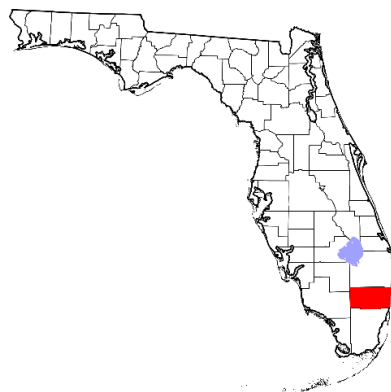


PART A PLANS



Ft. Lauderdale (Broward County)



BROWARD COUNTY

INTEGRATED CITY-ONLY HIV PREVENTION AND CARE
PLAN 2017-2021

SUBMITTED BY:
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FLORIDA DEPARTMENT OF HEALTH-
BROWARD HIV PREVENTION PROGRAM

SEPTEMBER 16, 2016



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Leading Change: The Broward County Approach to addressing HIV/AIDS— From Separate to Parallel to Integrated

Introduction

Broward County is a subtropical urban center on the Atlantic coast of Florida and is accessible by land, air and sea. As Florida's second largest metropolitan area, with 1.87 million residents, it is a tourist destination for more than 10 million visitors annually. Broward County offers 23 miles of sun-kissed beaches, great dining, a vibrant night life, unlimited entertainment and attractions. According to the U.S. Census (2010), Broward County is projected to be the most diverse county in the United States by the year 2030. Shifts in the county's demographics are driven by immigration of foreign-born minorities and includes residents representing more than 200 different countries and speaking more than 130 languages. The 2014 American Community Survey reports that 40% of Broward residents spoke a language other than English at home, compared to 28% for Floridians generally. Broward County is also home to more than 60,000 Lesbian, Gay, Bisexual and Transgender (LGBT) residents. National tourist publications have dubbed Broward "the second most popular LGBT tourist destination in the United States."

Broward and Palm Beach counties are part of the Miami-Dade County metropolitan statistical area (MSA). The proximity of these mostly urban counties results in a fluid "work, worship and play environment." In all three counties HIV reported cases are primarily among men who have sex with men (MSM). Social and sexual activities among this population group are not restricted by distance or county boundaries. Sex is a primary mode of HIV acquisition, however, drug use and in particular injecting drug use (IDU) continues to contribute to the ongoing number of new HIV infections among Broward County residents. Other populations who are disproportionately affected in Broward include African American gay, bisexual, and other MSM; White gay men; Latino gay men; and African American women. In addition, large immigrant communities with limited English proficiency may encounter barriers accessing health services and information, leaving many at risk for undiagnosed HIV infection. With improved quality of life issues such as the warm climate, beaches, and nightlife, Broward County has become a center

for gay tourism as well as a relocation and retirement destination for HIV positive individuals. This may also lead to an increase in HIV transmission locally.

Broward County's Ryan White Part A Recipient's Office and the Florida Department of Health in Broward County (DOH-Broward) HIV Prevention Program have identified the unique characteristics of its residents and visitors, its distinctive approach to addressing the epidemic, and its ability to bring together groups of diverse stakeholders. It is due to these distinct differences and variances within the community that Broward County opted to submit a Comprehensive Integrated Prevention and Care Plan particular to its diverse strengths and needs. The stakeholders recognize there are several universal principles that align and guide this approach consistent with the Statewide Coordinated Statement of Need (SCSN) and this plan reflects that alignment. Collectively, it is acknowledged that the strengths and challenges that define Broward County should be addressed as a community and thus the submission of the Integrated City-Only Prevention and Care Plan to the Center for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) is warranted. This plan is also included as a chapter in the State of Florida's Integrated Plan.

History of Funding and Planning for the Epidemic in Broward County: HIV/AIDS has severely impacted Broward County. As a result, federal funding has been received for Prevention, Care and Treatment services for over two decades, reflecting the large and growing epidemic. Historically, Broward County has been an HIV under-resourced jurisdiction. The county consistently ranks among the top jurisdictions for newly diagnosed HIV cases in the entire United States. The per capita cases of new infections in Broward has not decreased in over a decade, prompting government health agencies to direct more funding to AIDS prevention campaigns in Broward.

The recommended funding allocation and the approved budget for Broward County continues to limit the Eligible Metropolitan Area's (EMA) ability to fully implement and attain the goals outlined under the President's National HIV/AIDS Strategy (NHAS), the CDC's PS12-1201 cooperative agreement, and Broward County's local Integrated Prevention and Care Plan. As an HIV/AIDS epicenter, an important area for program consideration is the adequate provision of capacity building and technical assistance to DOH-Broward, the Ryan White HIV/AIDS Program (RWHAP), and the community in

Broward County. With adequate resources, the EMA can be successful in creating systems of care for people at-risk and living with HIV/AIDS.

Broward is committed to the provision of effective prevention, care and treatment strategies utilizing clinical quality management, monitoring, evaluation, and other local resources to ensure the populations and geographic areas most affected by HIV achieve a maximum level of impact. These strategies can be achieved through: 1) development of active measurement tools; 2) ongoing evaluation practices; 3) reporting of NHAS progress achieved; 4) continuous stakeholder engagement; and 5) integrated planning. Integrated Planning provides a tremendous collaborative opportunity for effective planning and efficiency in responding to the local jurisdictional needs.

All programmatic activities, organized by DOH-Broward HIV Prevention Program, Ryan White Parts A-F, HOPWA, Broward County Public Schools, and other community stakeholders include comprehensive evaluation components in addition to the regular monitoring of outputs. Evaluation findings are critical for the identification of best practices and opportunities for improvement which then provide vital information for effective program planning and quality improvement of services.

Prevention Funding and Planning: In 1981, the first cases of acquired immune deficiency syndrome (AIDS) were reported in California, New York, and Florida. As a result of these first cases, the state of Florida in 1981 implemented surveillance of AIDS cases. Subsequently, in 1983 the CDC declared AIDS a reportable disease and the Florida State Health Officer declared AIDS to be a public health emergency requiring physicians to report diagnosed cases immediately. As active surveillance for AIDS began in Florida, anonymous HIV counseling and testing sites were established in county public health units in 1985 including Broward County. This was followed by implementation of a five-year health education risk reduction project funded in 1986. During the following year, Florida received funding to expand HIV Prevention education to minorities and community-based groups.

As Florida began to develop public health HIV/AIDS programming and infrastructure, Governor Lawton Chiles commissioned a Red Ribbon Panel in 1992 to address prevention and treatment issues. The recommendations of the Red Ribbon Panel group

prompted the state of Florida to create the Florida HIV/AIDS Community Planning Group in 1993 followed by the development of the first HIV Prevention Plan for Florida in 1994.

While a statewide prevention plan was developed, the Broward County Health Department also established and convened the first Broward County Community Planning Partnership in 1994 in response to the growing need to further involve the community in the planning process. This planning body was charged with the responsibility to address local HIV prevention priorities and needs. For over 10 years, this group guided HIV Prevention in Broward County and included community members, Health Department officials and individuals affected by HIV. In 2005, the State of Florida Department of Health Bureau of HIV/AIDS announced a funding shift based on prioritization of resources. The Bureau of HIV/AIDS could no longer provide funding for local community planning groups thus in 2006 the Broward County Community Planning Partnership embarked on a reorganization plan to ensure that community planning for prevention continued. This plan identified the need to provide leadership and ongoing coordination to support HIV prevention services in Broward County, resulting in the development of the 2007-2009 Comprehensive HIV Prevention Plan for Broward County. During this time, three advisory committees were formed, and several focus groups and provider forums were conducted to inform the planning process and assist in prioritizing activities to reduce incidence.

It was in 2009 that President Barack Obama called for the development of a national framework that would signal a new strategic shift in HIV/AIDS priorities. The first ever National HIV/AIDS Strategy was released on July 13, 2010. This came as no surprise to Broward County's HIV/AIDS community stakeholders as the White House Domestic Policy Council Office of National AIDS Policy held a series of community meetings across the nation, including a town hall meeting held at Dillard High School in Fort Lauderdale. Locally, the community was afforded the opportunity to voice concerns to help inform and shape the agenda. This prompted the public health community to adjust its methodology to address the epidemic.

The revised approach incorporated over 30 years of research, program development, and implementation and through a community collaborative process, a "Vision for Thoughtful Change" was developed. Using this document as the foundation for the 2012-

BROWARD COUNTY'S INTEGRATED HIV PREVENTION AND CARE PLAN 2017-2021

2016 Prevention Jurisdictional Plan, the DOH-Broward HIV Prevention Program took steps to increase its response and effectiveness in addressing the social, cultural, sexual, and structural factors that place specific groups at risk for HIV/AIDS. This plan was created to complement the state of Florida's plan and was future-oriented with a focus on scalability. It emphasized health department and community collaborations in order to reach the county's "priority populations" through new and innovative initiatives. Intended to serve as a roadmap to guide prevention efforts in Broward County, the Jurisdictional HIV Prevention Plan was developed specific to Broward County due to the unique needs of the population and to assure alignment of activities.

Care and Treatment Funding and Planning: In 1986, HRSA's AIDS Service Demonstration Grants and the Robert Wood Johnson Foundation's AIDS Health Services Program were launched to support community-based care networks in urban communities grappling with how best to respond to the new and growing epidemic. This was the precursor to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Eight different programs in nine sites were funded, with Broward County joining Miami-Dade. For over four years, Broward received \$1.6 million in funding.

The CARE Act was enacted in 1990 and Fort Lauderdale was one of 16 cities who received the first Ryan White Part A Grant. This began the shift of accountability to local communities and included the creation of Planning Councils which were representative of the demographics of the community. Since its initial designation, Broward has continued to qualify as an EMA due to its consistently high HIV/AIDS prevalence.

The Fort Lauderdale/Broward EMA uses RWHAP Part A grant funds to support a comprehensive HIV Care Continuum of high-quality care and treatment for eligible HIV+ Broward residents. The EMA strives to sustain a seamless system of HIV care and treatment with high priority core medical and support services that ensure HIV+ residents obtain optimal clinical outcomes. Funds for these services support effective interventions for linking HIV+ individuals to care, retaining them in care, promoting adherence to antiretroviral therapy (ART), and achieving viral load (VL) suppression.

Part A grants to EMAs include formula and supplemental components as well as Minority AIDS Initiative (MAI) funds, which support services targeting minority populations. Formula grants are based on reported living HIV/AIDS cases as of

December 31 in the most recent calendar year for which data are available. Supplemental grants are awarded competitively on the basis of demonstrated need and other criteria. MAI funding is awarded using a formula that is based on the distribution of living HIV/AIDS cases among racial and ethnic minorities. Grants are awarded to the chief elected official (CEO) of the city or county that provides health care services to the greatest number of people living with AIDS in the EMA. In Broward County, the grant is awarded to the Broward County Board of County Commissioners and is administered by the Human Services Department.

Integration- A Collective Impact Framework: Broward County has worked collaboratively for over 2.5 years to create a unique plan and structure to foster a comprehensive approach to funding and services for HIV Prevention, Care and Treatment. The principals of the Integrated Planning effort chose to adopt and implement Collective Impact (CI) methodology as its framework for solving complex social problems. CI is “the commitment of a group of actors from different sectors to a common agenda for solving a complex problem.” This framework is based on the premise that no one organization alone can tackle or solve complex multi-faceted problems that affect society. The five conditions for a successful collective impact initiative include: 1) common agenda; 2) shared measurement; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization. Broward County has been addressing the complex challenges associated with this disease by engaging diverse groups of community stakeholders, collecting and using data to inform decision-making, and developing mutually reinforcing activities to create and sustain meaningful change.

The success of the Integrated Planning process relies on the support of both Prevention and Care and Treatment planning bodies, each of which involve stakeholders throughout their own planning and development processes. Both insist on parity, inclusion and representation (PIR), ensuring that the planning bodies reflect the communities served and both embrace a fully transparent process that allows opportunities for regular feedback and input. The following Guiding Principles were adopted during the beginning stages of the planning process: 1) the focus must be on eradicating the epidemic; 2) prevention and care must cooperate in order to be successful; 3) continuous communication and inclusivity must be the norm; 4) common definitions for terms must



be utilized by both prevention and care; and 5) the HIV care continuum must be the framework for the integrated planning process.

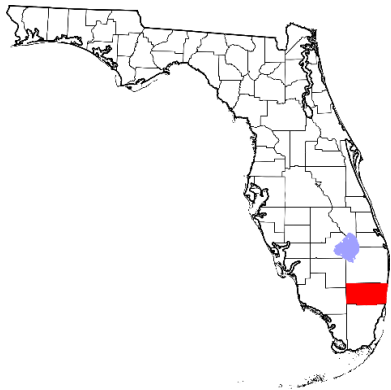
In order for the Integrated HIV Prevention and Care Plan to be implemented successfully, it needed to be created locally, with input from the people most affected and with the most to gain or lose. The backbone for the collective impact framework was created with the support of Broward County's Human Services Department through the Ryan White Part A Program and the Florida Department of Health in Broward County's HIV Prevention Program. By using this framework an Integrated HIV Prevention and Care Plan was created that when executed fully, will serve to eradicate the HIV epidemic in Broward County, Florida and it will be recognized as a national model for replication.

Section I: Needs Assessment

A. Epidemiologic Overview

Introduction: This data uses the Florida Department of Health (FDOH), Bureau of Communicable Diseases, HIV and AIDS surveillance data on HIV infection to give key insights into the epidemiologic issues in Broward County. The overview presents epidemiologic data demonstrating significantly high HIV disease prevalence rates, high HIV unmet need, and the disproportionate impact of the HIV/AIDS epidemic on vulnerable populations. The information represents the most recent data available. The FDOH generated the HIV/AIDS epidemiologic data for Broward with reporting through Calendar Year (CY) 2014, December 31, 2014, as annual data trends. Living (prevalence) data are presented as of June 30, 2015, and include cases currently residing in the Fort Lauderdale EMA, regardless of where they were diagnosed. This data was utilized to inform decision-making and planning processes.

Geographic Region/Jurisdiction: Broward County is located along the southeastern



coastline of the state of Florida with Miami-Dade County to the south and Palm Beach County to the north. According to the 2014 American Community Survey, Broward County had a total population estimate of 1.8 million, is the second most populous county in the state of Florida, accounting for 9.2% of the state's population and the seventeenth most populous county in the United States. The geographic

region is made up of 1,323 square miles and is accessible by road, rail, air and sea. Broward County also hosts an estimated 10 million annual visitors including an estimated 250,000 winter seasonal residents. There are 3 interstate highways, Florida's Turnpike, an international airport and 2 north-south rail corridors that extend into Miami-Dade and Palm Beach Counties. Port Everglades Seaport, located on the southeastern border of the County, services

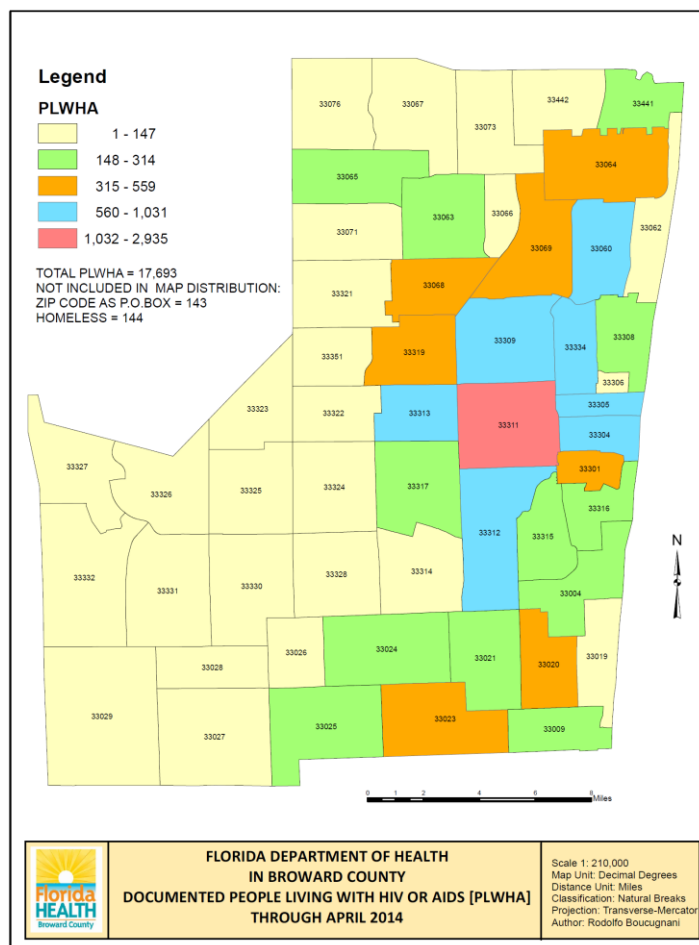


more than 4,180 ships annually and is one of the top three cruise ports in the world.

BROWARD COUNTY'S INTEGRATED HIV PREVENTION AND CARE PLAN 2017-2021

Broward County includes 31 municipalities, five of which are home to more than 100,000 residents. A diverse county in which racial/ethnic minorities are the majority of the population, the racial/ethnic breakdown includes 40% White, 29% Black or African American, and 4% other races. Twenty-seven (27%) are Latino/Hispanic (including individuals of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish descent). These diverse populations represent more than 200 different countries and 130 different languages. One-third (31.8%) of Broward's residents are foreign-born, which is a higher rate than the Florida average. In addition, 44.3% of foreign-born residents are not U.S. citizens.

Geographic Areas Affected by HIV Infection: Designated as one of the first 11



Socio-demographic

characteristics: The following provides a brief overview of several socio-demographic characteristics of persons newly diagnosed, PLWH and persons at higher risk for HIV in the geographic area/jurisdiction. While there are some limitations associated with data sources and retrieval of data

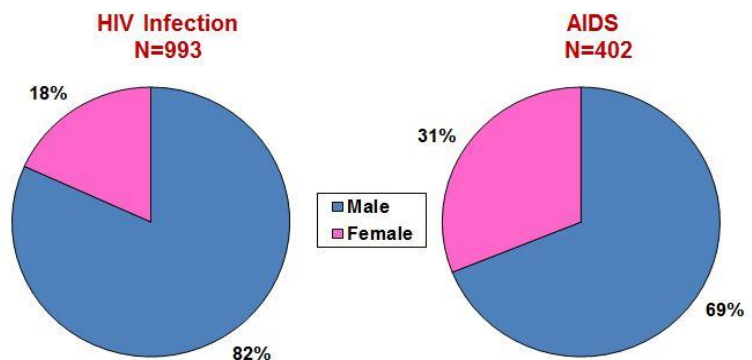
specific to the county, the information included is a description of the population disproportionately affected and provides a basis for planning purposes.

Gender and HIV/AIDS: HIV disproportionately impacts Broward males. One in 62 Broward male residents are PLWH, compared to 1 in 180 female residents. In 2014, a total of 812 adult males and 181 adult females were diagnosed with HIV infection, representing 82% and 18% of cases, respectively (Figure 2). Also, in 2014 a total of 277 adult males and 125 adult females were diagnosed with AIDS representing 69% and 31% of cases, respectively.

In 2014, 82% of the adult HIV infection cases (N=993) were male, compared to 73% in 2005 (Figure 3). Over the past ten years, the proportion of HIV infections among men has increased while the proportion of women has decreased. The increased male to female ratio from 2005 (2.7:1) to 2014 (4.5:1) is due to this

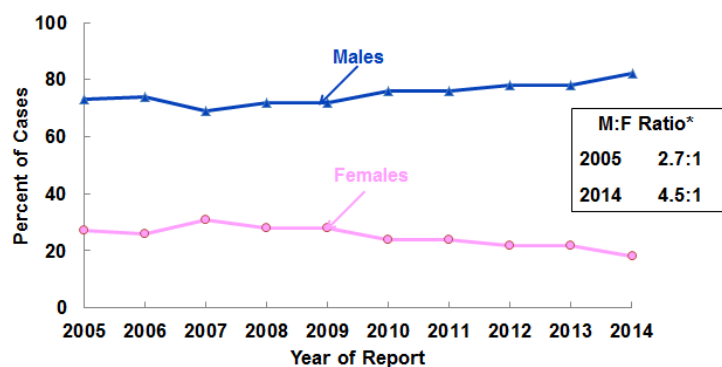
disproportionate infection rate between men and women, which may in turn be attributed to increases in HIV transmission among MSM.

Figure 2. Percent of Adult HIV Infection and AIDS Cases by Sex, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

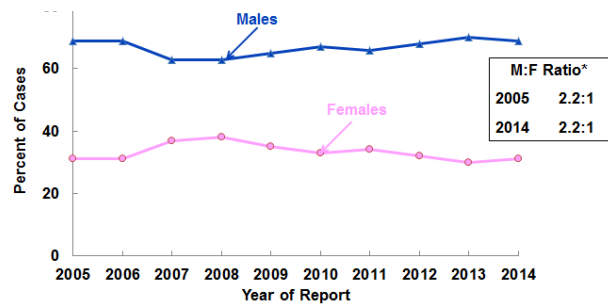
Figure 3. Percent of Adult HIV Infection Cases, by Sex and Year of Diagnosis, 2005-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

AIDS cases tend to represent HIV transmission that occurred many years ago. The number of adult AIDS cases for males and females from 2005 to 2014 remained relatively stable as seen in Figure 4. While it appears there was a slight increase in female AIDS cases between 2013 and 2014, the reason is not clear.

Figure 4. Percent of Adult AIDS Cases, by Sex and Year of Diagnosis, 2005-2014

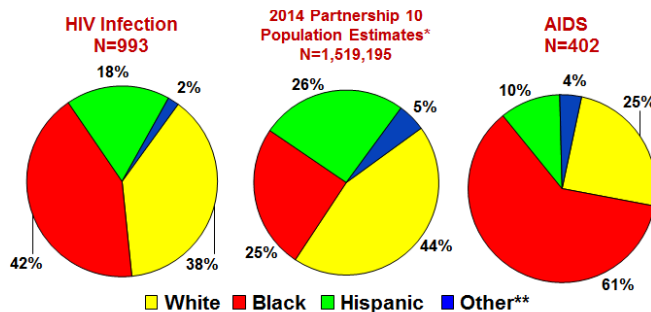


Source: Florida Department of Health HIV/AIDS Surveillance Program

Transgender: As FL-DOH does not collect data on the transgender population, this significantly impairs the EMA's ability to plan for the needs of PLWH transgender residents. Ryan White Part A does collect detailed data for transgender individuals through the client-level data system (PE), which indicated 52 transgender clients were served in 2014. Of the Part A transgender clients served in 2014, 98% were transgender male to female and 2% were transgender female to male.

Race and HIV: As previously stated, Broward County is a diverse geographic area, with shifts in demographics driven by immigration of foreign-born minorities, decreased White non-Hispanic birth rates, out-migration of White non-Hispanics, and increased White non-Hispanic death rates. The Hispanic population continues to grow more diverse, as new residents from Central and South America and the Caribbean immigrate to Broward. Less than one-half (48%) of adult Hispanic PLWH Broward residents were born in the United States (including 11% born in Puerto Rico). The remaining adult Hispanic PLWH residents were born in other countries. Haitians make up a growing portion of the

Figure 5. Adult HIV Infection Cases, AIDS Cases and Population Data, by Race/ Ethnicity, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Broward County population. The 2013 Census estimates that 63,343 Broward residents have Haitian ancestry and 53,000 speak Haitian Creole. Among the 7,455 Haitian-born PLWH Floridians reported through 2013, 23% resided in Broward. Residents born in Haiti and living in Broward represented 22% of Black non-Hispanic living AIDS cases and

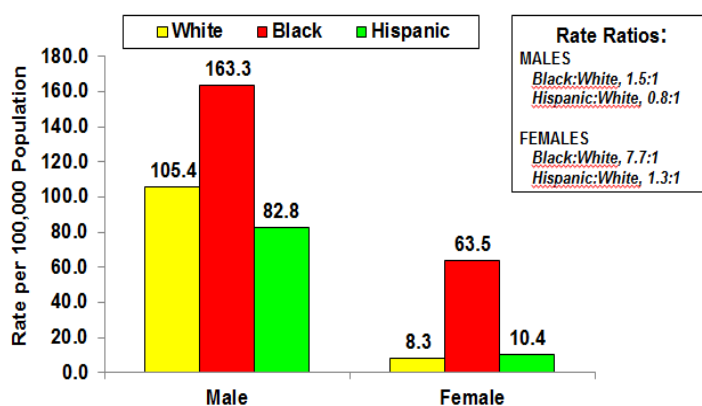
17% of Black non-Hispanic living with HIV (not AIDS) cases through 2014. In this snapshot for 2014, Blacks are disproportionately impacted by HIV/AIDS to the extent that the percentage of cases exceeds the percentage of the population (see Figure 5). Blacks accounted for 42% of adult HIV cases and 61% of adult AIDS cases, respectively, but only 25% of the adult population. For the past ten years, blacks represented 42% or more of the cases each year.

Numerous disparities can affect the increases of HIV disease in a given population. Among black males, the HIV infection case rate is nearly 2 times higher than the rate among white males (Figure 6). Similarly, among black females, the HIV case rate is nearly 8 times higher than the rate among white females. Hispanic females have a HIV case rate that is slightly higher than the rate among white females.

In contrast, Hispanic males have a slightly lower HIV case rate compared to the rate among white males.

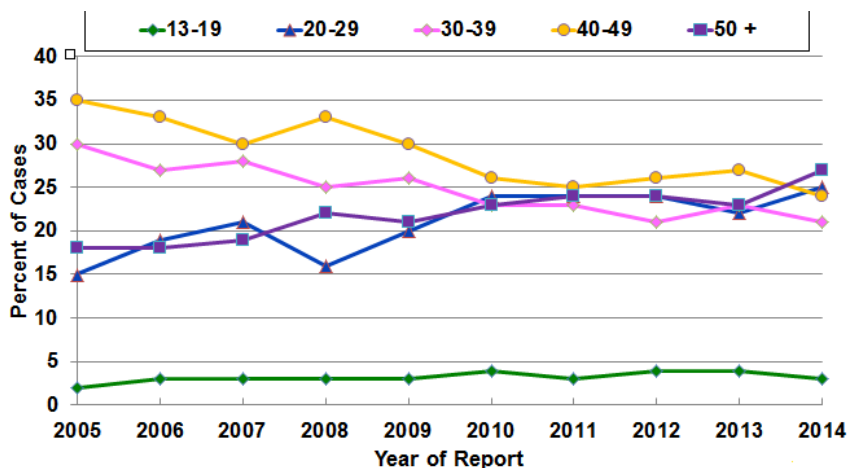
Age and HIV: Over the past ten years, the proportion of newly diagnosed adult HIV cases has shown an increase among the age group 20-29 by 10 percentage points. HIV infection trends show that adults 50 years or older are the fastest growing segment of the

Figure 6. Adult HIV Infection Case Rates by Sex and Race/Ethnicity, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Figure 7: Adult HIV Infection Cases, by Age Group at Diagnosis, and Year of Report, 2005-2014

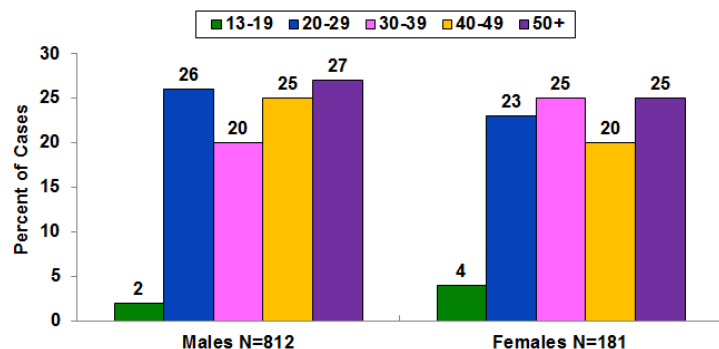


Source: Florida Department of Health HIV/AIDS Surveillance Program

Broward adult PLWH population. Aging of PLWH, in-migration of MSM, and Broward's popularity as a retirement community contribute to the rate of older PLWH as evidenced by a 9 percentage point increase from 2005 to 2014 among the '50 and over' age group. In contrast, the proportion of newly diagnosed adult HIV cases among those in the 30-39 and 40-49 age groups decreased by 9 and 11 percentage points respectively, over the same time period. The age group 13-19 remained relatively level during this time period with a 1 percentage point increase from 2005 to 2014 (Figure 7).

Sex and Age: With regard to the age groups and gender with the highest percent of HIV infection cases, recent estimates show that among males, 27% of HIV infection cases occur among those aged 50 or older, whereas among females, 25% of HIV infection cases occur among those aged 30-39 and 25% among those aged 50 or older (Figure 8).

Figure 8. Adult HIV Infection Cases, by Sex and Age Group at Diagnosis, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Socioeconomic Data: According to the U.S. Census Bureau, 2014 American Community Survey, the Broward County median household income was \$51,608. The percent of families whose income was below the poverty level in the past 12 months was 11.3%. Almost one-fifth (18.8%) of Broward residents 18-24 years of age earned less than a High School diploma. Persons aged 25 and older that attained a High School diploma or higher was 88% and those who attained a Bachelor's degree or higher were 30.5%. Overall, 18% of Broward residents had no health insurance coverage in 2014; 10% of those were 18 years of age or younger and 24% of individuals were 18-64 years of age. The 2014 American Community Survey reports that 59.5% of Broward residents have private health insurance, 19.7% report having either Medicare or Medicaid, and 18% report being uninsured.

Table 1 provides Part A client-level PE data system information on the number of Part A clients who are: (1) enrolled in Medicaid, Medicare, Qualified Health Plans (QHP), or private insurance, (2) uninsured, and/or (3) at or below 138% and 400% of the FPL- the income tier of the population that would be addressed if Florida expanded Medicaid.

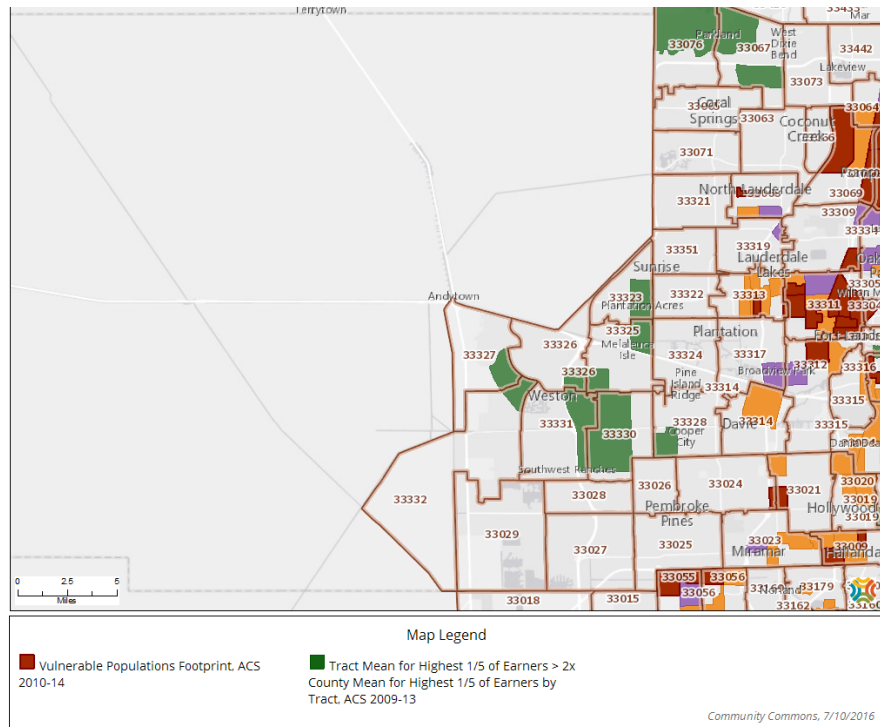
Table 1. Part A Clients Uninsured and Living in Poverty, 2014													
Medicaid		Medicare		QHP		Other Private Insurance		Uninsured		< 138% FPL		< 400% FPL	
#	%	#	%	#	%	#	%	#	%	#	%	#	%
999	12.5%	1,764	22.1%	771	9.7%	557	7.0%	3,879	48.7%	5,882	73.8%	7,945	99.7%

Homelessness: The number of individuals who are homeless in Broward County has grown significantly in Broward, contributed in part to insufficient affordable rental units, increased cost of living, and a sharp rise in the number of foreclosures. The Broward County Homeless Initiative Partnership surveyed residents in January 2015, and identified 2,624 individuals and families who were homeless, based on their residence in a place not meant for human habitation, emergency shelter, transitional housing, or temporary residence in an institution. An estimated 5% of the homeless were reported to be PLWH (137 respondents); 1% were in emergency housing; 3% were in a safe haven; 1% were unsheltered. Additionally, 16% were living in transitional housing.

The Part A client-level data system, PE, identified 1,675 PLWH Part A clients (23%) who were not permanently housed at some time in 2014. The 2014 consumer survey provided significant information on the Broward PLWH homeless population. Among respondents, 18% reported being homeless in the year. Black respondents reported the highest homeless rate (19%). Homeless respondents were significantly more likely than others were to be diagnosed within the past 10 years, to trade sex for something of value, and to be out of care at some point in the past six months. Only half of the respondents experiencing homelessness reported continuing to having a regular doctor, and 13% reported not receiving Outpatient Ambulatory Medical Care (OAMC) while homeless. They were less likely to be currently taking ART and less likely to be fully adherent if currently taking them.

There are two key social determinants of health-poverty and education-that have a significant impact on health outcomes. The map displayed in Figure 9 shows what is known as the “Vulnerable Footprint” of Broward County, based upon data from the United States Census Bureau, American Community Survey (2008-2012)

Figure 9. Broward County Vulnerable Footprint (the intersection of high poverty, lack of high school diploma, and low income)



and downloaded from www.communitycommons.org. This map identifies where high concentrations of population living in poverty and population living without a high school diploma overlap. These areas are also representative of the areas in which high concentrations of PLWH reside.

Burden of HIV: According to the CDC 2014 HIV Surveillance Report, Florida ranked second among states in the number of HIV infection cases with 5,332 estimated cases reported. Broward County is part of the Miami-Fort Lauderdale-West Palm Beach, FL MSA which accounts for 47.5% of Florida’s HIV infection cases. When examining the MSA by HIV infection case rate per 100,000 persons, Broward ranks second in the United States (44.7) just behind Miami (49.9), which ranks first. HIV prevention and service funds have not been equitably distributed to Broward. While the CDC, HIV/AIDS Bureau (HAB), and other federal agencies have targeted funds to address the Miami-Dade HIV epidemic, Broward’s epidemic receives limited funding reflecting a lack of understanding of the impact of the HIV epidemic in Broward and the need for targeted funds to address prevention and care efforts. Broward’s close proximity and juxtaposition between Miami and Palm Beach counties serves as a means for cross county social networking that can

increase this region's risk of HIV transmission. Broward's population of PLWH differs from the rest of the state, with a larger percentage of MSM living with HIV (56%) compared to the state of Florida (48%) (Table 2). This supports the need to have and evaluate targeted programs and interventions designed for the diverse gay and bisexual community of Broward County.

Table 2. Persons Living with HIV Infection by Selected Demographics and Risk Factors in Florida and Broward County, 2014

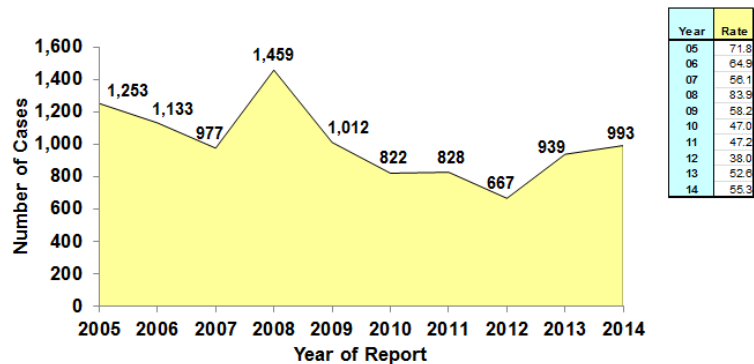
Subgroup	Florida (N=109,969)	Broward (N=19,391)
Male	72%	73%
Female	28%	27%
White	30%	35%
Black	47%	47%
Hispanic	21%	16%
Other	2%	2%
MSM	48%	56%
IDU	9%	9%
MSM/IDU	4%	3%
Heterosexual	37%	37%
Other	2%	1%
Age 0-24	4%	4%
Age 25-49	49%	48%
Age 50 and over	47%	49%

Source: Florida Department of Health HIV/AIDS Surveillance Program accessed:
<http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/partnership-slide-sets1.html>

While Broward residents make up 9% of the Florida population, they represent 18% of Florida's PLWH. Due to Broward's uncontrolled HIV epidemic, at least one in every 97 Broward adults is a PLWH. The true magnitude of the epidemic may be even greater due to in-migration of PLWH individuals from other states and counties. These rates far exceed any other Florida EMA or Transitional Grant Area (TGA). According to the CDC, the Fort Lauderdale metropolitan division within the Miami-Fort Lauderdale-West Palm Beach MSA ranked third in the United States for population-adjusted AIDS cases in 2014 with a case rate of 19.0. Since 1995, the number of persons reported living with HIV/AIDS has increased over 460%. In 2014, the prevalence increased by 5% over the previous year with 17,828 adults living with HIV disease. Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in

newly reported cases of HIV infection in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of HIV infection in 2013. An additional 6% increase

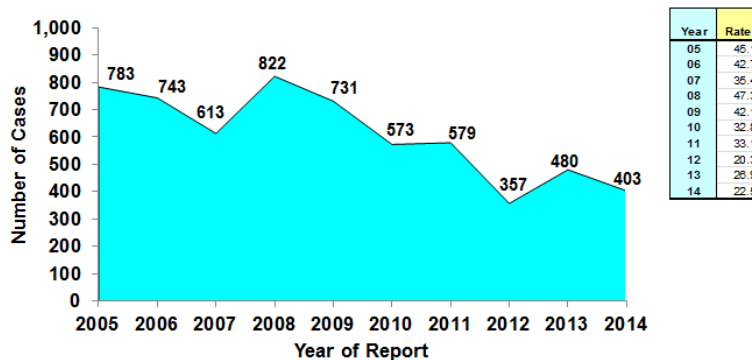
Figure 10. HIV Infection Cases and Rates, by Year of Diagnosis, 2005-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

was observed in 2014 compared to the previous year (Figure 10). This is higher than the 4% incline observed by the state during the same time period.

