalition of Broward
- Greater Fort Lauderdale Alliance/Six Pillars
- Health Foundation of South Florida
- Jewish Federation of Broward County
- South Florida Regional Planning Council

Appendix 2. 2022 DOH-Broward Culturally and Linguistically Appropriate Services-CLAS

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:		
Principal Standard:		
1	Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	Staff informs clients of services offered in the consumer's preferred language, collects client information via intake and needs assessment and addresses clients' needs through coordination of care with culturally and linguistically appropriate collateral providers.
Governance, Leadership, and Workforce:		
2	Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	DOH-Broward Leadership support CLAS and facilitate the implementation of the National CLAS Standards. DOH Office of Minority Health oversees the promotion of and training on the Cultural and Linguistic Appropriate Services (CLAS) Standards.
3.	Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	DOH-Broward recruits and hires staff that reflects the population/communities served by employing pipeline programs to facilitate diversity recruitment and retention and employing advocates for patient rights. Staff are provided opportunities for health care professionals to participate in cultural competency education and training on a regular basis through annual and new employee trainings. <u>Trainings within 30 days of hire:</u> (1) Addressing Health Equity: A Public Health Essential. (2) FDOH Unnatural Causes 1: Is inequality making us sick? (3) Cultural Awareness: Introduction to Cultural Competency. (4) Equal opportunity training
4.	Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	Staff is knowledgeable about diverse cultural groups and populations, including religious, ethnic, and racial groups, and has an appreciation for differences in values, beliefs, and customs.

Communication and Language Assistance:		
5.	Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	Multi-lingual staff have the capability to serve Haitian-Creole, French, Spanish, Portuguese, and English-speaking clients in their native language. The Language Line is utilized when needed. Additionally, DOH-Broward Program Directors ensure that department staff, volunteers, and providers of client services are trained on how to assist sensory and mobility impaired limited English proficiency clients and potential clients to obtain assisting devices and aids, or other reasonable accommodations.
6.	Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	Posters in multiple languages with available language services are visible at all DOH-Broward service sites.
7.	Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	Staff is knowledgeable about diverse cultural groups and populations, including religious, ethnic, and racial groups, and has an appreciation for differences in values, beliefs, and customs. DOH offers translator courses to staff on a regular basis at no cost to the employee. During the new hire process, Talent Management supplies each new employee with a Language Line Solutions Interpreter access card that is worn with the DOH-Broward ID badge; this ensures that language assistance information is readily available.
8	Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	In addition to English, handouts and forms are available in Spanish, Portuguese, and Haitian-Creole for clients needing information in their native language.

Engagement, Continuous Improvement, and Accountability:		
9	Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	DOH-Broward plans outline clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. Promotes the Standards internally and externally by creating and instituting CLAS-specific organizational plans, providing CLAS-related training opportunities for staff, and publishing community health needs assessments and diversity reports online.
10	Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	Every five years, a community health assessment is conducted. The CLAS assessment is reviewed and updated annually.
11	Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	Demographic data is maintained in HMS and FL WISE. FL Health CHARTS and GIS mapping are also used to inform service delivery.
12	Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	Every five years DOH-Broward conducts a community health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.
13	Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	DOH-Broward engages their local community in outreach activities, focus groups, and advocates for resources to support implementation.
14	Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	DOH-Broward has an established customer service and grievance procedure that is available in the customer's choice of language. Results are reviewed, analyzed, and discussed for areas of improvement at monthly Performance Management Council meetings that are attended by leadership and staff.

15	Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the public.	Adherence to CLAS standards is reviewed during audits and at monthly Performance Management Council meetings to conduct a business review. DOH-Broward foundational plans are posted on the website for community feedback, comment, and input.

Appendix 3. Analysis of the Health Disparities Among People living with a Disability

KNOWLI DATA SCIENCE
Informed Decisions. Better Outcomes.

Author: Knowli Data Science and the FSU Claude Pepper Center Faculty
Date: Wednesday, June 8, 2022

To Whom it May Concern:

This workbook accompanies Deliverable 6.5.2, "Data Analysis," for the following project:
Analysis of the Health Disparities Among
People living with Disability

This excel workbook contains 68 tables:

Sheet 1	Statewide Descriptive Statistics and Statistical Difference Tests (χ2 and T-Tests) Comparing Across Disability Status
Sheets 2 -68	County-Specific Descriptive Statistics, Statistical Difference Tests (χ2 and T-Tests)

Please do not hesitate to contact our Research Team with any questions or to request additional information.

All Best,
Emily & Team

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Informed Decisions. Better Outcomes.

Broward County Descriptive Statistics and t-Test and χ2 Test Results Comparing Across Disability Status