Figure 11. AIDS Infection Cases and Rates, by Year of Diagnosis, 2005-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

newly reported cases of AIDS in 2013. AIDS cases in 2014 dropped by 16% from the previous year (Figure 11). This is lower than the 20% decline observed by the state during the same time period.

Indicators of Risk: FDOH provides DOH-Broward with annual surveillance slides for the county, which contains a list of priority populations specific to Broward. These populations are determined by a formula that takes into account rank of race/risk groups among all persons living with HIV disease in the enhanced HIV/AIDS Reporting System (eHARS) and race/risk groups among those newly reported with HIV in the county. The two ranks are weighted and combined resulting in the final list. Broward County's top 9 priority populations in 2014 for primary and secondary HIV prevention is listed below. This

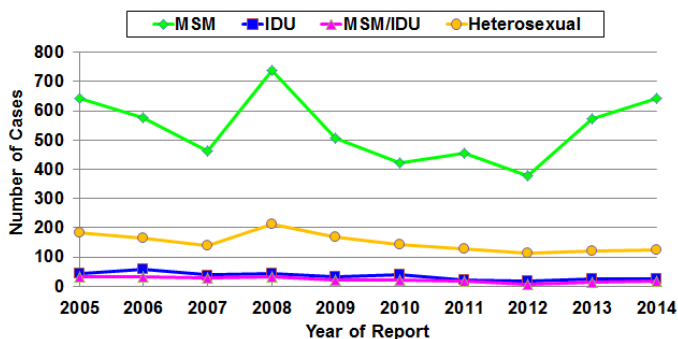
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list of priority populations guides the work that is designed and implemented through planning efforts.

1. White men who have sex with men (MSM)
2. Black heterosexual men and women
3. Black men who have sex with men
4. Hispanic men who have sex with men (MSM)
5. Black injection drug user (IDU)
6. Hispanic heterosexual men and women
7. White heterosexual men and women
8. White injection drug user (IDU)
9. Hispanic injection drug user (IDU)

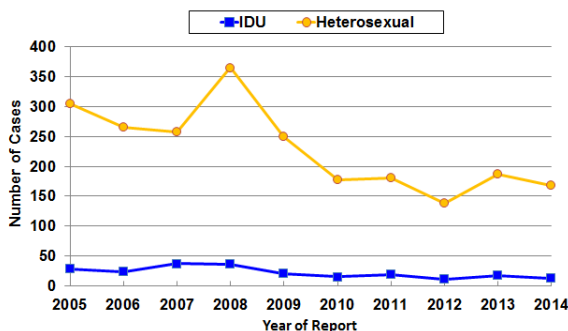
Over the past ten years, MSM remains the primary mode of exposure among male HIV infection cases. Over the years, the second highest mode of exposure for adult male HIV infection cases was heterosexual contact. From 2005 to 2014, IDU among adult male HIV infection declined by 47%. Similarly, the number of males infected by HIV by MSM/IDU decreased by 50% (Figure 12).

Figure 12: Adult Male HIV Infection Cases, by Mode of Exposure and Year of Report, 2005-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Figure 13: Adult Female HIV Infection Cases, by Exposure Category and Year of Report, 2005-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

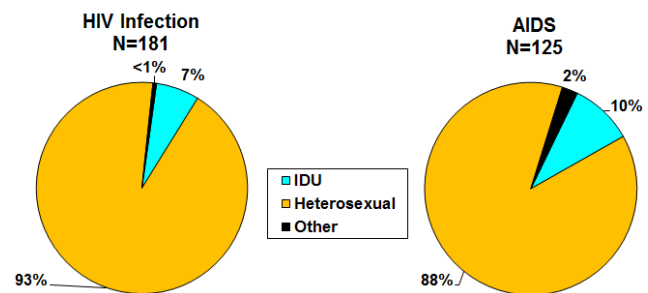
Heterosexual contact has remained the primary mode of exposure among adult female HIV infection cases in Broward County over the past ten years. This trend is followed by injection drug use. The number of adult females infected with HIV by heterosexual contact decreased by 45% from 2005 to 2014. Similarly, the number of adult females infected with HIV by way of

IDU decreased by 57% over the same time period (Figure 13).

Among the male HIV infection and AIDS cases reported for 2014, MSM was the most common risk factor (79% and 58%, respectively) followed by cases with a heterosexual risk (16% for HIV and 32% for AIDS) (Figure 14). MSM/IDU remains considerably lower than other modes of transmission for both HIV and AIDS cases.

The recent increase among MSM is indicated by the higher MSM among HIV infection cases compared to AIDS cases, as HIV infection cases tend to represent a more recent picture of the epidemic. MSM represents the highest risk for all races. White adult males have the greatest proportion of MSM (90%) and the smallest proportion of heterosexual contact risk (3%). Black adult males have the highest proportion of heterosexual contact (44%). The second highest proportion of mode of exposure for black males was MSM (43%). MSM contact represents the highest proportion for Hispanic adult males (82%).

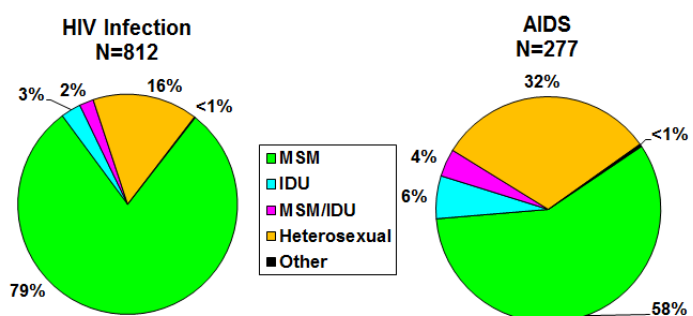
Figure 14. Adult Male HIV Infection and AIDS Cases by Mode of Exposure, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Among the adult female HIV infection and AIDS cases reported for 2014, heterosexual contact was the highest risk (93% and 88%, respectively) (Figure 15). This is compared to IDU, which was 7% and 10% of adult female HIV infection and AIDS cases, respectively. For adult females living with HIV by race/ethnicity in Broward County heterosexual contact is the majority risk for all races. Compared to other races, whites have the largest proportion of IDU risk (30%) for both males and females. Other modes of exposure are observed to be relatively lower than heterosexual contact.

Figure 15. Adult Female HIV Infection and AIDS Cases by Mode of Exposure, Diagnosed in 2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

Youth Risk Behavioral Surveillance System (YRBSS): The following displays a summary of indicators among 1,413 students in 29 public high schools surveyed in Broward County from 2009-2015 (Table 3). There was an overall decrease among all indicators with the exception of the percentage of students who experienced physical and sexual dating violence and those who used birth control to prevent pregnancy at last sexual encounter. Additional results from the 2015 Broward County High Schools Survey reveal that the among races/ethnicities, Blacks report the highest percentage of sexual contact with opposite sex only, sexual contact with same sex only, and sexual contact with both sexes. However, differences among Black males and Females exist: Black males have the highest percentage reporting ever having sexual contact (61.9%) while Black females have the highest percentage reporting never having sexual contact (51%). It appears that sexual initiation may occur earlier for young Black men compared to other youth, placing them at greater risk of acquiring HIV at earlier age.

Table 3. Youth Risk Behavioral Surveillance System (YRBSS) 2009-2015

Questions	2009	2011	2013	2015
Percentage of students who ever had sexual intercourse	52.2	48.8	41.4	39.9
Percentage of students who had sexual intercourse for the first time before age 13 years	9.2	8.3	5.9	5.3
Percentage of students who had sexual intercourse with four or more people during their life	19.8	16.8	12.4	10.6
Percentage of students who had sexual intercourse with one or more people during the past three months	38.4	33.6	28.2	27.6
Among the students who had sexual intercourse during the past three months, the percentage who drank alcohol or used drugs before last sexual intercourse	23.4	22.4	22.4	19.2
Among the students who had sexual intercourse during the past three months, the percentage who used a condom during the last sexual intercourse	70.6	71.2	70.0	61.5
Among students who had sexual intercourse during the past three months, the percentage who used birth control pills to prevent pregnancy before last sexual intercourse	9.9	7.9	13.3	13.8
Percentage of students who had ever been taught in school about AIDS or HIV infection	87.2	87.3	86.2	82.5
Percentage of students who have been physically forced to have sexual intercourse when they did not want to during the 12 months before the survey			5.4	6.1
Percentage of students who experienced physical dating violence (one or more times during the 12 months before the survey, including being hit, slammed into something, or injured with an object or weapon on purpose by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)			5.8	7.5
Percentage of students who experienced sexual dating violence (one or more times during the 12 months before the survey, including kissing, touching, or being physically forced to have sexual intercourse when they did not want to by someone they were dating or going out with among students who dated or went out with someone during the 12 months before the survey)			4.3	6.6

Source: Youth Risk Behavior Surveillance System accessed from <http://www.cdc.gov/yrbss>

Behavioral Risk Factor Surveillance System (BRFSS): The Florida Behavioral Risk Factor Surveillance System (BRFSS) has been collecting and reporting health behavior data since 1986. This statewide telephone survey is comprised of state-specific, population-based estimates of the prevalence of personal health and risk behaviors, selected medical conditions, and preventive health care practices among Florida adults. Table 4 displays estimates that 45.7 percent of adults have been tested for HIV in Broward County. Characteristics of persons reporting less frequent testing tend to be non-Hispanic White women, 65 years of age and older, those with less than a High School education, those with an annual income of \$25,000 - \$49,999, and persons who are married/coupled. The percent of adults who have ever been tested in Broward County will be monitored for increases due to Integrated Planning efforts.

Table 4. 2013 BRFSS Data for Broward County, Florida

2013 Florida BRFSS Data				Broward	
HIV/AIDS Screening					
Percentage of adults who have ever been tested for HIV					
		2013 County		2013 State	
		Measure	95% CI	Measure	95% CI
	ALL Overall	45.7	40.2 - 51.2	42.6	41.4 - 43.9
SEX	SEX Men	42.8	34.4 - 51.2	41.2	39.3 - 43.1
	Women	48.4	41.2 - 55.6	43.9	42.2 - 45.6
RACE/ETHNICITY	Non-Hisp. White	35.0	28.2 - 41.8	34.4	33.2 - 35.6
	Non-Hisp. Black	69.1	56.6 - 81.6	65.8	62.1 - 69.5
	Hispanic	41.6	29.0 - 54.2	48.7	44.9 - 52.5
SEX BY RACE/ETHNICITY	Non-Hisp. White Men	39.4	28.1 - 50.6	35.3	33.4 - 37.2
	Non-Hisp. White Women	30.9	22.7 - 39.1	33.5	32.0 - 35.1
	Non-Hisp. Black Men	64.0	42.6 - 85.5	62.0	55.9 - 68.0
	Non-Hisp. Black Women	73.5	59.7 - 87.3	69.3	64.7 - 73.8
	Hispanic Men	42.4	25.4 - 59.4	44.9	39.5 - 50.4
	Hispanic Women	40.6	22.0 - 59.3	52.3	47.0 - 57.6
AGE GROUP	18-44	58.0	48.2 - 67.9	56.9	54.7 - 59.2
	45-64	44.9	36.2 - 53.7	42.7	40.6 - 44.8
	65 & Older	19.5	12.5 - 26.4	15.9	14.3 - 17.6
EDUCATION LEVEL	<High School	33.2	16.4 - 50.1	39.4	35.0 - 43.7
	High School / GED	43.0	30.9 - 55.2	39.8	37.4 - 42.3
	>High School	49.1	42.6 - 55.5	45.0	43.5 - 46.5
ANNUAL INCOME	<\$25,000	56.9	46.3 - 67.6	48.8	46.3 - 51.3
	\$25,000-\$49,999	35.2	24.9 - 45.5	40.8	38.2 - 43.4
	\$50,000 or More	49.8	40.8 - 58.8	41.7	39.6 - 43.8
MARITAL STATUS	Married/Couple	46.0	38.1 - 53.9	39.9	38.2 - 41.6
	Not Married/Couple	46.2	38.3 - 54.0	46.1	44.1 - 48.1

Source: <http://www.floridahealth.gov/statistics-and-data/survey-data/behavioral-risk-factor-surveillance-system/reports/documents/2013county/documents/Broward.pdf>

CI=Confidence Interval

Co-morbidity: In 2014, co-morbidity data captured in eHARS and Patient Reporting Investigating Surveillance System (PRISM) as of June 30th, 2015 shows that of the people living with HIV/AIDS in Broward County; zero (0) were diagnosed with Tuberculosis, 162 were diagnosed with Infectious Syphilis, 324 were diagnosed with Gonorrhea, 325 were diagnosed with Chlamydia, and 1,768 were living with HIV/AIDS and also with Hepatitis C (which includes history of acute and/or chronic viral Hepatitis C). Of the people living with HIV/AIDS in Broward County, data as of June 30th, 2015, 68 were identified as homeless, 2,532 have a history of substance abuse, and 1,003 have a history of chronic mental illness.

STD Surveillance Data: The reporting of communicable and sexually transmitted diseases (STDs) is important for the purpose of planning and evaluation of disease prevention and control programs, the assurance of appropriate medical therapy, and in the detection of common-source outbreaks. The rates of STDs have increased since 2001 in both Broward County and the state of Florida. Broward County's infectious syphilis and congenital syphilis rates are among the highest in the State. The average number of annual TB cases reported from Broward County is 65 (2004 – 2013), making Broward County the 2nd or 3rd highest incidence county in Florida from year to year.

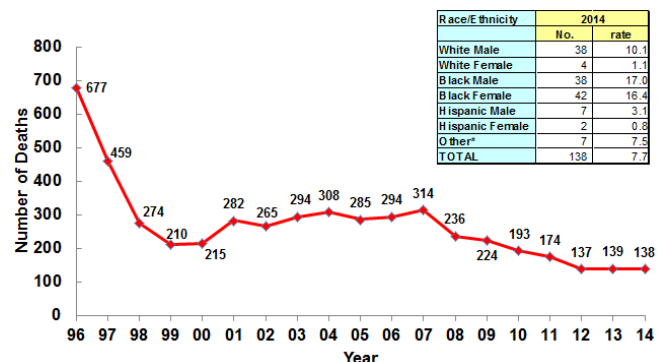
HIV-Related Deaths: The top five leading causes of death for residents of Broward County are heart disease, cancer, stroke, chronic lower respiratory disease, and unintentional injuries.

According to the Florida Vital Statistics

Annual Report 2014, HIV was the cause of death for 138 Broward County residents. Thirty (30) percent of the resident deaths due to HIV were among the age group 45-54, followed by 29% in the 55-64 age group. Due to increased use of ART and expanded virologic monitoring, the rate of Broward HIV/AIDS-related deaths has plateaued in recent years. HIV/AIDS accounted for approximately one percentage of all total deaths in 2014.

Figure 16 shows an 80% decline in HIV resident deaths due to HIV disease from the peak

Figure 16. Resident Deaths due to HIV Infection, by Year of Death, 1994-2014



Source: Florida Department of Health HIV/AIDS Surveillance Program

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year of 1995. This is slightly higher than the 79% decline observed by the state. Since 2007, deaths have maintained a downward trend. Of the resident deaths due to HIV disease in 2014, black females accounted for 42 of those resident deaths. In 2014, the second highest racial/ethnic resident deaths due to HIV were among white males and black males both with 38, while the highest case rate of resident deaths due to HIV disease were among black males at 17.0.

HIV Counseling and Test Data: Table 5 provides an overview of Counseling and Testing data from registered testing sites in Broward County during 2014. Review of this data provides information on persons who access publicly funded testing services. The table

Table 5. 2014 Counseling & Testing Summary

Sex	N	P	Total	P%
Female	39247	140	39412	0.36
Male	43685	498	44265	1.13
Transgender	74	6	80	7.50
Missing Data	246	2	248	0.81
Grand Total	83252	646	84005	0.77

Race	N	P	Total	P%
Asian	788	7	797	0.88
Black	45461	344	45864	0.75
Hispanic	15136	138	15289	0.90
Amer Indian/Alaskan	219	5	224	2.23
Native Hawaiian/ Pac Isle	192	0	192	0.00
White	18844	135	19006	0.71
Mixed	697	7	705	0.99
Refused	504	0	505	0.00
Missing Data	1411	10	1423	0.70
Grand Total	83252	646	84005	0.77

Site Type	N	P	Total	P%
01-Anonymous	6	0	6	0.00
02-STD	0	0	0	0.00
03-Drug Treatment	481	1	483	0.21
04-Family Planning	2021	6	2027	0.30
05-Prenatal/OB	0	0	0	0.00
06-TB	194	1	195	0.51
07-Adult Health	982	7	990	0.71
08-Prison/Usais	4408	12	4430	0.27
09-College	0	0	0	0.00
10-Private/MD	24605	86	24710	0.35
11-Special Projects	5970	66	6050	1.09
12-CBO	41558	419	42034	1.00
13-CHD Field/Visit	3027	48	3080	1.56
Other-Missing	0	0	0	0.00
Grand Total	83252	646	84005	0.77

Risk	N	P	Total	P%
MSM/IDU	1588	22	1613	1.36
MSM	14174	353	14572	2.42
IDU	6256	11	6271	0.18
Sex with HIV	665	42	711	5.91
Sex with MSM	453	1	455	0.22
Sex with IDU	936	6	944	0.64
Sex with Other	268	3	271	1.11
Perinatal	8	0	8	0.00
STD Diagnosis	11849	56	11917	0.47
Sex for Drugs/Money	598	6	604	0.99
Sexual Assault	62	0	62	0.00
Heterosexual	43818	130	43978	0.30
Other Risk	1250	3	1256	0.24
No Identifiable Risk	642	2	644	0.31
Refused	227	1	229	0.44
Missing Data	458	10	470	2.13
Grand Total	83252	646	84005	0.77

Age Group	N	P	Total	P%
<2	4	0	4	0.00
2-4	6	0	6	0.00
5-12	20	0	20	0.00
13-19	7025	20	7053	0.28
20-29	33091	220	33346	0.66
30-39	19116	169	19308	0.88
40-49	12119	116	12257	0.95
50+	11705	120	11844	1.01
Missing Data	166	1	167	0.60
Grand Total	83252	646	84005	0.77

**Indeterminate and unconfirmed reactive rapid test results are not shown, but are included in the total tested.

Source: Florida Department of Health Counseling and Testing Data Summary Report by Selected

shows the total number of tests conducted, the number of those testing negative (N) and those testing positive (P) and the positivity rate (P%). For sex, Transgender had the highest percent of positivity rates (7.5%) compared to males (1.13%) and females (0.36%). By race, the highest positivity rates were among American/Indian/Alaskan (2.23%) even though the largest majority of the tests were conducted among Blacks (54.6%). Sex with PLWH (5.91%) and MSM (2.42%) had the highest positivity percentage for reported risk factors. The age group with the highest positivity percentage were individuals 50 years and older. Of the 84,005 individuals that were tested for HIV in Broward County, 13,028 (16%) were first time HIV testers.

Satisfaction Surveys: almost 400 surveys (in English and Spanish) were distributed and returned over a six month period in 2016. Of the surveys returned, over 60% were from individuals who were HIV+ and receiving Ryan White Part A services. An additional 12% identified as HIV+ but not receiving Ryan White Part A services. The youngest respondent was 18 years old and the oldest, 78. The average age of respondents was 50. Sixty-nine percent (69%) of respondents were born in the United States, and thirty-one percent (31%) were born in a country other than the United States. Of those born in a country other than the United States, the majority (34%) were born in Haiti, 41% were born in Central or South America, and 14% were born in Jamaica. Fifty-one percent (51%) of respondents identified as Black or African-American, 42% identified as White or Caucasian, 6% identified as Multi-Racial, and 1% identified as Asian. In terms of ethnicity, 81% identified as not Latino or Hispanic, while 19% identified as Latino or Hispanic. Most respondents (77%) indicated that English was the language they spoke most often, followed by Spanish (9%) and French Creole (9%).

In terms of residential status, of the 344 individuals who responded to this question, 50% (166) rent an apartment or home, 29% (98) own their apartment or home, 8% (26) are staying or living with family (on a permanent or temporary basis), 3% (10) are staying or living with friends (on a permanent or temporary basis), 2.4% (8) are living in transitional housing for homeless persons, and 2.1% (7) are living in a residential treatment center for substance abuse. Most respondents 91% (308) were not receiving Section 8 housing. Zip codes in which respondents lived corresponded to the prevalence map previously presented, with 23% of respondents residing in zip code 33311.

Regarding health insurance, 231 of the 342 individuals (68%) who answered this question indicated that they had health insurance, while 111 (32%) said they did not. Although only 231 individuals indicated they had health insurance, 258 replied to the question asking about type of health insurance. 109 (42%) said they had private insurance through their employer, 61 (24%) said they had Medicaid, 59 (23%) had Medicare, 26 (10%) had insurance through the Affordable Care Act Marketplace, 6 (2%) had private insurance through their partner or parent, and 7 (3%) did not know what type of insurance they had. 33 (13%) stated they had some “other” type of insurance.

Stigma Survey: Surveys were administered to 106 individuals in the community to gauge their condom use, knowledge of HIV prevention measures, and stigma related to HIV infection. The sample was evenly distributed between genders. The majority of respondents were 18-25 and born in the United States. Results showed that stigma continues to permeate the community.

Considerations related to Epidemiology: Epidemiologic data for Broward County is provided by the State of Florida, and is not analyzed locally, therefore limiting the data presented in this section to that which is provided by the State Health Office. Information regarding HIV risk behaviors particular to Broward County is not included in this section as National HIV Behavioral Surveillance (NHBS) data is currently not collected specific to Broward County. Since 2008, Broward County was no longer an eligible NHBS site due to new funding criteria. Additional qualitative data is included in Section 1.D and limitations of data collection and analysis are further explained in Section I.E. The following are considerations when reviewing the above data:

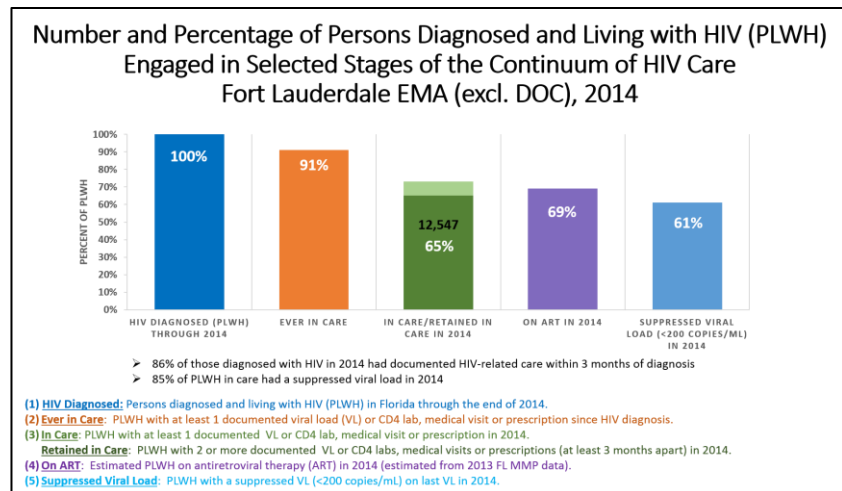
- HIV Infection reporting represents newly Adult HIV Infection Cases, regardless of AIDS status at time of report, that were previously reported.
- AIDS cases and HIV infection cases by year of report are NOT mutually exclusive and CANNOT be added together.
- Frozen databases of year-end data are generated at the end of each calendar year. These are the same data used for Florida CHARTS and all grant-related data where annual data are included.
- HIV prevalence data are generated later in the year, usually in July, when most of the “expected” death data are complete.
- Adult cases represent ages 13 and older, pediatric cases are those under age 13. For data by year, the age is age of diagnosis. For living data, the age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.
- Unless otherwise noted, whites are non-Hispanic and blacks are non-Hispanic.
- Unless otherwise noted, area and county data exclude any Department of Corrections cases.

B. HIV Care Continuum

An examination of the HIV Care Continuum model is vitally important in the identification of issues and opportunities related to the improvement of service delivery to PLWH across the entire HIV Continuum of Care and the subsequent prioritization of program activities. Shared outcome measures are based upon the continuum of care that provide population percentages for individuals who are aware of their HIV positive status, linkage to care, retention in care, on ART and virally suppressed. The continuum of care is a shared set of measurements that fall under the responsibility of both Prevention and Care and Treatment. The targets for these indicators are set forth by NHAS 2020: 1) Increase the proportion of newly diagnosed patients linked to medical care to 85 percent; 2) Increase the proportion of PLWH who are in continuous care to 90 percent; and 3) Increase the proportion of virally suppressed to 80 percent. Broward County has developed a diagnosed-based approach to the HIV care continuum which depicts each step of the continuum as a percentage of the number of people living with diagnosed HIV as of the end of 2014. The diagnosed-based continuum informs steps that can be taken to help individuals with HIV access care and get them to viral suppression. This approach also gives more detailed information regarding persons who are diagnosed with HIV. The prevalence-based HIV Care Continuum shows each step of the continuum as a percentage of the total number of PLWH. Broward County is currently developing a prevalence-based continuum that includes the number of people who have been diagnosed with HIV *and* the estimated number of those who have not been diagnosed with HIV. The most difficult undertaking in the development of the prevalence-based continuum is the estimation of the size of the undiagnosed population. Broward will continue its efforts by conducting surveys of populations at high-risk and by obtaining data on HIV testing trends and percent positive by population subgroups over time. This approach will help determine whether people unaware of their HIV status are getting tested and to evaluate if the number of never tested individuals is decreasing.

The diagnosed-based HIV care continuum shows each step of the continuum as a percentage of the number of people living with diagnosed HIV as of the end of 2014. Figure 17 depicts the Continuum and illustrates the rate of HIV+ Broward residents engaged at each Continuum stage:

Figure 17. Diagnosed-Based Continuum of HIV Care, Fort Lauderdale EMA, 2014



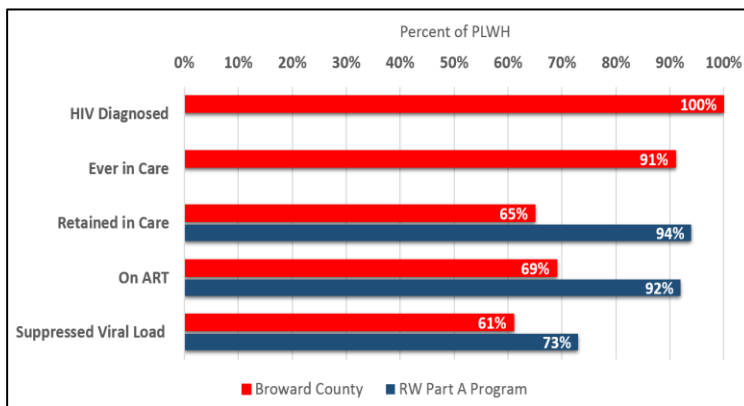
linked to OAMC, retained in care, prescribed ART, and virally suppressed. The data reflects CY 2014 for HIV+ individuals presumed alive and living in Broward. The sources include eHARS, CAREWare, AIDS Drugs Assistance Program (ADAP), and estimates based on 2013 data from the Florida Medical Monitoring Project (MMP). The analysis is impacted by: 1) completeness of eHARS lab reports; 2) maintaining timely death reporting; and 3) maintaining accurate current addresses to account for in and out-migration.

In a 2014 CDC Dear Colleague letter, all state and local health departments were encouraged to use HIV case surveillance data to improve the continuum of care in their communities, including the use of individual-level data to offer linkage and re-engagement to care services when appropriate. This data-to-care strategy was introduced as a resource to assist programs in moving forward with these activities. FDOH made significant strides to address data issues at the State and County levels. Efforts will be continued to improve the completeness of reporting. The diagnosed, linked to OAMC, retained in OAMC, and virally suppressed stages of the Continuum reflect eHARS data, including CAREWare and ADAP matching. Data for the prescribed ART stage was estimated from 2013 FL MMP data. FDOH could not generate County level data for the prescribed ART stage. Thus, FDOH applies the statewide estimated prescribed ART rate to Broward. In the coming years, FDOH will consider use of electronic health records (EHRs) to supplement eHARS for a more accurate estimate for the State and counties.

Locally, DOH-Broward collects and reports to FDOH the number of Broward HIV+ residents diagnosed and linked to OAMC. The results are then disseminated to the Broward Part A Recipient, who routinely monitors the accuracy of data collection efforts.

Part A-funded clients have higher rates in the Continuum stages than other Broward HIV+ residents (as shown in Figure 18). This data is included to provide a comparison of the health outcomes of Broward's Part A clients to all HIV+ Broward residents. The Part A data reflect

Figure 18. Diagnosed-based HIV Continuum of Care, Fort Lauderdale EMA, 2014



the care status for RWHAP Part A clients served in FY 2014. PE collects data on the last three stages of the Continuum including the number of clients who are in care, prescribed ART, and virally suppressed. PE data completeness depends on accurate reporting from Part A sub-recipients who are contractually required to report client-level PE data. As part of the integration, proposed plans are being developed to further enhance the use of data by implementing data-to-care activities that utilize eHARS in addition to improving data sharing within the PE database to identify and track clients as they move along the Continuum. Figure 18 illustrates how Part A data were superimposed over the last three indicators in Figure 17 to provide a comparison of the health outcomes of Broward's Part A clients to all HIV+ Broward residents. Note, however, these populations are limited to those HIV+ individuals with information collected in PE, the Ryan White Part A database. The PE data system and usage is further explained in Section I.E. The comparison of continuum measures provides evidence for the effectiveness of the Ryan White program in improving outcomes for those living with HIV. The targets set forth will also assist in measuring success of the combinations of activities selected to be implemented in Broward County within the Integrated Plan in Section II.

Definitions of the numerators and denominators used to compute each Continuum stage are explained below:

- **Diagnosed:** Stage 1 of the Continuum shows the rate of Broward HIV+ residents diagnosed and living with HIV disease through 2014, regardless of AIDS status or where diagnosed. A total of 19,391 HIV+ individuals were known to be diagnosed and living in Broward through 2014, regardless of where they were diagnosed. FDOH provided these data, which are current as of June 30, 2015.
- **Ever in Care:** Stage 2 of the Continuum shows the rate of Broward residents through 2014 (n=17,731) with at least 1 documented VL or CD4 lab, medical visit or prescription since HIV diagnosis.
- **Retained in Care/In Care:** The Stage 3 numerator (Retained in Care) (n=12,547) is the number of HIV+ persons with two or more OAMC visits, or VL or CD4 tests at least three months apart in 2014. The denominator is the number of Broward HIV+ cases diagnosed through 2014 (n=19,391). The rate of Ryan White Part A clients in care (shown in Figure 18) was calculated by dividing the number of clients with at least one documented OAMC visit, VL, or CD4 test (7,523) by the total number of clients served in FY2014 (n=8,018).
- **Prescribed ART:** The Stage 4 numerator (Prescribed ART) (n=13,304) is based on MMP data that estimates the number of HIV+ Florida residents diagnosed in 2014 and prescribed ART. The denominator is the number of Broward HIV+ cases diagnosed through 2014 (n=19,391). The rate of Part A clients prescribed ART (shown in Figure 18) was calculated by dividing the number of clients with a documented OAMC visit and on ART (n=5,848), by the total clients with a documented OAMC visit in FY 2014 (n=6,355).
- **Virally Suppressed:** The Stage 5 numerator (Virally Suppressed) (n=11,872) is the number of HIV+ individuals whose most recent VL test in 2014 is < 200 copies/mL. The denominator is the number of HIV+ Broward cases diagnosed through 2014 (n=19,391). The rate of Part A clients who are virally suppressed (shown in Figure 18) was calculated by dividing the number of clients with a documented OAMC visit and a suppressed VL < 200 copies/mL (n=4,661) by the total clients with a documented OAMC visit in FY2014 (n=6,355).

Data Limitations

- An estimate of 4,000 out-of-state cases who were in care in Florida through 2012 were not yet entered into eHARS at the time of these analyses, therefore the data were adjusted accordingly to account for the un-reported cases.
- Laboratory data may not be complete; therefore the percent in care this year were adjusted to accommodate the estimated number of missing data.
- MMP data were used to estimate those on ART and those with a suppressed viral load. Estimates were not available below the state level, therefore the statewide estimates were applied to each of the local areas. Eventually, a process may be in place to link the patient care databases with eHARS to get a more accurate estimate by area.

Disparities in Engagement among Key Populations: While significant success was achieved in integrating the Continuum into the Part A planning and implementation process, Broward has experienced one of the most intractable HIV epidemics in the US. Broward's long standing ranking in HIV incidence and prevalence among MSAs underscores the major challenges encountered. Due to clients' changing needs, the Continuum was expanded to the extent to which Federal, State, local, and third party insurance funds are available. *Systems remain in Broward to facilitate linkage and engagement of newly infected, underserved, hard-to-reach, and emerging populations. While services target disproportionately impacted racial/ethnic minorities, these systems are highly stressed due to sharply increased demand for services and decreased funds.*

Broward addresses disparities in access to HIV screening and linkage services among target and other groups by promoting expanded HIV screening and adoption of rapid HIV testing in communities where targeted and other groups reside. Timely epidemiologic data will continue to be used by DOH-Broward and other HIV screening programs to identify those groups. The Integrated Plan will ensure that culturally and linguistically appropriate HIV screening is available to diverse populations based on race/ethnicity, gender, sexual orientation, age, HIV behavioral risk factors, and immigration status. The cultural norms and concerns about HIV stigma and disclosure will be considered, for

example, in the placement of HIV mobile testing units in neighborhoods hardest hit by the HIV epidemic. HIV screening programs will routinely meet to share their experiences in optimizing the location of mobile testing units or incorporating HIV screening in community health screening events to address concerns about HIV disclosure.

The DOH-Broward Prevention Program will continue to lead efforts in identifying HIV+ unaware individuals by promoting HIV screening in community and healthcare settings. This responsibility will continue to be shared by Broward Health, Broward's only Part C Recipient, which will use available Part C Early Intervention Services (EIS) funds for HIV screening in their system and to supplement FDOH HIV screening funds. CDC funds will continue to be used by DOH-Broward to conduct the Broward>AIDS Initiative, a comprehensive community education, prevention, and media campaign targeting high-risk populations. The campaign will maintain its focus on health promotion and wellness, with messaging centered on Broward>AIDS and other evidence-based population-focused campaigns designed to change community norms. In Fiscal Year (FY) 2015, the DOH-Broward collaborated with Part A to expand the media campaign to address linkage and retention in care. Part A launched the "Get Care Broward. Treat HIV. Beat HIV." media campaign to promote increased linkage to care for HIV+ individuals. DOH-Broward has identified 10 diverse physician ambassadors to implement this campaign in private healthcare settings. DOH-Broward will continue to deploy its mobile HIV, Sexually Transmitted Infections (STI), and Hepatitis C Virus (HCV) testing unit to non-traditional sites to the extent that funds are available. Community-Based Organizations (CBO) mobile testing units will continue to be deployed throughout Broward. FDOH will maintain funding for HIV awareness, outreach, screening, linkage, and prevention interventions in Federally Qualified Health Centers (FQHCs), Emergency Departments (EDs), and CBOs. FDOH will also continue to fund agencies based on their expertise in HIV screening and linkage with the priority populations addressed by the Integrated Plan. Agencies must demonstrate the ability to implement services in a timely manner, test large numbers of individuals, identify individuals unaware of their HIV+ status, link HIV+ persons to OAMC, and participate in data collection, Quality Management (QM), and evaluation.

Key stakeholders in Broward have determined that it is critical to increase viral suppression among all HIV+ residents, particularly among groups with the greatest

burden of disease including young adults, Black non-Hispanic men and women, MSM, homeless, and transgender individuals. Efforts to decrease community VL depends on coordinated efforts across funders to maximize available resources and access to services. Data sharing among funders presents a challenge to ensuring clients' needs are addressed consistently across the Continuum. With many clients receiving services from various funders, data sharing is critical in providing clients' complete and efficient services. Limited data sharing by FDOH, for example, compromises Broward's ability to be fully informed. DOH-Broward is required to collect and report data to FDOH. These data are analyzed and redistributed by FDOH at a later time, impairing availability of meaningful data for efficient and timely decision-making. Broward is addressing this challenge via Data Use Agreements with Housing Opportunities for People with AIDS (HOPWA), integrating PE with the DOH-Broward prevention programs, and ongoing data sharing with all other RWHAP recipients.

The Broward Continuum is consistent with increasing access to services and decreasing HIV health disparities among disproportionately impacted sub-populations and historically under-served communities.

HIV Care Continuum Used in Planning, Prioritizing, and Targeting Resources:

The Continuum framework helps to plan, prioritize, target, and monitor available resources in response to the needs of HIV+ Broward residents and improving engagement at each Continuum stage. The Continuum framework allows Broward to measure progress and to direct HIV resources most effectively. Broward has successfully supported PLWH as they move across the Continuum stages. It has become increasingly important for Care and Treatment and CDC-funded prevention providers to align effectively their prevention and care activities to maximize their impact. Integration of prevention and care offers new potential to increase significantly the number of Broward HIV+ residents linked, engaged, or re-engaged in OAMC. The recent introduction of the Continuum model and the increasing intersection of HIV primary and secondary prevention, care, and treatment have prompted Broward stakeholders to consider new HIV service strategies in recent years.

HIV+ Broward residents access the Continuum through many entry points. Most Broward HIV screening activities are funded by the CDC, Part C EIS, and health insurers.

To address this need, Broward uses CDC-funded and Part C EIS to support anonymous and confidential testing at DOH-Broward's Counseling and Testing Sites (CTS). Broward's EIS activities support the Continuum's diagnosis and linkage stages for newly identified HIV+ residents. Part A funded Client Intake and Eligibility Determination (CIED) coordinates with EIS funders in Broward to ensure timely linkage to OAMC within 48 hours via Memoranda of Understanding (MOUs) and co-location of service sites, Part A-funded CIED and prevention providers have collaborated to close the gap between diagnosis and linkage to OAMC. Part A has established protocols and implemented strategies through CIED to assist clients to be retained in OAMC. CIED conducts eligibility certification and recertification every six months using PE to ensure clients are engaged in OAMC. A PE scheduling system alerts CIED staff when clients are out of care, and facilitates rapid re-engagement in OAMC through appointment making. Part A requires that all sub-recipients use PE to monitor retention in OAMC. This approach allows sub-recipients to query PE and receive alerts on their clients' kept or missed OAMC visits. PE also alerts sub-recipients when a client has not had an OAMC appointment in the last six months. Currently, numerous databases are used to collect data on HIV positive individuals. These databases are fragmented and lack integration, preventing a comprehensive and complete surveillance system. HIV CTS data is collected locally and then sent to FDOH for aggregate data analysis. This process prolongs the time to produce local data reports and utilize the local client-level data. Integrated data systems are critical in promoting effective linkage of newly identified HIV+ individuals to ensure linkage to OAMC. The Part A and DOH-Broward CTS staff plan to integrate HIV CTS data in PE. Accurate data needed to calculate the rates of Continuum stages cannot be achieved until integration of these databases are complete.

A significant drop-off in transition occurs between linkage and retention in OAMC. This drop-off between Continuum stages points to the need to improve the rate of HIV+ Broward residents retained in OAMC. In 2014, there were 993 reported HIV infection cases with 86% linked to care. Even with high linkage rates, only 65% of the estimated 19,391 individuals living with HIV are currently retained in care and 61% are virally suppressed. There is a need to increase outcomes along the Continuum of Care for Individuals living with HIV in Broward County. To further this effort, DOH-Broward has

developed PROACT (Participate, Observe, Adhere, Communicate and Teamwork), a linkage, retention, re-engagement, and adherence program. PROACT is a public health initiative designed to support the community-based provision of HIV primary care services in Broward County through the delivery of high-intensity interventions (which include linkage to care at 1st visit), as well as to promote retention in care and adherence to ART for all Broward County residents living with HIV. Newly and previously diagnosed HIV positive individuals referred to PROACT have a 95% and 96% (respectively) linkage rate within 90 days, which is higher than the overall county rate of 86%. In order to accomplish this a PROACT Database has been created in addition to the regular monitoring of monthly program performance through DOH-Broward's Internal Review System, Active Strategy Enterprise. HIV DIS also have access to the PE database and are able to get reports of PLWH in the Part A system that are not in care. This allows for accurate data on information for retention in care reporting. PROACT referrals come from DOH-Broward contracted providers, FQHCs, CBOs, HIV care providers and the local Ryan White Part A program. PROACT staff aim to contact clients referred within 2 days of referral and keep a database on client dispositions. As of July 2016, PROACT HIV Disease Intervention Specialist (DIS) staff have successfully contacted 1,355 referred clients and facilitated their linkage to care.

Part A CIED conducts Part A eligibility screening, insurance eligibility screening, enrollment assistance, linkage services, and referral to OAMC and other services. As part of the Integration of Prevention, Care and Treatment in Broward County, proposed plans are being developed to enhance the program by implementing data-to-care activities that utilize eHARS in addition to the existing database and expanding the use of the PE system to identify clients in need of being re-engaged in care and monitoring viral suppression. For several years, PROACT staff have been essential in facilitating HIV screening and transitioning PLWH to Part A CIED for rapid RWHAP eligibility and linkage to OAMC. PROACT staff will also assist PLWH to schedule their CIED and OAMC appointments and accompany them if requested.

To reinforce collaborative efforts, PROACT also intersects with DOH-Broward's Perinatal Program, where pregnant women who are HIV positive are identified, tracked and provided Intensive Case Management. This service consists of the following: 1)

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comprehensive HIV education; 2) linkage to care, retention and monitoring and 3.) ART adherence counseling and support. In 2014, 68% of the female HIV cases were women were of childbearing age (13-49). New HIV cases among Black women were more than 14 times higher than among non-Hispanic White women in Broward. In 2015, there were 22,205 births among women aged 13–49 and 128 known HIV positive pregnant women. Of these pregnant women, 104 (81%) were Black, 14 (11%) were White and 10 (8%) were Hispanic. Since the Perinatal Program’s inception in July 2013, the perinatal program has been able to keep perinatal transmission to as close to zero as possible as shown in Table 6.

Table 6. Number of Perinatal Transmission Cases in Broward County by Year

Year	Number of Perinatal Transmission cases
2013	0
2014	0
2015	1
2016	0 as of 9/1/2016

Another drop-off exists between the Continuum ART coverage and viral suppression stages. This drop-off is addressed by emphasizing the importance of adherence and viral suppression. Broward County Ryan White Part A funded services are designed to fill service gaps and ensure accessibility along the stages of the Continuum. The HIVPC examines the rate of PLWH engaged at each Continuum stage to identify barriers in linking them to sustained, high quality care and to implement improvements to support individuals transitioning through the Continuum. The HIVPC understands and seeks to address through the Priority Setting and Resource Allocation (PSRA) process, factors contributing to drop-off between Continuum stages, including disparities associated with subpopulations. The Recipient and HIVPC consider the services supported by other funders to avoid duplicated services and ensure seamless transition along the Continuum. Part A covers services that engage individuals along the Continuum from linkage onward, including core medical and support services. Part A monitors available resources in response to the needs of HIV+ Broward residents to improve engagement at each Continuum stage.

Services such as Oral Health Care (OHC), substance abuse and mental health

treatment, and home health services are supported by these funders. Several funders support mental health and substance abuse treatment that promotes OAMC retention. The Florida Department of Children and Families (FL-DCF) funds a mental health and substance abuse system serving all eligible indigent Broward residents. Due to inadequate funding, Part A funds are used only for HIV+ Broward residents with severe mental illness and addictions for which rapid entry in care is critical. For example, Part A substance abuse and mental health services complement FL-DCF funded services to ensure that HIV+ Broward residents receive mental health and substance abuse treatment and adhere to medical regimens. Part B and the Medicaid Project AIDS Care (PAC) Waiver Program support home health. Hospice services at three licensed facilities provide nursing, physician, social work, and pastoral services to terminally ill patients. Hospices also provide nutritional and bereavement counseling for terminally ill patients and their families. In addition to core services, many other social support services are offered in Broward to support the goals of the NHAS including linkage to and retention in OAMC, access to ART, and viral suppression. Parts A and B fund support services including emergency food bank, home-delivered meals, legal, medical transportation, and non-medical case management (non-MCM). These services are designed to promote engagement and retention in OAMC. Federal, State, and local funds support these and other services to enhance Broward's high quality Continuum. Part A medical case management (MCM) and non-MCM assist clients to engage in OAMC, adhere to ART, and address barriers that impede adherence to OAMC appointments. MCM and non-MCMs advocate on behalf of their clients, counsel patients on effective ways to navigate the healthcare and entitlements systems, and link clients to other services to achieve viral suppression. MCMs and CIED intake specialists follow-up on client referrals and eligibility recertification, which helps to engage and retain clients in OAMC.

Broward County also collaborates with key funders and other stakeholders to identify HIV+ residents, link them to OAMC, initiate and sustain ART, and retain them in OAMC. Broward also considers the Continuum in the Part A PSRA process. Part A and DOH-Broward collaborate to implement the Continuum and improve engagement at each stage and have taken considerable efforts to plan and integrate Broward's HIV prevention and care services.

Improving Engagement and Outcomes along the Continuum: Despite the challenges, Broward has successfully supported PLWH as they move across the Continuum stages. Broward understands the importance of supporting effective interventions for each stage of the Continuum and of assessing related data to improve quality of care and health outcomes. Broward is committed to working with consumer, clinical, public health, and community partners to improve performance, ensure data quality, and monitor outcomes across the Continuum so that HIV+ residents are linked, engaged in OAMC, and initiate ART as early as possible. Services along the Continuum expanded based on the availability of federal, state, local, and health insurance resources to meet evolving needs. Highly developed, integrated systems operate in Broward to promote linkage and engagement of newly infected, underserved, hard-to-reach, and emerging populations including disproportionately impacted racial/ethnic minorities. Despite expansion, the Continuum is overburdened due to increased demand and decreased per capita funding.

The Part A Recipient has led Florida's Part A recipients in creating a renewed focus on insurance reimbursement and eliminating duplicated funding. All Florida Part A recipients work with Florida ADAP to avoid duplicative funding. Access to health insurance assistance promotes linkage and retention in OAMC, and ensures access to ART. Parts A and B fund the Health Insurance Continuation Program (HICP) to purchase insurance premiums, co-payments, and deductibles for clients enrolled in Qualified Health Plans (QHP) through the Affordable Care Act (ACA) Marketplace. Both Parts A and B assist clients to enroll in insurance plans that cover ARTs. Part A clients not enrolled in QHPs predominantly receive access to ART through ADAP. Clients ineligible for ADAP receive access to ART and other medications through Local AIDS Pharmaceutical Assistance Program (LPAP). The Part A LPAP and Part B ADAP offer adherence counseling that encourages collaboration between patients and their clinicians. Nationally, the CDC estimates that 37% of HIV+ Americans who received OAMC in 2011 were prescribed ART. In contrast, 69% of Broward HIV+ residents receiving OAMC were prescribed ART in CY 2015, compared to 92% of Part A clients receiving OAMC, reflecting the benefit of having health insurance.

Broward has identified several gaps, barriers, and unique challenges while developing
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and applying the Continuum model. Part A addresses these issues through collaborations with community stakeholders and the implementation of a high quality Continuum. Most HIV screening activities undertaken in Broward are through CDC funding, Part C EIS, and health insurance payments. Through MOUs and co-location of service sites, Part A-funded CIED and prevention collaborate to address the gap between diagnosis and linkage. The prevention recipient facilitates HIV testing and CIED assists with rapid linkage to care. An important component of addressing this gap is the integration of data systems to track newly tested HIV+ individuals to ensure their engagement in OAMC. The Part A Recipient and DOH-Broward CTS staff are working towards the integration of HIV CTS data into PE. Until the data systems are integrated, this presents a unique challenge to accurate data collection about the Continuum.

Examining outcomes across the continuum is necessary to be able to evaluate program effectiveness and monitor program utilization. Moving forward with evaluation, Broward will begin to utilize a prevention care continuum, similar to the care and treatment continuum but building on HIV testing as the foundation of linking “high-risk” negative individuals to prevention, retention, and adherence to services, helping with the prevention of HIV acquisition and transmission. This is necessary in framing a comprehensive response to HIV in Broward and in measuring the performance of HIV prevention program services. Next steps regarding improvements along the care continuum will be to create several additional continuums that reveal more specific information such as 1) HIV Incidence continuum which would exclude retention in care measures; 2) HIV Prevalence continuum which would exclude linkage to care measures; 3) HIV Prevention continuum for ‘high risk’ negative individuals; and 4) Ryan White funded services only continuum. Common definitions for each continuum measure will also be developed between both Prevention, Care and Treatment and a local monitoring and evaluation report will be produced outlining Prevention, Care and treatment progress towards the goals of the NHAS.

C. Financial and Human Resources Inventory

Broward County Florida has an extensive inventory of financial and human resources dedicated to supporting HIV/AIDS services. The financial resources include comprehensive funding for the Ryan White Part A, B, C, D and F Programs in addition to funding provided by the CDC under FOA PS12-1201 High Impact Prevention and FOA PS13-1308 awarded to Broward County Public Schools for promoting adolescent health through School based HIV/STD Prevention and School based Surveillance. Funding for HIV/AIDS services is also provided through the Substance Abuse and Mental Health Services Administration (SAMHSA), HOPWA, the Veterans Health Administration (VA) and the Florida Medicaid Program.

In this section each funding component is described for the jurisdiction. It is important to note that while the funding sources may appear distinct and separate from each other, all funding sources enhance and complement one another to ensure integration of prevention and care and treatment services.

HRSA funds Ryan White Part A, B, C, D and F services. The Broward County Board of County Commissioners receives funds for Ryan White Part A Services. These services provide core medical and support services for eligible PLWH which includes Outpatient and Ambulatory Medical Care (OAMC), Local AIDS Pharmaceutical Assistance Program (LPAP), Oral Health Services, Health Insurance Premium and Cost Sharing Assistance, Mental Health Services, Outpatient Substance Abuse Treatment Services, Medical Case Management–Disease Management, Case Management (Non-Medical), Centralized Intake and Eligibility Determination (CIED), Emergency Financial Assistance (EFA), Food Services, Legal Services and Outreach Services. For a list of commonly used acronyms, please see Attachment 1 and for a definition of these services please refer to the Integrated Lexicon of Terms in Attachment 2.

Care and treatment services are provided by DOH-Broward through the Ryan White Part A and Part B funded programs. These services include HIV/AIDS medications through ADAP, health insurance premium cost sharing assistance, home and community based-health services (home health services and durable medical equipment), outpatient substance abuse services, food bank and home delivered meals, medical transportation (bus passes) and treatment adherence counseling.

Part C provides funding to local community-based organizations to promote outpatient ambulatory health service and support services through EIS. The Part C EIS funds comprehensive primary health care in outpatient settings for people living with HIV. Part C providers are organizations seeking to enhance their response to the HIV epidemic in their area through the provision of comprehensive primary HIV medical care and support services. Broward Health, a local hospital district, receives funding for Part C services.

Part D providers render outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children, and youth living with HIV. Part D providers are local, CBOs seeking to enhance their response to the HIV epidemic in their area through the provision of family-centered primary medical care and support services to women, infants, children, and youth living with HIV when payments for such services are unavailable from other sources. The Children's Diagnostic & Treatment Center (CDTC) receives funding for Part D Services in Broward County.

Part F funds the Community-Based Dental Partnership Program to increase access to oral health care services for people living with HIV while providing education and clinical training for dental care providers, especially those practicing in community-based settings. Nova Southeastern University provides Part F services in Broward County.

The CDC funds FOA PS12-1201 High Impact Prevention (HIP) which is an approach to reducing HIV infections in the United States. DOH-Broward County receives funds through the State of Florida for HIP activities. The five components of HIP are: 1) effectiveness and cost; 2) feasibility of full-scale implementation; 3) coverage in the target populations; 4) interaction; and 5) targeting and prioritization. HIP activities include HIV testing, condom distribution, prevention for positives, policy initiatives, social marketing media and mobilization and evidence-based interventions for high risk negatives.

The CDC FOA PS13-1308 was awarded to Broward County Public Schools for promoting adolescent health through school-based HIV/STD Prevention and school-based surveillance. The purpose of this funding is to build the capacity of school districts and individual schools to effectively contribute to the reduction of HIV infection and other STDs among adolescents, reduce disparities in HIV infection and other STDs experienced by specific adolescent sub-populations and conducting school-based surveillance through the YRBS and School Health Profiles implementation.

SAMHSA funds the Men Educating and Gaining Awareness (MEGA) grant implemented by Broward House. This five year grant is a substance abuse intervention program focused on high-risk minority MSMs ages 18-29.

The HOPWA is funded by the Department of Housing and Urban Development (HUD). HOPWA meets the emergency housing needs of people infected with the disease. Services include short-term rent, mortgages, utilities, permanent housing placement, housing case management, project-based rent, facility-based housing and tenant-based rental vouchers. The City of Ft. Lauderdale provides HOPWA services in Broward County.

Attachment 3 summarizes the availability of public funds for HIV services in FY 2016. The table includes funding amount, funded service provider agencies, services delivered and HIV Care Continuum Steps Impacted. The table specifies RWHAP funding (e.g., Parts B, C, D, and F), federal, State, and local public funding, and HIV/AIDS-related service funds available in FY 2016. Attachment 4 provides information specific to the providers and the services they render in Broward County.

HIV Workforce Capacity: The HIV workforce in Broward County is skilled and culturally diverse. The HIV workforce provides services for Prevention, Care and Treatment. The HIV Workforce is composed of professionals and paraprofessionals of health and social service backgrounds, including licensed Medical Doctors, Registered Nurses, Licensed Practical Nurses, Licensed Clinical Social Workers, Medical Case Managers, Non-medical case managers, Community Health Workers, Public Health Professionals and other allied health care workers.

The jurisdiction employs over 550 full-time employees and over 40 part-time employees dedicated to providing HIV-related services. All organizations require employees to maintain licensure and certification in keeping with their identified professions. In addition, providers offer continuous education and training to the workforce in a variety of areas. Providers indicated that for the most part, they had staffing resources to meet the current need, however identified the need for additional case managers and financial counselors.

In Broward County there is a need for additional training of the workforce on the science and treatment of HIV/AIDS and biomedical interventions. In 2013, the Black AIDS Institute, in partnership with the CDC, National Alliance of State and Territorial AIDS

Directors (NASTAD), Johns Hopkins University and the National Latino Commission on AIDS, conducted the first national Knowledge, Attitudes, and beliefs survey of the HIV/AIDS workforce. The purpose of the survey was to assess the workforce knowledge on the science and treatment of HIV/AIDS and biomedical interventions. Nationally, a total of 3,663 individuals participated in the study. In the state of Florida, 210 participated and in the Miami/Ft. Lauderdale area 80 individuals participated. The overall grade for the nation, state, and the local area was a “D.” Most individuals had completed some or all post graduate studies (50%), while 19% had earned their Bachelor’s degrees and 31% had earned an Associate’s degree or less.

Collaborations between Funding Sources: Prevention and Care and Treatment coordinates with other public HIV funders to: 1) link newly diagnosed individuals to care; 2) retain individuals in care; 3) achieve viral suppression; 4) ensure that Ryan White funds are the payer of last resort; 5) maximize the number and accessibility of services available; and (6) reduce duplication of services. Prevention and Care and Treatment work collaboratively to ensure a seamless and continuous system of care by linking newly diagnosed HIV positive clients to care and treatment services including medical and support services and access to life saving medications through ADAP. Additional collaboration includes linkage and re-engagement to care for those PLWH who have fallen out of care.

In an effort to engage stakeholders, the Integrated Development Collaborative was created. This Integrated Development Collaborative was the first step toward bringing all key funders in Broward County with established work plans together to plan for and expand funding for HIV services in the County. Broward County intends to expand the Integrated Development Collaborative by including other key funding stakeholders to plan for the provision of integrated service delivery such as the Florida Medicaid Program and the Veterans Health Administration. To that end, Broward County has undertaken additional efforts to engage funders providing specific resources including:

Medicaid: Covered benefits, budget, and reform activities are major considerations in planning a comprehensive Continuum and PSRA. Florida Medicaid has not expanded eligibility, which has resulted in continued demand for RWHAP services through FY 2015. FL-DCF, the agency handling Medicaid enrollment, is represented on the HIVPC. Part

A collaborates with Medicaid to coordinate fee structures, benefits, and Medicaid eligibility changes. The Agency for Healthcare Administration (AHCA), the Florida agency that finances Medicaid payment systems, provides detailed Medicaid enrollment and expenditure data to the Florida Part A Recipient to further PSRA. The local field office representative also participates on the HIVPC. AHCA cooperates with Part A to link PE to Medicaid enrollment and paid claims files to ensure that Medicaid patients' covered services are not billed to Part A. PE completes a monthly, automated check to determine if Part A clients have enrolled in Medicaid. The process identifies individuals receiving Medicaid services and those who become eligible after intake or six-month recertification are completed.

Medicare (including Part D): The Recipient and HIVPC closely monitor changes in Medicare medication benefits due to the large number of Broward Medicare beneficiaries enrolled in Florida ADAP. CIED staff verify Medicare enrollment through the Florida ADAP. The Centers for Medicare/Medicaid Services (CMS) provides trainings and shares resource materials to the HIVPC and sub-recipients on an annual basis. PE was programmed to identify clients who may potentially qualify for Medicare based on their eligibility criteria. CIED assists with the application process for Medicare enrollment.

State Children's Health Insurance Program (SCHIP): FL-DCF also administers the Florida KidCare Program, which is represented on the HIVPC and provides routine programmatic updates.

ACA Marketplace: Part A closely monitors QHP enrollment in Broward and across Florida and collaborates with CBOs, such as the Epilepsy Foundation and BRHPC, to enroll clients into QHPs and works with ADAP to transition clients into QHPs most suitable to HIV+ individuals.

VA: HAB's VA policy is considered in Part A planning and care coordination. Broward Part A MCMs participated in a mandatory Part A training focusing on HAB's VA policy and specific activities that must be undertaken. Curriculum included advising clients about the voluntary use of VA services, coordinating VA benefits with RWHAP services, and assessing for VA eligibility at which point potentially eligible clients would be referred to the VA site in South FL selected by clients. Part A continues to monitor adherence to the HAB VA policy.

HOPWA: The City of Fort Lauderdale HOPWA recipient participates planning activities for Care and Treatment and Integration. HOPWA staff also collaborates with Part A and the Part B administrative agent to conduct planning and assessment activities, including the consumer and provider surveys. HOPWA providers also participate in Part A QI initiatives and training. HUD has recognized this integration as a model and has highlighted it as a best practice model nationally.

CDC Prevention: DOH-Broward and Broward County HIV Prevention Planning Council (BCHPPC) members participate in the HIVPC and its committees. Moving forward, the close collaboration between Part A and DOH-Broward will be vital. Broward was one of two communities that made presentations at the 2014 Bi-Regional NHAS Meeting and the collaboration was recognized nationally.

Services for Women, Infants, Children, and Youth (WICY): The Parts A and D providers collaborate closely to assess and address the needs of the WICY population. CDTC, the only Part D recipient in Broward, participates on the HIVPC, committees, and Quality Improvement (QI) Networks. Parts A and D conduct monthly meetings to coordinate services and identify trends among HIV+ youth. The FL-DCF, which operates Targeted Assistance for Needy Families (TANF), also participates on the HIVPC. FL-DCF also administers substance abuse treatment programs for pregnant women. FDOH, the agency that administers the Special Supplemental Food Program for WICY, also participates on the HIVPC. FDOH also administers Targeted Outreach for Pregnant Women Act (TOPWA), a program designed to reach Florida high-risk women or HIV+ pregnant women to ensure access to prenatal care and other services that lower their risk of HIV infection or substance abuse. TOPWA-funded providers participate on the HIVPC.

Social Security Administration (SSA): Part A works closely with SSA field staff to undertake processes for verifying enrollment in SSA disability and retirement programs by Part A-funded CIED. SSA staff collaborates with CIED staff to facilitate enrollment of clients in SSA programs.

Local, State, and Federal Funds for Substance Abuse and Mental Health Treatment: The erosion of public substance abuse and mental health treatment funds continues to reduce already limited capacity of those systems. Part A continues to allocate substance abuse and mental health treatment funds for HIV+ clients to promote access, retention,

and adherence to OAMC to the extent that new Part A and MAI funds are available. FL-DCF staff participates in the HIVPC. Staff represents DCF-funded mental health and substance abuse programs, including HIV EIS for HIV+ individuals with substance abuse problems.

Local, State, and Federal Public Health Programs: Part A collaborates closely with the FDOH and DOH-Broward staff responsible for operating the HIV prevention, ADAP, Part B, STI, TB, OHC, and other programs.

Other RWHAP Funding (Parts B-F): As previously mentioned, Part A coordinates closely with Parts B-D. Additionally, Nova Southeastern University is a Part F Community-Based Dental Partnership recipient and receives Part A OHC funds. Parts A and F funds support separate programs to avoid funding duplication. Nova participates in the HIVPC OHC QI Network.

Ongoing analyses of factors affecting program eligibility are reviewed to assess their impact. Broward County has established several mechanisms, including joint planning among all RWHAP recipients to consider funding of core and support services across the Continuum:

- The Recipient and DOH-Broward HIV Prevention Program have worked since FY 2012 to improve integration of HIV prevention, screening, linkage, care, and treatment to increase the number of Broward residents aware of their HIV status and their rapid engagement in care. Broward County Part A and DOH-Broward have established joint planning efforts, integrated data to further planning and evaluation efforts, and developed new strategies for effective HIV screening, linkage, engagement and retention activities.
- RWHAP recipients and key funders provide the HIVPC with monthly funding and utilization reports. The HIVPC reviews monthly updated Part A and MAI expenditure data to minimize over or underutilization of RWHAP funds. The EMA has successfully addressed unexpected service needs by rapid reallocation of funds to service categories with needs or shortfalls. For example, the HIVPC allocated funds to HICP to ensure a smooth transition from RWHAP to QHPs for

approximately 250 clients. Recipient staff conducts “sweeps” and reallocation processes annually to address service shortfalls in core services.

- The HIVPC adopted a process that is similar to the Statewide Coordinated Statement of Need (SCSN) to maximize funds. Part A PSRA activities are closely coordinated with other RWHAP recipients and other funders. Core services are prioritized as essential to supporting the Continuum. To the extent feasible, they are “held harmless” if funds are reduced or “flat.” While this policy ensures access to core services, access to support services is subject to reductions based on decreased funds. The Recipient evaluates Part A-funded services to ensure they are cost-effective, achieve their objectives, and of high quality. The Recipient also has provided considerable technical assistance to sub-recipients to enhance capacity, ensure retention of clients in care, and achieve improved quality.
- Key stakeholders and funders, including all RWHAP recipients, meet to discuss policy, legislative, cost, and funding issues that influence the Broward Continuum. Program, service, and utilization trends, as well as emerging issues also are discussed. These ongoing discussions assist policymakers to respond proactively to changes that may affect the Continuum. Press releases, forums, presentations, technical assistance, and training needs are jointly designed and conducted.
- Part A collaborates with DOH-Broward and HOPWA to conduct countywide needs assessments and planning activities. The HIVPC considers the results of these assessments in PSRA. The local ADAP staff prepares monthly reports about enrollment, expenditures, and applicants on the waiting list. They make monthly presentations at HIVPC committee meetings, and meet monthly with Part A staff to coordinate medication and other services.
- Part A staff carefully reviewed the HAB Program and Fiscal Monitoring Standards to ensure compliance. The Recipient has distributed the Standards to Part A sub-recipients to ensure their compliance with the Standards, and provided training to sub-recipients to ensure their understanding and implementation of the Standards.

Needed Resources: Unfortunately, not all needed resources and services are provided in Broward County. Additional gaps exist and they are expanded upon in the

following section “Addressing Needs, Gaps, and Barriers” and steps to secure them are included in Section II.

D. Assessing Needs, Gaps, and Barriers

Strategies used to target, recruit, and retain participants in the HIV planning process: Broward County has a rich history of active recruitment and engagement of participatory involvement, including the BCHPPC and the HIVPC and their respective subcommittees. In the past, needs assessment processes were undertaken independently by each Council. Results were utilized to inform decision making for each funding organization. Beginning in 2011 the principals of DOH-Broward's HIV Prevention Program and Broward County's Ryan White Part A Division began engaging in meaningful, substantive dialogue. This partnership preceded the requirement to integrate planning efforts by CDC/HRSA and included the development of activities and strategies to address the HIV epidemic collectively. In order to develop this Integrated Plan, a coordinated, collaborative course of action was undertaken to identify existing resources as well as needs, gaps, and barriers. The structure that was created included the formation of additional committees. These entities and their representatives are acutely aware of the community's needs, enlisting the support and involvement of individuals representing priority populations as well as those identified as at highest risk. The Councils, subcommittees and Integrated Committee represent providers, funding organizations, and persons living with HIV.

The process of collecting data to identify and assess the needs, gaps and barriers has been conducted in a comprehensive and inclusive manner. In order to formulate the strategies and action steps and to create alignment, the needs of individuals impacted by HIV as well as the community context needed to be assessed. While several methods addressed the general community, others were specific in nature, focusing on the special needs of priority populations. The needs, gaps, and barriers identified through these processes follows.

HIV prevention and care service needs of persons at risk for HIV and PLWH: Recurrent challenges identified through surveys, community forums, focus groups, and key stakeholder interviews emerged during the needs assessment process. These included the need for expanded access to Pre-exposure Prophylaxis (PrEP), for comprehensive education to middle school and high school students, and the need to empower and engage communities disproportionately impacted, as well as to provide

gender-specific prevention and care services to the female and transgender populations. Additional needs included adequate transportation, consistency of providers, and access to necessary referrals.

Specifically, individuals indicated that sexual health education and free condom distribution were extremely important and should be continued, with activities targeted to particular populations, such as women, middle and high school students, older adults, and in culturally and linguistically appropriate and relevant manners. Knowledge of PrEP was limited and therefore, there is a need to educate the broader community, especially physicians. While free HIV testing is widely available, there is a need to empower Hispanic and African American communities with new approaches, to hire community health workers, to engage politicians, and to help people understand that prevention and treatment work.

From a care and treatment perspective, the following needs were most frequently identified: inability (long wait) to get appointments, lack of transportation to get to appointments, inability to receive necessary referrals, difficulty accessing doctors who provide HIV services, and staff not being available at convenient days/hours of the week. Participants spoke specifically about the need to be able to make and cancel appointments and submit eligibility documents through a single portal, and to have eligibility appointments for ADAP and Ryan White services scheduled on the same day.

Service gaps identified by and for persons at higher risk for HIV and PLWH: Throughout the needs assessment process service gaps for prevention, care and treatment, as well as necessary support services were identified. These included housing, transportation, employment, and co-morbid issues (mental health, substance use, and additional physical health conditions). In particular, individuals recognized the need for affordable and sustainable housing, for meaningful employment, and for peer support and mentoring. Participants identified gaps in case management services, and in the linkage to care immediately following diagnosis. They specifically discussed the lack of funding for mental health services and the necessity to address individuals with disparate issues (language, transgender, undocumented immigrants, and rural residents) in a culturally relevant manner.

Barriers to HIV prevention and care services: The needs and gaps portray only part of the larger context of the Broward County community. In addition to the needs and gaps, barriers exist that often prevent or preclude the provision of necessary services. The following provides detail regarding several of those barriers and the circumstances in which they occur.

Social and Structural Barriers

- **Multilingual, multiracial, multicultural barriers:** Broward County is the 16th largest county in the nation, and the 2nd largest county in the state of Florida. It is the 2nd most racially diverse county in Florida and has become a “minority majority.” 9% of Florida’s population resides in Broward County, which is also a large gay and straight tourist destination, increasing the population particularly in the winter months. Broward County is the 6th largest school district in the country, with over 260,000 students enrolled. 32% of residents are foreign-born, and many households have family members that have limited English proficiency.
- **Racism and Discrimination:** While Broward County is a racially, ethnically, and culturally diverse region, there is a strong history of institutional and structural racism. A recent study conducted by the Children’s Services Council of Broward County demonstrates the deep divides that have occurred over decades in educational institutions, housing, and employment. The Vulnerable Footprint map shown in Section I.A exemplifies the areas of Broward County that are not only at greater risk for incarceration, fetal and infant mortality, lower graduation rates and higher unemployment, but that are also more racially segregated.
- **Health Profession Shortage and Medically Underserved:** Broward County has received federal designations of both a Health Professional Shortage Area and Medically Underserved Area and Population in the same geographic areas as the Vulnerable Footprint.
- **Poverty:** 14% of households are living below the poverty level, with an additional 33% considered to be ALICE households. **ALICE**, an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed, are households that earn more than the U.S. poverty level, but less than the basic cost of living for the county. Combined, 47%

of Broward County households are struggling to afford basic needs. 16 of the 31 municipalities in Broward County have a population in which over 50% of households are living below the poverty level or considered ALICE households.

- **Insurance:** The state of Florida has opted not to accept the Federal expansion of Medicaid which would have provided 567,000 nonelderly uninsured adults with access to affordable healthcare. According to a recent report published by the Kaiser Family Foundation (January 2016), 57% of these individuals are people of color and 82% are adults without dependent children. While the ACA has allowed more individuals to purchase their own health insurance, many others cannot afford the subsidy. These individuals are living on the brink of not only poverty, but also physical and health challenges. Taken as a whole, these people are at risk for a number of social and health related issues. Basic needs, such as food, shelter, and clothing are prioritized while personal health is often neglected.
- **Stigma:** The issue of stigma has been discussed in a variety of formats throughout community conversations. In addition to conducting a Stigma Survey, DOH-Broward, Ryan White Part A and their partners collect and review feedback about stigma on a continuous basis. According to participants, individuals are reluctant to disclose their status or even to get tested due to familial and cultural beliefs that are associated with stigma. Seeking, accepting, and remaining in treatment is often difficult due to the stigma attached with the disease.
- **Housing and Homelessness:** Broward County experiences high rates of homelessness, particularly among the young adult population. Human trafficking, runaway youth, access to illegal and dangerous drugs, high rates of removals and foster care placements put an already vulnerable population at greater risk for HIV and other challenges. Many individuals who are homeless sell their medications in order to meet their basic needs. Broward County also has a shortage of affordable housing, placing a significant burden on those individuals who do not fall below the poverty level but who are underemployed and underinsured.
- **In-migration, transient and mobile population:** Broward County experiences high rates of geographic mobility, both from within and outside the county and

state. Older gay retirees are moving to south Florida in large numbers. The aging adult population presents several challenges-individuals not getting tested and young MSM “hooking up” with older men.

Federal, state, or local legislative/policy barriers:

Medicaid expansion: Previously stated, the lack of expansion of Medicaid for adults under the age of 65, with income up to 133% of the federal poverty level, is a barrier for health care coverage for uninsured Broward County residents. Access to care is critical to HIV treatment. The ACA provides the option for states to expand Medicaid coverage; however, the State of Florida has chosen not to. Expanding Medicaid would mean the Federal Poverty Level guidelines would allow more individuals and families, who are currently uninsured, to have health care coverage. Expansion would not only mean access to care but it would also cut costs of uncompensated health care.

Testing Legislation: Current HIV/AIDS rapid site guidelines states, “Non-healthcare sites wanting to become a new rapid test site must demonstrate a successful history of conventional HIV testing for one year, must be in compliance with all state and federal policies, procedures and guidelines, and must have a positivity rate of at least 1% for newly identified positives.” This precludes many providers who would be interested in providing this service the ability to do so. Additionally, DOH-Broward continues to anticipate guidance and instruction from the state health office regarding the recently passed Florida HIV Testing Bill (HB 321), which took effect July 1st, 2015. Until the FDOH “Dear Colleague Letter” referencing the July 1st, 2015 HIV “Opt-Out” Testing Law is received, progress in disseminating this important information continues to be delayed.

Harm Reduction: There are many tools for prevention, care and treatment of HIV. One of those is harm reduction by way of needle exchanges. Needle and syringe exchange programs provide sterile needles and syringes in exchange for used sharps to reduce the transmission of HIV and other blood-borne infections associated with the reuse of contaminated needles by injection drug users. This has been a struggle at the federal and local level. Currently, there is only one pilot program in South Florida (in Miami-Dade County) which has not received funding and therefore is responsible for its total costs. This is an opportunity to provide an evidence-based practice to address the epidemic.