	Total Population (Ages 18 to 65)		People with No Disabilities (Ages 18-65)		People with At Least 1 Disability (Ages 18-65)		PLW 0 vs. PLW 1+ Difference tests (χ2 and t-Tests)
Measure	*Mean/Prop*	*N*	*Mean/Prop*	*N*	*Mean/Prop*	*N*	
Disability Measures							
Deaf (Yes=1)	0.03	282	-	-	0.13	58	***
Blind (Yes=1)	0.06	279	-	-	0.28	57	***
Difficulty Concentrating or Remembering (Yes=1)	0.12	279	-	-	0.59	58	***
Difficulty Walking (Yes=1)	0.88	279	-	-	0.41	58	***
Difficulty Dressing or Bathing (Yes=1)	0.10	279	-	-	0.49	58	***
Difficulty Doing Errands Alone (Yes=1)	0.04	279	-	-	0.19	58	***
General Health Measures							
General Health	3.55	293	3.69	225	2.95	57	***
Number of Days Physical Health Not Good	3.51	290	1.96	221	9.95	58	***
Number of Days of Poor Physical and Mental Health	1.81	291	0.18	224	8.56	56	***
Ever Depressive Disorder Diagnosis (Yes=1)	0.14	293	0.05	224	0.50	58	***
Weight (In Pounds)	173.09	267	171.02	207	180.50	58	Not Sig.
Height (In Inches)	67.18	262	67.09	204	67.20	55	+
Weight (In kg)	78.32	273	77.34	213	81.87	58	Not Sig.
Height (In Meters)	1.71	263	1.70	205	1.71	55	+
BMI (kg/m^2)	27.08	255	26.84	198	28.01	55	*
Smoke at least 100 Cigarettes in Life (Yes=1)	0.70	277	0.69	219	0.73	58	Not Sig.
Number of Cigarettes Smoked a Day							Not Sig.
Not at all	0.85	276	0.86	219	0.82	57	
Some Days	0.06	276	0.05	219	0.12	57	
Everyday	0.09	276	0.09	219	0.06	57	
Exercise (Yes=1)	0.71	266	0.76	213	0.53	53	*
Cardiovascular Health Measures							
High Blood Pressure (Yes=1)	0.27	294	0.22	225	0.50	58	***
Blood Pressure Medication (Yes=1)	0.74	82	0.64	51	0.91	28	Not Sig.
High Cholesterol (Yes=1)	0.34	275	0.29	208	0.56	56	**
Cholesterol Medication (Yes=1)	0.42	87	0.39	56	0.50	28	Not Sig.
Heart Attack (Yes=1)	0.02	292	0.01	224	0.05	57	**
Heart Disease (Yes=1)	0.03	293	0.03	225	0.05	57	Not Sig.
Stroke (Yes=1)	0.04	294	0.01	225	0.16	58	***
Diabetes Measures							
Diabetes (Yes=1)	0.06	293	0.05	225	0.11	57	**
Age Diagnosed with Diabetes	43.75	18	43.73	10	43.78	8	Not Sig.
Pre-Diabetes (Yes=1)	0.10	258	0.08	203	0.20	45	+
Had Diabetes Test in Last 3 Years (Yes=1)	0.60	250	0.56	198	0.71	43	Not Sig.
Had Class on Diabetes Education (Yes=1)	0.50	19	0.39	9	0.65	10	Not Sig.
Respiratory Health Measures							
Ever Diagnosed with Asthma (Yes=1)	0.13	293	0.11	225	0.14	57	+
Currently Has Asthma (Yes=1)	0.08	292	0.06	224	0.10	57	*
C.O.P.D. (Yes=1)	0.04	292	0.03	225	0.08	57	+
Social Determinants of Health Measures							
Income							**
Less than $10,000	0.05	249	0.03	192	0.11	52	
Less than $15,000 ($10,000 to less than $15,000)	0.03	249	0.02	192	0.09	52	
Less than $20,000 ($15,000 to less than $20,000)	0.07	249	0.06	192	0.14	52	
Less than $25,000 ($20,000 to less than $25,000)	0.17	249	0.15	192	0.22	52	
Less than $35,000 ($25,000 to less than $35,000)	0.12	249	0.12	192	0.10	52	
Less than $50,000 ($35,000 to less than $50,000)	0.19	249	0.22	192	0.12	52	
Less than $75,000 ($50,000 to less than $75,000)	0.14	249	0.14	192	0.07	52	
$75,000 or more	0.24	249	0.25	192	0.15	52	
Education							**
Never attended school or only attended kindergarten	0.00	294	0.00	225	0.00	58	
Grades 1 though 8 (Elementary)	0.05	294	0.04	225	0.06	58	
Grades 9 through 11 (Some High School)	0.06	294	0.04	225	0.11	58	
Grades 12 or GED (High School Graduate)	0.22	294	0.19	225	0.33	58	
College 1 Year to 3 Years (Some college or tech school)	0.40	294	0.44	225	0.28	58	
College 4 years or more (College Graduate)	0.28	294	0.28	225	0.21	58	
Not Able to Pay Bills in Last 12 Months (Yes=1)	0.13	233	0.08	185	0.31	48	***
Moved More than 2 Times in Last 12 Months (Yes=1)	0.06	234	0.02	184	0.20	50	**
Consider Neighborhood Unsafe (Yes=1)	0.09	235	0.05	186	0.25	49	**
Food Insecure-Not Enough Money for Food (Yes=1)	0.26	233	0.20	184	0.48	49	***
Food Insecure-Not Enough Money for Balanced Meals (Yes=1)	0.31	232	0.23	183	0.57	49	***
Financially Insecure (Yes=1)	0.13	228	0.07	180	0.37	48	***
Could Not Take Medication Because of Cost (Yes=1)	0.12	279	0.07	213	0.35	56	***
Experience Stress Most or All of the Time (Yes=1)	0.15	231	0.09	184	0.35	47	***
Last Medical Checkup Within Past 12 Months (Yes=1)	0.74	292	0.70	223	0.85	58	Not Sig.
Health Care Coverage (Yes=1)	0.81	293	0.83	224	0.76	58	Not Sig.
Most Important Reason for Delayed Medical Care-Transportation (Yes=1)	0.06	276	0.03	211	0.21	55	***

Note: *** p<0.001, ** p<.01, * p<.05, + p<0.1

Appendix 4. Health Equity Profile – Broward County, Florida 2020 (from FLHealth Charts)

(See Next Page)

Florida Department of Health
Bureau of Community Health Assessment
Division of Public Health Statistics and Performance Management

Health Equity Profile - Broward County, Florida 2020

			RACE/ETHNICITY						COUNTY RATE RATIOS				STATE RATE RATIOS			
Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non-Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic
Population																
Population	Total Population	2020	1,946,104	63.1%	30.2%	6.7%	31.1%	68.9%	0.5:1	0.1:1	0.5:1	2.2:1	0.2:1	0.1:1	0.4:1	2.7:1
Population under 18	Population under 18	2020	409,671	54.1%	37.5%	8.4%	33.8%	66.2%	0.7:1	0.2:1	0.5:1	2:1	0.3:1	0.1:1	0.5:1	2.1:1
Population 18-64	Population 18-64	2020	1,202,977	62.6%	30.6%	6.7%	32.8%	67.2%	0.5:1	0.1:1	0.5:1	2:1	0.2:1	0.1:1	0.4:1	2.5:1
Population 65 and Over	Population 65+	2020	333,456	75.6%	19.8%	4.5%	21.5%	78.5%	0.3:1	0.1:1	0.3:1	3.7:1	0.1:1	0:1	0.2:1	5.3:1
Income and Employment																
Income Inequality	Index	2016-20	0.4893													
Median household income	Dollars	2016-20	$60,922	$66,381	$49,656	$54,314	$58,851	$69,806	0.7:1	0.8:1	0.8:1	1.2:1	0.7:1	0.8:1		
Households with 1 worker	Percent	2016-20	39.4													
Individuals below poverty level	Percent	2016-20	12.7	10.9	16.7	12.1	13	9.4	1.5:1	1.1:1	1.4:1	0.7:1	1.8:1	1.3:1	1.7:1	0.6:1
Children under 18 below poverty level	Percent	2016-20	16.9	12.7	24.5	19.1	15.8	9.4	1.9:1	1.5:1	1.7:1	0.6:1	2:1	1.7:1	1.9:1	0.5:1
Unemployed civilian labor force	Percent	2016-20	5.9	4.6	8.1	6.8	5.7	4.4	1.8:1	1.5:1	1.3:1	0.8:1	1.8:1	1.2:1	1.1:1	0.9:1
Civilian labor force employed in management, business, science, or arts	Percent	2016-20	37													
Housing and Households																
Occupied households with monthly housing costs of 30% or more of household income	Percent	2016-20	42.9													
Occupied housing units without a vehicle	Percent	2016-20	6.8													
Median owner-occupied housing unit value	Dollars	2016-20	$282,400													
Owner-occupied housing units	Percent	2016-20	62.8	68.4	49.7	52.7	57.1	72.5	0.7:1	0.8:1	0.8:1	1.3:1	0.7:1	0.7:1	0.7:1	1.4:1
Owner-occupied households with monthly housing costs of 30% or more of household income	Percent	2016-20	33.2													
Renter-occupied housing units	Percent	2016-20	37.2	31.6	50.3	47.3	42.9	27.5	1.6:1	1.5:1	1.6:1	0.6:1	1.8:1	1.8:1	1.9:1	0.5:1
Renter-occupied households with gross rent costing 30% or more of household income	Percent	2016-20	61.8													
Rental vacancy rate	Percent	2016-20	6.8													
Severe housing problems	Percent	2018	24.2													
Individuals 1 year and over that lived in a different house 1 year earlier	Percent	2016-20	13.4	13	14.1	4.5	13.4	12.9	1.1:1	0.3:1	1:1	1:1	1.2:1	0.5:1	1:1	1:1
Occupied housing units with more than 1 occupant	Percent	2016-20	4.1	2.8	7.3	7.5	6	1.3	2.6:1	2.7:1	4.6:1	0.2:1	2.3:1	3.6:1	5.3:1	0.2:1

Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non-Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic
per room																
Homeless	Count	2020	2312													
Children under 18 in single-parent households	Percent	2016-20	53.3													
Community Determinants																
Life expectancy	Years	2018-20	80.6 (80.4-80.7)													
Racial residential segregation	Index	2019	0.51													
Individuals 25 years and over with no high school diploma	Percent	2016-20	10.6	8.3	14.3	18.8	13.5	5.9	1.7:1	2.3:1	2.3:1	0.4:1	1.7:1	2.5:1	2.8:1	0.4:1
High school graduation rate	Percent	2020	89.4	92.4	86.5		90		0.9:1				0.9:1			
Population living within ½ mile of a park	Percent	2019	69.8													
Population living within ½ mile of a fast food restaurant	Percent	2019	50.1													
Workers who walked to work	Percent	2016-20	1.2													
Behaviors and Exposures																
Adults who are current smokers	Percent	2019	12.6	16.5	7.8		12.2		0.5:1				0.8:1			
Adults who engage in heavy or binge drinking	Percent	2019	16.7	21.2	6.3		19.3		0.3:1				0.7:1			
Adults who are obese	Percent	2019	27.1	20.4	35.2		30.1		1.7:1				1.4:1			
Adults who are overweight	Percent	2019	37.9	39.2	34.6		42.9		0.9:1				0.9:1			
Adults who are sedentary	Percent	2019	24.1	22.6	28.1		22.6		1.2:1				1.2:1			
Adults who are inactive or insufficiently active	Percent	2016	58.4	56.1	67.7		52.5		1.2:1				1.2:1			
Adults who meet aerobic recommendations	Percent	2016	43.1	44.8	33.5		49.7		0.7:1				0.8:1			
Adults who meet muscle strengthening recommendations	Percent	2019	32.7	35.4	32.4		32.1		0.9:1				1.1:1			
Out-of-school suspensions grades K-12	Per 100,000 population	2020	1430.4													
Inmate Admissions	Count	2020	973													
Incarceration rate	Per 1,000 population	2020	1.5													
Access to Care																
Civilian non-institutionalized population with health insurance	Percent	2016-20	85.8	87.4	83.7	78.9	82	90.5	1:1	0.9:1	0.9:1	1.1:1	1:1	0.9:1	0.9:1	1.1:1
Adults who could not see a doctor at least once in the past year due to cost	Percent	2019	18.5	13.7	22.8		21.4		1.7:1				1.2:1			
Adults who have a personal doctor	Percent	2019	72.8	77.1	79		64.2		1:1				0.9:1			
Adults who said their overall health was good to excellent	Percent	2019	81.2	81	82.8		78.3		1:1				1:1			
Adults who had a medical checkup in the past year	Percent	2019	80.8	82.3	88.1		73.9		1.1:1				1:1			
Adults who visited a dentist or a dental clinic in the past year	Percent	2016	62.5	69.8	50.5		60.5		0.7:1				0.9:1			

Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non-Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic
Adults who received a flu shot in the past year	Percent	2019	30.6	35.6	24.5		29.7		0.7:1				0.8:1			
Adults who have ever received a pneumonia vaccination	Percent	2019	28.1	34.9	23.8		23.1		0.7:1				0.7:1			
Diet/nutrition																
Food insecurity rate	Percent	2019	9.9													
Child food insecurity rate	Percent	2019	15.5													
Households receiving cash public assistance or food stamps	Percent	2016-20	13.6													
Ambulatory Care Sensitive Hospitalizations From Nutritional Deficiencies (Aged 0-64 Years)	Per 100,000 population	2020	50.9													
Nutritional deficiency age-adjusted death rate	Per 100,000 population	2020	0.5	0.5	0.7	1.8	0	0.7	1.4:1	3.6:1	0:1	N/A	1.4:1	1:1	0.4:1	2.5:1
Health Outcomes																
Cancer																
Cancer Incidence	Per 100,000 population	2018	414.7	429.4	361.4	247.2	320.7	445.1	0.8:1	0.6:1	0.7:1	1.4:1	0.9:1	0.7:1	0.7:1	1.4:1
Cancer cases diagnosed at advanced stage	Percent	2018	45.3	44.4	50.2		48.2	44.6	1.1:1		1.1:1	0.9:1	1.1:1		1:1	1:1
Cancer age-adjusted death rate	Per 100,000 population	2020	127.9	129.5	121.1	120.2	101.3	135.6	0.9:1	0.9:1	0.7:1	1.3:1	1:1	0.8:1	0.7:1	1.4:1
Cervical Cancer																
Women 18 years of age and older who received a Pap test in the past year	Percent	2016	54.7	54.8	56.3		54.7		1:1				1.2:1			
Cervical cancer age-adjusted incidence rate	Per 100,000 Females	2018	7.5	7.2	9.4	6.8	6.7	8	1.3:1	0.9:1	0.8:1	1.2:1	1.4:1	0.8:1	0.9:1	1.1:1
Cervical cancer age-adjusted death rate	Per 100,000 Females	2020	3.1	2.5	5.2	1.2	2.9		2.1:1	0.5:1			1.5:1	0.4:1		
Prostate Cancer																
Men 50 years of age and older who received a PSA test in the past two years	Percent	2016	56.1	62.8									0.8:1			
Prostate cancer age-adjusted incidence rate	Per 100,000 Males	2018	77.4	71.3	103.9	44.6	69.2	79.9	1.5:1	0.6:1	0.9:1	1.2:1	1.6:1	0.7:1	0.9:1	1.1:1
Prostate cancer age-adjusted death rate	Per 100,000 Males	2020	15	11.8	31	15.4	11.5		2.6:1	1.3:1			2.2:1	1:1		
Breast Cancer																
Women 40 years of age and older who received a mammogram in the past year	Percent	2016	62.3	56.9			80.3						1:1			
Breast cancer age-adjusted incidence rate	Per 100,000 Females	2018	116.6	121.1	104.8	65.5	90.6	124.8	0.9:1	0.5:1	0.7:1	1.4:1	0.9:1	0.9:1	0.7:1	1.4:1
Breast cancer age-adjusted death rate	Per 100,000 Females	2020	16.5	14.4	20.7	18.1	10.1		1.4:1	1.3:1			1.4:1	0.8:1		
Colorectal Cancer																
Adults 50 years of age and older who received a sigmoidoscopy or colonoscopy in the past five years	Percent	2016	50.1	50	58.8		50.8		1.2:1				0.9:1			
Adults 50 years of age and older who received a blood stool test in the	Percent	2016	14.3	11.9	16.6		19.6		1.4:1				1.2:1			

Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non-Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic
past year																
Colorectal cancer age-adjusted incidence rate	Per 100,000 Population	2018	34.5	34.6	35.9	16.6	27.1	37.1	1:1	0.5:1	0.7:1	1.4:1	1.1:1	0.8:1	0.8:1	1.2:1
Colorectal cancer age-adjusted death rate	Per 100,000 Population	2020	12.2	11.8	12.3	12.8	10.2		1:1	1.1:1			1.2:1	0.9:1		
Lung Cancer																
Lung cancer age-adjusted incidence rate	Per 100,000 Population	2018	44.3	49.1	27.1	30	25.8	49.8	0.6:1	0.6:1	0.5:1	1.9:1	0.7:1	0.6:1	0.6:1	1.8:1
Lung cancer age-adjusted death rate	Per 100,000 Population	2020	24.9	27.2	17.2	19	12.4		0.6:1	0.7:1			0.7:1	0.6:1		
Chronic Lower Respiratory Disease (CLRD) and Asthma																
Emergency room visits due to asthma, age-adjusted rate	Per 100,000 Population	2020	323.7	192.1	567.1	260	195.7	386.7	3:1	1.4:1	0.5:1	2:1	3.2:1	2.8:1	0.8:1	1.2:1
Age-adjusted asthma hospitalization rate	Per 100,000 Population	2020	443.9	332.2	657.1	428.8	290.8	515.6	2:1	1.3:1	0.6:1	1.8:1	2:1	2.4:1	0.8:1	1.2:1
Hospitalizations from C.L.R.D. (including asthma)	Per 100,000 population	2020	128.1	116.6	139.7	120.1	75	148.1	1.2:1	1:1	0.5:1	2:1	1.5:1	1.6:1	0.7:1	1.5:1
Chronic Lower Respiratory Disease (CLRD) age-adjusted death rate	Per 100,000 population	2020	28.3	31	17.8	18.1	17.3	30.4	0.6:1	0.6:1	0.6:1	1.8:1	0.6:1	0.4:1	0.5:1	1.9:1
Diabetes																
Adults who have ever been told they had diabetes	Percent	2019	11.5	10.7	14.5		7.6		1.4:1				1.4:1			
Emergency room visits due to diabetes	Per 100,000 population	2020	209.3	124	425.2	186.8	115.5	251.6	3.4:1	1.5:1	0.5:1	2.2:1	3.4:1	2.6:1	0.8:1	1.2:1
Ambulatory Care Sensitive Hospitalizations From Diabetes (Aged 0-64 Years)	Per 100,000 population	2020	105.3													
Hospitalizations from or with diabetes	Per 100,000 population	2020	1878.6	1428.7	2952.3	2740.2	1357.4	2080.7	2.1:1	1.9:1	0.7:1	1.5:1	2.2:1	2.6:1	0.9:1	1.1:1
Diabetes age-adjusted death rate	Per 100,000 population	2020	23.5	17.4	44.4	28.3	18	25.3	2.6:1	1.6:1	0.7:1	1.4:1	2.4:1	1.2:1	1:1	1:1
Heart Disease																
Coronary heart disease age-adjusted hospitalization rate	Per 100,000 Population	2020	183.1	174.7	167.1	337.4	142.7	196.8	1:1	1.9:1	0.7:1	1.4:1	1:1	2.1:1	0.8:1	1.2:1
Coronary heart disease age-adjusted death rate	Per 100,000 population	2020	88.2	88.5	79.2	107.2	59.3		0.9:1	1.2:1			1.1:1	0.8:1		
Congestive heart failure age-adjusted hospitalization rate	Per 100,000 Population	2020	909	739.2	1295.6	1215.2	557.6	1028.6	1.8:1	1.6:1	0.5:1	1.8:1	2:1	2.1:1	0.7:1	1.4:1
Congestive heart failure age adjusted death rate	Per 100,000 Population	2020	14.8	14	16.6	12.5	11.9	15.4	1.2:1	0.9:1	0.8:1	1.3:1	1.3:1	0.6:1	0.7:1	1.5:1
Injury																
Unintentional injury hospitalizations	Per 100,000 population	2020	431.9													
Unintentional injury age-adjusted death rate	Per 100,000 population	2020	61.2	71.9	45.1	35.7	39.4	66.8	0.6:1	0.5:1	0.6:1	1.7:1	0.7:1	0.5:1	0.5:1	2:1
Unintentional poisoning age-adjusted death rate	Per 100,000 population	2020	34.6	46	16.9	13.4	16.6	40.2	0.4:1	0.3:1	0.4:1	2.4:1	0.5:1	0.4:1	0.4:1	2.8:1
Drug poisoning age-adjusted death rate	Per 100,000 population	2020	35.2	47.1	16.8	11.7	16.9	41	0.4:1	0.2:1	0.4:1	2.4:1	0.5:1	0.4:1	0.4:1	2.8:1
Hospitalizations for non-fatal unintentional falls	Per 100,000 Population	2020	246.3	319.9	102.7	185.9	122.8	300.3	0.3:1	0.6:1	0.4:1	2.4:1	0.3:1	0.8:1	0.4:1	2.3:1

Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non-Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic
Unintentional falls age-adjusted death rate	Per 100,000 population	2020	4.9	5.4	3.4	4.3	4.3	4.9	0.6:1	0.8:1	0.9:1	1.1:1	0.4:1	0.6:1	0.5:1	2:1
Hospitalizations for non-fatal motor vehicle traffic related injuries	Per 100,000 Population	2020	70	63.7	85.9	46.7	45.6	79.9	1.3:1	0.7:1	0.6:1	1.8:1	1.3:1	1.9:1	0.8:1	1.3:1
Motor vehicle crash age-adjusted death rate	Per 100,000 Population	2020	15.3	13.8	19.3	10	13.6		1.4:1	0.7:1			1.3:1	0.7:1		
Hospitalizations for non-fatal traumatic brain injuries	Per 100,000 Population	2020	75.4	83.8	56.3	69.6	46.1	86.9	0.7:1	0.8:1	0.5:1	1.9:1	0.7:1	1.4:1	0.7:1	1.5:1
Traumatic brain injury age-adjusted death rate	Per 100,000 Population	2020	13.9	13.9	13.2		10.6	15	0.9:1		0.7:1	1.4:1	0.8:1		0.6:1	1.7:1
Hospitalizations for non-fatal firearm injuries	Per 100,000 Population	2020	11.6	4	29.2	3.8	4.3	14.8	7.3:1	0.9:1	0.3:1	3.4:1	9.5:1	2.8:1	0.4:1	2.4:1
Firearms-related age-adjusted death rate	Per 100,000 Population	2020	13.6	9.2	20.4	9.8	5.7		2.2:1	1.1:1			2.1:1	0.6:1		
Hospitalizations for non-fatal unintentional firearm injuries	Per 100,000 Population	2020	4.2	1.5	10.2	1.5	2	5.1	6.8:1	1:1	0.4:1	2.5:1	7.8:1	2.7:1	0.5:1	2.1:1
Unintentional deaths due to fire age-adjusted death rate	Per 100,000 Population	2020	0.2	0.2	0.2	1.1	0		1:1	5.5:1		N/A	1.7:1	1:1		
Unintentional drowning age-adjusted death rate	Per 100,000 Population	2020	2	2.2	2.2	0	1.7		1:1	0:1			1.1:1	1.1:1		
Homicide age-adjusted death rate	Per 100,000 population	2020	9.1	3.5	19.4	7.3	3.3	11.8	5.5:1	2.1:1	0.3:1	3.6:1	5.6:1	1.1:1	0.5:1	2:1
Suicide age-adjusted death rate	Per 100,000 population	2020	10.4	13.2	3.7	8.1	6.8	11.3	0.3:1	0.6:1	0.6:1	1.7:1	0.3:1	0.6:1	0.5:1	2.1:1
HIV/AIDS																
Adults who had ever been tested for HIV	Percent	2019	52.8	41	71.2		52.6		1.7:1				1.6:1			
HIV Diagnoses	Per 100,000 population	2020	24	14.7	40.7	14.6	20.8	25.4	2.8:1	1:1	0.8:1	1.2:1	5.7:1	1.1:1	1.4:1	0.7:1
Persons with HIV (PWH)	Per 100,000 population	2020	1055.5	945	1726.5	462.3	673.2	1227.9	1.8:1	0.5:1	0.5:1	1.8:1	5.4:1	0.8:1	0.9:1	1.1:1
AIDS Diagnoses	Per 100,000 population	2020	12.6	7.2	26	7.3	7.4	15	3.6:1	1:1	0.5:1	2:1	6.8:1	1.3:1	0.9:1	1.1:1
HIV/AIDS age-adjusted death rate	Per 100,000 population	2020	3.4	1.6	8.4	1.2	1.5	4.1	5.3:1	0.7:1	0.4:1	2.7:1	8.2:1	0.8:1	0.5:1	2.1:1
Kidney Disease																
Ambulatory Care Sensitive Hospitalizations From Kidney/Urinary Infection (Aged 0-64 Years)	Per 100,000 population	2020	17.7													
Nephritis, nephrotic syndrome and nephrosis age-adjusted death rate	Per 100,000 population	2020	10.9	8	20.4	14	6.5	12.1	2.5:1	1.8:1	0.5:1	1.9:1	2.6:1	1.5:1	0.7:1	1.5:1
Liver Disease																
Chronic liver disease and cirrhosis age-adjusted death rate	Per 100,000 population	2020	10.8	13.2	3.4	11.8	8.8	11.4	0.3:1	0.9:1	0.8:1	1.3:1	0.5:1	0.5:1	0.7:1	1.4:1
Mental Health Conditions and Trauma																
Hospitalizations for mental disorders	Per 100,000 population	2020	1070.5	954.3	1338.5	727.6	470.2	1325.8	1.4:1	0.8:1	0.4:1	2.8:1	1.4:1	1:1	0.5:1	1.9:1
Stroke																
Adults who have ever been told they had a stroke	Percent	2019	4.8	5.9	3.7		2.7		0.6:1				1.1:1			