Health department barriers: Health Department challenges and barriers are regularly documented in CDC's Annual Progress Reports, which are required for those funded under PS12-1201. The information gathered for these reports include Health Department staff narrative and are provided to the contract managers from organizations receiving funds for High Impact Prevention Implementation. The Department barriers are included below:

Comprehensive Prevention with Positives: Multiple data systems do not interface with each other and are cumbersome to navigate thus it is difficult to ensure that optimal care and treatment is provided.

Social Marketing, Media and Mobilization: Limitations and restrictions on the utilization of social media continues to be one of the greatest barriers to mobilizing and educating the community.

PrEP and Post-Exposure Prophylaxis (PEP) Capacity Building and Technical Assistance: Technical Assistance and database integration needed regarding measuring community viral load.

Social Network and Social Media Strategies: Training on Social Network Strategy (SNS) and social media strategies remains a priority for Broward County. Inability of submitting Capacity Building Assistance Request Information System (CRIS) requests directly leads to decreased effectiveness and timeliness of Capacity Building Assistance (CBA) trainings. DOH-Broward would like to see more training based in Fort Lauderdale as a significant portion of the epidemic in Florida is in Broward County and it is difficult for staff and providers to travel outside the county. This was identified as a high priority need by the community during the HIP Town hall meeting held June 25th, 2015.

Program Planning, Monitoring and Evaluation, and Quality Assurance: Additional resources and staffing are needed to maintain and support various successful initiatives such as Business Responds to AIDS.

Program Barriers: In addition to Department barriers, program barriers have also been identified. These have been assessed and evaluated through a variety of mechanisms, including Provider Surveys, a Workforce Forum and Staff Focus Groups. The duplication of paperwork and the lack of continuous communication processes were identified as barriers for programs and organizations to address the needs of the individuals they

serve. In addition, funding and regulatory challenges such as the lack of Medicaid expansion, the process to access funding in an expeditious manner and to streamline the monitoring of programs were also identified as program barriers. Peer support, the use of community health workers, family engagement, staff training and development, and the delivery of culturally and linguistically competent and relevant services were all noted as areas for improvement. Further, nontraditional hours and venue testing continues to be a challenge for community providers due to staffing, as well as financial and liability insurance cost constraints. Programs also report that identifying new positives continues to be an ongoing challenge despite attempts to increase utilization of observational surveillance techniques and other strategies.

Service Provider Barriers: A collective impact initiative as large as this requires non-traditional partners to be engaged in the process. It also entails continuous evaluation of the needs of service providers, including the resources needed to address prevention and care and treatment more effectively. The challenges faced by service providers and the barriers encountered have been identified through provider surveys, key stakeholder interviews, and workplace forums. A number of non-traditional partners were acknowledged as necessary collaborators in the plan to eliminate HIV in Broward County. These partners included: private physicians, providers of housing services as well as realtors, the business community, media, politicians, faith-based leaders, behavioral health organizations, representatives of the criminal justice system, and non-Ryan White providers of HIV-related services. In addition, the following specialty resources were identified to effectively meet the complex needs of individuals living with HIV: expanded and increased mental health and addiction services, employment counseling, affordable housing, efficient transportation, peer counseling and mentoring, enhanced case management services, development of enhanced Internet capability for easier access to appointments and eligibility determination, and re-entry counseling for formerly incarcerated individuals. Providers identified that access to 4th generation confirmatory testing proves to be a challenge, as providers find it costly to secure the supplies needed. Obtaining organizational buy-in and approval of a new and innovative approach to fiscally sustaining HIV testing into the future is a struggle. Finally, service providers identify that CBOs and/or laboratories need to understand proposed benefits, have a desire to

operationally collaborate, are willing to orient key personnel, and able to introduce additional management processes required in Broward County.

Client Barriers: The assessment of needs related to client barriers was conducted through Focus Groups, Community Forums, Key Stakeholder Interviews, and Satisfaction Surveys. The barriers experienced by individuals living with HIV mirror those previously identified, however are experienced on a very personal level.

- **Housing:** Many individuals identified the lack of affordable, sustainable, and stable housing as an impediment to their health and wellness. They stated that the stress of everyday living is a barrier and the additional concerns about stable housing exacerbate that stress. Unstable housing can lead to increased stigma, with PLWH not wanting their roommates, family members or others to know about their illness while they are trying to maintain a stable living arrangement.
- **Stigma:** Not wanting their families, friends, employers, and others to know about their illness is a significant barrier to accessing care and treatment and to remaining in treatment. This is particularly true for individuals who are working who may need to take time off for medical and other appointments. Many individuals stated that this is a reason why people do not get tested initially and once diagnosed, fail to continue with treatment (particularly in the neighborhoods in which they live). They report that there is a cultural mistrust of institutions serving LGBT and minority populations.
- **Employment:** Most individuals surveyed and interviewed indicated they would like to be self-supporting. While many individuals living with HIV are able to be employed full-time, there are many others who have difficulty finding and maintaining full-time employment. Part-time and flexible employment do not provide a livable income and this complicates the ability to live in adequate housing. Individuals affected by the lack of employment opportunities also include women (who oftentimes have a need for affordable, quality childcare), individuals with criminal backgrounds, and individuals who are receiving disability benefits. For the transgender community, this is of particular concern and often members of the transgender community resort to sex work in order to afford their basic needs.

- **Transportation:** The lack of accessible, convenient, affordable, and efficient transportation was often cited as a barrier or challenge to accessing treatment. Non-public transportation is expensive and inconvenient. While vans are available for testing, they are not available for treatment. Treatment services are not always convenient or in locations that are accessible. At the same time, people don't want to go to neighborhood clinics because of stigma. The time required to spend on public transportation to attend an appointment is an obstacle. Several individuals stated they were concerned about the cleanliness of the public transportation system and did not want to jeopardize their already compromised health by riding in unsanitary conditions.
- **Co-occurrence of other conditions:** The co-morbidity of mental illness, substance abuse, and other physical conditions (diabetes, hypertension, high cholesterol) makes the HIV diagnosis even more challenging and complex. Individuals identified the use of substances as an impediment to their health and wellness (particularly the use of cocaine and methamphetamine). The interaction of medications, side effects, and the need for multiple medical appointments intensifies the barriers already identified.
- **Treatment Adherence and Treatment Fatigue:** Several individuals stated that treatment fatigue occurs after years of being on medication, therefore this requires intensive counseling and case management services. As a result, enhanced monitoring and evaluation efforts for treatment adherence is required.
- **Navigation of the System of Care:** In addition to insurance challenges and affordability, the need for multiple certifications, attendance at numerous appointments, and referrals to specialty care make living with HIV more complicated. The cumbersome process to navigate the system of care makes individuals not want to access care and treatment. Individuals stated they would like to have Part A and ADAP eligibility and re-certification combined and have service providers conduct the eligibility and certification process instead of adding an extra process. They also would like to see the process streamlined and conducted annually rather than every six months. In terms of referrals, some

individuals stated they had difficulty accessing the services they needed and in particular, doctors who provided HIV services.

- **Insurance:** There is a Medicaid coverage gap, particularly among the working poor. Because of the lack of Medicaid expansion in the state of Florida, individuals who do not meet the eligibility requirements are often living just above the federal poverty level, with limited assets. They are underemployed or barely earning a minimum living (income constrained). Faced with competing needs, individuals are faced to make choices based on priorities. Unless they have stable housing, there is no priority to take care of anything else. There is also a perception that Ryan White funding is for gay people only and therefore, others may not attempt to access services.
- **Language:** There are not enough services provided in Creole and medical professionals (nurses, doctors, others) who are proficient in the provision of culturally relevant services to the Creole speaking population. There is a perception that not enough outreach is being conducted in the Haitian community. In addition, individuals stated that service providers should reflect the community they are serving and that translation should be completed by people, not machines.

While multiple barriers and needs exist, the Collective Impact methodology adopted by Broward County will serve to address these challenges. With community and stakeholder engagement, continuous communication, shared measurement systems, and mutually reinforcing activities implemented through the strategic approach to addressing these challenges, Broward's common agenda and goals will be achieved.

E. Data: Access, Sources, and Systems

Main Sources of Data and Data Systems used to conduct the Needs Assessment: The advancing intersection of HIV prevention, care, and treatment has recently prompted Broward County to adopt new HIV service strategies. The Part A Recipient works closely with the DOH-Broward HIV Prevention Program, other funders, and community stakeholders to ensure an integrated Continuum. Integration of planning, reports, and activities between the HIVPC, BCHPPC, and others has helped Broward progress further in reaching the NHAS goals and improving outcomes on the Continuum. Broward uses epidemiologic, utilization, lab, clinical outcomes, consumer assessments, and other data to identify trends, gaps in the Continuum, and to prioritize the needs of HIV+ Broward residents.

It is essential to collect and analyze data in addition to the existing data collected through client databases and surveillance, to appropriately identify and assess the needs, gaps and barriers in a comprehensive and inclusive manner. In order to formulate adequate objectives, strategies and activities for the Integrated Plan, a summary of the findings from past and ongoing needs assessment studies has been summarized in Table 7. The results of these studies help to create alignment, and highlight the needs of individuals impacted by HIV as well as the community context needed to be assessed. While several studies addressed the general community, others were specific in nature, focusing on the special needs of priority populations. The table below provides information about data sources and systems that were utilized to compile the analysis for the Integrated HIV Prevention and Care Plan.

Table 7. Needs Assessment Studies conducted in Broward County, Florida

Needs Assessment Tool	Target Population	Objective
Transgender Needs Assessment (CATCH)	Transgender individuals	To determine services needed or requested by the Transgender Community
Condom Survey Power Point	General Population in Broward County	To gather baseline data on condom use, HIV knowledge, and condom accessibility, acceptability and availability in Broward County
Men's Health Flash Survey	Men who have sex with Men	Gather information on condom accessibility, acceptability, and availability among MSM
BTAN Science and Treatment Evaluation Report	HIV Workforce	Pre and Post surveys measuring workforce knowledge on science and treatment
PrEP Summit Evaluations	HIV Workforce and Community	To measure PrEP knowledge among HIV workforce and community
Men's Health and Wellness Evaluation Report	HIV workforce and Community	Identify HIV and Hep C testing behaviors, PrEP knowledge, other health behaviors and topics of interest concerning Men's Health Wellness and Prevention
Hep C Pilot Data	Medical providers	To evaluate the benefit of incorporation Hep C and HIV dual testing in medical settings
Navigation Surveys	HIV positive community	To evaluate the need for HIV Navigation services and to monitor and evaluate the benefit of HIV Navigation service provision
Linkage Database	HIV positive community receiving DOH-Broward linkage, retention and re-engagement services (PROACT)	To monitor and evaluate the benefit of DOH-Broward PROACT Program on HIV health outcomes along the Continuum of Care
SOS Report	Black Women	Measure of HIV community awareness
2014 HIV Testing Data Summary	Individuals testing at Publicly Funded Testing sites in Broward	Estimated prevalence of demographics and risk behaviors of individuals receiving publicly funded testing services in Broward County
Broward County Schools YBRFSS	Broward County Youth	Estimated prevalence of demographics and risk behaviors of Broward County Youth
Stigma Survey	General Population in Broward County	Qualitative study to describe HIV stigma in Broward County
Broward County HIV Prevention, Care and Treatment Client Survey	General Population in Broward County	Identifying knowledge and awareness about HIV as well as satisfaction of experiences in Ryan White Part A program services and knowledge about prevention in Broward.
Broward County HIV Prevention, Care and Treatment Provider Survey	HIV Workforce	To assess organizational capacity and needs
Part A Quality Management Studies	Broward County Priority Populations	To address special needs of priority populations
Part A Priority Setting and Resource Allocation Process	HIV positive community	To analyze data and identify priority areas to allocate resources
Stakeholder Interviews	HIV Stakeholders	To gather information and feedback about HIV services in Broward County
Satisfaction Surveys	Prevention, Care and Treatment Clients	To determine level of satisfaction of current Prevention, care and Treatment Services
National Workforce Evaluation	HIV Workforce	To determine HIV work force knowledge
Community Feedback Forums	General Population in Broward County (Focus on Blacks and Latinos)	To receive feedback on Broward County's Integrated plan and efforts
Workforce Community Forum	HIV workforce	To receive feedback on Broward County's Integrated plan and efforts
Workforce Focus Groups	HIV workforce	Identify perceived needs and barriers of PLWH
Community Focus Groups	PLWH	Identify perceived needs and barriers of PLWH

Data Policies that facilitated and/or served as barriers to the conduct of the Needs Assessment, including the development of the HIV Care Continuum: The FDOH method focuses on reported AIDS and HIV (not AIDS) cases who were alive through CY 2014 and whose last known residence was in Florida, regardless if the case was initially reported in Florida or out of state (OOS). Cases known to be living *outside* of Florida by December 31, 2014 were excluded from analysis. These data are generated from the merging of the following databases: eHARS, CAREWare, and ADAP. This revised process provides a more complete and accurate snapshot of Florida's unmet need by: 1) excluding cases known to be living outside of Florida; and 2) including cases reported outside of Florida, but obtaining care in Florida. This process addresses in and out-migration of cases in Florida which is an improved process than previous methods.

The majority of all HIV-related lab results are received electronically and imported into eHARS within a week of receipt. Significant efforts were made this past year to ensure that the most current addresses and vital statistics of PLWH are reflected in eHARS. Current addresses are being imported with all lab results. In addition, the current addresses for persons known to have moved OOS are updated accordingly. Ongoing matches with the Florida Office of Vital Statistics and annual matches with the National Death Index (NDI) ensure timely and complete reporting of deaths in eHARS. An in-depth evaluation of several thousand cases diagnosed in 1981 to 1995, and not in OAMC, were manually reviewed to determine the current vital statistics and/or current state of residence. Their current status was updated accordingly. However, several thousand cases were unresolved and remain as presumed alive in eHARS. Finally, significant efforts continue to be made to eliminate duplicate cases in the system. At present the estimated duplication rate in the database is less than 0.1%.

Routine matches are made between eHARS, CAREWare, and ADAP. Staff is dedicated to assist with the validation of the matched data. The merged datasets rely on accurate matching cases by name, date of birth, and social security number (SSN). Other variables including address are used to ensure an accurate match. Probable matches are researched in Lexis Nexus for validation. Missing or incorrect name, birthdate, and/or SSN may restrict the probability of a good match and result in an HIV case not matching with any of the care data, therefore indicating that the case was not in care.

FDOH is identifying care patterns in Broward and Florida. The number of individuals in OAMC was calculated at the EMA-level using both the unmet need and Continuum frameworks. eHARS cases were assumed to live in Florida (regardless of state of report) through 2014 if they were found in ADAP or CAREWare files. Based on the unmet need framework, cases were considered in care if they had at least one documented lab, medical visit, or prescription in the CY. Based on the Continuum framework, cases were considered in OAMC if they had two or more documented OAMC visits, labs, or prescriptions at least three months apart in the CY.

The Part A Recipient funds PE, a web-based relational, integrated data system. PE was designed to ensure alignment with Ryan White Services Report (RSR) reporting and allows direct upload of XML files from PE to HAB's RSR portal. PE collects client-level data on demographic and epidemiologic characteristics, intake and eligibility, detailed procedure-level service units, clinical outcomes, invoices, and payments. PE is designed similar to health insurance eligibility and claims systems, supplemented with electronically transmitted lab results and features common to electronic health record systems. PE has a system-wide clinical management alert and reminder system to ensure continuity of care and coordinated care management. MCM intake, assessment, and progress note screens are integrated in PE to increase MCM efficiency. Sub-recipients add scanned client records such as SSA award letters, health insurance cards, and clinical consultant reports to reduce paperwork. PE updates Florida Medicaid enrollment data via a monthly, automated query. PE is also used by HOPWA and includes client-level housing assessment and housing case management screens. PE's highly secure computing environment protects clients' confidentiality and privacy. The Recipient has developed a process for electronically collecting required data elements for each client served in Broward. Required data elements include client-level data components necessary for Clinical Quality Management (CQM) assessment, including ICD-9 and procedure codes. Entry of required data elements auto populate the necessary data for Part A client-level outcomes and indicators, National Quality Centers In+Care Campaign retention rates, HAB measures, and NHAS indicators.

The Recipient works continuously to improve data quality. Clinical outcomes and performance measures are integrated into sub-recipient contracts, monitoring and quality

improvement, Service Delivery Models (SDM) for all funded service categories, and CQM reporting, monitoring, and improvement. The Recipient uses a comprehensive data collection strategy to conduct annual program evaluations, sub-recipient outcome reports, and chart reviews. CQM staff review sub-recipient outcome reports and conduct site visits to assess program accomplishments based on HAB and Part A Care performance and outcome measures. The Recipient will continue to use PE data to assess client-level outcomes and HAB performance measures for Part A service categories. The PE contractor has assisted several OAMC sub-recipients to design routine lab extractions to populate electronically VL and CD4 count data in PE. The Recipient assessed the quality of OAMC PE data by systematically tracking data from health records to automation, PE, and RSR data. All sub-recipients submit client-level data directly to PE or export data from EHRs into PE. All sub-recipients received training and have direct access to assistance from the PE vendor helpdesk. The Recipient and PE staff works with sub-recipients to improve this process even further, including building interfaces between PE, sub-recipient electronic lab data, and Florida Medicaid. The Medicaid interface was particularly helpful in ensuring that the CIED and Part A-funded providers comply with HAB's payer of last resort policy, by linking automatically to Medicaid using clients' Social Security number to determine if clients are enrolled and ascertain their Medicaid numbers. PE includes client-specific alerts aimed at integrating QM measures with retention and adherence efforts for front-line workers' operations. PE alerts facilitate a collaborative system wide approach that ensures efforts are taken to assist patients meet their health outcomes. As outlined in the Integrated Plan, Broward has developed goals that both Part A and prevention recipient staff will continue to address to promote integration from an administrative perspective, sharing programmatic data, and conducting dual monitoring for sub-recipients.

Barriers to Data Collection Methods: Despite improved processes for determining need, there are some data limitations. FDOH acknowledges the limitations of the data on which these estimates are based. At present, the most significant limitation is ensuring that all 110,000 PLWH presumed in eHARS to be alive and living in Florida are completely valid. FDOH strives to eliminate duplicate cases in eHARS, with less than 0.1% of cases estimated to be duplicates. Routine reports are generated to identify possible duplicates

so that they may be resolved in a timely manner. FDOH has dedicated staff assigned to assist in the eHARS de-duplication. Electronic and paper lab reports are imported into eHARS, thus simplifying the matching process. Each year, a greater rate of lab reports is reported via electronic lab reporting (ELR). Routine matches between eHARS and CAREWare are undertaken routinely. The matched databases are merged into a separate database for detailed analysis of viral suppression. The other significant limitation results in assuming that persons not in care, based on the data matches above, are truly not in care. FDOH has determined that the data used and assumptions made are fairly robust in avoiding errors and bias. Each year, Florida strives to improve this method to provide the most reflective analysis of the Florida HIV epidemic.

Data Development: Moving forward, the stakeholders have identified the need for data sharing across systems as well as accurate and timely reporting of data to the county from FDOH. The utilization of a robust system such as PE has afforded Part A and DOH-Broward Prevention Program to collaborate effectively and to address the epidemic using data to inform decision-making processes.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

Integrated HIV Prevention and Care Plan Development: The goal of integration in Broward County is to streamline HIV prevention and care planning in a manner that will enhance prevention efforts for the highest risk populations. It will also improve the metrics along the Continuum of Care for those infected with HIV to create a coordinated response to the HIV epidemic and a seamless provision of HIV services. These metrics include the percentage of persons diagnosed and living with HIV, percentage linked to care, percentage retained in care and percentage with suppressed viral load.

This integrated approach to prevention and care has allowed Broward County to develop a clear roadmap to effectively plan for the provision and coordination of services for PLWH. It also allows for the most efficient use of limited resources by minimizing duplication of services. Integration of planning activities between the HIVPC and BCHPPC will help the EMA to progress further in reaching the NHAS goals and improve outcomes along the Continuum.

The attached Integrated Plan (Attachment 5) is reflective of the goals, objectives, strategies and activities of the HIVPC's Part A Comprehensive Plan and BCHPPC's Jurisdictional Prevention Plan. The activities described in the Integrated Plan are overarching coordinated activities that support the individualized efforts of both planning councils and their workgroups, as evidenced in their respective work plans. As such, specific activities for priority populations are addressed in the aforementioned work plans. The HIVPC and BCHPPC will continue to function as separate bodies to implement the assigned activities required in this plan as well as in their individual work plans and to work collaboratively to address mutually reinforcing activities.

In addition to incorporating both planning bodies' previously developed Plans and associated sub-committee work plans, several activities occurred in Broward County that allowed for the inclusion of the voices of persons impacted and affected by the epidemic. Results of Satisfaction Surveys, Focus Groups, Key Stakeholder Interviews, Community Feedback Forums, and a Workforce Forum have been synthesized and integrated into this planning document. Those activities that were the direct result of the input of the aforementioned feedback mechanisms are indicated in *blue and italicized text*.

B. Collaborations, Partnerships, and Stakeholder Involvement

Contributions of Stakeholders and Key Partners in Development of the Plan:

The integration process involved the active participation of the prevention and care planning bodies, the BCHPPC and the HIVPC respectively. Both the BCHPPC and the HIVPC are structured to have parity, inclusion and representation (PIR) of the community. Key stakeholders in both groups include PLWH, service providers, County and DOH-Broward staff, and other community members.

The BCHPPC—a government-community partnership—was created in June 2012. The mission of the BCHPPC is to “become a community with a collaborative and coordinated system of HIV Prevention and Care, where new HIV infections are rare and when they do occur, every person regardless of age, gender identity, race/ethnicity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.” It is based on a partnership between the federal government, local and state health department and community participation.

The BCHPPC is comprised of 21 voting members who meet quarterly and are governed by PIR. BCHPPC consists of (7) work groups totaling over 150 active members and four (4) core teams, each of which has a government and community co-chair. The BCHPPC structure includes an Executive Team, Epidemiology Team, High Impact/Core Prevention (HIP) Team and Policy Team. Advisory workgroups of the BCHPPC include the Broward County Schools Advisory Group, the Men who have Sex with Men (MSM) Advisory Group, the Transgender Advisory Group, the Perinatal Group, the Black Treatment Advocacy Network (BTAN), Black AIDS Advisory Group (BAAG), Latinos En Acción Advisory Group and the PrEP Advisory Group. The advisory groups represent the groups disproportionately affected by the HIV/AIDS epidemic in Broward County.

Work groups and teams meet monthly and are structured as open working groups, allowing fluidity of participation, each with its own specific work plan to guide activities and HIP implementation. The HIP Team of the BCHPPC reviews all work plans annually to monitor progress towards the NHAS goals, ensure alignment with the local jurisdictional prevention plan, provide recommendations to improve HIP activities, and streamline prevention work for maximized effectiveness. The work plans provided by the teams and work groups of the BCHPPC feed information back into the jurisdictional

prevention plan. Updates on all work plans are presented publicly at quarterly BCHPPC meetings. The community at-large is provided with opportunities to comment on the jurisdictional activities and is continuously encouraged to participate in the work groups.

The following provides an overview of the committees of the BCHPPC:

BCHPPC: Consists of a total of 15-21 voting members. In order to improve coordination of services there are two appointed seats on the BCHPPC: Broward County School District (funded by CDC-DASH) and Academic Research. The membership must achieve Parity, Inclusion and Representation, reflecting the priority populations: African-American, Latino, and MSM (as outlined in the National HIV/AIDS Strategy).
BCHPCC Committee and Team Descriptions
Executive Team - The main responsibility is to conduct and guide the planning required to direct the Full Council (i.e. setting agendas, creating the bylaws, etc.). The Executive Committee is comprised of the community co-chair, the governmental co-chair, representatives from the following advisory groups-MSM, Transgender, Latinos en Accion, BTAN (BAAG), Perinatal HIV, PrEP, and Broward County Schools.
Epidemiology and Research Team - Reviews biomedical, behavioral, and operational research to develop new HIV prevention strategies and improve existing programs. This team also assists the Council with the interpretation of the epidemiological data for prevention planning purposes.
High Impact/Core Prevention Team - Focuses on activities with the greatest potential to prevent the most new HIV infections, to the populations most affected and ensures that the four core prevention components identified in PS12-1201 are implemented.
Policy Initiatives Team - Supports efforts to align structures, policies, and regulations in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts.
Broward County Public Schools HIV Advisory Youth Workgroup - serves the District and Broward County as an advisory and action group. Engages and empowers youth to increase HIV/AIDS/STI awareness and testing. Composed of a group of 10-20 BCPS members whose work is guided by the BCHPPC mission and goals.
MSM (Men who have Sex with Men) Advisory Group - Is implementing the core components of PS12-1201, this group organizes thought leaders and decision-makers to fully mobilize the MSM community in Broward County and build capacity to address the various factors that facilitate HIV infection in the MSM community.
Transgender Health In Action (THIA) - provides peer on peer assistance as well as collaborative educational workshops specific to the transgender community in implementation of the core components of PS12-1201. Addresses issues of health, safety, prevention, testing and stigma and provides mentorship to reinforce a sense of self- worth and positive well-being.
Perinatal Advisory Group - ensures implementation of PS12-1201 core components while providing updated education on perinatal HIV to the community, yearly updates to medical providers, and seeks to increase testing and awareness for all women of child-bearing age.
Black Treatment Advocacy Network/Black AIDS Advisory Group (BTAN/BAAG) - strengthens Black leadership, links Black PLWHA into care, raise HIV science literacy, and mobilizes communities to advocate for policy and research priorities. While implementing core components of PS12-1201, BTAN/BAAG aims to reduce new infections and eliminate racial/ethnic HIV/AIDS disparities within the Black community.
Latinos en Acción Advisory Group- A coalition of Latino community members, representatives from Latino-serving organizations, and the DOH-Broward, Latinos en Acción utilizes HIP strategies to improve HIV health outcomes for Latinos in Florida while implementing core components of PS12-1201.
PrEP Advisory Group – provides recommendations on strategies, goals, and actions for the coordinated implementation of PrEP as a biomedical HIV prevention strategy in Broward County. Components of implementation may include public awareness campaigns, healthcare provider educational efforts, organization of CBO/ASO programs across the County, examination of policy affecting PrEP, or any other aspect of PrEP execution as needed. The PrEP advisory group will all act as a resource/advisor to all other BCHPPC Advisory Groups who include PrEP specific goals in their work plans.

The Part A Recipient works in partnership with the HIVPC to plan, prioritize, and assess the HIV/AIDS service system. The HIVPC is guided by a vision directing a coordinated and effective community response to the HIV epidemic to ensure access to a high quality system of care. The vision of the HIVPC is “to ensure the delivery of high quality comprehensive HIV/AIDS services to low income and uninsured Broward County residents living with HIV, by providing a targeted, coordinated, cost-effective, sustainable, and client-centered system of care.”

There are currently seven (7) standing committees that address needs identified by the HIVPC and an additional three (3) ad-hoc committees that address needs as they arise. The HIVPC Structure includes the Executive Committee, the Priority Setting Resource Allocation Committee, the Needs Assessment Committee, the Quality Management Committee, the Client Empowerment Committee, the Membership Council Development Committee, System of Care, Ad-Hoc By Laws, Ad-Hoc Local Pharmacy Advisory Committee, and the Ad-Hoc Nominating Committee. In total, HIVPC has 29 voting members and over 45 committee members.

The following provides an overview of the committees of the HIVPC:

HIV Health Services Planning Council (HIVPC) - Monitors, evaluates, and continuously improves systematically the quality and appropriateness of HIV care and services provided to all patients receiving Part A and MAI-funded services.
HIVPC Committee Descriptions
Community Empowerment Committee (CEC) - Encourages the participation of individuals infected and affected with HIV/AIDS in the planning, priority-setting and resource-allocation processes.
Membership/Council Development Committee (MCDC) - Recruits and screens applications based on objective criteria for appointment to the Council in order to ensure demographic requirements of the Council are maintained according to the Ryan White Treatment and Modernization Act. Presents recommendations to the Council. Institutes orientation and training programs for new and incumbent members.
Needs Assessment/Evaluation (NAE) Committee - Develops and updates the annual Needs Assessment, including determining focuses for the client survey, provider survey, and client focus groups. Evaluates and updates the Comprehensive Plan to determine progress.
Quality Management Committee (QMC) - Ensures highest quality HIV medical care and support services for PLWHA by developing client and system based outcomes and indicators. Provides oversight of standards of care, develops scopes of service for program evaluation studies, assesses client satisfaction, and provides QM staff/client training/education.
Priority Setting Resource Allocation (PSRA) Committee - Recommends priorities and allocation of Ryan White Part A funds. Facilitates the Priority Setting and Resource Allocation Process to include the review of appropriate data (service utilization, epidemiological data). Develops, reviews, and monitors eligibility, service definitions, as well as language on ‘how best to meet the need.

System of Care (SOC) Committee - Evaluates the system of care and analyzes the impact of local, state, and federal policy and legislative issues impacting PLWH in the Broward County EMA. Plans and addresses coordinated care across diverse groups by engaging community resources to eliminate disparities in access to services.

Executive Committee - Sets agenda for Council meetings. addresses conflict of interest issues, reviews attendance reports, oversees the planning activities established in the Comprehensive Plan, oversees committee work plans, reviews committee recommendations, ratifies recommendations for removal for cause, and addresses unresolved grievance issues.

HIVPC Ad-Hoc Committee Descriptions

Ad-Hoc By Laws Committee - Periodically reviews, updates and maintains the Council By-Laws

Ad-Hoc Local Pharmacy Advisory Committee (LPAC) - Makes recommendations to the appropriate committees to improve the quality, cost-effectiveness and allocation of resources to pharmacy services. Develops and implements a standardized mechanism for pharmacy services. Efficiently collect and evaluate current pharmacy data. Coordinates pharmacy services in collaboration with other funding streams Reviews current pharmacologic therapeutic regimes and federal guidelines.

Ad-Hoc Nominating Committee - The Ad-Hoc Nominating Committee prepares for and oversees the HIVPC leadership elections process.

South Florida AIDS Network (SFAN) - In addition to the above advisory workgroups and committees of the Planning Councils, the South Florida AIDS Network (SFAN) serves as a Ryan White Part B Care Consortia. The purpose of this Consortia is to “act in an advisory capacity to the state for the purpose of planning and prioritizing the use of Part B funds; provide a forum for the infected individuals and affected communities, providers and others; and facilitate the provision of coordinated, comprehensive health and support services to people infected and affected by HIV/AIDS. A consortium must include people living with HIV/AIDS.”

Development of the Integrated HIV Prevention Care and Treatment Plan: Beginning in 2011, discussions around the Early Identification of Individuals with HIV/AIDS (EIIHA) took place. This process was designed to include the input of key stakeholders such as HAB-funded recipients and sub-recipients, public health prevention program, disease control and intervention service, healthcare systems, CBOs, correctional facilities, faith-based community, HIV+ residents, and community leaders. Other notable collaborative efforts include Prevention and Ryan White Part A representatives’ attendance at the Communities Advocating Emergency AIDS Relief (CAEAR) Coalition joining the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS), a group in which Prevention participates.

Also in 2011 and 2012, a series of public health leadership meetings, site visits, think tanks and presentations led by DOH-Broward HIV Prevention Program Office were held to develop a new strategic framework for HIV service delivery. At this time, Broward County ranked first in the nation for AIDS case rates. In the first ten months of 2011, Broward County had reported 907 new HIV cases, more than in 2009 and 2010 combined. Initially, site visits and think tanks were convened to assess willingness in changing the way HIV prevention services are implemented in Broward County by both DOH-Broward and community partners. This historic collaborative journey between the Flowers Heritage Foundation, Get Screened Oakland, and the Broward County Health Department HIV Prevention Program resulted in the document “A Vision of Thoughtful Change.” The Summary of Recommendations that emerged from those dialogues included the following: 1) Integrated Surveillance-data collection tools, datasets, and reporting processes should be complementary; 2) Technology-building technology for online capacity and supporting the use of peer navigators and community health workers should be enhanced to ensure linkage to care and treatment; 3) Coalitions and Networks-engagement of stakeholders, including unlikely partners should be used as a catalyst for change; 4) Policy and Advocacy-policy is an important tool that should be used to respond to HIV/AIDS and other health concerns; 5) Systems Approaches- scalability and replicability of evidence-based and scientific-based practices should be analyzed and implemented; 6) Building New Leaders-emerging leaders from within the HIV/AIDS community should be provided opportunities for growth and involvement; and (7) Multi-Sector Partnerships-integrating multiple partners from across sectors-government, business, non-profit, faith-based and the media should be seen as an integral component of providing information and reducing stigma.

The implementation of PS 12-1201 (2013) High Impact Prevention (HIP) CDC Funding Opportunity Announcement and the establishment of the BCHPPC by DOH-Broward (2012) was also a part of early integration efforts. In forming the BCHPPC and responding to joint letters from CDC and HAB stressing integration, the stakeholders and HIVPC redoubled their efforts to integrate fully HIV prevention, screening, linkage, care, and treatment. Broward was further prompted to consider new HIV service strategies due to the federal adoption of the Continuum model and the increasing intersection of HIV

prevention, care, and treatment. Additional integration efforts included the development of an integrated quarterly newsletter known as “POZabilities” to inform the community about integrated planning and keep them updated on the process.

In May 2013, HAB and CDC released letters supporting integration between Prevention, Care and Treatment. Prior to the release of the letters about integration, the Broward County Prevention and Ryan White Part A Programs had already taken several steps to foster collaborative integration of HIV prevention and care. In December 2013, Technical Assistance (TA) requests were made to the HRSA Project Officer regarding involvement of both Prevention and Care Planning bodies. This decision was based on an assessment of the community and realizing there was a need for additional assistance. By September 2014, a work session on the development of an Integrated Committee for HIV Planning was facilitated by Emily Gantz McKay in response to the TA request. The ultimate goal of the TA efforts helped to streamline HIV Prevention, Care and Treatment planning to increase access to and effectiveness of prevention, care, and treatment services. As a result, The HIVPC collaborated with the BCHPPC to develop a Comprehensive HIV Plan “Crosswalk.” The presentation of the Integrated “Crosswalk” provided a Master Comprehensive Chart of Prevention, Care and Treatment services in Broward County and the progress made to date. The crosswalk was used as a foundation for integration.

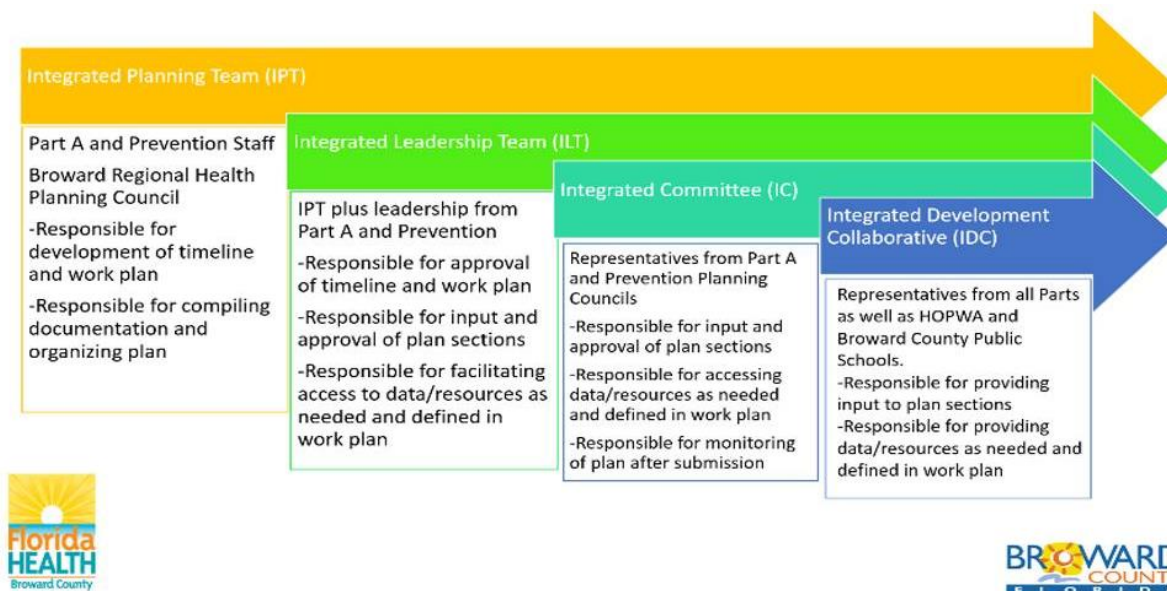
The coordinated approach is further illustrated through recent activities undertaken in Broward: 1) participation from HIVPC and BCHPPC members; 2) retreat presentations focusing on collaboration among the prevention and care sectors, where representatives from both sectors discussed how to accomplish joint NHAS goals; 3) coordinated needs assessments that incorporate care and prevention to fulfill HAB and CDC requirements; and 4) forming an Integrated Committee to develop and monitor the 2017-2021 Integrated HIV Prevention and Care Plan.