Indicator	Measure	Year(s)	Total	White	Black	Other Race	Hispanic	Non-Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic	Black/ White	Other Race/ White	Hispanic/ Non-Hispanic	Non-Hispanic/ Hispanic
Hospitalizations from stroke	Per 100,000 population	2020	270.4	244.8	322.9	244.8	137.4	326.9	1.3:1	1:1	0.4:1	2.4:1	1.1:1	1.2:1	0.5:1	2.1:1
Stroke age-adjusted death rate	Per 100,000 population	2020	56.3	52.8	65.1	60.3	47.6	58.3	1.2:1	1.1:1	0.8:1	1.2:1	1.5:1	1:1	1:1	1:1
Maternal and Child Health																
Births to mothers ages 15-19	Per 1,000 Females 15-19	2020	9.2	6	14.7	4.4	8.5	9.4	2.4:1	0.7:1	0.9:1	1.1:1	1.6:1	0.8:1	1.3:1	0.8:1
Repeat births to mothers Ages 15-19	Percent	2020	12.7	13.8	12.2		15	11.7	0.9:1		1.3:1	0.8:1	1.1:1		1:1	1:1
Births to unwed mothers ages 15-19	Percent	2020	95.2	92.8	96.6		93.5	95.9	1:1		1:1	1:1	1.1:1		1:1	1:1
Births to unwed mothers ages 15-44	Percent	2020	43.1	34.1	60.4		40.3	44.6	1.8:1		0.9:1	1.1:1	1.6:1		1.1:1	0.9:1
Births to mothers 19 and over without high school education	Percent	2020	8.5	7.4	10.9		10.6	7.5	1.5:1		1.4:1	0.7:1	1:1		2.2:1	0.5:1
Resident live births to mothers who smoked during pregnancy	Percent	2020	0.6	0.8	0.2	0.6	0.4	0.6	0.3:1	0.7:1	0.7:1	1.5:1	0.6:1	0.5:1	0.2:1	4.5:1
Births to mothers who are underweight (BMI <18.5) at time pregnancy occurred	Percent	2020	3.1	3.1	2.8		2.3	3.5	0.9:1		0.7:1	1.5:1	0.9:1		0.8:1	1.3:1
Births to mothers who are overweight (BMI 25.0-29.9) at time pregnancy occurred	Percent	2020	28.5	28	29.1		31.5	27	1:1		1.2:1	0.9:1	1:1		1.2:1	0.8:1
Births to mothers who are obese (BMI >= 30) at time pregnancy occurred	Percent	2020	25.3	20.1	35.1		22.6	26.8	1.7:1		0.8:1	1.2:1	1.5:1		0.9:1	1.1:1
Births with inter-pregnancy interval < 18 months	Percent	2020	30.5	30.9	30.5		27.6	32	1:1		0.9:1	1.2:1	1:1		0.8:1	1.3:1
Births with 1st trimester prenatal care	Percent	2020	73.5	76.3	68.2	78.7	73.7	73.4	0.9:1	1:1	1:1	1:1	0.9:1	1:1	1:1	1:1
Births with no prenatal care	Percent	2020	2.3	1.6	3.3	2.3	1.5	2.6	2.1:1	1.4:1	0.6:1	1.7:1	1.7:1	1:1	0.8:1	1.3:1
Births < 37 weeks of gestation	Percent	2020	10.9	8.7	14.4	10.3	9	11.9	1.7:1	1.2:1	0.8:1	1.3:1	1.6:1	0.9:1	0.8:1	1.2:1
Very low birthweight infants born in subspecialty perinatal centers	Percent	2020	83.1	76.4	87.2		76	85.3	1.1:1		0.9:1	1.1:1	1:1		1:1	1:1
Births < 1500 grams (very low birth weight)	Percent	2020	1.8	1	2.9	1.4	1.2	2	2.9:1	1.4:1	0.6:1	1.7:1	2.7:1	1:1	0.7:1	1.4:1
Births < 2500 grams (low birth weight)	Percent	2020	9.1	6.4	13.2	9.2	6.6	10.3	2.1:1	1.4:1	0.6:1	1.6:1	2:1	1.1:1	0.7:1	1.4:1
Mothers who initiate breastfeeding	Percent	2020	89.1	92	84		92.9	87.2	0.9:1		1.1:1	0.9:1	0.9:1		1.1:1	0.9:1
Severe Maternal Morbidity	Per 1,000 Delivery Hospitalizations	2020	16.2	12.3	21.5	16.9	12	18	1.7:1	1.4:1	0.7:1	1.5:1	1.9:1	1.3:1	0.9:1	1.1:1
Fetal deaths	Per 1,000 Deliveries	2020	7.5	4.1	10.8	4.1	4.6	6.9	2.6:1	1:1	0.7:1	1.5:1	2.3:1	1.1:1	0.8:1	1.3:1
Infant deaths	Per 1,000 births	2020	5.1	3	8	6.2	4.1	5.3	2.7:1	2.1:1	0.8:1	1.3:1	2.5:1	1.5:1	0.8:1	1.3:1
Sudden Unexpected Infant Deaths (SUID)	Per 1,000 Births	2020	0.7	0.3	1.4	0.7	0.5	0.8	4.7:1	2.3:1	0.6:1	1.6:1	2.7:1	1.1:1	0.6:1	1.6:1
Maternal deaths	Per 100,000 Births	2020	20.1	9.1	40.6	0	15.4	22.6	4.5:1	0:1	0.7:1	1.5:1	6.9:1	3.9:1	0.9:1	1.1:1

Data Note(s):

Rate ratios in this report compare rates of two populations. For example, if the ratio of the black rate to the white rate is 2:1 it would mean that the black rate is two times the white rate. A ratio of 0.5:1

would mean that the black rate is half of the white rate. Rate ratios are not calculated when a rate is zero, and the county ratio cell will contain "N/A".

All indicators in this profile, except the indicators from the Behavioral Risk Factor Surveillance System (BRFSS), report rates based on the entire black population and entire white population. Indicators from the BRFSS only include non-Hispanic blacks and non-Hispanic whites in the rates reported. These indicators all begin with the word "Adults".