A total of five (5) formal integrated retreats and exploratory meetings were held throughout 2014 and 2015 to identify and clearly understand the meaning and purpose of the integrated plan and determine what was needed to move forward with planning. Representatives from the Ryan White Part A Program, DOH-Broward Prevention Program, and Broward County Public Schools were participants of these

meeting and retreats. These retreats and meetings resulted in conversations regarding the necessary infrastructure to be responsible for the development, monitoring and evaluation of the integrated plan. The Integrated HIV Prevention and Care Plan further formalizes relationships and joint planning activities among HIV prevention, other RWHAP recipients and sub-recipients, public and private sector providers conducting HIV screening, and health and support service agencies. The Plan aims to avoid duplication among local HIV prevention, screening, and treatment efforts funded by the CDC, DOH, RWHAP, insurers, and other funders. As both the BCHPPC and the HIVPC function efficiently as separate bodies, with defining organizational cultures, funding parameters and priorities, it was determined that it was not feasible nor necessary to merge both Planning Councils. However, agreement was reached that the integration process required the active participation of Prevention, Care and Treatment planning body members. As a result, an Integrated Committee was formed, representative of members of both the BCHPPC and the HIVPC. In addition, each Planning Council includes integration as a standing agenda item at their meetings.

As a result, an integrated framework was developed that included the development of an infrastructure to support the integrated planning process. This infrastructure includes several groups: 1) Integrated Development Team (IDT): responsible for developing and implementing strategies that strengthen collaboration and coordination among all Ryan White parts, HOPWA, and Prevention; 2) Integrated Leadership Team (ILT): comprised of HIV Prevention and Ryan White Senior Leadership responsible for the direction and guidance of the integrated planning process and has authority to approve final integrated products; 3) Integrated Development Collaborative (IDC): comprised of HIV Prevention, Care and Treatment Recipients including Broward County Public Schools (with established and completed work plans) in Broward County; and 4) Integrated Committee (IC): Comprised of ten members, inclusive of two co-chairs, of community stakeholders and PLWH from each planning body (HIVPC and BCHPPC). This committee is responsible for the oversight and implementation of the Integrated Plan. The Integrated Committee has been responsible for the approval of all integrated planning activities and will continue to oversee the overall progress of the implementation of the Integrated HIV

Prevention and Care Plan. The committee serves as a quality assurance component and will be critical to monitoring the content and execution of the Integrated Plan.



The success of the integrated planning process relies on the support of both Prevention and Care and Treatment planning bodies. Each of these bodies involve stakeholders throughout their own planning and program development as they rely extensively on PIR meaning that both planning bodies represent the communities that are served. Both planning bodies are kept abreast of integrated planning updates and are allotted regular platforms for community feedback. They are also accountable for selecting the individuals responsible for reviewing the plan. The HIVPC and BCHPPC as well as their respective workgroups and committees have reviewed and approved the integrated plan and activities. The monitoring of the success and outcomes of the plan will be conducted by third-party resources and is discussed further in Section III: Monitoring and Improvement.

Between September 2014 and the present, numerous meetings occurred between the Grantees to formalize this process. In addition, staff from both Prevention and Care and Treatment collaborated to provide training at several conferences to present the “Broward Approach” to integration. The following serves to highlight some of the steps that were taken to ensure the collaborative planning process was implemented systematically, thoughtfully, and in a coordinated fashion. ***This approach has been recognized as a***

best practice and received the National Association of County and City Health Officials (NACCHO) Model Award in April 2016.

- By-laws were developed for the Integrated Committee
- Members of the Integrated Committee (a total of 10 members-5 representing BCHPPC, 5 representing HIVPC and one at-large member) were chosen by their respective peers to serve
- A timeline for development of the plan was created as well as a Work Plan with timeframes and action steps
- A public forum was held to announce the Integrated Planning process and to invite community stakeholders to participate in planning efforts
- An Integrated Collaborative was formed that includes members of the Integrated Committee as well as representatives of all Ryan White Parts, HOPWA, the School Board of Broward County, and the South Florida AIDS Network (SFAN).
- In addition to previously collected stakeholder data that informed earlier plans for both Prevention and Care and Treatment, additional data was collected from target populations, including focus groups, surveys, and key stakeholder interviews.
- Both planning bodies were continuously informed about the progress of the planning process and provided feedback through their Integrated Committee representatives.
- Several Town Hall meetings were held to inform the public and community stakeholders about the planning process and to gather feedback and input.
- A structure for continuous monitoring and evaluation post plan submission has been established and will be implemented by the Integrated Committee.

Integrated Presentations:

- Department of Health and Human Services (HHS) Region IV and VI National HIV/AIDS Strategy Meeting. Atlanta, Georgia. August 12, 2014. Panel presentation.
- United State Conference on AIDS (USCA) 2014. San Diego, California. October 2-5, 2014. Oral Presentation.

- American Public Health Association Conference (APHA) October 31-November 4, 2015. Chicago, Illinois. Poster Presentation.
- 2015 Centers for Disease Control and Prevention (CDC) National HIV Prevention Conference. Atlanta Georgia. December 5-9, 2015. Panel Presentation.
- Urban Coalition for HIV Prevention Services (UCHAPS) Technical Assistance Provider on Integration March 2016.

Letter of Concurrence. Attachment 6 includes the Letters of Concurrence from both the HIVPC and BCHPPC Chair, and co-chairs of the Integrated Planning Committee. This includes documented Agreements and Assurances certifying compliance with the goals and objectives of the Integrated HIV Prevention and Care Plan.

C. People Living with HIV (PLWH) and Community Engagement

Stakeholders involved in the development and creation of the Integrated HIV Prevention and Care Plan are fully committed to eradicating the epidemic of HIV/AIDS in the community. The process utilized to create this plan ensured that individuals who participated were inclusive of at-risk groups as well as representative of PLWH. Broward County is diverse as described earlier, and as such participants were characteristic of the varying races, ethnicities, gender identification, sexual orientation, and ages of those impacted by HIV. Both the HIVPC and the BCHPPC and their respective committees and workgroups are also representative of the community and include many PLWH. Multiple activities, meetings, and opportunities for feedback were organized in order to receive input as well as to guide the development of specific strategies to enhance the cooperation and collaboration between the two Planning bodies and other interested stakeholders to achieve the goals outlined in this plan. This section describes the process for engagement and inclusion in plan development.

Multiple individuals, organizations, and groups have been involved in the development of the Integrated HIV Prevention and Care Plan for Broward County. This collaborative effort has included individuals who have been disproportionately impacted by the HIV/AIDS epidemic, whether directly infected or affected as family members, providers, funding organizations, and community members. Both the HIVPC and BCHPPC are reflective of the epidemic in Broward County. In particular, several committees and workgroups exist to reflect the specific needs of the priority populations, as identified in the overviews previously described. In addition to the planning bodies, the other Parts funded by CDC/HRSA have been involved since the beginning of the planning process.

There have been numerous opportunities for community engagement and for the participation of PLWH to contribute to the planning process. These have included focus groups, satisfaction surveys, community forums, planning body and committee meetings, and key stakeholder interviews. By using a Collective Impact framework in the approach to the Integrated Plan development, the emphasis began with and continued to value the voice of persons directly impacted by the epidemic. Having key stakeholders present during the development of this plan, from review of data, to facilitation of community dialogues, to identification of strategies and objectives is considered a hallmark of this

approach. Additionally, continuous communication occurred through ongoing meetings and sharing of feedback. The structure of the overall planning process ensured that members of both Planning Councils participated on the Integrated Committee, with equal representation. Agendas for full Planning Council meetings include an item to provide updates about the planning process and to receive feedback from members. This cycle of communication has helped to enhance and fortify the Integrated Plan by allowing for the inclusion of many diverse voices and viewpoints.

The following serves to provide an overview of the strategies used to include people living with HIV/AIDS in the development of this plan:

- Focus Groups
- Satisfaction Surveys
- Key Stakeholder Interviews
- Community Forums for People Living With HIV/AIDS
- Community Forum for the Workforce
- Stigma Survey
- HIV Workforce Evaluation
- Provider Survey
- Integrated Committee Meetings

Focus Groups: several focus groups were held with a cross-section of the diverse population of individuals living with HIV/AIDS. These included persons served (African American males, African American females, two with MSM) and the workforce. Four of the focus groups were held with individuals living with HIV/AIDS and three were with employees of organizations providing direct services. Several additional focus groups are scheduled and will take place on a continuous basis. These include focus groups with transgender individuals, pregnant HIV+ women, young adults, Hispanic men, and Hispanic women.

Satisfaction Surveys: almost 400 surveys (in English and Spanish) were distributed and returned over a six month period. Of the surveys returned, over 60% were from individuals who were HIV+ and receiving Ryan White Part A services. An additional 12% identified as HIV+ but not receiving Ryan White Part A services.

Key Stakeholder Interviews: Several stakeholder interviews were conducted with individuals representing the HIV community. These individuals included a School Board member, several CEOs, a frontline supervisor, and several persons living with HIV/AIDS. Moving forward, the intent is to continue these dialogues in particular with individuals representing priority and vulnerable populations.

Stigma Survey: Surveys were administered to 106 individuals in the community to gauge their condom use, knowledge of HIV prevention measures, and stigma related to HIV infection. The sample was evenly distributed between genders. The majority of respondents were aged 18-25, born in the United States. Most respondents demonstrated some knowledge about prevention measures such as condom use. Results showed that stigma continues to permeate the community, with frequent comments citing “death”, “disease”, and the notion of HIV being “scary.”

HIV Workforce Evaluation: A national HIV Workforce Study regarding HIV Knowledge, Attitudes and Beliefs was conducted and a total of 3,663 individuals participated in the study. In the state of Florida, 210 participated and in the Miami/Ft. Lauderdale area 80 individuals participated. The overall grade for the nation, state, and the local area was a “D.” Specific to the Miami/Ft. Lauderdale workforce, of the 80 individuals who participated, 51% identified as male at birth, 49% identified as female at birth. Most respondents were 45-54 years of age, and there were 51% identifying as male currently, 48% female, and 1% transgender. Most respondents identified as heterosexual (58%), 34% as gay or lesbian, and 9% as bisexual. In terms of race and ethnicity, 41% were African-American, 35% were white, and 18% were Hispanic. Most respondents (70%) were HIV negative, while 28% were HIV positive. Most had completed some or all post graduate studies (50%), while 19% had earned their Bachelor’s degrees and 31% had earned an Associate’s degree or less.

As previously described, Broward County has implemented a Collective Impact framework to approach the complex challenge of developing an Integrated HIV Prevention and Care Plan. The development of the infrastructure, creating an Integrated Committee, and providing continuous feedback through the Planning Council bodies has afforded the community numerous opportunities to create the Goals, Objectives, Strategies, and Activities identified in Section II.A. Broward County believes that it takes

a group of diverse and committed stakeholders to tackle these complex social and health challenges and has provided a number of occasions to offer feedback about such solutions. The following highlights those meetings and dialogues:

Community Feedback Forums: As objectives, strategies, and activities were being developed, the community was engaged to receive feedback and input. A series of three dialogues with persons served took place, followed by a workforce forum. The three community forums with persons served included one focused on the Latino/a community, one focused on the African-American community, and one focused on the general community. A total of 98 individuals participated in those forums. An additional Workforce Community Feedback forum was held, with 96 people in attendance.

Lessons learned from the Community Feedback forums: There was not enough community participation for the persons served forums. Many individuals were employed by HIV service organizations, although they were representative of frontline staff and several were HIV positive. Recommendations moving forward included the need to hold the meetings in geographic locations that are accessible to the population served and at times (such as the late afternoon or early evening) that are convenient. For the Spanish speaking population, information should be distributed in Spanish and all materials should be available as paper distribution. Advertisement of meetings should also be more specific and focused on the community's needs.

Provider Survey: A provider survey was conducted in April 2016 to identify resources available, assets, gaps, and barriers. A total of thirteen (13) providers participated, representing both prevention and care and treatment. The majority of organizations provided HIV prevention education (10 out of 13 providers), counseling and testing for HIV (9 out of 13 providers), and testing for STDs (8 out of 13 providers). Services that were provided by only one or two organizations were: child/family support, employment assistance, food bank/vouchers, home health care, housing assistance, legal support, and inpatient substance use/abuse treatment. All providers surveyed indicated that individuals can walk in and access services the same day and 12 of 13 providers can call and schedule themselves for an appointment. All organizations also provide individuals with referrals for other services. In terms of frequency of core medical service referrals made, HIV medication referrals were the most frequent, followed by case

management/care coordination, and mental health services. Least frequent were home health care and nutritional counseling. When asked about supportive services and the frequency of referrals made, the most frequent referrals were made for housing assistance, food bank/vouchers, and transportation/transportation vouchers. The least frequent referrals were made to translation/interpretation assistance, employment assistance, and legal support.

Integrated Committee meetings: As described previously, the infrastructure for the planning process included the development of an Integrated Committee that is representative of both planning bodies. This group of individuals met regularly to review the document as well as to provide input regarding the Goals, Objectives, Strategies, and Activities. Members of the Integrated Committee facilitated all of the Community and Workplace Forums. In addition, members provided continuous updates to their respective planning bodies and presented the plan upon completion for consensus. The development of this plan and its ensuing action steps has truly been a collaborative community process and has resulted in strategies and activities that will promote the achievement of the NHAS goals.

Section III: Monitoring and Improvement

Broward County supports the National HIV/AIDS Strategy for the United States (NHAS) related to: reducing new HIV infections; increasing access to care and improving health outcomes for people living with HIV; reducing HIV-related disparities and health inequities; and achieving a more coordinated national response to the HIV epidemic. In order to achieve these goals, the jurisdiction is committed to the provision of effective prevention and care strategies to the populations and geographic areas most affected by HIV, utilizing local resources to achieve a maximum level of impact, and increased monitoring and accountability through the following:

- Development of Integrated HIV Prevention, Care and Treatment indicators
- Ongoing evaluation practices
- Reporting of progress achieved
- Continuous stakeholder engagement

The goal of integration in Broward County is to streamline HIV prevention and care planning in a manner that will enhance prevention efforts for the highest risk populations and improve the metrics along the Continuum of Care for those infected with HIV to create a coordinated response to the HIV epidemic and a seamless provision of HIV services. Broward County has identified a set of shared metrics that include the percentage of persons diagnosed and living with HIV, percentage linked to care, percentage retained in care and percentage with suppressed viral load.

Proposed monitoring and improvement steps include the creation of several additional continuums that reveal more specific information such as 1) an HIV Incidence continuum; 2) an HIV Prevalence continuum; 3) an HIV Prevention continuum for 'high risk' negative individuals; and 4) a Ryan White only continuum. Common definitions for each continuum measure will also be developed between both Prevention, Care and Treatment and a local monitoring and evaluation report will be produced outlining Prevention, Care and Treatment progress towards the goals of the NHAS. This evaluation will also include local data sources including Active Strategy (DOH-Broward's Performance Indicator database), PE, PRISM, ADAP and eHARS. Examining outcomes across the Continuum is necessary to be able to evaluate program effectiveness and monitor program utilization.

In order to accomplish this a PROACT Database has been created in addition to the regular monitoring of monthly program performance through DOH-Broward's Internal Review System, Active Strategy Enterprise. As part of the Integration of Prevention, Care and Treatment in Broward County, proposed plans are being developed to enhance these two programs by implementing data-to-care activities that utilize eHARS in addition to the existing database to identify clients in need of being re-engaged in care and monitoring viral suppression.

Additionally, process objectives of the integrated approach include achieving a mutual understanding of the local health departments, Ryan White Recipients, and local planning bodies in HIV integrated planning, creating a comprehensive work plan, maximizing collaboration during implementation, and identifying the critical elements of integrated planning. This is accomplished by using the Collective Impact framework and methodology and documenting lessons learned for continuous improvement as well as for use by other jurisdictions. Collective Impact, a framework for solving complex social problems, was applied by the partners, creating a mechanism through which achieving a coordinated response to the HIV epidemic could be addressed.

Outcome objectives to measure the progress of integration in achieving the goals of the NHAS have been developed and are shown in Table 8. Monitoring progress on objectives and activities in this plan is critical in ensuring the advancement in the access to quality HIV prevention and care services in Broward County. The Broward County HIV Integrated Prevention, Care & Treatment Indicators Report is aligned and supports national initiatives from the NHAS 2020 updates published July 2015. Indicators were developed to represent measurable outcomes and are derived from existing data/other sources of information. Data sources have identified data that can be comparable across the years and are readily available to monitor progress toward the strategy goals. Using available 2014 data sources as the baseline year, progress will be measured throughout the five years of the plan. Performance data will be derived from available data sources such as Active Strategy (DOH-Broward's Performance Indicator database), PE, PRISM, ADAP and eHARS. Additional data sources are also described in Section I.E. As monitoring and evaluation is enhanced, measures may concurrently evolve to capture relevant information and activities that reflect current science.

Table 8: Indicators to Measure Progress of Broward’s Integrated Prevention, Care and Treatment Plan, Updated 2021 Targets

Indicator	2014 Baseline	Data Source	2021 Target
Reduce the number of new infections by 25%	993	eHARS	745
Reduce the number of pediatric transmission cases to zero	0	eHARS	0
Increase the number of Broward county residents who have not previously tested for HIV by 5% each year.	13,028	1628 Testing and Counseling Database	16,627
Increase the percentage of newly diagnosed individuals who are linked to HIV medical care within 1 month of diagnosis to 85%.	53.7%	eHARS	85%
Increase the percentage of PLWH who are retained in medical care to 90%.	65%	eHARS	90%
Reduce disparity in the rate of HIV-related mortality among Black males by at least 15%.	17.0	Vital Statistics	14.5
Reduce disparity in the rate of HIV-related mortality among Black females by at least 15%.	16.4	Vital Statistics	13.9
Reduce disparity in the rate of HIV-related mortality among White males by at least 15%.	10.1	Vital Statistics	8.6
Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%	61%	eHARS	80%

Evaluation findings are critical for the identification of best practices and opportunities for advancement which then provide vital information for effective program planning and quality improvement of services. Over the next five years, hired external consultants will review the data yearly to measure impact of the Integrated Plan on the local HIV epidemic. A Scientific Advisory Group (SAG), comprised of university and research partners, will provide an external evaluation to the Integrated Plan to provide additional feedback

needed to improve prevention and patient care efforts and drive decision making in the Broward County area. The results of this evaluation will be submitted for academic publishing and then larger dissemination. The SAG will also be responsible for presenting to both planning bodies on the outcomes of their evaluation.

Stakeholder Engagement: Having the right stakeholders and subject matter experts from the appropriate organizations is necessary to establish community ownership for a plan that impacts such a large amount of people. The integration of prevention, care and treatment is not an easy process and requires collective input and efforts from all those involved. Continuous communication between key stakeholders and organizations in the form of regularly scheduled integrated retreats and meetings, joint project officer calls, co-authored published articles, co-presentation on the integration process, and regular updates at both planning meetings is a core component of the Collective Impact methodology. Having the Collective Impact methodology to help drive the process, engage stakeholders and guide integration early in the development has resulted in a comprehensive and organized approach. Having stakeholder buy-in and representation from the appropriate organizations not only assists in communication of integration updates, it also facilitates the engagement and support of the overall community by building trust, addressing community perceptions, and incorporating community representation.

The success of the integrated planning process relies on the support and commitment of both the HIVPC and BCHPPC. Both planning bodies are kept abreast of integrated planning updates and are allotted regular platforms for community feedback. Both planning bodies have been responsible for selecting the individuals responsible for reviewing the plan (Integrated Committee) and have provided a letter of concurrence for the Integrated Plan.

The indicators listed above will serve as a guide for an *Integrated Progress Report* that will be created by DOH-Broward and Ryan White Part A Program Recipient Office. This annual report will serve as a vehicle for communication, including a summary of lessons learned, and will be disseminated to each respective planning council, the community at large, and other interested stakeholders. The Integrated Committee, comprised of ten members, inclusive of two co-chairs, of community stakeholders and

PLWH from each planning body (HIVPC and BCHPPC) will be responsible for reviewing the monitoring and evaluation of the plan (*Integrated Progress Report*) and thus serve as a quality assurance component in evaluating activities that are to be executed by the respective responsible parties. Ongoing facilitated meetings among the committee throughout the year will be necessary in providing feedback on the implementation of the plan. The activities described in the plan are coordinated activities that will be supported by DOH-Broward, Ryan White Part A Program Recipient Office, Broward County Public Schools, BCHPPC and HIVPC planning councils and their workgroups. BCHPPC and HIVPC work group work plans will also provide information and data back into the monitoring of the Integrated Plan. Both planning councils will continue to review and monitor their respective work plans to evaluate progress towards the NHAS goals, ensure continued alignment with the local jurisdictional plan, provide recommendations to improve activities, and streamline prevention and care work for maximized effectiveness.

Engaging partners is vital in this collective impact approach. The community at-large will be provided with opportunities to comment on the jurisdictional activities and is continuously encouraged to participate in the planning bodies work groups which ultimately deliver the necessary feedback and assess strategies for improvement. Utilizing feedback from stakeholders will assist in evaluating whether the strategies and activities promote a coordinated, collaborative, and seamless approach to increased access/linkage to prevention, care, and treatment services; improve health outcomes for PLWH; and move the jurisdiction towards a decrease in new HIV infections. As previously mentioned, all planning bodies will be regularly updated on the progress of the plan implementation conducted through BCHPPC and HIVPC at quarterly council meetings.

Concluding Statement: The primary lesson learned from the integration of prevention, care and treatment in Broward County is that integration guidance cannot be prescriptive. What works well in one jurisdiction may not work for another. For example, the merging of Prevention and Care and treatment planning bodies is not recommended for Broward County and is not necessary to complete an integrated plan. The culture, directives, organizations and priorities for BCHPPC and HIVPC are not easily merged, which would be a large challenge within itself. Both bodies function efficiently as separate bodies to complete the tasks required for the integrated process. However, members do

actively participate on both planning bodies and each planning body has integration as a standing agenda item. Knowledge of the local epidemic and landscape including available resources and key stakeholders is essential and fundamental to the integration process in order to include the appropriate individuals, organizations and activities into the integration process and plan. Integration is not an easy process and there are very few models and best practices to follow as guidance. CDC and HRSA have provided support for integrated activities; however, they have provided very general guidance as to how this process should be executed at the local level. Therefore, it is imperative to document the integrated process as it occurs, including the outcomes of integrated meetings and best practices. From the integrated meetings held to date, one of the best practices is the inclusion of external facilitators to structure and moderate some of the meetings and or retreats between all individuals and organizations represented at integrated meetings. Having outside facilitators allows for meetings to stay on task, to manage and resolve conflict effectively as it arises, and to ensure that objectives are met.

The integrated planning process has provided an opportunity for multiple system partners to work together towards a common goal. While there have been challenges along the way, utilizing the collective impact approach has provided a blueprint for the work completed. Recognizing that multiple system partners have a common agenda led to utilizing common language. This resulted in better communication and a way to overcome conflict. As an integrated team, Broward County has been able to bring multiple different perspectives to the table to solve the complex challenges in the community. Identifying shared measurement will assist in the future as the Integrated Plan will be utilized to improve the lives of Broward County residents living with HIV.

Attachment 1: List of Commonly Used Acronyms

AACTG: Adult AIDS Clinical Trials Group	EMA: Eligible Metropolitan Area
ACA: The Patient Protection and Affordable Care Act 2010	FDOH: Florida Department of Health
ADAP: <i>AIDS Drugs Assistance Program*</i>	FPL: Federal Poverty Level
AETC: <i>AIDS Education and Training Center*</i>	FQHC: Federally Qualified Health Center
AHCA: Agency for Health Care Administration	FL-DCF: Florida Department of Children and Families
AHF: AIDS Health Care Foundation	FY: Fiscal Year
AHRQ: Agency for Healthcare Research and Quality	HAB: HIV/AIDS Bureau
AICP: AIDS Insurance Continuation Program	HCV: Hepatitis C Virus
AIDS: Acquired Immuno-Deficiency Syndrome	HHS: U.S. Department of Health and Human Services
AIMS: Advice and Information Management System	HICP: Health Insurance Continuation Program
ALICE: Asset Limited, Income Constrained, Employed	HIP: High Impact Prevention
ASO: AIDS Service Organization	HIV: Human Immunodeficiency Virus
ARV: Antiretroviral	HIVPC: <i>Broward County HIV Health Services Planning Council*</i>
BARC: Broward Addiction Recovery Center	HMSM: Hispanic Men who have Sex with Men
BCBCC: Broward County Board of County Commissioners	HOPWA: Housing Opportunities for People with AIDS
BCFHC: Broward Community and Family Health Centers	HRSA: Health Resources and Service Administration
BCHSD: Broward County Human Services Department	HUD: U.S Department of Housing and Urban Development
BCHPPC: <i>Broward County HIV Prevention Planning Council*</i>	IC: <i>Integrated Committee*</i>
BH: Behavioral Health	IDC: <i>Integrated Development Collaborative*</i>
BMSM: Black Men Who Have Sex with Men	IDU: Intravenous Drug User
BRHPC: Broward Regional Health Planning Council, Inc.	ILT: <i>Integrated Leadership Team*</i>
CAEAR: Communities Advocating Emergency AIDS Relief	IPT: <i>Integrated Planning Team*</i>
CAP: Corrective Action Plan	JLP: <i>Jail Linkage Program*</i>
CBA: Capacity Building Assistance	LPAP: <i>Local AIDS Pharmaceutical Assistance Program*</i>
CBO: Community-Based Organization	MAC: Minority AIDS Coordinator
CDC: Centers for Disease Control and Prevention	MAI: Minority AIDS Initiative
CDTC: <i>Children's Diagnostic and Treatment Center*</i>	MCM: Medical Case Management
CHC: Community Health Center	MH: Mental Health
CIED: <i>Client Intake and Eligibility Determination*</i>	MOE: Maintenance of Effort
CLAS: Culturally and Linguistically Appropriate Services	MOU: Memorandum of Understanding
CLD: <i>Client Level Data*</i>	MSA: Metropolitan Statistical Area
CM: Case Management	MSM: Men Who Have Sex with Men
CMS: Centers for Medicare/Medicaid Services	NBHD: North Broward Hospital District (Broward Health)
CQI: <i>Continuous Quality Improvement*</i>	NHAS: National HIV/AIDS Strategy
CQM: Clinical Quality Management	nPEP: Non-Occupational Post Exposure Prophylaxis
CRIS: Capacity Building Assistance Request Information System	NSU: Nova Southeastern University
CTS: Counseling and Testing Site	OAMC: Outpatient Ambulatory Medical Care
CY: Calendar Year	OHC: Oral Health Care
DCM: Disease Case Management	OOS: Out of State
DOH-Broward: Florida Department of Health in Broward County	PAC: Project AIDS Care
eHARS: Electronic HIV/AIDS Reporting System	PE: <i>Provide Enterprise*</i>
EIIHA: Early Intervention of Individuals Living with HIV/AIDS	PEP: Post-exposure Prophylaxis
EIS: Early Intervention Services	PIR: Parity, Inclusion, Representation
	PLWHA: People Living with HIV/AIDS
	PrEP: Pre-Exposure Prophylaxis
	PRISM: Patient Reporting Investigating Surveillance System

PROACT: Participate, Retain, Observe, Adhere, Communicate and Teamwork is DOH-Broward’s treatment adherence program.

PSRA: Priority Setting & Reallocation

PTC: Prevention Training Consultant

QHP: Qualified Health Plan

QI: Quality Improvement

QIP: Quality Improvement Project

QM: Quality Management

RSR: Ryan White Services Report

RWHAP: Ryan White HIV/AIDS Program

SA: Substance Abuse

SAETC: Southeast AIDS Education and Training Center

SAG: Scientific Advisory Group

SBHD: South Broward Hospital District (Memorial Healthcare System)

SCHIP: State Children’s Health Insurance Program

SCSN: Statewide Coordinated Statement of Need

SDM: Service Delivery Model

SEQY: Summary Earnings Query

SFAN: *South Florida AIDS Network**

SPNS: Special Projects of National Significance

SSA: Social Security Administration

SSDI: Social Security Disability Income

SSI: Supplemental Security Income

STD/STI: Sexually Transmitted Diseases or Infection

TA: Technical Assistance

TANF: Temporary Assistance to Needy Families

TasP: Treatment as Prevention

TB: Tuberculosis

TGA: Transitional Grant Area

TOPWA: Targeted Outreach to Pregnant Women Act

TPQY: Third Party Query

UCHAPS: Urban Coalition for HIV/AIDS Prevention Services

VA: United States Department of Veteran Affairs

VL: *Viral Load**

WMSM: White Men who have Sex with Men

WICY: Women, Infants, Children, and Youth

**Also in Integrated Lexicon of Terms (Attachment 2)*

ATTACHMENT 2: Integrated Lexicon

Integrated Lexicon

ACRONYM

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**Language approved by Integrated Planning Team*

ADAP	AIDS Drug Assistance Program	Administered by States and authorized under Part B of the Ryan White Treatment Modernization Act. Provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured Ryan White HIV/AIDS Program clients as long as the insurance costs do not exceed the cost of drugs through ADAP and the drugs available through the insurance program at least match those offered through ADAP.
	ADAP Premium Plus	A component of the AIDS Drug Assistance Program that assists with private and public insurance coverage for persons living with HIV/AIDS (PLWHA)
AETC	AIDS Education and Training Center	Regional centers providing education and training for primary care professionals and other AIDS-related personnel. Part F (AETC)s are authorized under Part F of the Ryan White HIV/AIDS Program and administered by the HRSA HIV/AIDS Bureau's Division of Training and Technical Assistance (DTT).
BCHPPC	Broward County HIV Prevention Planning Council	This is a government-community partnership to enhance High Impact Prevention (HIP) for the highest risk populations and includes key stake holders in HIV Prevention and care and related services and organizations that support the development and implementation of a jurisdictional HIV prevention plan. Leadership is guided by the co-chairs.
	Broward County Priority Populations:	The top 9 priority populations, in the most recent year, for primary and secondary HIV prevention based on persons living with HIV disease.
CD4	Cluster of differentiation 4	Also known as a T-cell or T4-cell. HIV destroys the CD4 cells and weakens the immune system. The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The normal adult range for CD4 cell counts is 500 to 1500 per cubic millimeter of blood. (The normal range for infants is considerably higher and slowly declines to adult values by age 6 years.) CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm ³ . If the count is lower, testing every 3 months is advised. (In children with HIV infection, CD4 values should be checked every 3 months.) A CD4 count of 200 or less is an AIDS-defining condition.

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<i>CIED</i>	Centralized Intake and Eligibility Determination	Entry point for Broward County HIV positive residents accessing Part A medical and support services.
<i>CLD</i>	Client Level Data	A client record including demographic status, HIV clinical information, HIV-care medical and support services received, and the client's 'UCI', an encrypted, unique client identifier.
	Community	Representatives of HIV/AIDS care in community, including but not limited to consumers, providers, regulators, businesses, and Broward County Schools.
	Data to Care	Data to Care is a new public health strategy that aims to use HIV surveillance data to identify HIV-diagnosed individuals not in care, link them to care, and support the HIV Care Continuum.
	HIV Care Continuum	The HIV Care Continuum is a model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression, and shows the proportion of individuals living with HIV who are engaged at each step. It provides a frameworks to better understand HIV care and treatment in the United States.
	HIV Prevention Care Continuum	The HIV Prevention Care Continuum builds on HIV testing as its foundation followed by linkage of HIV-uninfected persons to prevention services, retention in services, and adherence to services to prevent HIV acquisition and transmission. The common desired endpoint of the prevention continuum is ensuring that individuals remain HIV-uninfected.
	HRSA Continuum of Care	The continuum focuses on several steps of HIV service delivery, including diagnosis, linkage to care, retention in care, ART, and viral load suppression. It encompasses the fluid nature of HIV health care delivery and patient experience.
<i>HIVPC</i>	Broward County HIV Health Services Planning Council	A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to assess needs, establish a plan for the delivery of HIV care in the EMA, and establish priorities for the use of Ryan White HIV/AIDS Program Part A funds. Created in Chapter 21, Part X, Broward County Administrative Code, and mandated by the Ryan White ACT.
<i>IC</i>	Integrated Committee	Comprised of eight members, inclusive of two co-chairs, of community stakeholders and consumers from each planning body (HIVPC and BCHPPC) responsible for the general oversight and implementation of the integrated plan.
<i>IDC</i>	Integrated Development	Comprised of HIV Prevention, Care and Treatment grantees (with established and completed work plans) in Broward County, including but not limited to Florida

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	Collaborative (Stakeholder)	Department of Health in Broward County, Ryan White Part A-F, HOPWA, and CDC/DASH.
<i>ILT</i>	Integrated Leadership Team	Comprised of HIV Prevention and Ryan White senior leadership responsible for the direction and guidance of the Integrated planning process and has authority to approve final Integrated plan products.
<i>IPT</i>	Integrated Planning Team	The core committee responsible to develop and implement strategies that strengthen collaboration and coordination among all Ryan White Parts, HOPWA, and Prevention. This committee also oversees the overall progress of all integrated planning activities
<i>JLP</i>	Jail Linkage program	Interventions in providing linkages to HIV primary care services for jail releases, and integrating services for them within the community's HIV continuum of care.
<i>LPAP</i>	Local Pharmaceutical Assistance Program	A supplemental means of providing medication assistance when an ADAP has a restricted formulary, waiting list and/or restricted financial eligibility criteria. It is operated by a Ryan White Part A or B recipient or sub-recipient.
	Mathematical Modeling	A methodology used to estimate the costs necessary to achieve the NHAS Goals on the epidemiologic and economic importance of the National AIDS Strategy for the United States.
<i>PE</i>	Provide Enterprise	Provide Enterprise developed by Groupware Technologies, Inc. (GTI) is a web-based relational, integrated data system used by Broward County Ryan White Part A program to collect client-level data on sociodemographic and epidemiologic characteristics, intake and eligibility, detailed procedure-level service units, clinical outcomes, invoices, and payments. This software is used system-wide across a network of providers to collect data that is subsequently utilized for electronic reporting as well as synchronized real time care coordination of Broward County Ryan White Part A Clients.
	Public Health Detailing	A primary care provider outreach initiative modeled on pharmaceutical detailing.
	Ryan White Comprehensive Plan	The process of determining the organization and delivery of HIV Services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for PLWH.
	Ryan White CARE Act	CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act) is a federal legislation created to address the unmet health care and service needs of people living with HIV (PLWH) disease and their families. It was enacted in 1990 and reauthorized in 1996 and 2000. Reauthorized in 2006 as the Ryan White Treatment Modernization Act.

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	Ryan White HIV/AIDS Treatment Modernization Act of 2006	(Public Law 109-415, December 19, 2006)
	Ryan White Part A	The part of the Ryan White HIV/AIDS Program (formerly, Title I) that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV/AIDS epidemic. This includes outpatient medical care, AIDS Pharmaceuticals Assistance, Oral Care, Health Insurance premiums and cost sharing assistance, mental health services, Medical Case Management, Outpatient Substance Abuse, Food Bank/home delivered meals, and legal services.
	Ryan White Part B	The part of the Ryan White HIV/AIDS Program (formerly, Title II) that provides funds to States and territories for primary health care (including HIV treatments through the AIDS Drug Assistance Program, ADAP) and support services that enhance access to care to PLWHA and their families. This includes ADAP, Health Insurance Premium and cost sharing assistance, Home and Community Based Health Services, and Medical Transportation Services.
	Ryan White Part C	The part of the Ryan White HIV/AIDS Program (formerly, Title III) that supports outpatient primary medical care and early intervention services to PLWHA through grants to public and private non-profit organizations. Part C also funds capacity development and planning grants to prepare programs to provide Early Intervention Services. This includes Early Intervention Services, Non-medical Case Management, Treatment Adherence Counseling, and HIV Testing.
	Ryan White Part D	The part of the Ryan White HIV/AIDS Program (formerly, Title IV) that supports coordinated services and access to research for children, youth, and women with HIV disease and their families. This includes Outpatient Medical Care, Mental Health Services, Medical Nutrition Therapy, medical Case Management, Non-medical Case Management, Health Education/Risk Reduction, Outreach Services, and Psychosocial Support Services.
	Ryan White Part F	Oral Health Care.
VZ	Viral Load	In relation to HIV, the quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.
SFAN	South Florida AIDS Network	Consortia act in an advisory capacity to the state for the purpose of planning and prioritizing the use of Part B funds; provide a forum for the infected individuals and affected communities, providers and others; and facilitate the provision of coordinated, comprehensive health and support services to people infected and affected by HIV/AIDS. A consortium must include people living with HIV/AIDS.

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		Responsibilities include: participation in the needs assessment process; development of service priority funding recommendations; participation in the development of the comprehensive; Promotion of the coordination and integration of community resources.
	Transgender	Umbrella term for those who identify or express themselves in a manner different than that which was assigned at birth.
	Vulnerable Populations	A subset of the Broward County Priority Populations that has documented disparities in either the receipt of HIV related services or outcomes along either the HIV Prevention and HIV Care Continuums.

Provider list:

Broward Addiction Recovery Center

Children's Diagnostic and Treatment Center

North Broward Hospital District (Broward Health)

Nova Southeastern University

South Broward Hospital District (Memorial Healthcare System)

Attachment 3: Availability of Public Funds for HIV services in FY 2016

Coordination of Services and Funding, Broward County FY 2016																																
Funding Source	FY 2016 Budget	HIV Care Continuum					Core Medical Services										Support Services															
		HIV Diagnosed	Linkage to Care	Retained in Care	Antiretroviral Use	Viral Suppression	OAMC (Outpatient / Ambulatory Medical Care	ADAP	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home & Community-based Health Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing	High Impact Prevention
	\$ Amount																															
Part A	\$14,833,220	x	x	x	x	x	x		x	x		x			x						x			x								
Part B	\$1,814,776	x	x	x	x	x					x	x				x					x				x					x		
Part C	\$452,547	x	x	x	x	x							x					x												x	x	
Part D	\$1,896,580	x	x	x	x	x	x						x	x	x		x					x				x	x					
Part F	\$235,000	x	x	x	x	x				x																						
CDC PS12-1201 (High Impact Prevention)	\$5,523,405	x	x	x	x	x																										x
CDC – PS13-1308 (School Based HIV/STD Prevention)	\$578,000	x																													x	
SAMHSA	\$499,886	x	x	x	x	x											x														x	
HOPWA	\$6,799,511			x													x		x			x	x					x	x			

Coordination of Services and Funding, Broward County FY 2016																															
Funding Source	FY 2016 Budget	HIV Care Continuum			Core Medical Services								Support Services																		
		HIV Diagnosed	Linkage to Care	Retained in Care	Antiretroviral Use	Viral Suppression	OAMC (Outpatient / Ambulatory Medical Care	ADAP	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home & Community-based Health Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing
Total	\$32,632,925																														

Attachment 4: Provider and Service Inventory

AGENCY NAME	AGENCY ADDRESS/TELEPHONE NUMBER	Ryan White Services											Prevention Services										
		Centralized Intake (CIB)	Medical	Pharmacy	Dental	Mental Health	Substance Abuse	Care Management	Medical Case Management	Health Insurance Continuation Program	Legal Services	Financial Services	Referral for Health Care Services	HIV Testing	STI Testing	Outreach	Condom Distribution	Interventions	BRITA/TEETA	Pregnancy Testing	TOPWA Enrollment	Social Marketing	
AIDS Healthcare Foundation (AHF)	AHF Wilton Center & Pharmacy Wilton Mason - 954-494-6013			•										•	•	•	•						
	2077 Wilton Dr., Wilton Mason 33016			•										•			•						
	Southport Healthcare Center - 954-772-2411	•	•	•				•	•					•			•						
	6405 N. Federal Highway # 2115 Ft. Lauderdale 33308																						
	One of the Corner & Pharmacy Intake - 954-492-9223																•						
	1725 E Sunrise Blvd., Ft. Lauderdale 33304																•						
Broward Community & Family Health Centers	Oakland Park Healthcare Center - 954-561-6000	•	•	•				•	•					•			•						
	1104 E. Oakland Park Blvd., 3rd Floor Ft. Lauderdale 33304																•						
	Broward Wilton Center - 954-760-0273																						
	645 SE and Ave. 4th Floor Ft. Lauderdale 33309	•	•					•	•					•			•						
	One River Park Healthcare Center - 954-767-0877													•	•								
	301 S. Andrews Ave. #900, Ft. Lauderdale 33301	•	•					•	•					•			•						
Broward Health (NBHD)	Health Center - 954-970-8883		•					•	•					•			•						
	645 North Broward Blvd., Broward 33060		•											•			•						
	Central Broward Community Health - 954-553-4710		•																				
	1279 NW 4th Ave., Broward 33311																						
	Comprehensive Care - 954-447-6880													•		•	•	•					
	1111 N.W. 1st Street, Ft. Lauderdale 33311													•			•						
	Children's Diagnostic & Treatment - 954-728-1038	•	•											•			•				•	•	
	1851 S. Federal Highway, Ft. Lauderdale 33316																						
	Broward P. Rick Health Pharmacy - 954-527-0642			•																			
	1111 W. Broward Blvd., Ft. Lauderdale 33312																						
	Broward Health Medical Center - 954-522-3355			•																			
	1600 S. Andrews Ave., Ft. Lauderdale 33317			•	•																		
Broward County Health Department	Cam E. Broward Family Health - 954-759-6600		•																				
	200 NW 7th Ave., Ft. Lauderdale 33311																						
	One E. Broward Health Center																						
	2011 N.W. 3rd Avenue, Pompano Beach 33060		•																				
	Medical - (954) 766-5920																						
	Care Management - (954) 766-1929																						
	Specialty Care Center																						
	1111 W. Broward Blvd., Ft. Lauderdale 33312	•	•	•																			
	Medical - 954-463-7313																						
	Pharmacy - 954-463-7313																						
	Care Management - 954-463-7313																						
	Comprehensive Care at Broward House - 954-522-4749		•																				
Broward Regional Health Planning Council	1726 SE 1st St., Ft. Lauderdale 33316																						
	First Hughes Health Center - 954-233-6068	•		•	•									•			•						
	205 NW 6th Ave, Pompano Beach 33060																						
	First Lauderdale Health Center - 954-447-6780			•	•					•		•	•	•	•	•	•	•	•	•	•	•	
	3211 SW 6th Ave., Ft. Lauderdale 33317																						
	S. Regional Health Center																						
Broward House	6115 Ponderosa Rd., #C107, Hollywood 33021																						
	Dental - 954-972-2812																						
	Broward Regional Health Planning - 954-566-1417	•																					
	205 Oakland Lane #100 Hollywood 33020																						
	501 S.E. 1st Ave., Ft. Lauderdale 33316																						
	954-420-0254																						
Care Resource	2001 N. Andrews Ave., Wilton/Mason 33311	•																					
	954-466-7313																						
	671 W. Oakland Park Blvd., Oakland Park 33311	•	•											•	•	•	•	•					
	954-563-1111																						
	954-763-8950																						
	991 South State Road 7, Pompano, FL 33067										•												
Memorial Healthcare System (MHS)	Memorial Regional Hospital Center - 954-233-6068	•	•											•									
	1130 N. 35th Avenue, Hollywood 33021																						
	Memorial Center for Educator Health - 954-233-6068																						
	3400 N. 36th Ave., Hollywood 33021																						
	954-563-7709																						
	3200 S. University Drive, Ft. Lauderdale 33328																						
Powerello Center	954-466-7709																						
	630 E. Oakland Park Blvd #100, Oakland Park 33334																						
	954-463-3903																						
	2036 N. Dixie Hwy., Wilton/Mason 33306	•																					
	4720 N. Federal Hwy., Fort Lauderdale, FL 33308													•									
	2040 N. Dixie Hwy., Fort Lauderdale, FL 33305														•	•	•	•	•	•	•	•	
Lathams School	2330 Wilton Dr., Wilton/Mason, FL 33305													•	•	•	•	•	•	•	•	•	
														•	•	•	•	•	•	•	•	•	

Attachment 5: Broward County's Integrated HIV Prevention and Care Plan 2017-2021

Broward County's Integrated Prevention and Care Plan 2017 – 2021					
Our VISION: A transformative and transparent integrated planning process that embraces local funding, leverages opportunities for collaboration with strategic alliance, into a singular process to achieve National HIV/AIDS Strategy (NHAS) goals and objectives. Our MISSION: We are committed to the stewardship of public funds through efficient, deliberate, and innovative processes that maximize the use of resources to reduce new HIV infections and community viral load in Broward County.					
Goal 1: Reduce New HIV Infections					
Objective 1.1 Reduce the number of new infections by 25%.			2021 Target: 745	2014 Baseline Measure: 993	
Strategy 1.1.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Provide education to medical providers and community based organizations to promote HIV routine testing	1. Establish a partnership with the Broward County Medical Association to promote HIV testing as part of routine medical care. 2. Provide professional development and technical assistance to build skills and increase knowledge to promote routine HIV screening and testing in clinical and non-clinical settings. 3. Develop and disseminate Provider Toolkits to enable	1. Broward County Medical Association 2. Medical and non-medical providers 3. Medical providers 4. Prevention and Ryan White providers; Medical associations; Southeast AETC	1. Year 1 2. Year 1-5 3. Year 1-5 4. Year 1-5 5. Year 1-5 6. Year 1-5 7. Year 1-2 8. Year 2 9. Year 1-5	1. DOH-Broward; BCHPPC 2. DOH-Broward 3. DOH-Broward 4. DOH-Broward; BCHPPC 5. DOH-Broward 6. DOH-Broward 7. DOH-Broward; BCHPPC 8. DOH-Broward; Ryan White Part A	1. Partnership Established 2. Number of medical providers that received technical assistance 3. Number of provider toolkits disseminated 4. Number physician ambassadors recruited and retained 5. Number of HIV/STIs/HCV education and testing events 6. Number outreach and education sessions provided

	effective implementation of routine HIV testing, including state and local “Dear Colleague” letters referencing the new Florida HIV testing law. 4. Recruit and retain physician ambassadors from Prevention and Ryan White providers, medical associations and Southeast AETC to promote routine HIV/STI/HCV screening and testing in clinical settings. 5. Conduct education and testing events each year that screen for HIV/STIs/HCV in conjunction with medical providers and community-based organizations. 6. Provide outreach and education to healthcare providers about innovations in funding HIV testing in clinical settings and third party billing reimbursement. 7. Develop and support culturally sensitive and linguistically appropriate social marketing and media campaigns for effective messaging and interventions, for example, CDC Campaign “Razones”	5. Broward County Priority Populations 6. Medical providers 7. Broward County Priority Populations 8. Medical providers 9. Broward County Priority Populations		Program Recipient Office 9.DOH-Broward; BCHPPC	7. Number of culturally sensitive and linguistically appropriate social marketing and media campaigns 8. Number of developed aggregate reports 9. Measure of availability, accessibility, and acceptability of condoms

	8. Develop aggregate reports to include provider score cards regarding key processes, performance measures and outcomes. 9. Increase the availability, accessibility, and acceptability of condoms.				
Strategy 1.1.b	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Increase education and access to PrEP/nPEP for persons at highest risk of HIV acquisition.	1. <i>Conduct a demonstration project involving the direct provision of PrEP/nPEP through STD clinics or with community clinical partners with specific emphasis on minority communities.</i> 2. Create social marketing and social media campaigns to inform individuals living with HIV and the general community about the appropriate use of PrEP/nPEP. 3. Develop and implement PrEP community ambassadors program and marketing materials to disseminate information and available PrEP resources to individuals who are at-risk of new HIV infections. 4. Conduct public health detailing and companion	1. Broward County Priority Populations; STD Clinics; Community clinic partners 2. Broward County Priority Populations 3. Broward County Priority Populations 4. Medical and non-medical providers	1. Year 2 2. Year 2 3. Year 3 4. Year 5	1.DOH-Broward; BCHPPC 2. DOH-Broward; BCHPPC 3.DOH-Broward; BCHPPC 4. DOH-Broward	1. Demonstration project conducted 2. Number of social marketing and social media campaigns created 3. PrEP community ambassadors program implemented; Number of marketing materials distributed. 4. Number of public health detailing and workshops conducted

	workshops to support implementation of PrEP throughout Broward County.				
Strategy 1.1.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Increase provider knowledge of PrEP and other bio medical interventions.	1. Include PrEP/nPEP as a core competency in provider-focused HIV prevention education and training with special emphasis on clinical settings and emergency departments. 2. Develop a PrEP/nPEP toolkit for dissemination to the provider community. 3. Increase provider web-based content about PrEP/nPEP on the www.BrowardGreaterthan.org website with links to clinical guidelines. 4. Develop a Broward PrEP/nPEP Referral Network and provide technical assistance to sites wishing to participate. 5. Monitor the uptake of PrEP/nPEP in Broward County through the use of surveys, provider report forms, databases, etc. to further guide program implementation.	1. Medical providers 2. Medical providers 3. Broward County Priority Populations; 4. Medical providers 5. Broward County Priority Populations	1. Year 1-5 2. Year 1-2 3. Year 1-5 4. Year 1-3 5. Year 1-5	1. DOH-Broward; 2. DOH-Broward; BCHPPC 3. DOH-Broward 4. DOH-Broward 5. DOH-Broward	1. Number of provider-focused HIV prevention education and trainings that include PrEP/nPEP as a core competency 2. PrEP/nPEP toolkit developed 3. Number of provider web-based content added or updated on PrEP/nPEP 4. Broward PrEP/nPEP Referral Network developed; Number of sites that received technical assistance. 5. Monitoring and Evaluation plan conducted

Objective 1.2 Reduce the number of pediatric HIV transmission cases to zero			2021 Target: 0	2014 Baseline Measure: 0	
Strategy 1.2.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Engage and educate medical providers	1. Provide education and training to birthing centers and venues that support alternative birthing methods to provide rapid HIV testing. 2. Distribute Perinatal HIV toolkits to all delivery hospitals, OB/GYN, and Pediatrician offices in Broward County. 3. Provide perinatal symposiums to the medical provider community on emerging issues and trends facing positive pregnant women.	1. Birthing centers 2. Delivery hospitals, OB/GYN, and Pediatrician offices 3. Medical providers	1. Year 1-5 2. Year 1-5 3. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward	1. Number of trainings provided 2. Number Perinatal HIV toolkits distributed 3. Number of perinatal symposiums provided
Strategy 1.2.b	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Provide effective case management services to positive pregnant women to ensure compliance with medication and monitoring of viral load.	1. Expand visits to birthing centers, venues that support alternative birthing methods and OB/GYN offices to foster collaboration and communication. 2. Conduct prenatal classes to help prepare women for childbirth. 3. Provide education and training to partners as appropriate to promote	1. Birthing centers 2. Pregnant individuals 3. Medical providers 4. Pregnant individuals	1. Year 1-5 2. Year 1-5 3. Year 1-5 4. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward 4. DOH-Broward	1. Number of visits conducted 2. Number of prenatal classes 3. Number of training sessions provided 4. Number of pregnant clients who are contacted by Linkage to Care Coordinators (PROACT Staff)

	healthy pregnancy and birth outcomes. 4. Maintain and document contact with pregnant individuals who are HIV positive to ensure compliance with treatment and medication adherence.				
Strategy 1.2.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Provide timely follow-up to positive delivering women and exposed newborns immediately upon delivery.	1. Conduct chart reviews at delivery to further reduce mother to child transmission. 2. Conduct post-delivery follow-ups to ensure mother and child are continuing with treatment and medication as prescribed. 3. Expand postnatal classes to provide education and support for mothers and their partners.	1. Medical providers; pregnant individuals 2. Medical providers; pregnant individuals 3. Pregnant individuals	1. Year 1-5 2. Year 1-5 3. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward	1. Number of chart reviews conducted 2. Number of post-delivery follow-ups conducted 3. Number of postnatal classes conducted
Objective 1.3 Increase the number of Broward county residents who have not previously tested for HIV by 5% each year.			2021 Target: 16,627	2014 Baseline Measure: 13,028	
Strategy 1.3.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Increase the number of routine testing sites in publicly funded healthcare, and	1. Provide education and promote adherence to operate under the guidance of the new Florida HIV Testing Law (Statute 381.004). 2. Establish a collaborative agreement to model routine	1. Medical providers 2. Medical providers 3. Broward County Priority Populations	1. Year 1-5 2. Year 1-2 3. Year 1-5 4. Year 1-5 5. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward 4. DOH-Broward; Ryan White Part A	1. Number of educational sessions provided 2. Collaborative agreements established 3. Number of testing activities conducted in

non-healthcare settings.	testing in accordance with the new Florida HIV Testing Law (Statute 381.004). 3. Use geo mapping to identify areas that are underserved by HIV/STI/HCV testing staff in order to coordinate testing activities by using geo-mapping and other methodologies. 4. <i>Expand the number of community providers for the delivery of key sexual health services, with a focus on HIV/STIs/HCV testing and treatment for vulnerable populations (i.e. adults over 50, youth, transgender, etc.)</i> 5. Develop education strategies for testing and treating vulnerable populations.	4. Community providers 5. Broward County Priority Populations		Program Recipient Office 5. DOH-Broward; BCHPPC	underserved areas identified 4. Number of community providers 5. Number of developed strategies for testing and treating vulnerable populations
Strategy 1.3.b	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Inform 100% of positive individuals of their diagnosis within 30 days of testing.	1. Provide expanded opportunities for on-site rapid testing. 2. Identify individuals testing positive who have not returned for their results, engage them through outreach efforts to inform them of their diagnosis and provide linkage to care and follow-up services.*	1. Broward County Priority Populations 2. PLWH 3. PLWH	1. Year 1-5 2. Year 1-5 3. Year 1-5	1. DOH-Broward 2. DOH-Broward 3. DOH-Broward	1. Number of on-site rapid testing with timely results and counseling 2. Number of clients who are contacted by HIV DIS within 14 days of diagnosis; Number of positive clients linked to care by DIS and linkage coordinators

	3. Monitor and evaluate the numbers of individuals testing positive who have not returned for their results and track activities to engage.*				3. Monitoring and Evaluation conducted
Strategy 1.3.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Identify opportunities to expand HIV testing efforts in non-traditional settings.	1. Develop and implement concierge in-home HIV testing. 2. <i>Identify and collaborate with agencies to create and promote social marketing platforms on HIV testing.</i> 3. Conduct geo mapping and ethnographic methodologies to identify underserved areas	1. Broward County Priority Populations 2. Agencies in Broward County 3. Underserved areas	1. Year 1-5 2. Year 1-5 3. Year 1	1. DOH-Broward 2. DOH-Broward; BCHPPC 3. DOH-Broward; BCHPPC	1. Number of in-home HIV testing conducted 2. Number of collaborations with agencies on social marketing platforms on HIV testing 3. Number of identified underserved areas through the use of geo mapping and ethnographic methodologies

Goal 2: Increase Access to Care and Improve Health Outcomes					
Objective 2.1 Increase the percentage of newly diagnosed individuals who are linked to HIV medical care within 1 month of diagnosis			Target: by 85%	2014 Indicator: 53.7%	
Strategy 2.1.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Establish a seamless system between testing and care and treatment to facilitate access and ensure linkage.	- Design a Ryan White/Prevention Collaborative model that ensures a seamless continuum for PLWH to transition from testing and counseling sites to linkage, treatment and retention in Medical Care. * - Implement “Test and Treat” immediately following a positive HIV test result to reduce transmission and improve morbidity and mortality in all stages of infection. * - Design and/or modify data reporting systems to track PLWH along the HIV Care Continuum from time of diagnosis.* - Develop targeted strategies and interventions for individuals who may not seek care or who may fall out of care. *	- Broward County Priority Populations; PLWH - PLWH - PLWH - PLWH - Ryan White Providers - PLWH - Ryan White medical providers	- Year 1-2 - Year 1-5 - Year 1-5 - Year 1-2 - Year 1-5 - Year 1-5 - Year 1-5	- BCHPPC; HIVPC - DOH-Broward; Ryan White Part A Program Recipient Office - Ryan White Part A Program Recipient Office; HIVPC - Ryan White Part A Program Recipient Office; HIVPC - Ryan White Part A Program Recipient Office; HIVPC - BCHPPC; HIVPC - Ryan White Part A Program Recipient Office; HIVPC; All Ryan White Grantees	- Design a model that ensures a seamless continuum - Number of clients that received ART following the “Test and Treat” model - Data reporting system designed - Number of developed interventions for vulnerable populations who may not seek care or who may fall out of care. - Number of targeted strategies and interventions - Pilot project established - Barriers and limitations identified - Contract monitoring and reporting

	- Establish pilot project for integrated electronic medical record sharing across providers. - Identify access barriers and limitations to HIV medical care related to other support services, such as housing, transportation, employment, education, behavioral health, intimate partner violence, incarceration, and childcare.* - Ensure MOUs between testing and Ryan White funded medical care and treatment providers are implemented.				
Strategy 2.1.b	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Strengthen the delivery of integrated services through the provision of training, technical assistance, and access to community resources.	- Refine roles and responsibilities and develop competencies for linkage providers, peer education, eligibility, non-medical/medical case management, clinical, and ancillary personnel. - Provide training and coaching in culturally sensitive and linguistically	Linkage providers, peer education, eligibility, non-medical/medical case management, clinical, and ancillary personnel.	- Year 1-2 - Year 1-5 - Year 1-5 - Year 1-5	- Ryan White Part A Program Recipient Office; HIVPC - Ryan White Part A Program Recipient Office; HIVPC - DOH-Broward; Ryan White Part A Program	- Competencies developed - Number of trainings and coaching provided - Community Resource Guide developed - Capacity building assistance received

	appropriate competencies with pre and post testing to assess knowledge acquisition and skill development. 3. Develop and maintain a Community Resource Guide inclusive of all available services by priority population and geographic location. 4. Request capacity building assistance on evidence based biomedical interventions, public health strategies and behavioral interventions	2. Medical Providers 3. Medical services in Broward County 4. HIV prevention workforce		Recipient Office; BCHPPC; HIVPC 4. DOH-Broward	
Strategy 2.1.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Support retention in care to achieve viral suppression that can maximize the benefits of early detection and reduce transmission risk.	1. Develop and implement standardized Patient Navigator tool. * 2. Research the development of a Patient Assistance mobile device application.*	1. Medical providers 2. PLWH	1. Year 1-5 2. Year 1-5	1. DOH-Broward; BCHPPC 2. DOH-Broward; Ryan White Part A Program Recipient Office	1. Number of service providers utilizing Patient Navigator tool 2. Research on mobile device application conducted
Objective 2.2 Increase the percentage of PLWH who are retained in medical care.			Target: by 90%	2014 Indicator: 65%	
Strategy 2.2.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators

<i>Increase retention in care and viral load suppression through coordinated and integrated activities between and among prevention and care and treatment providers.</i>	- Utilize engagement reports to identify areas of improvement, including characteristics of individuals who are not retained in care as well as those who have unsuppressed viral loads. * - Conduct utilization focused evaluation of the HIV Care Continuum to identify and address the “drop-offs” along the stages specific to testing site, service provider, geographic location, and individual characteristics. * - Develop data sharing agreements among all HIV prevention, care and treatment providers for designated MIS system.	- PLWH - PLWH - HIV Prevention, Care and Treatment providers	- Year 1-2 - Year 1-2 - Year 1-5	- Ryan White Part A Program Recipient Office; Ryan White grantees - Ryan White Part A Program Recipient Office; DOH-Broward - Ryan White Part A Program Recipient Office; DOH-Broward	- Areas of improvement identified - Utilization focused evaluation conducted - Data sharing agreements developed
<i>Strategy 2.2.b</i>	<i>Activity/Intervention</i>	<i>Target Population</i>	<i>Timeframe</i>	<i>Responsible Parties</i>	<i>Data Indicators</i>
<i>Identify individuals who have fallen out of care and implement strategic interventions to re-engage.</i>	- Create a system to obtain real-time, client level data for all ADAP clients. <i>Develop and implement a plan to provide simultaneous certification for ADAP and Ryan White Part A services.</i>	- ADAP - ADAP and Ryan White Part A clients - Ryan White Part A receipts - MCMs, pharmacists, and Part A clinician	- Year 1-5 - Year 1-5 - Year 1-5 - Year 1-5 - Year 1-2 - Year 1-3 - Year 1-5 - Year 1-2 - Year 1-2	- Ryan White program - Ryan White Part A Program Recipient Office; Ryan White grantees - Ryan White Part A Program	- System created - Number of clients certified simultaneously - Emergency ART provided - Number of MCMs, pharmacists, and Part A clinicians

	3. Provide emergency ART through Part A and other community resources to ensure clients do not experience disruption in treatment.* 4. Educate MCMs, pharmacists, and Part A clinicians about the availability of emergency ART. 5. Develop feedback mechanisms with individuals who have fallen out of care as well as those with unsuppressed viral loads to determine root causes.* 6. Enhance and expand the linkage and retention program (PROACT) module in the MIS system to allow data sharing and develop aggregate reports of Ryan White Part A clients and for referral mechanisms. 7. Monitor and evaluate the use of linkage and retention services and conduct analysis of the services to identify trends, challenges with data reporting, and areas for improvement.*	5. PLWH 6. Ryan White Part A clients 7. Linkage and retention services 8. Disease Intervention Specialists 9. Peer Network 10. PLWH 11. Case managers, peers, and community health workers 12. PLWH	10. Year 1-2 11. Year 1-5 12. Year 1-3	Recipient Office; Ryan White grantees 4. Ryan White Part A Program Recipient Office; HIVPC 5. Ryan White Part A Program Recipient Office; HIVPC 6. Ryan White Part A Program Recipient Office 7. Ryan White Part A Program Recipient Office 8. DOH-Broward 9. Ryan White Part A Program Recipient Office 10. Ryan White Part A Program Recipient Office; HIVPC 11. Ryan White Part A Program Recipient Office 12. DOH-Broward	5. Feedback mechanisms developed 6. Aggregate reports developed 7. Monitoring and Evaluation of linkage and retention services 8. Number of individuals re-engaged by DIS 9. Outreach and engagement activities provided 10. Opportunities created 11. Number of case managers, peers, and community health workers that participated in training modules 12. Evaluation conducted

	8. Expand the use of Disease Intervention Specialists to re-engage individuals who have fallen out of care.* 9. <i>Enhance Peer Network to provide outreach and engagement activities through case management services.</i> 10. <i>Create Community Health Worker certification and Peer Specialist certification opportunities for individuals working with PLWH.</i> 11. Design and implement a Ryan White System of Care training modules for local case managers, peers, and community health workers. 12. Evaluate the efficacy of prevention for positives evidence-based interventions in Broward County				
Strategy 2.2.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Expand collaborative partnerships with support service providers to reduce	1. Strengthen coordination with support services providers through case management models to	1. Ryan White Care Providers 2. Medical and support service providers	1. Year 1-3 2. Year 1-2 3. Year 1-3 4. Year 1-2	1. Ryan White Part A Program Recipient Office; All Ryan White grantees; HIVPC	1. Percent of clients retained in medical care 2. Strategy developed 3. Barriers identified; Strategies developed

<i>the risks associated with social determinants of health.</i>	maintain retention in medical care.* 2. Develop a strategy to provide comprehensive care including access to both medical and support services not covered by insurance plans.* 3. Identify barriers through satisfaction surveys and develop strategies to address those barriers.* 4. Develop relationships and MOUs with ancillary providers-housing, transportation, correctional health, education, employment, behavioral health, domestic violence, childcare, food and nutrition services and faith-based communities.	3. Support service providers 4. Ancillary providers		2. Ryan White Part A Program Recipient Office; HIVPC 3. Ryan White Part A Program Recipient Office; HIVPC 4. Ryan White Part A Program Recipient Office	4. relationships and MOUs developed

Goal 3: Reduce HIV-Related Disparities and Health Inequities					
Objective 3.1 Reduce disparities in the rate of HIV-related mortality among Black males, Black females and White males by at least 15%.			2021 Target: 14.5, 13.9 and 8.6 respectively	2014 Baseline: 17.0, 16.4 and 10.1 respectively	
Strategy 3.1.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators

<i>Provide targeted interventions to populations and geographic locations identified as high risk for HIV.</i>	1. Develop strategies specific to the needs, attitudes, and behaviors of the identified priority populations. 2. Develop a recruitment plan to increase the number of individuals applying for certification as Community Health Workers/Peer Specialists who may represent the people being served.	1. Broward County Priority Populations 2. Broward County Priority Populations	1. Year 1	1. BCHPPC 2. BCHPPC	1. Strategies developed 2. Recruitment plan developed
<i>Strategy 3.1.b</i>	<i>Activity/Intervention</i>	<i>Target Population</i>	<i>Timeframe</i>	<i>Responsible Parties</i>	<i>Data Indicators</i>
<i>Provide culturally sensitive and relevant training to healthcare providers in the provision of scientifically proven, evidence-based care.</i>	1. Continue education for all Care and Treatment Providers on HAB/Public Health standards. 2. Provide training to medical providers to address sexual health history, sexual orientation, gender identification, and social determinants of health. 3. Expand the Partnership for Health (PFH) model to train medical providers and contracted HIP medical providers to engage patients in discussions on sexual history, health, and disclosure.	1. Care and Treatment Providers 2. Medical Providers 3. Medical providers	1. Year 1 – Year 5 2. Year 2 3. Year 2	1. HIVPC 2. BCHPPC	1. Education sessions provided 2. Trainings provided 3. Medical providers trained on the expanded PFH model

Strategy 3.1.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Increase access to community resources that support the reduction of risk due to social determinants of health in areas of greatest disparity.	1. Develop pilot projects to address critical social and structural determinants of health. 2. Provide training to increase awareness and develop a response to structural and institutional racism in Broward County to medical and non-medical providers.	1. Broward County Priority Populations 2. Medial and non-medical providers	1. Year 3 2. Year 4	1. HIVPC; BCHPPC 2. DOH- Broward; Ryan White Part A Program Recipient Office	1. Pilot project developed 2. Trainings provided
Objective 3.2 Reduce stigma and discrimination against PLWH through implementation of at least 75% of identified strategies.			2021 Target: 75% implementation	2014 Baseline: 0%	
Strategy 3.2.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Increase community engagement to promote education and awareness to affirm support for PLWH.	1. Coordinate feedback mechanisms that address HIV prevention, stigma, and treatment to assess HIV literacy. 2. Develop and implement education and awareness strategies that incorporate results from feedback mechanisms to increase HIV literacy. 3. Coordinate and train peer specialists and community ambassadors to educate and disseminate messaging to combat HIV-related stigma.	Broward County Priority Populations	1. Year 1 – 5 2. Year 2 3. Year 2 4. Year 3	1. HIVPC; BCHPPC 2. HIVPC; BCHPPC 3. HIVPC; BCHPPC 4. DOH- Broward; Ryan White Part A Program Recipient Office	1. Feedback mechanisms coordinated 2. Strategies developed and implemented 3. Number of peer specialists and community ambassadors trained 4. Social media and marketing strategies developed

	4. Develop social media and marketing strategies to target priority populations.				
Strategy 3.2.b	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Identify priorities related to legislation, regulations, and funding to promote opportunities for advocacy efforts to support individuals living with HIV.	1. Work with local, state, and federal leaders to identify legislative priorities. 2. Develop training opportunities for PLWH to learn how to become effective advocates for change. 3. <i>Identify funding opportunities to enhance the existing system and to develop collaborative partnerships with ancillary providers.</i>	1. Broward County Legislative Officials 2. Broward County Priority Populations 3. Ancillary Providers	1. Year 3 2. Year 3 3. Year 3	1. HIVPC; BCHPPC 2. DOH-Broward; Ryan White Part A Program Recipient Office	1. Legislative priorities identified 2. Training opportunities developed 3. Funding opportunities developed
Strategy 3.2.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Increase leadership opportunities for individuals living with HIV.	1. Identify emerging leaders representative of the HIV community. 2. Develop and implement an HIV Leadership Academy. 3. Promote opportunities for advocacy and leadership within the HIV community.	Broward County Priority Populations	1. Year 2 2. Year 3 3. Year 2-5	1. DOH-Broward; Ryan White Part A Program Recipient Office 2. DOH-Broward; Ryan White Part A Program Recipient Office	1. Number of Leaders identified 2. Number of individuals graduating from HIV Leadership Academy 3. Opportunities for advocacy and leadership promoted



				3. HIVPC; BCHPPC	

Goal 4: Achieve a More Coordinated Response to the Local HIV Epidemic					
Objective 4.1 Establish mechanisms for integration of cross-sector collaboration by implementing at least 50% of the identified strategies.			2021 Target: 50% implementation	2014 Baseline: 0%	
Strategy 4.1.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Develop a coordinated and integrated priority setting and resource allocation process and combined funding initiatives.	1. Establish formalized collaborative structure with stakeholders to ensure the community is meeting the needs of individuals and families. 2. Develop a combined data review process specific to integrated services and utilization. 3. Establish integrated priority setting and resource allocation protocols.	Broward County Prevention, Care and Treatment Stakeholders	Year 4	DOH-Broward, All Ryan White Grantees, and Broward County Public Schools	1. Formalized collaborative structure established 2. Data review process developed 3. Protocols established
Strategy 4.1.b	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Create a system for standardized data	1. Develop strategies to	Funders and providers of	Year 5	DOH-Broward, All Ryan White	1. Strategies developed

collection and reporting.	streamline reporting requirements for funders of prevention, care, and HOPWA. 2. Develop and implement Shared Data Agreements between funders and providers to collect and analyze data in a more comprehensive manner.	prevention, care and treatment in Broward County		Grantees, and Broward County Public Schools	2. Shared data agreements developed and implemented
Strategy 4.1.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Cultivate a streamlined process for program monitoring and evaluation using Collective Impact Methodology.	1. <i>Develop strategy for coordinated RFP response.</i> 2. <i>Establish comprehensive monitoring tool across funders to reduce duplication and increase efficiency.</i> 3. <i>Foster shared outcomes across funders.</i>	Funders and providers of prevention, care and treatment in Broward County	Year 5	DOH-Broward, All Ryan White Grantees, and Broward County Public Schools	1. Strategy developed 2. Comprehensive monitoring tool established 3. Shared outcomes fostered
Strategy 4.1.d	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators

Provide networking and communication opportunities to address the epidemic.	1. <i>Create forums for Community Summits to identify strengths, challenges, opportunities and barriers for individuals living with HIV in Broward County.</i> 2. <i>Develop and disseminate multi-lingual and culturally sensitive information and forums to address the Latino community and other targeted populations.</i> 3. <i>Establish a multi-lingual Broward County Prevention, Care and Treatment Services website and social media strategy to comprehensively address the epidemic with</i>	Broward County Priority Populations	1. Year 1 2. Year 2 3. Year 3	1. HIVPC; BCHPPC 2. HIVPC; BCHPPC 3. DOH-Broward, Ryan White Part A Program Recipient Office and Broward County Public Schools	1. Strengths, challenges, opportunities and barriers identified 2. Information disseminated; Forums developed 3. Broward County Prevention, Care and Treatment Services website and social media strategy established

	<i>consistent messaging across media outlets.</i>				
Objective 4.2 Establish a structure for integrated continuity of care by implementing at least 50% of the identified strategies			2021 Target: 50% Implementation	2014 Baseline: 0%	
Strategy 4.2.a	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
<i>Develop opportunities for an integrated electronic healthcare record that is shared across providers.</i>	<i>Create an Ad Hoc Task Force to identify essential elements to include in integrated healthcare record.</i> <i>Identify funding opportunities to support integrated healthcare record model.</i> <i>Identify vendor to create integrated healthcare record and opportunities to share across providers.</i>	Broward County's Care and Treatment Providers	Year 4	DOH-Broward and Ryan White Part A Program Recipient Office	- Ad Hoc Task Force created - Funding opportunities identified - Vendor identified; Integrated healthcare record created
Strategy 4.2.b	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
<i>Create career paths for peer advocates and peer leaders.</i>	<i>Define roles for peers that include both specific</i>	HIV positive persons	Year 1	HIVPC, BCHPPC and Integrative Collaborative	- Roles defined - Number of individuals who attended peer training sessions

	<i>responsibilities and follow-up to case managers.</i> 2. <i>Develop and implement peer training sessions to equip individuals with the needed skills to serve in the capacity on health care teams.</i>				
Strategy 4.2.c	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
<i>Establish competency standards for all levels of providers and provide opportunities for workforce development.</i>	1. <i>Identify competency standards for all levels of staff.</i> 2. <i>Develop training curriculum with pre and post testing to assess increase in knowledge and skills.</i> 3. <i>Assess the need for training and coaching follow-up sessions for all levels of providers.</i>	1. HIV Prevention, Care and Treatment workforce 2. HIV Prevention, Care and Treatment workforce 3. HIV Prevention, Care and Treatment providers	1. Year 1 2. Year 2 3. Year 1	HIVPC, BCHPPC and Integrated Collaborative	1. Competency standards identified 2. Training curriculum developed 3. Completed assessment
Strategy 4.2.d	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators

<i>Promote cross-system, cross-sector collaboration.</i>	<i>Strengthen coordination across data systems and the use of data to inform decision making among grantees and local organizations.</i> <i>Establish ongoing networking and communication with HIV and ancillary providers to identify prospects for collaboration and challenges related to barriers.</i>	HIV prevention, care and treatment providers; ancillary providers	Year 3	DOH-Broward, All Ryan White Grantees, and Broward County Public Schools	- Data systems strengthened; Data systems used to inform decision making - Ongoing networking and communication established
Strategy 4.2.e	Activity/Intervention	Target Population	Timeframe	Responsible Parties	Data Indicators
Commence a local implementation plan for “Getting to Zero” initiative.	- Receive technical assistance for International Association of Providers of AIDS Care (IAPAC). - Obtain support from public and private sector stakeholders (i.e. elected officials)	- Broward County Priority Populations - Public and private stakeholders - Broward County Priority Populations	- Year 1 - Year 2 - Year 3	DOH-Broward, All Ryan White Grantees, and Broward County Public Schools	- Technical assistance received - Number of stakeholders providing support - Mathematical modeling evaluation conducted

	and corporations) to gain consensus around attaining the Fast Track Cities Initiative targets. 3. Utilize mathematical modeling to evaluate the resources needed to end AIDS in Broward County				

Table 2: Indicators to Measure Progress of Broward's Integrated Prevention, Care and Treatment Plan, Updated 2021 Targets

Indicator	2014 Baseline	Data Source	2021 Target
Reduce the number of new infections by 25%	993	eHARS	745
Reduce the number of pediatric transmission cases to zero	0	eHARS	0
Increase the number of Broward county residents who have not previously tested for HIV by 5% each year.	13,028	1628 Testing and Counseling Database	16,627
Increase the percentage of newly diagnosed individuals who are linked to HIV medical care within 1 month of diagnosis to 85%.	53.7%	eHARS	85%

<i>Increase the percentage of PLWH who are retained in medical care to 90%.</i>	65%	eHARS	90%
<i>Reduce disparity in the rate of HIV-related mortality among Black males by at least 15%.</i>	17.0	Vital Statistics	14.5
<i>Reduce disparity in the rate of HIV-related mortality among Black females by at least 15%.</i>	16.4	Vital Statistics	13.9
<i>Reduce disparity in the rate of HIV-related mortality among White males by at least 15%.</i>	10.1	Vital Statistics	8.6
<i>Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 80%</i>	61%	eHARS	80%



Attachment 6: Letters of Concurrence

Dear Ms. Greene and Mr. Young:

The Broward County HIV Health Services Planning Council (HIVPC) and the Broward County HIV Prevention Planning Council (BCHPPC) concur with the following submission by the Ryan White Part A Program and Florida Department of Health-Broward County HIV Prevention Program in response to the guidance set forth for the health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

Both the HIVPC and BCHPPC have reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. Both planning bodies concur that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1202 and the Ryan White HIV/AIDS Program legislation and program guidance.