Indicators included in the profile are based, in part, on the Prevention Institute's report for the Robert Wood Johnson Foundation in June 2015 titled "Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health".

When the Racial Residential Segregation Index is less than 0.3 the county's population is "well integrated." Values between 0.3 and 0.6 indicate the county's population is "moderately segregated." Values above 0.6 indicate the county's population is "very segregated."

Income inequality is an index that ranges from 0 to 1. Zero indicates a perfect distribution of income where everyone receives an equal share. One indicates an imperfect distribution of income where only one or a group of recipients receive all the income.

Some indicators that are important to understanding the context of health disparities are displayed even when race and ethnicity breakouts are not available. In these cases, only the totals are provided.

Excerpts from the 2017-2019 Broward County Behavioral Risk Factor Surveillance System (BRFSS) Data

The Florida Department of Health is pleased to release 2017-2019 Florida Behavioral Risk Factor Surveillance System (BRFSS) county-level data. This surveillance effort would not have been possible without the support of Florida's 67 County Health Departments (CHDs).
The Florida BRFSS is a statewide telephone survey that has been collecting and reporting health behavior data since 1986. This survey is the only source of state-specific, population-based estimates of the prevalence of various health conditions and related risk behaviors among Florida residents aged 18 and older. The purpose of this survey is to gather information regarding personal health and risk behaviors, selected medical conditions and preventive health care practices among Florida adults. Beginning in 2007, the BRFSS has been providing counties with local-level data every three years to estimate the prevalence of personal health behaviors and chronic health conditions that contribute to morbidity and mortality.

County-level surveys were previously conducted in 2002, 2007, 2010, 2013 and 2016. In 2017, the Department began using a three-year rolling rate methodology to provide county-level data. Combining three years of data creates a larger sample size, which decreases data suppression and allows annual reporting of county estimates. Completed surveys from each of the 67 counties were combined across the 2017-2019 survey period to produce statistically valid county-level estimates. This new methodology was designed in collaboration with the CHDs to better meet programmatic needs for local-level data.

A total of 54,260 interviews were completed statewide during the 2017-2019 period. 1,268 adults in Broward County responded to the BRFSS across these three years.

This report presents survey data on a variety of issues including health status, health care access, lifestyle, chronic illnesses, and disease prevention practices. Because BRFSS respondents are randomly selected, measures of prevalence and mean are subject to random sample errors. Measures listed in the data tables include the 95% confidence interval. If the confidence intervals overlap, there is no statistically significant difference in the prevalence rates. However, if the confidence intervals do not overlap, there is a statistically significant difference. The significance of measures with very wide confidence intervals should be interpreted with caution. Measures of prevalence and mean are excluded from the tables for any subpopulation with a sample size less than 30, which would yield statistically unreliable estimates.
The prevalence rates are weighted by the Centers for Disease Control and Prevention to represent all Florida adults. Weighting is a procedure that adjusts for the chance of an adult being selected to complete the survey and for discrepancies between the adults who completed the survey and the overall population of Florida adults. The data were weighted to the respondent's probability of selection by county, as well as age, sex, marital status, race/ethnicity and education level.

2017-2019 Florida BRFSS Data Report **Broward**

Health Care Access & Coverage

Percentage of adults who have a personal doctor

		2017-2019 County			2019 State			2016 County
		Measure	95% CI		Measure	95% CI		Measure
ALL	Overall	72.8	69.2	76.3	72.0	70.5	73.5	72.7
SEX	Men	69.4	64.0	74.9	66.6	64.3	68.9	64.8
	Women	75.9	71.3	80.4	77.1	75.2	79.0	81.4
RACE/ETHNICITY	Non-Hisp. White	77.1	72.3	81.8	76.8	75.3	78.3	81.3
	Non-Hisp. Black	79.0	72.3	85.6	72.1	67.6	76.6	71.1
	Hispanic	64.2	56.7	71.8	61.5	57.4	65.5	60.9
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	73.9	66.8	81.1	72.5	70.1	74.8	76.5
	Non-Hisp. White Women	80.0	73.7	86.4	80.9	79.0	82.9	86.8
	Non-Hisp. Black Men	78.6	67.6	89.6	65.7	58.4	73.0	52.5
	Non-Hisp. Black Women	79.3	71.1	87.4	77.6	72.3	82.9	85.0
	Hispanic Men	60.1	49.0	71.1	54.9	48.8	60.9	50.7
	Hispanic Women	68.9	58.8	79.1	67.5	62.3	72.8	73.0
AGE GROUP	18-44	58.7	52.6	64.8	54.6	51.9	57.4	57.6
	45-64	77.7	71.7	83.7	77.9	75.2	80.5	79.1
	65 & Older	90.5	86.7	94.4	91.2	89.6	92.7	90.5
EDUCATION LEVEL	<High School	57.5	44.2	70.7	60.4	55.4	65.3	62.1
	H.S. / GED	75.8	69.0	82.6	70.3	67.4	73.1	66.6
	>High School	74.6	70.6	78.6	75.3	73.5	77.2	76.1
ANNUAL INCOME	<$25,000	68.0	60.0	76.0	69.2	66.0	72.3	63.1
	$25,000-$49,999	66.5	58.5	74.5	68.9	65.5	72.4	69.7
	$50,000 or More	79.5	74.6	84.3	77.4	75.1	79.7	77.4
MARITAL STATUS	Married/Couple	74.7	69.6	79.8	76.2	74.2	78.1	75.0
	Not Married/Couple	70.4	65.4	75.4	67.2	64.9	69.6	70.3

2017-2019 Florida BRFSS Data Report **Broward**

Health Care Access & Coverage

Percentage of adults with any type of health care insurance coverage

		2017-2019 County			2019 State			2016 County
		Measure	95% CI		Measure	95% CI		Measure
ALL	Overall	82.3	79.1	85.5	84.2	83.0	85.4	85.6
SEX	Men	81.0	76.0	86.1	81.9	80.0	83.9	83.9
	Women	83.4	79.3	87.5	86.3	84.8	87.9	87.5
RACE/ETHNICITY	Non-Hisp. White	89.4	85.7	93.1	88.6	87.4	89.7	90.0
	Non-Hisp. Black	80.8	73.8	87.7	81.4	77.3	85.4	80.4
	Hispanic	74.3	67.2	81.3	76.1	72.7	79.6	83.9
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	92.2	88.3	96.1	86.2 *	84.3	88.1	89.8
	Non-Hisp. White Women	86.8	80.7	92.8	90.8	89.4	92.1	90.2
	Non-Hisp. Black Men	76.8	64.4	89.3	78.6	72.3	85.0	79.1
	Non-Hisp. Black Women	83.9	76.6	91.2	83.7	78.5	89.0	81.4
	Hispanic Men	71.3	60.7	81.9	73.8	68.4	79.2	78.2
	Hispanic Women	77.7	68.7	86.6	78.2	73.9	82.6	90.7
AGE GROUP	18-44	72.8	67.0	78.5	75.4	73.1	77.7	79.6
	45-64	83.9	78.3	89.5	83.5	81.1	85.9	85.1
	65 & Older	97.6	95.6	99.5	98.1	97.4	98.8	98.0
EDUCATION LEVEL	<High School	61.1	47.9	74.3	69.0	64.4	73.6	59.9
	H.S. / GED	80.1	73.5	86.6	83.1	80.9	85.3	73.2
	>High School	87.7	84.6	90.8	88.0	86.5	89.5	92.5
ANNUAL INCOME	<$25,000	70.3	62.2	78.4	76.1	73.2	79.1	69.8
	$25,000-$49,999	83.5	77.6	89.5	81.9	78.8	85.0	87.6
	$50,000 or More	92.7	89.5	95.9	92.7	91.3	94.1	93.0
MARITAL STATUS	Married/Couple	85.1	80.6	89.6	88.0	86.5	89.5	85.2
	Not Married/Couple	79.8	75.2	84.4	79.9	77.8	82.0	85.8

2017-2019 Florida BRFSS Data Report **Broward**

Health Care Access & Coverage

Percentage of adults who could not see a doctor in the past year due to cost

		2017-2019 County Measure	95% CI		2019 State Measure	95% CI		2016 County Measure
ALL	Overall	18.5	15.4	21.7	16.0	14.8	17.3	17.2
SEX	Men	19.0	14.3	23.8	15.8	13.9	17.8	14.2
	Women	18.1	14.0	22.2	16.2	14.6	17.8	20.5
RACE/ETHNICITY	Non-Hisp. White	13.7	10.0	17.5	13.5	12.3	14.7	15.2
	Non-Hisp. Black	22.8	15.5	30.2	16.8	13.0	20.7	21.8
	Hispanic	21.4	15.0	27.7	22.7	19.0	26.3	20.6
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	13.9	8.6	19.2	12.7	10.9	14.5	12.3
	Non-Hisp. White Women	13.6	8.2	19.0	14.3	12.6	15.9	18.3
	Non-Hisp. Black Men	26.4	14.1	38.7	15.9	9.9	21.9	18.7
	Non-Hisp. Black Women	20.0	11.4	28.7	17.7	12.6	22.7	24.0
	Hispanic Men	20.7	11.3	30.1	25.2	19.4	31.0	18.9
	Hispanic Women	22.1	13.7	30.5	20.4	15.9	24.8	22.7
AGE GROUP	18-44	24.8	19.5	30.1	21.9	19.6	24.2	21.8
	45-64	20.1	14.5	25.6	19.3	16.8	21.8	17.6
	65 & Older	5.2	0.6	9.8	3.7	3.0	4.4	8.0
EDUCATION LEVEL	<High School	28.7	16.9	40.4	21.4	17.7	25.0	26.6
	H.S. / GED	17.8	11.4	24.2	16.9	14.6	19.3	23.9
	>High School	16.8	13.2	20.3	14.5	12.8	16.2	14.1
ANNUAL INCOME	<$25,000	25.2	17.8	32.7	25.7	22.8	28.6	28.2
	$25,000-$49,999	22.2	15.4	29.0	19.6	16.4	22.8	20.1
	$50,000 or More	9.9	6.2	13.7	9.2	7.4	11.0	10.3
MARITAL STATUS	Married/Couple	15.6	11.3	19.9	13.0	11.4	14.7	15.4
	Not Married/Couple	21.1	16.6	25.7	19.5	17.4	21.5	19.1

2017-2019 Florida BRFSS Data Report **Broward**

Depression

Percentage of adults who have ever been told they had a depressive disorder

		2017-2019 County Measure	95% CI		2019 State Measure	95% CI		2016 County Measure
ALL	Overall	13.0	10.4	15.7	17.7 *	16.4	18.9	13.9
SEX	Men	11.9	8.1	15.6	13.1	11.4	14.8	10.8
	Women	14.1	10.4	17.8	21.9 *	20.1	23.8	17.4
RACE/ETHNICITY	Non-Hisp. White	15.8	11.9	19.6	20.0	18.6	21.4	19.4
	Non-Hisp. Black	8.0	3.4	12.6	11.9	9.1	14.8	9.1
	Hispanic	13.5	8.1	18.9	14.8	11.8	17.8	9.5
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	14.8	9.3	20.2	14.5	12.7	16.3	15.9
	Non-Hisp. White Women	16.7	11.3	22.0	25.2 *	23.2	27.2	23.1
	Non-Hisp. Black Men	9.7	1.9	17.4	12.1	7.5	16.8	4.7
	Non-Hisp. Black Women	6.6	1.1	12.1	11.8	8.3	15.2	12.4
	Hispanic Men	12.2	4.1	20.4	9.9	6.5	13.3	6.6
	Hispanic Women	14.9	8.0	21.8	19.3	14.5	24.1	13.2
AGE GROUP	18-44	12.1	8.0	16.1	17.5	15.5	19.5	12.8
	45-64	16.3	11.1	21.4	20.4	18.0	22.8	16.3
	65 & Older	11.1	6.7	15.5	14.5	12.8	16.2	12.0
EDUCATION LEVEL	<High School	12.8	4.7	20.9	22.9	18.7	27.1	13.9
	H.S. / GED	14.7	8.6	20.9	16.1	14.0	18.3	15.4
	>High School	12.4	9.4	15.4	17.1 *	15.6	18.6	13.6
ANNUAL INCOME	<$25,000	19.4	12.9	25.9	25.5	22.5	28.4	21.5
	$25,000-$49,999	7.0	3.2	10.7	19.2 *	16.4	22.0	21.8 ^
	$50,000 or More	11.7	8.0	15.4	12.9	11.2	14.5	8.4
MARITAL STATUS	Married/Couple	9.3	6.4	12.3	13.9 *	12.3	15.5	7.8
	Not Married/Couple	16.7	12.4	21.0	22.2	20.2	24.2	19.3

2017-2019 Florida BRFSS Data Report **Broward**

Health Status & Quality of Life

Average number of unhealthy mental days in the past 30 days

		2017-2019 County Measure	95% CI		2019 State Measure	95% CI		2016 County Measure
ALL	Overall	3.7	3.1	4.4	4.4	4.1	4.7	3.9
SEX	Men	3.9	2.8	5.0	3.7	3.3	4.1	3.1
	Women	3.5	2.7	4.3	5.0 *	4.5	5.4	4.6
RACE/ETHNICITY	Non-Hisp. White	4.6	3.6	5.6	4.6	4.3	4.9	3.8
	Non-Hisp. Black	3.2	1.9	4.5	4.0	3.1	4.9	4.3
	Hispanic	3.5	2.1	4.8	4.2	3.3	5.0	3.6
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	4.3	2.9	5.7	3.9	3.5	4.4	3.1
	Non-Hisp. White Women	4.8	3.4	6.2	5.2	4.8	5.7	4.5
	Non-Hisp. Black Men	4.5	2.0	6.9	4.3	2.7	5.8	4.7
	Non-Hisp. Black Women	2.2	1.1	3.2	3.8	2.8	4.7	4.1
	Hispanic Men	3.9	1.6	6.3	2.9	2.1	3.7	2.3
	Hispanic Women	2.9	1.5	4.3	5.4	4.0	6.8	5.1
AGE GROUP	18-44	3.9	2.9	4.9	5.1	4.6	5.6	4.9
	45-64	4.9	3.6	6.3	4.5	4.0	5.1	3.5
	65 & Older	1.6	1.0	2.3	3.0 *	2.6	3.5	2.4
EDUCATION LEVEL	<High School	5.7	2.8	8.7	5.9	4.8	7.0	4.4
	H.S. / GED	3.7	2.3	5.0	4.5	3.9	5.1	4.1
	>High School	3.3	2.7	3.9	4.0	3.6	4.4	3.8
ANNUAL INCOME	<$25,000	5.2	3.5	6.8	6.3	5.5	7.1	4.1
	$25,000-$49,999	3.3	2.1	4.5	4.3	3.8	4.9	5.7
	$50,000 or More	3.0	2.2	3.9	3.2	2.8	3.6	3.4
MARITAL STATUS	Married/Couple	2.7	2.0	3.4	3.4	3.1	3.8	1.9
	Not Married/Couple	4.5	3.5	5.6	5.5	5.0	6.0	5.6