The HIVPC and the BCHPPC identified members from their respective planning bodies to form the Integrated Committee (workgroup); responsible for developing, monitoring, and updating the Integrated Prevention and Care Comprehensive Plan for Broward County. The committee conducted a comprehensive analysis and review of data from both Part A and Prevention used to develop the plan and to provide robust recommendations to the Prevention and Care planning bodies. The committee received information from both planning bodies, synthesized the information, and served as the feedback loop for collaborative implementation of the Plan.

Based on the review of the Integrated HIV Prevention and Care Plan for 2017 through 2021, the HIVPC and BCHPPC reached consensus and concurrence with the priorities and strategies proposed in the Plan.

The HIVPC Chair and BCHPPC Community Co-Chair are designated as signatories to this letter of concurrence.

Sincerely,

Brad Gammell, Chair
Broward County HIV Health Services Planning Council

9/16/2016

Date

Jorge Gardela, Community Co-Chair
Broward County HIV Prevention Planning Council

9/16/2016

Date



Dear Ms. Greene and Mr. Young:

It is with great pleasure that we submit this letter of concurrence as Co-Chairs of the Integrated Committee (Workgroup), designated by the Broward County HIV Health Services Planning Council (HIVPC) and the Broward County HIV Prevention Planning Council (BCHPPC) in response to Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Integrated Committee (Workgroup) worked diligently to ensure planning activities encompassed comprehensive needs assessment, information and data sharing, cross representation on prevention and care planning bodies, and coordinated/combined projects. Members of the Integrated Committee (Workgroup) met monthly to ensure all HIV planning approaches were streamlined to increase access to and effectiveness of prevention, care and treatment services within the jurisdiction. Community involvement was an essential component for planning comprehensive and effective HIV prevention and care programs. This was exhibited through client and provider surveys, focus groups representing disproportionately affected populations, and several forums obtaining information directly reflected in the goals, objectives, activities and strategies identified in the Plan.

Furthermore, the Integrated Committee (Workgroup) concurs that the Plan demonstrates alignment with the goals of the National HIV/AIDS Strategy to effectively depict and address the HIV epidemic within Fort Lauderdale/Broward County.

The signatures below confirm the concurrence of the Integrated Committee (Workgroup) with the Integrated HIV Prevention and Care Plan.

Sincerely,

Will Spencer, Co-Chair (Part A)
Integrated Committee (Workgroup)

9/16/2016
Date

Jorge Gardela, Co-Chair (Prevention)
Integrated Committee (Workgroup)

9/16/2016
Date

Jacksonville (Clay, Duval, Nassau, and St. Johns Counties)



**METROPOLITAN JACKSONVILLE AREA HIV HEALTH SERVICES
PLANNING COUNCIL**

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Planning Council Members:

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June 23, 2016

LCDR Anderson A. Tesfazion, US Public Health Service
Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, 09W-13D
Rockville, Maryland 20857

Re: Letter of Concurrence

Dear Lcdr Tesfazion:

The Metropolitan Jacksonville Area HIV Health Services Planning Council concurs with the following submission by the Florida Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Planning Council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.



The Planning Council's Continuum of Care Coordination Committee began conducting meetings in October 2015. This committee included approximately 25 members from local agencies, the PLWHA community, and interested parties from the prevention side. Committee reports were provided during the Planning Council's monthly meetings, and updates were also given to the local prevention group, First Coast Community AIDS Prevention Partnership. The majority of the work on Goals 1, 2, and 3 was done during the March, April, and May meetings. Narrative writing assignments were divided up in May and reviewed in June. Final revisions were completed this week.

The Planning Council will be submitting their Integrated HIV Prevention and Care Plan to the Florida Department of Health in the next few days.

The signature below confirms the concurrence of the Planning Council with the Integrated HIV Prevention and Care Plan.

Sincerely,

A handwritten signature in black ink, appearing to read "Kendall Guthrie", with a stylized flourish at the end.

Kendall Guthrie, Vice-Chair
Metropolitan Jacksonville Area
HIV Health Services Planning Council

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

Celeste Philip, MD, MPH
Surgeon General and Secretary

Vision: To be the Healthiest State in the Nation

June 24, 2016

LCDR Anderson A. Tesfazion, US Public Health Service
Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, 09W-13D
Rockville, Maryland 20857

Re: Letter of Concurrence

Dear LCDR Tesfazion:

The First Coast Community AIDS Prevention Partnership (FCCAPP), concurs with the following submission by the Florida Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The FCCAPP has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The FCCAPP concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The FCCAPP Planning Group joined the Care Coordination Committee of The Metropolitan Jacksonville Area HIV Health Services Planning Council in October 2015, and met monthly to strategically plan our efforts for Area 4. Our planning group consist of PLWHA's, Community Based Organizations, AIDS Service Organizations, Department of Health, and community members. Committee reports and updates were provided regularly from the Care Coordination Committee to our local prevention group, First Coast Community AIDS Prevention Partnership. The majority of the work on Goals 1, 2, and 3 was done during the March, April, and May meetings. Narrative writing assignments were divided up in May and reviewed in June. Final revisions were completed this week.

The signature below confirms the concurrence of the FCCAPP with the Integrated HIV Prevention and Care Plan.

Sincerely,

Joseph Mims, Chair
First Coast Community AIDS Prevention Partnership (FCCAPP)

Florida Department of Health

Duval County - Office of Disease Control
AIDS PROGRAM OFFICE
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Jacksonville, FL 32244
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Public Health Accreditation Board

**Metropolitan Jacksonville Area HIV Health Services Planning Council
And
Florida First Coast Community AIDS Prevention Partnership**

Integrated HIV Prevention and Care Plan: 2017-2021

Acknowledgements

The Integrated HIV Prevention and Care Plan (IHPCP) is the product of collaboration among members of the Metropolitan Jacksonville Area HIV Health Services Planning Council (Planning Council), the First Coast Community AIDS Prevention Partnership (FCCAPP) and other agencies and individuals representing multiple stakeholders in Baker, Clay, Duval, Nassau, and St. Johns Counties. Specifically, we thank members of the Joint Planning Council Coordination Committee and Prevention Planning Committee whose hard work created this document:

Committee Members

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Michael Bennett (Gateway Community Services)
Debbi Carter (Community Leader)
Mark Cleveland (Affected Community)
Gloria Coon (Affected Community)
Sandra Ellis (AIDS Program Office, Department of Health)
Audrey Gardner (Northeast Florida AIDS Network)
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Brandi Williamson (Department of Health in Duval County)
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Part A Staff

Deidre Kelley, Program Manager
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Executive Summary

The geographic area of the Jacksonville Transitional Grant Area (JTGA)/Partnership 4 is generally known as Florida's First Coast or Northeast Florida. This region, also known as the Jacksonville Metropolitan Statistical Area (MSA), includes the five counties of Baker, Clay, Duval, Nassau, and St. Johns. The population of the region is approximately 1.3 million. Whites comprise 65% of the population, Blacks comprise 22%, Hispanics comprise 8% and other races represent 5%. Duval County has 64% of the total population, 87% of persons living with AIDS, and 89% of persons living with HIV. St. Johns County's population represents 15% of the region, 5% of persons living with AIDS, and 5% living with HIV. Clay County's population represents 14% of the region's population, 5% of persons living with AIDS, and 4% of persons living with HIV. Nassau County's population represents 5% of the region, 2% of persons living with AIDS, and 1% of persons living with HIV. Baker County's population represents 2% of the region, 1% of persons living with AIDS, and 1% of persons living with HIV. Against this background, AIDS prevalence is 63% among Blacks, 29% among whites, 5% Hispanics, and 3% among other races while HIV prevalence is 65% among Blacks, 27% among whites, 5% Hispanics, and 3% among other races. These data point to the disproportionate impact of AIDS in the African-American community.

The mixed urban nature of the five county area creates geographical barriers to clients attempting to access prevention and patient care services. HIV counseling and testing services as well as primary and specialty medical services are provided at public health clinics located in Macclenny (Baker County), Orange Park (Clay County), Jacksonville (Duval County), Fernandina Beach (Nassau County), and St. Augustine (St. Johns County). Additionally, prevention and patient care services are provided in Duval County at the AIDS Healthcare Foundation Riverside Clinic and UF CARES, both of which are Ryan White HIV/AIDS Program (RWHAP) Part C grantees. The fact that the majority of prevention and patient care services are only available in Jacksonville/Duval County limits some clients' ability to access services in or near their home. A lack of adequate public transportation throughout the area adds to the burden of trying to access care. Economic and social barriers to care include a lack of resources to pay for needed services, lack of adequate housing, few opportunities for under privileged persons to find employment, and low literacy levels.

This five-year Integrated HIV Prevention and Care Plan utilizes data from the area epidemiological profile, State and local needs assessments, client utilization data, quality management/outcomes data and other sources as the primary impetus for developing an evidentiary basis for the plan. The plan is a living document that will guide the Metropolitan Jacksonville Area HIV Health Services Planning Council, First Coast Community AIDS Prevention Partnership, RWHAP grantees, and prevention and care service providers in reaching the goals of the National HIV/AIDS Strategy which include preventing new infections, increasing access to care and improving health outcomes, and reducing HIV-related health disparities.

2017 – 2021 JACKSONVILLE, FL TRANSITIONAL GRANT AREA (TGA)/PARTNERSHIP 4 INTEGRATED HIV PREVENTION AND CARE PLAN

Introduction

The Jacksonville, FL Transitional Grant Area (JTGA)/Partnership 4 2017 – 2021 Integrated HIV Prevention and Care Plan (IHPCP) is being submitted as part of the Florida Department of Health, HIV/AIDS Section, CDC/HRSA Integrated HIV Statewide Coordinated Statement of Need/Prevention and Care Plan. The plan was developed by the Metropolitan Jacksonville Area HIV Health Services Planning Council (Planning Council) in collaboration with the First Coast Community AIDS Prevention Partnership (FCCAPP), Ryan White HIV/AIDS Program (RWHAP) Parts A, B, C, and D grantees, mental health and substance abuse treatment providers, community leaders, and persons living with HIV/AIDS (PLWHA) in care and lost to care. The plan identifies HIV prevention and care needs of more than 6,646 PLWHA residing in the region as of 2014, the available resources to meet those needs, barriers to accessing care, gaps in services, and outlines strategies to address them.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

A. Epidemiologic Overview

a. Counties of the JTGA/Partnership 4 include Baker, Clay, Duval, Nassau, and St. Johns and are located in the northeastern corner of Florida with an estimated population of 1,394,624 in 2013. In Calendar Year (CY) 2014, the region's HIV/AIDS prevalence rate—485.67 per 100,000—was 14.03% greater than the United States HIV/AIDS prevalence rate—417.5 per 100,000. The rate of infection has risen steadily in the past 21 years. In the three years between 2012 and 2014, the number and percentage of people living with HIV/AIDS increased 3.4% from 6,421 to 6,646 representing a steady state of conversion: 460.41 per 100,000 in 2012 to 476.54 per 100,000 in 2014. According to the 2014 Florida Department of Health (FDOH) HIV/AIDS Reporting System (eHARS), the region had 1,127 new HIV cases reported between January 1, 2012 and December 31, 2014.

Duval County is the local metropolis and hub of the HIV epidemic in Northeast Florida. Of the five counties, Duval County has 64% of the region's total population, 87% of persons living with AIDS, and 89% of persons living with HIV. St. Johns County's population represents 15% of the region, 5% of persons living with AIDS, and 5% living with HIV. Clay County's population represents 14% of the region's population, 5% of persons living with AIDS, and 4% of persons living with HIV. Nassau County's population represents 5% of the region, 2% of persons living with AIDS, and 1% of persons living with HIV. Baker County's population represents 2% of the region, 1% of persons living with AIDS, and 1% of persons living with HIV. The population is predominately white (65%) with African-Americans representing 22% of the population, Hispanics representing 8%, and other races representing 5%. However, AIDS prevalence as of December 31, 2014, was 63% among Blacks, 29% among whites, 5% Hispanics, and 3% among other races. HIV prevalence was 65% among Blacks, 27% among whites, 5% Hispanics, and 3% among other races. African-Americans are overrepresented in incidence and prevalence of AIDS, indicating late diagnosis, poor treatment adherence, compromised CD4-cell recovery, immunologic failure, comorbid states that complicate HIV treatment adherence such as diabetes, or multiple social and behavioral risk factors that do not support immune system reconstitution.

b. In 2014, the State of Florida ranked number one in the United States (U.S.) for number of HIV cases reported with at least one HIV infection case diagnosed in all but six counties in Florida and at least one AIDS case diagnosed in all but nine counties in Florida. Although the AIDS epidemic is widespread through Florida, the majority of cases were diagnosed from seven counties: Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, and Pinellas, all reporting over 100 cases in 2014.

i. Table 1 presents calendar year (CY) 2014 demographic characteristics of persons newly diagnosed with AIDS and persons living with AIDS and HIV (Non AIDS) infection:

Table 1: AIDS PREVALENCE AND HIV (NON AIDS) INCIDENCE AND PREVALANCE DATA BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY						
Demographic Group/ Exposure Category	AIDS Prevalence as of 12/31/14		HIV (Not AIDS) Incidence: 1/01/12 to 12/31/14		HIV (Not AIDS) Prevalence as of 12/31/14	
<i>Race/Ethnicity</i>	Number	% of Total	Number	% of Total	Number	% of Total
White, not Hispanic	1081	29	308	27	773	27
Black, not Hispanic	2382	63	705	62	1860	65
Hispanic	203	5	77	7	144	5
Not Specified/Other	121	3	37	4	82	3
Total	3787	100	1127	100	2859	100
<i>Gender</i>						
Male	2509	66	824	73	1832	64
Female	1278	34	303	27	1027	36
Total	3787	100%	1127	100	2859	100
<i>Age at Diagnosis (Years)</i>						
<12 years	4	0	4	0	13	1
13 – 19 years	13	1	59	5	44	2
20 – 29 years	284	7	380	34	586	20
30 – 39 years	646	17	252	22	706	25
40 – 49 years	1078	28	236	21	699	24
50 – 59 years	1229	33	142	13	585	20
60+ years	533	14	54	5	226	8
Total	3787	100	1127	100	2859	100
<i>Adult/Adolescent AIDS Exposure Category</i>						
Men who have sex with men	1543	41	602	54	1277	45
Injection drug users	415	11	46	4	182	6
Men who have sex with men and inject drugs	189	5	16	1	74	3
Heterosexuals	1573	42	455	41	1279	45
Other	63	2	4	0	34	1
Total	3783	100	1123	100	2846	100
<i>Pediatric AIDS Exposure</i>						
Mother with/at risk for HIV	4	100	4	100	13	100
Risk not reported/Other	0	0	0	0	0	0
Total	4	100	4	100	13	100

African-American males 20 to 59 years of age, MSM, and heterosexuals accounted for the largest share of disease burden in their respective demographic

grouping. These data, although non-etiological, may be explored further as the social, cultural, psychological, and/or environmental determinants that define vulnerabilities to HIV incidence and prevalence.

ii. The total estimated population of the region in 2013 was 1,394,624, ranking the area 40th in population size among the 381 total MSAs in the country. According to the U.S. Census Bureau, Florida 2013, the total estimated population, population density and racial/ethnic breakdown for each of the five counties are depicted from the largest to the smallest total estimated population size in Table 2:

County	Total Estimated Population	Population Density – Persons per Square Mile	Racial/Ethnic Breakdown (2013)
Duval	885,855	1,113.9	White: 62.3% Black: 30.0% Latino: 8.3%
St. Johns	209,647	316.4	White: 89.7% Black: 5.7% Latino: 5.8%
Clay	196,399	315.8	White: 82.8% Black: 10.6% Latino: 8.7%
Nassau	75,710	113.0	White: 90.4% Black: 6.5% Latino: 3.8%
Baker	27,013	46.3	White: 84.0% Black: 13.4% Latino: 2.3%
Florida	19,552,860	350.6	White: 78.1% Black: 16.7% Latino: 23.6%

The City of Jacksonville is located in Duval County, the most densely populated county in Northeast Florida, with 885,855 estimated county residents in 2013. Compared to St. Johns County, the area with the second largest population center, Duval's population was four times greater and its population density was 3.5 times greater. Within this geo-social-political context, Duval County has the highest proportion of African-Americans, rivaled only by Baker and Clay counties in the ratio of at least 2 to 1. The City of Jacksonville is not only the largest city by land mass in the continental U.S. but also the most densely populated landmass in the region. The Jacksonville Children's Commission 2009 report titled *Racial and Ethnic Disparities Report*, pages 21 and 22, presented this word picture of the City of Jacksonville:

“...The St. Johns River separates Jacksonville into two separate cities and realities. The Southside and certain segments of the Westside represent the [most] affluent sections of the city, while the North, Northwest, and East sectors represent larger areas of poverty and predominantly African-American communities. The most poverty-stricken, high crime and predominantly African-

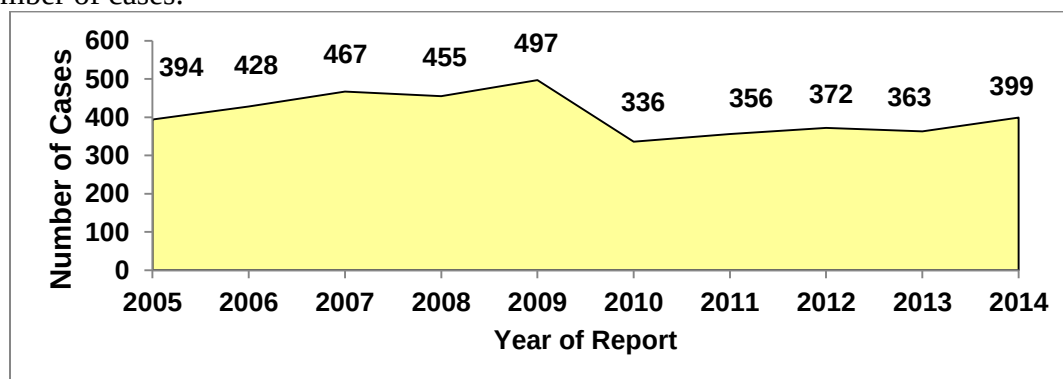
American area [go by the label] Northwest Quadrant or the Urban Core and is also nestled within the geographic location known as Health Zone 1 [zip codes 32202, 32204, 32206, 32208, 32209, and 32254]...Health Zone 1 has the absolute highest concentration of poverty and related health and social ills.”

Table 3 presents U.S. Census Bureau, Florida 2013 poverty and income data for all persons residing in the region:

Table 3: POVERTY AND INCOME DATA FROM JTGA/PARTNERSHIP 4				
County		Poverty Rate-All Persons (2009 – 2013)		Median Household Income (2009 – 2013)
St. Johns		9.6%		\$64,876
Clay		9.8%		\$59,482
Nassau		12.6%		\$55,315
Duval		16.9%		\$48,323
Baker		17.3%		\$49,236
Florida		16.3%		\$46,956
Uninsured Rates Comparison of Jacksonville, Jacksonville TGA/Partnership 4, and Florida (5-year estimates, 2009 – 2013)				
Location	No health insurance, under 18 years old	Employed, no health insurance	Unemployed, no health insurance	Not in labor force, no health insurance
City of Jacksonville	9.6%	19.3%	50.1%	24.2%
Jacksonville TGA/Partnership 4	8.9%	18.1%	49.3%	21.6%
Florida	12.3%	25.4%	56.5%	28.0%

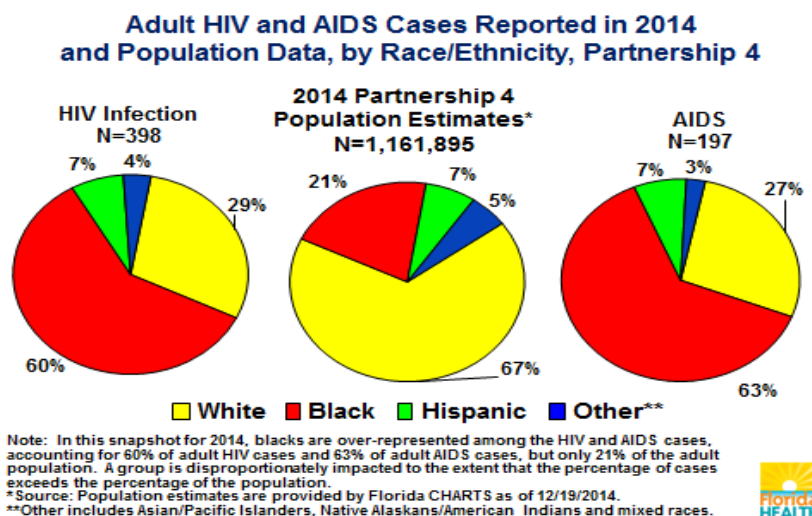
Within Northeast Florida, the differences among the income levels and poverty rates of the five individual counties reflect the socioeconomic disparities within the region. The overall poverty rate in the counties from 2009 to 2013 ranged from a low of 9.6% to a high of 17.3% and the median household income ranged from \$48,323 to \$64,876. Duval County had the second highest overall poverty rate among the five counties (16.9%). The number and percentage of PLWHA living at or below 138% FPL in 2014 were 3,704 (82.86%). In contrast, the number and percentage of PLWHA living at or below 400% FPL in 2014 were 4,470 (99.98%). Ryan White Part A eligibility for all funded services is 0% to 400% of FPL.

c. Figure 1 shown below, presents 10-year temporal trends in HIV infection by year and number of cases.



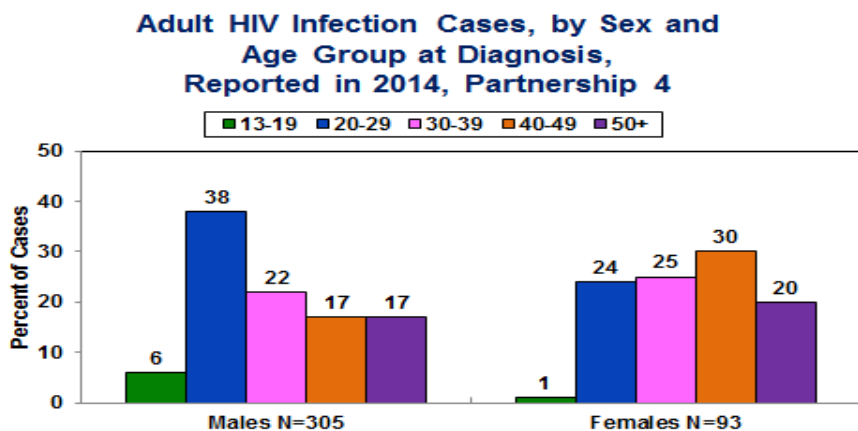
The burden of HIV in the region has been largely consistent. However, enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly diagnosed cases of HIV infection in 2009. The period after 2009 incurred a short decline in diagnosed cases through 2010, after which a steady increase on the magnitude of 5% to 9% occurred annually.

Figure 2 below presents aggregated HIV and AIDS cases for the 3 years beginning January 1, 2012 to December 31, 2014:



Clear disparities exist by race in the burden of HIV and AIDS prevalence in Northeast Florida. Blacks comprise less than $\frac{1}{4}$ of the general population of the region, but account for more than $\frac{1}{2}$ of HIV infections and AIDS cases. Hidden from view, in these aggregated data, are cross-over patterns by risk categories, which annual data analyses unmask. For example, the percentage of new HIV cases, over the three year period beginning January 1, 2012 and ending December 31, 2014 increased steadily among Whites, but decreased among Blacks, which may support the delayed testing and later diagnosis hypothesis. A similar pattern existed for males compared to females and for men who have sex with men (MSM) compared to heterosexuals.

Figure 3 shown below presents HIV incidence by sex and age group at diagnosis in 2014:



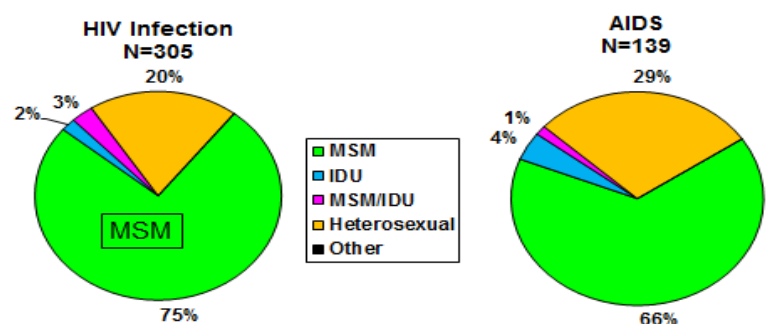
Note: HIV infection cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic. With regard to the age group with the largest proportion of HIV infection cases, recent estimates show that among males, 38% of HIV infection cases occur among those aged 20-29, whereas among females 30% of HIV infection cases occur among those aged 40-49.



Disparities exist by sex and age group. With regard to the age group with the largest proportion of HIV infection cases, recent estimates show that among males, 38% of HIV infection cases occur among those aged 20 to 29 years, whereas among females 30% of HIV infection cases occur among those aged 40 to 49 years. In addition, the percentage of youth (13 to 24 years) living with HIV/AIDS as a percentage of all persons living with HIV was 8% in 2014 indicating no increase or decrease in the three year period from 2012 to 2014. These findings are clinically significant. They indicate that earlier exposure of young men to HIV compared to young women may indicate the need for early and targeted HIV prevention messages.

See Figure 4 for adult male HIV infection and AIDS cases by mode of exposure in 2014:

**Adult Male HIV Infection and AIDS Cases,
by Mode of Exposure, Reported in 2014, Partnership 4**



Note: NIRs redistributed. Among the male HIV infection and AIDS cases reported for 2014, men who have sex with men (MSM) was the most common risk factor (75% and 66% respectively) followed by cases with a heterosexual risk (20% for HIV and 29% for AIDS).



There has been little change in the number and percentage of HIV/AIDS incidence over the past three years indicating that the risk of infection remains a threat to the public's health. For the three year period January 1, 2012 to December 31, 2014, 95% of HIV/AIDS incidence mapped two exposure modes: MSM and heterosexual. Three of every four new HIV cases self-reported MSM and one of every five reported heterosexual. Among new AIDS cases, 2/3 reported MSM and almost 3 in 10 reported heterosexual contact. There were 49 mothers reported at risk for HIV infection in the past three years.

Risk for acquiring HIV is not equally distributed across all demographics, African-Americans, young and middle aged adults, and men who have sex with men (MSM) are disproportionally represented in our region's epidemic. Further stratification of these groups revealed unsettling trends. For example, the percentage of women, infants, children and youth (WICY) with AIDS in the Jacksonville TGA/Partnership 4 is the highest percentage in Florida and the 4th highest percentage in the U.S. As of December 31, 2013, WICY made up 39.86% of living AIDS cases. The ratio of males to females with HIV/AIDS has not changed significantly in the past three years beginning January 1, 2012 to December 31, 2014. In 2012, the ratio of males to females with HIV/AIDS was 2.1:1 and in 2014 it was 2:1. In the heterosexual exposure category, women represented 66% of reported HIV/AIDS cases in the past three years. This exposure mode is a clear risk factor for women.

The socio-demographic data presented above has value beyond its descriptive epidemiological significance. Two groups of PLWHA that remain underrepresented in the region's RWHAP funded system of HIV/AIDS primary medical care are African-American

MSM (BMSM) and African-American women. An analysis of the unmet need for medical services in the Jacksonville TGA/Partnership 4 indicated that 65% (1080) of HIV/AIDS infected African-Americans did not receive medical services in 2014. Of this group, one in three or 34% (565) of HIV/AIDS infected women did not access medical care in 2014. By race, African-American women represented 47% (272) of women not receiving medical care in 2014. Reasons given by African-American women for not accessing medical care include lack of childcare, transportation and need for specialty care. Reasons for not accessing care create gaps in services that the Part A/B Planning Council considered in setting priorities and allocating funds to address the needs of these groups. For BMSM, reasons for not accessing medical care, according to the 2013 Needs Assessment, include stigma, fear of disclosure, family isolation, church scorn, and other non-supportive social environments. Mortality studies show that BMSM are more likely to die of an AIDS-related complication because they are less likely to seek medical care before being diagnosed with AIDS.

d. Table 4 presents Partnership 4 HIV testing data for CY 2014:

Table 4: TOTAL NUMBER OF TESTS PERFORMED AT STATE LABORATORIES FOR ALL TESTING SITES							
2014 Exposure Category	Number of Tests	Number Positive	Percent Positive	Gender	Number of Tests	Number Positive	Percent Positive
Male Sex With Male/IDU	67	8	11.9	Male	14,271	238	1.7
Male Sex With Male	2,077	138	6.6	Female	16,395	91	0.6
Injecting Drug User	882	10	1.1	Unknown	453	8	1.8
Sex Partner at Risk	897	37	4.1	Total	31,119	337	1.1
Child of Woman with HIV/AIDS	13	0	0.0	Race/ Ethnicity	Number of Tests	Number Positive	Percent Positive
STD Diagnosis	6,461	31	0.5	White	6,530	60	0.9
Sex for Drugs or Money	308	4	1.3	Black	20,927	242	1.2
Hemophilia/Blood Recipient	0	0	0.0	Hispanic	2,164	24	1.1
Victim of Sexual Assault	82	2	0.0	Asian	509	2	0.4
Health Care Exposure	0	0	0.0	Am. Native	69	1	1.4
Heterosexual	18,473	86	0.5	Other	248	4	1.6
No Acknowledged Risk	707	0	0.0	Unknown	672	4	0.6
Unknown	1,152	21	1.8	Total	31,119	337	1.1
Total	31,119	337	1.1	Total	31,119	337	1.1

In 2014, the HIV positivity rate was 1.1%. However, as expected, aggregated data masked important subgroup differences. Specifically, the MSM/IDU exposure mode had a positivity rate almost 11 times greater than the overall rate. In contrast, the MSM exposure mode had a positivity rate six times greater than the overall rate. The group with the next highest positivity rate, which was 3.7 times greater than the overall rate, belonged to persons who reported Sex Partners at Risk. Regarding gender, HIV positivity among males was 1.5 times greater than the overall positivity rate, whereas the HIV positivity among females was ½ the overall positivity rate. By race-ethnicity, where the number of HIV tests among Black respondents were at least three times greater than any other group, positivity rates were highest for persons who self-identified as Other, American Native, and Black.

Table 5 presents Partnership 4 HIV Counseling and Testing data for three target groups for January 1, 2015 to June 30, 2015:

Table 5: Counseling and Testing Data for Three Target Populations in Partnership 4							
Targeted Populations	HIV Testing Event	HIV Positive Result	Linked to Medical Care	Confirmed New Positives	Referred to Partner Services	Referred to Prevention Services	Received CD4 Cell Count & VL Testing
New Positives	An HIV-positive test result associated with a client who does not self-report having previously tested HIV positive and has not been reported to jurisdiction's surveillance department as being positive.						
Black MSM	490	41	35	41	38	12	35
White MSM	438	6	4	5	4	2	4
Black Women	4906	23	18	19	18	7	18
Targeted Populations	HIV Testing Event	HIV Positive Result	Linked to Medical Care	Confirmed Positive	Referred to Partner Services	Referred to Prevention Services	Received CD4 Cell Count & VL Testing
Previous Positives	An HIV-positive test result associated with a client who self-reports having previously tested HIV positive, or has been reported to jurisdiction's surveillance department as being HIV positive.						
Black MSM	490	10	8	10	8	2	8
White MSM	438	2	2	2	2	0	2
Black Women	4906	8	6	8	7	1	6

HIV surveillance plays a major role in pinpointing target groups affected by the HIV pandemic. As the data indicates, populations most at risk for HIV infection, among newly and previously diagnosed, are Black MSM, White MSM, and Black heterosexual women.

Among Black MSM, 8.36% were found to be HIV positive, 85.36% accessed medical care at least one time in a 12-month period, 92.68% were referred to partner services, 29.27% were referred to prevention services, and 85.36% received CD4 and viral load testing. Among White MSM, 1.37% were found to be HIV positive, 66.67% accessed medical care at least one time in a 12-month period, 66.67% were referred to partner services, 33.33% were referred to prevention services, and 66.67% received CD4 and viral load testing. Among Black women, .46% were found to be HIV positive, 78.26% accessed medical care at least one time in a 12-month period, 78.26% were referred to partner services, 30.43% were referred to prevention services, and 78.26% received CD4 and viral load testing.

Among previous positive Black MSM, 2.04% were found to be HIV positive, 80% accessed medical care at least one time in a 12-month period, 80% were referred to partner services, 20% were referred to prevention services, and 80% received CD4 and viral load testing. Among previous positive White MSM, 0.45% were found to be HIV positive, 100% accessed medical care at least one time in a 12-month period, 100% were referred to partner services, 0% were referred to prevention services, and 100% received CD4 and viral load testing. Among previous positive Black women, 0.16% were found to be HIV positive, 75% accessed medical care at least one time in a 12-month period, 87.5% were referred to partner services, 12.5% were referred to prevention services, and 75% received CD4 and viral load testing.

From the data, it appears that a higher percentage of newly diagnosed Black MSM accessed medical care and received CD4 and viral load testing than the other groups followed by previously diagnosed White MSM.

Table 6 presents social and biological co-morbidities among PLWHA in the JTGA/Partnership 4 in 2014:

Table 6: CO-MORBIDITIES, QUANTITATIVE DATA			
CO-MORBIDITY	Prevalence within the general population		Data Source and Date
Tuberculosis	50 cases or 3.7 /100,000 (3 cases of HIV co-infection)		State of FL Dept. of Health 2015
Syphilis	65 cases or 4.8/100,000 (34 cases of HIV co-infection)		State of FL Dept. of Health 2015
Gonorrhea	2554 cases or 186.6/100,000 (117 cases of HIV co-infection)		State of FL Dept. of Health 2015
Intravenous Drug Users	7300 cases or 504/100,000 (860 cases of co-infection)		State of FL Dept. of Health 2015
Other Substance Abuse (<i>alcohol, Methamphetamine, and cocaine</i>)	61,982 cases or 5,635/100,000 (541 cases of co-infection)		State of FL Dept. of Health 2015 National Survey on Drug Use and Health, SAMHSA, 2010
Homelessness	2594 individuals or 189/100,000 (24 cases of co-infection)		State of FL Dept. of Children and Families, <i>Council on Homelessness Report 2014</i>
Severe Chronic Mental Illness	12,500 cases or 1,136/100,000 (86 cases of co-infection)		State of FL, Dept. of Children and Families 2015
Other co-morbidities Chlamydia	7228 cases or 528.2/100,000 (115 cases of co-infection)		State of FL Dept. of Health 2015
Chronic Hepatitis C	1593 cases or 116.4/100,000 (592 cases of co-infection)		State of FL Dept. of Health 2015
	240,547	18%	
RELEASE OF FLORIDA DEPARTMENT OF CORRECTIONS OFFENDERS INTO THE JACKSONVILLE TGA			
	Total Released	HIV Released	
Offenders who returned to area in 2014	2658	70	Dept. of Corrections Offender-based Information System 2013
Offenders who returned to area in 2013	2726	86	Dept. of Corrections Offender-based Information System 2012
Offenders who returned to area in 2012	2803	65	Dept. of Corrections Offender-based Information System 2011

High rates of bacterial STD's create fertile conditions for rapid HIV infection in the region. The CDC states that individuals with a sexually transmitted disease are two to five times more likely than uninfected individuals to acquire HIV if exposed to the virus. Duval County's population is ½ the size of Broward County, 1/3 the size of Miami-Dade County and less than

10% of the state population. Yet, Chlamydia and bacterial STDs among women of childbearing age is at least 75% higher in Duval than comparison areas in Florida. Identifying people early in the disease process and linking them to care begins with counseling and testing. Historical trends show disparities between males and females who complete voluntary HIV tests.