2017-2019 Florida BRFSS Data Report **Broward**

Health Status & Quality of Life

Average number of days where poor mental or physical health interferred with activities of daily living in the past 30 days (among adults who have had at least one day of poor mental or physical health)

		2017-2019 County			2019 State			2016 County
		Measure	95% CI		Measure	95% CI		Measure
ALL	Overall	6.0	4.8	7.2	5.6	5.2	6.0	4.6
SEX	Men	7.4	5.4	9.4	5.5	4.8	6.1	4.3
	Women	4.8	3.4	6.1	5.7	5.1	6.2	4.8
RACE/ETHNICITY	Non-Hisp. White	5.8	4.4	7.2	5.9	5.4	6.3	4.7
	Non-Hisp. Black	5.7	3.1	8.3	5.3	4.0	6.5	5.7
	Hispanic	6.0	3.5	8.5	5.2	4.1	6.3	2.9
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	7.1	4.6	9.5	5.8	5.1	6.4	3.5
	Non-Hisp. White Women	4.5	3.1	6.0	6.0	5.4	6.5	5.9
	Non-Hisp. Black Men	7.8	3.1	12.5	5.9	3.6	8.3	
	Non-Hisp. Black Women	3.7	1.8	5.6	4.8	3.6	5.9	5.0
	Hispanic Men	8.0	3.6	12.4	5.0	3.3	6.6	3.2
	Hispanic Women	4.1	1.8	6.4	5.3	3.9	6.8	2.6
AGE GROUP	18-44	3.7	2.4	4.9	4.0	3.4	4.6	2.4
	45-64	7.9	5.5	10.3	7.3	6.4	8.1	7.8
	65 & Older	7.4	5.0	9.8	6.4	5.7	7.1	4.6
EDUCATION LEVEL	<High School	9.7	4.9	14.6	8.7	7.2	10.2	
	H.S. / GED	8.0	5.1	10.8	5.5	4.8	6.1	5.7
	>High School	4.3	3.3	5.4	5.0	4.5	5.5	3.9
ANNUAL INCOME	<$25,000	9.1	6.3	12.0	8.0	7.0	9.1	8.9
	$25,000-$49,999	5.5	3.3	7.7	5.3	4.6	6.1	3.9
	$50,000 or More	3.2	2.1	4.2	3.7	3.2	4.3	3.1
MARITAL STATUS	Married/Couple	4.5	3.2	5.8	5.3	4.7	5.8	2.7
	Not Married/Couple	7.2	5.3	9.1	5.9	5.3	6.5	5.7

2017-2019 Florida BRFSS Data Report **Broward**

HIV/AIDS Screening

Percentage of adults who have ever been tested for HIV

		2017-2019 County Measure	95% CI		2019 State Measure	95% CI		2016 County Measure
ALL	Overall	52.8	48.6	56.9	50.7	49.0	52.4	57.9
SEX	Men	51.0	44.8	57.2	50.3	47.7	52.9	55.3
	Women	54.4	48.9	60.0	51.1	48.7	53.5	60.9
RACE/ETHNICITY	Non-Hisp. White	41.0	35.3	46.7	42.2	40.4	44.1	54.9 ^
	Non-Hisp. Black	71.2	63.4	79.0	66.0	60.9	71.1	65.4
	Hispanic	52.6	44.2	61.0	62.5	58.1	66.9	65.0
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	42.8	34.4	51.2	43.1	40.4	45.8	52.1
	Non-Hisp. White Women	39.4	31.7	47.1	41.5	39.0	43.9	58.1
	Non-Hisp. Black Men	67.9	54.9	80.9	68.8	61.1	76.5	58.7
	Non-Hisp. Black Women	73.8	64.5	83.1	63.4	56.6	70.2	70.7
	Hispanic Men	53.0	40.8	65.2	58.1	51.6	64.6	64.9
	Hispanic Women	52.1	40.6	63.7	66.7	60.8	72.6	65.2
AGE GROUP	18-44	60.6	53.9	67.2	62.2	59.2	65.1	68.3
	45-64	62.0	55.1	69.0	58.8	55.8	61.9	61.9
	65 & Older	25.6	19.0	32.1	24.3	22.1	26.6	31.7
EDUCATION LEVEL	<High School	46.9	32.6	61.2	45.9	40.6	51.2	49.3
	H.S. / GED	51.6	43.0	60.2	48.6	45.1	52.1	55.0
	>High School	54.8	49.9	59.7	52.9	50.7	55.0	60.0
ANNUAL INCOME	<$25,000	54.6	45.4	63.7	54.4	50.7	58.1	56.9
	$25,000-$49,999	61.1	52.7	69.5	51.0	47.2	54.8	59.1
	$50,000 or More	52.4	46.1	58.7	52.6	49.7	55.4	59.3
MARITAL STATUS	Married/Couple	52.9	46.9	58.9	49.7	47.3	52.1	55.7
	Not Married/Couple	52.8	47.0	58.6	51.7	49.1	54.3	60.0

2017-2019 Florida BRFSS Data Report								Broward
HIV/AIDS Screening								
Percentage of adults less than 65 years old who have ever been tested for HIV								
		2017-2019 County			2019 State			2016 County
		Measure	95% CI		Measure	95% CI		Measure
ALL	Overall	61.2	56.4	66.1	60.7	58.6	62.8	65.3
SEX	Men	58.4	51.3	65.5	57.6	54.5	60.8	59.4
	Women	64.0	57.5	70.5	63.7	60.8	66.5	72.6
RACE/ETHNICITY	Non-Hisp. White	52.4	45.1	59.8	54.1	51.6	56.5	62.5
	Non-Hisp. Black	75.6	67.2	84.1	73.5	67.9	79.1	74.1
	Hispanic	59.3	50.1	68.5	67.1	62.4	71.8	72.1
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	52.1	41.7	62.5	52.3	48.8	55.8	55.0
	Non-Hisp. White Women	52.8	42.4	63.3	55.8	52.4	59.2	71.2
	Non-Hisp. Black Men	73.5	59.7	87.4	75.2	67.0	83.3	
	Non-Hisp. Black Women	77.4	67.1	87.6	72.0	64.3	79.7	85.2
	Hispanic Men	57.8	44.9	70.7	59.2	52.1	66.3	68.6
	Hispanic Women	61.1	48.2	74.0	75.5	69.7	81.4	76.8
AGE GROUP	18-44	60.6	53.9	67.2	62.2	59.2	65.1	68.9
	45-64	62.0	55.1	69.0	58.8	55.8	61.8	61.5
EDUCATION LEVEL	<High School	54.3	36.3	72.4	53.6	46.8	60.4	
	H.S. / GED	66.2	56.4	76.1	58.4	54.2	62.6	61.5
	>High School	60.7	55.1	66.3	63.2	60.6	65.8	68.0
ANNUAL INCOME	<$25,000	64.6	53.6	75.7	63.5	59.0	68.0	67.2
	$25,000-$49,999	72.6	63.4	81.9	62.8	58.1	67.5	69.0
	$50,000 or More	57.5	50.5	64.5	60.2	57.0	63.4	63.0
MARITAL STATUS	Married/Couple	61.8	55.0	68.6	60.5	57.6	63.4	62.1
	Not Married/Couple	61.1	54.3	68.0	60.9	57.7	64.0	68.1