According to FDOH, the percentage of males who complete voluntary HIV tests has increased from 44.61% in 2013 to 45.86% in 2014 while the percentage of females decreased from 54.23% in 2013 to 52.68% in 2014. However, the high rates of HIV/AIDS incidence among African-Americans (64%) and the percentage of HIV tests conducted with African-Americans in 2014 was comparable at 67.25%. A critical element in responding to racial disparities in HIV infection is making more people aware of their HIV status or behaviors that increase their risk of contracting HIV.

Duval County ranks third among Florida's 67 counties in reported gonorrhea cases per 100,000 population. The table below shows epidemiologic trends for gonorrhea in Duval County, the epicenter of the local HIV/AIDS epidemic. Illustrated are occurrences of gonorrhea in the last three years. Gonorrhea has increased 17%

Co-morbidity	2012	2013	2014
Gonorrhea (all races)	143.5	173.6	186.6

among all races from 143.5 to 186.6 cases per 100,000 between 2012 and 2014. This trend is discouraging particularly when analyses by race

show that African-Americans remain the group more heavily impacted (530.5 cases per 100,000) than whites (60.0 per 100,000) or any other group. In 2014, gonorrhea was 9 times higher among African-Americans than whites living in Duval County, and since it renders a person three to five times more susceptible to HIV, it's an indicator of possible future HIV. One hundred seventeen persons were co-infected with HIV and gonorrhea in 2014. Other than Duval County, the only other county in the region with notable cases of gonorrhea is Clay County with .80 cases per 100,000.

Duval County ranks fifth among Florida's 67 counties in reported Chlamydia cases per 100,000 population. Chlamydia prevalence has also increased from 496.9 to 528.2 cases per 100,000 in the past three years. This level of infection alarms the local community because the national Chlamydia rate in 2013 was 446.6 cases

Co-morbidity	2012	2013	2014
Chlamydia (all races)	496.9	526.9	528.2

per 100,000 population. In 2014, Duval County had more Chlamydia cases for African-Americans

(1,250.1 cases per 100,000) than whites (187.6 per 100,000). Analyses by gender showed that Chlamydia infection among women was 728.4 per 100,000 population and among African-American women was 2.62 times greater than for other women. The infection rate among African-American women in Duval County raises serious concerns for women's health. Women exposed to Chlamydia are up to three times more likely to become infected with HIV if exposed. One hundred fifteen persons were co-infected with HIV and Chlamydia in 2014. Other than Duval County, the only other county in the region with notable cases of Chlamydia is Clay County with 5.27 cases per 100,000.

Duval County ranks fifth in reported syphilis cases per 100,000 population among Florida's 67 counties. The rate increased between 2013 and 2014 but remains lower than the national syphilis estimate, which was 5.5 cases per 100,000 population in 2013. Analyses by race using 2014 data show that African-Americans were 17

Co-morbidity	2012	2013	2014
Syphilis (all races)	3.3	3.1	4.8

times more likely to have syphilis than whites and cases were largely reported among MSM. Syphilis also facilitates HIV infection, increasing the likelihood of HIV infection two to five

fold. Thirty-four persons were co-infected with HIV and syphilis in 2014. Other than Duval County, the only other county in the region with notable cases of infectious syphilis was St. Johns County with .03 cases per 100,000.

In the five county area, Duval County has the highest number of persons considered homeless. The number of homeless persons has remained relatively the same from 2012 to 2014. A person is considered homeless if he or she is not currently in a stable housing or residential situation. For the vast majority of people who experience it, homelessness is an acute or episodic crisis, not a chronic condition. According to the State of Florida Department of Children and Families *Coalition on Homelessness 2014 Report*, 2,594 persons were counted as homeless in Jacksonville in 2014. Of those persons, 24 have been reported as HIV+. Emergency shelters are filled beyond capacity every night. In addition to the temporarily sheltered homeless, more than 600 people each day call the street their home.

Homelessness in Duval County touches every socio-demographic group. Males comprise the majority of homeless persons (65%). Caucasians represent 54.3% and African-Americans represent 34% of homeless persons. The most represented age range was 24 - 60 years or 64.8% of the homeless population. However, 18.6% were under the age of 18 years. Together with patterns of race and ethnicity, the gender patterns indicate that the rise in homeless adults in Jacksonville is mainly among African-American men. Less than one out of five (11.81%) of Jacksonville's homeless were families. A breakdown by type of disability common among homeless adults indicates that the greatest issues are substance abuse (37.1%) and mental illness (29.8%).

Economic instability such as unemployment and the foreclosures on personal property have created an epidemic of homelessness. Florida has the third highest number of persons who are living on the streets or in emergency shelters in the nation. Those who are poor often find it difficult to obtain housing that is both suitable and affordable. Those who do find housing most frequently spend in excess of 50% of their limited incomes making it difficult to pay for other life essentials such as food, medical care, and medications. According to the Council on Homeless Report, those most at risk of homelessness are people living in poverty, single parents, the unemployed or underemployed, the physically and mentally disabled, substance abusers, victims of domestic violence, runaway children and throwaway youth, veterans, and those without family support networks.

Criminal justice involvement is also a social risk factor that affects client retention in care. The impact on the service delivery system of individuals who were formerly Federal, State or local prisoners has been partially mitigated by a project strengthening the linkage to care for recently released inmates coordinating funding with Parts A and B, and City general revenue. The Jacksonville Sheriff's Office (JSO) provided primary medical care, medications, and dental to PLWHA incarcerated for 90 days or less in 2013. The program includes STD screening and HIV counseling and testing. In 2014, 19 of 3,360 inmates tested positive for HIV. In addition to the medical staff, JSO employs one full time community transition coordinator in the jail to help with transitioning inmates with HIV into community services. The coordinator also enrolls chronically mentally ill PLWHA into Medicaid so that benefits are active on the date of release. The program was responsible for referring and linking 82 former inmates with medical services between September 2013 and August 2014. Upon release from incarceration, former inmates are bused to the Jacksonville Re-entry Center (JREC) where they are offered assistance with day-to-day functions such as life skills, pre-employment training, showers, hygiene kits, and clothing. PLWHA are referred and linked to AIDS service agencies (ASOs) for continued medical care

and support services. Part A and B funds pay for medical visits, medications and other support services such as substance abuse treatment and/or mental health counseling needed by former inmates until other funding sources can be secured. Of particular note is that HIV inmates are arrested 2.8 times per year.

Severe and persistent mental illness is another co-morbidity that affects the cost and complexity of providing HIV/AIDS services. Severe and persistent mental illnesses such as depression and bipolar disorder, have reportedly affected an estimated 12,500 of the region's total population. According to the Ryan White Needs Assessment conducted in 2016, 44% of PLWHA surveyed expressed a need for mental health and psychosocial support services. The FDOH estimates that 75 PLWHA residing in the JTGA/Partnership 4 are severely and chronically mentally ill. Mental illness can range from routine short-term depression to a Diagnostic and Statistical Manual (DSM) IV mental illness classification. According to the National Institute of Mental Health (NIMH), depression is a highly treatable illness but mainly undiagnosed in people with HIV. Depression is usually treated by a licensed psychiatrist or psychologist. If left untreated, it can cause a person to cease accessing needed medical treatment and medications. Bipolar disorder, also known as manic-depressive illness, affects more than two million Americans (NIMH, 2000). Treatment for this type of disorder is more costly than treatment for depression because it generally requires treatment for a longer period of time and more complex medication regimens.

Intravenous drug use (IDU) is a major problem in Northeast Florida. The Florida Department of Health, Bureau of HIV/AIDS (FHAB) estimates that 7,300 persons buy, sell, and inject illegal drugs in Duval County. Of the 7,300 IDUs, it is estimated that 821 are co-infected with HIV. Since Jacksonville has no needle exchange program, the practice of sharing unclean, reused syringes and needles result in the spread of HIV to other drug users. Infected drug users also pass HIV to their sexual partners and children born to their partners. Heroin is the intravenous drug of choice and used by at least 4,800 of the estimated 7,300 injecting drug abusers. Injectable opiates are becoming more popular. Most IDUs have numerous health problems in addition to HIV and need assistance meeting their basic needs for food, clothing, and shelter.

Other substance abuse including alcohol, cocaine and crystal methamphetamine, affects an estimated 61,982 persons in the region. The Florida Department of Children and Families (DCF) Circuit 4 Substance Abuse and Mental Health (SAMH) office reported funding agencies to provide substance abuse treatment and mental health services to 21,694 persons between July 1, 2013 and June 30, 2014. The majority of clients (72%) who received substance abuse treatment services were female (64%) and white (60%). The number of persons accessing substance abuse treatment and/or mental health services who are co-infected with HIV is estimated to be 536. Interview information collected by the Florida Supplement to HIV/AIDS Surveillance (SHAS) Project indicates that the majority (74%) of persons newly diagnosed with HIV or AIDS, who have been accessing primary medical services for at least six months, had used marijuana, crack and/or cocaine in their lifetime. The estimated 821 HIV/AIDS infected IDUs and other infected persons who abuse alcohol and other drugs have a variety of needs. Many are dually diagnosed with mental illness and drug and alcohol dependence.

In Duval County, the number of reported cases of hepatitis C similarly increased in 2013 and then declined in 2014. The rate of hepatitis C has fluctuated from year to year with 114.6 cases per 100,000 people in 2012 to 116.4 cases per 100,000 people in 2014. The rate in 2014

Co-morbidity (all races)	2012	2013	2014
Hepatitis C	114.6	119.0	116.4

among whites (48.9 per 100,000) was significantly higher than African-Americans (24 per 100,000). Hepatitis C is common among male IDUs (37%) who share unclean needles and MSM (31%), particularly those with multiple partners. Among women, 64% contracted hepatitis C through injecting drug use and 35% contracted it through heterosexual encounters. Thus, eliminating or reducing the prevalence of hepatitis C and other co-morbidities are a local prevention priority. Five hundred ninety-two persons were co-infected with HIV and hepatitis C in 2014.

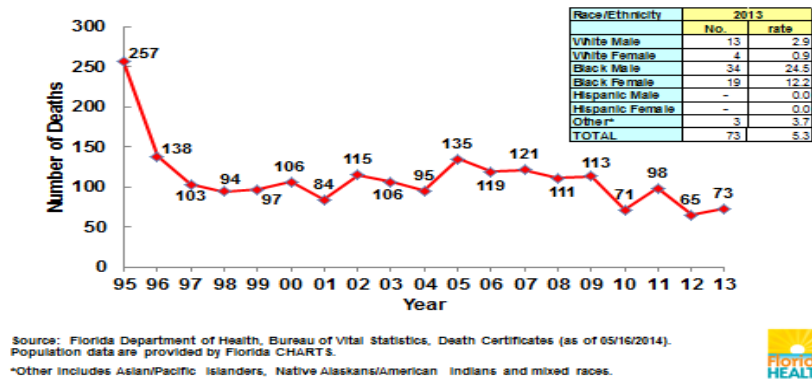
The health of youth and young adults is a local priority. The Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of priority health-risk behaviors among youth and young adults: 1) behaviors that contribute to unintentional injuries and violence; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that contribute to unintended pregnancy and sexually transmitted infections (STIs), including human immunodeficiency virus (HIV) infection; 5) unhealthy dietary behaviors; and 6) physical inactivity. In addition, YRBSS monitors the prevalence of obesity and asthma. YRBSS includes a national school-based Youth Risk Behavior Survey (YRBS) conducted by CDC and state and large urban school district school-based YRBSs conducted by state and local education and health agencies. The Youth Risk Behavior Survey (YRBS) is a self-administered, school-based, confidential, and anonymous survey that was conducted in Duval County Public Schools during the spring of 2015. This is part of a national effort by the CDC to obtain information pertaining to youth health behaviors that contribute to the leading causes of death and disability among youth and adults.

Calendar year 2013 YRBS data are of special significance to the IHPCP plan. Analysis of YRBS data on sexual behaviors revealed the following information about middle school (MS) and high school (HS) youth. In 2013, 46% of HS students and 15% of MS students had sex, 16% of HS students had 4+ sexual partners and 6% of MS students had 3+ partners, 64% of HS students used a condom last time they had sex and 65% of MS students did so, 45% of HS students had oral sex, 26% of HS students drank alcohol or used drugs before last sexual intercourse, 20% of HS students were never taught in school about AIDS or HIV education, 72% of lesbian, gay, and bisexual (LGB) HS students reported being victims of violence (e.g., threatened, bullied), and 54% of LGB students report experiencing depression compared to 25% of their heterosexual peers. Sexual behavior was more common among male students than female students.

STD/Pregnancy rates among Duval youth are among the highest in the state and country. Duval ranked 5th among counties in Florida for STDs among 15 to 19 year olds. Duval County's STI rate of 3,048/100,000 is 50% higher than Florida's rate of 2,039/100,000 for teens 15 to 19 years old. The results demonstrate a strong need for sexuality education and services for youth in schools. To meet the need, Duval County Schools have adopted evidence-based programs to meet state requirements to include *Draw the Line* and *Respect the Line* in MS, and *Reducing the Risk* in HS.

Health disparities related to race, gender, sexual orientation and age were noted in African-American men and women, and African-American MSM between the ages of 30 - 39 years and 50 - 59 years. Significant health disparities include higher rates of STIs, higher rates of chronic mental illness, and higher death rates due to HIV. Although the number of deaths continues to decline, African-American men and women are the most impacted. See Figure 6 below:

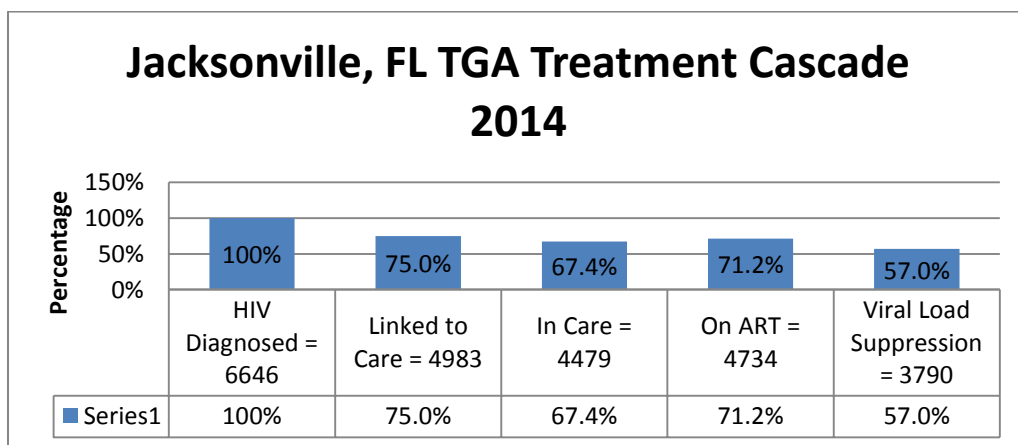
Resident Deaths due to HIV Disease by Year of Death, 1995-2013, Partnership 4



These populations have been identified as the most underserved in the region for the past three years and all new initiatives focus on bringing them into care are being employed. The RWHAP Part A has a Retention in Care initiative that has yielded positive results (95.45% relinked) in the reduction of lost to care in all of these populations. Medical case management is also very important in keeping targeted populations in care. Follow-up with referrals to mental health and substance abuse treatment and case conferencing with other medical and support service providers has provided positive results in health outcomes.

B. HIV Care Continuum

a. The JTGA/Partnership 4 *diagnosed-based* HIV Care Continuum (HCC) below was developed from data in the Part A CAREWare database, Florida Department of Health HIV/AIDS Surveillance data, and state and national estimates available online. See Table 7 below:



Five indicators appear on the HCC. **HIV-Diagnosed** is the number of people diagnosed with HIV, regardless of AIDS (stage 3 HIV infection) status, living in a jurisdiction. The number does not include the number of persons undiagnosed. **Linked to care** refers to the number of people diagnosed with HIV in a given calendar year that had one or more documented medical visits, viral load or CD4 tests within three months after diagnosis. The denominator is the number of people diagnosed with HIV infection (regardless of AIDS status) in a given

calendar year. **Retained in care** refers to the number of diagnosed people who had two or more documented medical visits, viral load tests, or CD4 tests, performed at least three months apart in the measurement year. **Antiretroviral Use** refers to the number of people receiving medical care and who have a documented antiretroviral therapy prescription in their medical records in the measurement year. **Viral load suppression** refers to the number of people whose most recent HIV viral load within the measurement year was less than 20 copies/mL.

HCC gaps prompted the Part A/B Planning Council to define areas of concern. For example, the gap noted between linked to care and retained in care led to a literature review that identified comorbid psychiatric illness—depression and anxiety—as barriers of access to care, participation in care decisions and medication compliance. Pursuant to this research the Planning Council directed Parts A, B, C, and D program leaders/managers to integrate plans of care. Hence, sub-recipients assess PLWHA at highest risk of attrition from the HCC, for mental health, substance abuse, medical case management, and HIV primary medical care needs. The Part A Administrative Agency implemented the first step of this plan by utilizing a “life coach model” to facilitate readiness for change to allow for early access/identification of PLWHA with mental health needs, or those who would benefit from increased care to ensure medical adherence. The goal of life coaching is partnership with distressed individuals to co-facilitate transition across personal hurdles, thus easing clients into accepting mental health services as a helping resource rather than perceiving it as treatment for disturbed individuals. Hosting the initial meeting with a life coach rather than a mental health counselor is one plug to stop leaks in the HCC. Individuals providing the role of life coach would be a bachelors or masters level mental health counselor. Focus would be on PLWHA who may not be ready to enter mental health counseling, but are in need of extra support, such as those who have been lost to care, newly diagnosed or not adherent to HIV treatment.

The key to viral load suppression is retention in care and treatment adherence. All Part A sub-recipients are instructed to review the number of medical visits, viral load lab results, and counsel clients on the importance of adhering to treatment regimens at each visit. The Part A Administrative Agency annually reviews client records for treatment adherence counseling as well as medical charts for viral load lab results. Sub-recipients who are not compliant with this requirement are in jeopardy of losing their Part A funding if corrected actions are not promptly implemented.

In the past two years, success has been achieved in Planning Council and sub-recipient efforts to close gaps in the HCC. For example, from 2013 to 2014, Table 8 below shows that linkage to care increased 2% and retention in care increased 13%.

	HIV Diagnosed	Linked to Care	Retained In Care	On ART	Suppressed Viral Load
2013	100%	91%	62%	56%	44%
2014	100%	93%	75%	71%	57%
Florida 2014	100%	71%	64%	67%	58%

The 17% increase in viral load suppression clearly shows that efforts to connect and retain PLWHA in care are achieving desired results. However, it is also evident that more improvements could be made to support additional PLWHA movement from one stage to the next in the HCC. As a result, the Planning Council allocated additional FY 2015 funds to “outreach” to support a Retention in Care initiative targeted at PLWHA who had received at least one RWHAP Part A funded activity but who had not attended a medical appointment in the

most recent 12 month period. Two Retention in Care Coordinators were hired to utilize CAREWare data to identify PLWHA who had not received one medical visit, had a lab drawn or a CD4 test conducted for 12 months or more. Within the first two months of the project, 296 of the 361 PLWHA identified as lost-to-care were found and relinked to care. The remaining 65 had either left the area, had been jailed, had died, or were not interested in medical care for various reasons. As case finding becomes a normative patient care activity, the Planning Council anticipates that viral load suppression percentages will increase as the JTGA/Partnership 4 achieves more success in keeping and relinking PLWHA in care for longer periods of time. If the anticipated results are not achieved, the Part A administrative staff will work with sub-recipients and the Planning Council to develop additional strategies to address immune reconstitution, which results in viral load suppression.

In the JTGA/Partnership 4, the HCC is being used to plan, prioritize, target, engage providers, and monitor available resources in responding to the needs of PLWHA. In 2013 and 2014, the HCC was presented to the Planning Council and Ryan White Parts A, B, C, and D funded sub-recipients, pointing out gaps in care. The first indicator on the HCC is HIV-Diagnosed. In order to increase the percentage of persons who are aware of their HIV status and linked to care, the Florida Department of Health Area 4 AIDS Program Office (APO) received supplemental funding from a HRSA/CDC initiative known as Partnerships for Care (P4C). Partnerships for Care is a national demonstration project where state departments of health partner with federally qualified health centers (FQHCs) to provide HIV early intervention and treatment to populations at high risk of HIV infection. The local health department partnered with the Sulzbacher Center in Jacksonville to expand HIV services to the homeless population. Homelessness is a huge social problem in Florida and Duval County. In the first month, 40 persons had been tested for HIV. Of those tested, one was positive and linked to care along with six previously positive clients.

Another health department initiative expands prevention education to youth in an after school program called the Teen Health Center (THC). The Jacksonville Partnership for Promoting Health for Emerging Adults (JPPHEA) is a partnership between the Duval County Public Schools (DCPS), Full Service Schools of Jacksonville (FSSJ), the Florida Department of Health in Duval County (DOH-Duval), the Jacksonville Area Sexual Minority Youth Network (JASMYN), the University of North Florida (UNF), and many other partners. During September 2015, THC provided services at four schools in Duval County and served 101 youth. Of those receiving services, 92 received group education, 41 were screened for HIV, 38 were screened for gonorrhea/chlamydia (six tested positive for Chlamydia), and 12 received pregnancy testing. There were six confirmed, positive Chlamydia cases and one pregnant teen. In addition, staff at the THCs made referrals for HPV vaccine at DOH, prenatal care/WIC/Healthy Start for pregnant teens, and contraception services at DOH Duval Woman and Children Center.

C. Financial and Human Resources Inventory

a. Within the JTGA/Partnership 4, there are Part A, B, C and D grantees. These and other local, state, and federal funding sources are taken into consideration during the Planning Council priority and allocation process. Part B funds are prioritized and allocated at the same time as Part A funds. Part A and B funds are not allocated to services funded by Parts C, and D. Part A and B funds are allocated to provide a continuum of HIV/AIDS care to persons who do not qualify for any other source of private, local, state, or federal funding. Taking all available sources of funding into consideration, Part A Administrative Agency staff prepare an unmet

service need matrix calculating the estimated cost of medical and support services for the upcoming grant year based on the estimated number of patients to be served including newly identified PLWHA. All local, state, and federal funding sources are subtracted from the total need, leaving an unmet need to be funded by Part A and B. The Part A and Part B Planning Council utilize the matrix to prioritize services and allocate funds.

Federal, state and local sources of funding include Medicaid, Medicare, Veterans Administration (VA) Services, Housing Opportunities for People with AIDS (HOPWA), Centers for Disease Control (CDC), Targeted Outreach for Pregnant Women Act (TOPWA), and Substance Abuse and Mental Health Services Administration (SAMHSA). The State of Florida Medicaid Program provides medical care, medications, and support service benefits to disabled individuals diagnosed with AIDS. Generally, Medicaid is available to pregnant women, disabled adults, caretakers of children under age 18, adults over age 65, and children under age 19 who meet low-income requirements. Florida Medicaid enrollees who have been diagnosed with AIDS may be eligible to enroll in the 1915(c) Project AIDS Care (PAC) Medicaid waiver program for home and community based services (HCBS). Florida originally received federal approval for this program in 1990 with an expiration date of December 31, 2012. The expiration date has been extended twice for a three year period. The latest extension expires June 30, 2017. To be eligible, an individual must be otherwise eligible for Medicaid, must show documentation of an AIDS diagnosis and the presence of AIDS related opportunistic infections, must have been determined to be at risk of hospitalization or institutionalization in a nursing facility, must not be enrolled in another Medicaid HCBS waiver program, and be capable of remaining safely in the home and community. The Florida Legislature did not expand Medicaid coverage to low income, non-disabled people living with HIV/AIDS as part of the Affordable Care Act (ACA). Thus, an applicant must demonstrate disability before applying for Medicaid and cannot use Medicaid to access therapies that might prevent disability.

In addition to the state's traditional Medicaid program, in 2006 Florida obtained an 1115 waiver to launch an experimental Medicaid pilot program in Duval and Broward counties. Through this program, traditional Medicaid was replaced with a managed-care model, in the hopes of reducing costs and improving efficiency by allowing beneficiaries to enroll in any available plan, including capitated managed care plans (HMOs) and provider-sponsored networks (PSNs). The managed care program was eventually expanded to Baker, Clay, and Nassau Counties, enrolling over 288,000 consumers in those areas, about ten percent of Florida's statewide Medicaid enrollment. Independent research shows that the pilot program's efficiency and cost-saving impacts have been mixed at best.

Medicare, including Medicare Part D, is a federally funded program that provides health insurance and prescription assistance to people over age 65 years. Disabled adults who are under age 65 and who have worked enough years to be eligible for Social Security Disability Insurance (SSDI) also automatically qualify for Medicare after receiving their SSDI benefit for two years. In Florida, 3.3 million individuals were enrolled in Medicare in 2014 (18% of the state's total population). Originally launched in 2006 and intended to help beneficiaries pay for prescription drugs, Medicare Part D requires an additional premium that varies by plan. Part D plans are required to offer a statutorily defined standard benefit which currently has a \$310 deductible, then coinsurance of 25% up to \$2,830 in total drug costs followed by a gap in coverage between \$2,830 and \$4,550 (known as the "donut hole"). Of the 27 private prescription drug plans in Florida, ten offer at least some gap coverage. The plans vary in their coverage of generic drugs.

It's worth noting that most antiretroviral medications that treat HIV/AIDS do not have generic equivalents.

The impact of the HIV/AIDS Bureau's (HAB) **Veterans Administration (VA)** policy advising Part A grantees that veterans may access funded services through either the VA or Ryan White care system increased the use of Part A services by veterans. The Planning Council considered this factor when increasing core service allocations. The Part A Administrative Agency is continuing to monitor veteran service utilization of Part A services to assess the impact of this policy.

Part A funds are allocated for transitional housing assistance as part of the Jail Link program. These funds are utilized by recently released inmates of the Duval County Detention Center for up to 90 days at a time. Housing funds have not been allocated for use in other areas because the City receives an allocation of **HOPWA** funds through a Housing and Urban Development entitlement grant. Additionally, the Sulzbacher Center for the Homeless receives a HOPWA grant to house and counsel 30 PLWHA with substance abuse issues.

The expansion of the **Centers for Disease Control and Prevention's (CDC)** HIV testing initiative has resulted in an increased demand for HIV ambulatory/outpatient health and support services as newly identified HIV positive individuals are engaged in care. Five local agencies receive CDC funding passed through the State of Florida to provide counseling and testing targeted to Black MSM, crack-using Black women of child bearing age, and Black youth. There is also a testing initiative in the emergency department at UF Health Jacksonville Medical Center and a mobile van that visits substance abuse treatment facilities and homeless shelters.

The Florida Department of Health funds the **Targeted Outreach for Pregnant Women Act (TOPWA)** Program that establishes targeted outreach programs to high-risk pregnant women who may not seek proper prenatal care and who may suffer from substance abuse or HIV infection. The Department of Health contracts with UF CARES to provide TOPWA services in Jacksonville. In 2014, 294 women were tested for HIV and 259 women were tested for pregnancy. Sixty-one of the women were found to be HIV positive which includes newly diagnosed and previous positives. UF CARES utilizes TOPWA funding to conduct extensive outreach in homeless shelters, the jail, substance abuse treatment facilities, low-income housing projects, and the UF Health high risk OB clinic to find and link HIV positive women and their children to medical care. In 2014, the UF CARES enrolled 44 HIV+ pregnant women. Since receiving their first award of TOPWA funding in 2008, no woman enrolled in the program has had an HIV+ birth outcome.

Two community based organizations in the JTGA/Partnership 4 receive **SAMHSA** funding to provide HIV prevention services and **substance abuse and mental health** services to PLWH. However, these funds have been reduced in the past three years. The continued demand for substance abuse treatment has resulted in waiting lists for detoxification and residential treatment facilities. Due to funding shortfalls, local mental health services are highly prioritized for the severely and persistently mentally ill. Part A continues to monitor the level of funding for substance abuse treatment and mental health services for PLWHA to ensure access, retention, and adherence to HIV medical care. A summary of services by funding source can be found below in Table 9:

Funding Sources	2015 Budget	APEL	Catholic Charities	JASMYN	AIDS Healthcare Foundation	Community Rehabilitation Center	Gateway Community Services	FDOH Baker County	FDOH Clay County	FDOH Duval County	FDOH Nassau County	FDOH St. Johns County	Jacksonville Area Legal Aid	Lutheran Social Services	NE Florida AIDS Network	River Region Human Services	UF CARES
Part A	5,833,018			j	a,c,j l,s	h,j s	k,v			c,d, l			q	g,h,j, p,s,t, w	f,g,j, p,s,t, w	h,k,v s	a,h,i, j,m,n,
Part B	1,859,718							a,j	a	a,j	a	a					
ADAP	5,297,032							b	b	b	b	b					
Part C	1,609,750				e,x					e		e					e,x
Part D	695,529																a,h, j,t
CDC	1,983,334	x		m, x,o, t,u		x		x	x	x	x	x				x	
SAMHSA	800,000			x,m			k,v									k,v	
HOPWA	2,300,000		p				p							p	p	p	
Total	20,378,381																

Funded services:

(a) Outpatient/Ambulatory Medical Care	(m) Non-Medical Case Management
(b) AIDS Drug Assistance Program	(n) Child Care
(c) Local AIDS Pharmaceutical Assistance	(o) Health Education & Risk Reduction
(d) Oral Health	(p) Housing
(e) Early Intervention Services	(q) Legal Services
(f) Health Insurance Premium and Co-Pay Assistance	(r) Linguistic Services
(g) Home and Community Based Health Care	(s) Medical Transportation
(h) Mental Health	(t) Outreach
(i) Medical Nutrition Therapy	(u) Psychosocial Support
(j) Medical Case Management	(v) Substance Abuse - Residential
(k) Substance Abuse – Outpatient	(w) Food Pantry/Vouchers
(l) Emergency Financial Assistance	(x) HIV Counseling and Testing

b. The HIV Workforce Capacity of the region is adequate to meet the needs of all PLWHA accessing care. There are some areas that could use additional licensed professionals. Those areas are outpatient medical care, oral health, and medical case management. Although there are six funded medical clinics (AHF, UF CARES, and four county health departments), there are a limited number of physicians to see clients. In addition, physicians have a tendency to move from one clinic to another creating a lack of care continuity. All of the medical clinics continue to solicit and engage additional physicians to provide medical care to PLWHA. There are only two Ryan White funded oral health providers, one located at the health department in Duval County and one located at the health department in St. Johns County. The Ryan White Part A Administrative Agency has attempted on numerous occasions to engage other oral health providers to no avail. The problem seems to be that other oral health providers do not want their existing clients to know they treat PLWHA and they do not want all the legislative requirements that come with the funding. There are nine funded agencies providing medical case management services. Those agencies employ approximately 34 medical case managers at any given time to serve 4050 clients. With a standard of 75 PLWHA per case manager and the number of PLWHA requiring services, the JTGA/Partnership 4 is short 16 medical case managers. Even with

additional funding, medical case managers are hard to find and keep and agencies experience a high rate of turnover.

c. The Part A/B Planning Council has a process that ensures continuity of HIV prevention, care, and treatment services through the interaction of different funding sources. The Planning Council's prioritization and allocation process ensures that RWHAP funds are the payer of last resort, maximize the number and accessibility of services available, and reduce any duplication in the HIV/AIDS care system. In addition to PLWHA, the Planning Council's established and fully integrated planning process engages representatives of key funders and stakeholders in all levels of planning, decision-making, implementation, and evaluation activities. Representatives include the District 4 Medicaid office, City of Jacksonville Housing Opportunities for Persons with AIDS (HOPWA), FDOH AIDS Program Office (the lead agency for Part B, ADAP, and CDC prevention initiatives), FDOH in Duval County (the grantee for Part C funds and WIC in Duval County), FDOH in St. Johns County (the grantee for Part C funding in St. Johns County), the UF CARES (the grantee for Targeted Outreach for Pregnant Women Act [TOPWA], Part C and Part D funding), the Sulzbacher Center (the Federally Qualified Health Center [FQHC] grantee), and the City of Jacksonville (the grantee of Part A and Minority AIDS Initiative funding [MAI]).

To illustrate how different funding sources interact, Part A Administrative Agency staff prepare a table showing need for funding, available funding, and gaps in funding by service category. During the priority setting and allocations process, Planning Council members use this gap analysis to allocate Part A and B funding. For example, the amount of funding needed to provide primary medical services is calculated based on the number of PLWHA to be served. Sources of funding for primary medical care are identified as Medicaid, Medicare, and private insurance, and the sources of funding are subtracted from the total need for funding. Part A and B funds are then allocated to fill gaps. Where there is no gap identified, there is no recommendation to allocate funds.

d. Needs assessment data, current and past, have consistently identified the need for additional funding for stable (not transitional) housing, transportation, mental health counseling, and substance abuse treatment. Although the City of Jacksonville receives \$2,300,000 in HOPWA funding each year to provide five months of transitional housing per client in a 12 month period, there is no source of funding for stable housing. The wait for public housing is three years. Several agencies in the region are considering development of affordable housing for PLWHA within the next two years. One agency has the land but not the funding. Transportation has been an identified need for the past 20 years. With the rural nature of the 5 county area, accessing care is very difficult for PLWHA. Many PLWHA live more than 20 miles from a medical clinic. Funding for mental health counseling has been available through Part A and B but clients fail to access the services. As a result, funding has been reduced by the Planning Council for the past six years. The Planning Council sponsored a Mental Health forum in 2015 that revealed the fact that many clients do not access mental health services because they do not believe they are "crazy" or they are too depressed to leave the house. As a result, the Part A Administrative Agency initiated a "life coach" approach to mental health counseling that is still in the development stage. If successful, the Planning Council will be willing to allocate more funding for mental health services. The need for substance abuse residential treatment exceeds available resources. The Part A Administrative Agency and Part B Lead Agency initiated a program in 2016 to reengage inmates of the Duval County Detention Facility into medical care. Part of the initiative allows inmates with substance abuse issues to receive

treatment upon their release. As a result, some PLWHA who are not eligible for the Jail Link Program but needing treatment are not being served because of a shortage of funding.

D. Assessing Needs, Gaps, and Barriers

a. The process used to develop a collaborative and coordinated needs assessment that resulted in greater alignment and access to HIV prevention, care, and treatment services included: 1) identifying and assembling stakeholders representative of HIV prevention, care, and treatment programs as well as substance abuse, mental health, and housing service providers, community leaders and PLWHA; 2) identifying data that needed to be collected and developing a method for collecting the data; 3) identifying existing resources among HIV prevention, care, and treatment programs that currently exist and those that are needed; and 4) identifying barriers that impede access to existing services. The region needs assessment process targeted PLWH who knew their HIV status, but were not in care, persons at higher risk for HIV infection, the recently incarcerated, and other underserved populations.

The Care Coordination Committee of the Ryan White Part A and B Metropolitan Jacksonville Area HIV Health Services Planning Council (Planning Council) in collaboration with the Prevention Planning Subcommittee of the First Coast Community AIDS Prevention Partnership (FCCAPP), served as the forum for developing the Integrated HIV Prevention and Care Plan (IHPCP). Members of the Joint Planning Committee, members of FCCAPP, and RW Part A and B Program staff targeted and recruited representative service providers, PLWHA, and other community leaders to participate in the planning process. PLWHA were recruited from recently lost to care rolls, consumer advisory boards (CABs), consumer luncheons, and service provider waiting rooms.

The Joint Planning Committee utilized several methods to collect information about the target populations, barriers to care, and gaps in existing services to develop goals, objectives, strategies, and activities to reduce new HIV infections, increase access to medical care, reduce HIV-related health disparities and health inequities, and enhance the overall quality of HIV services for all PLWHA. The first method for collecting information was to review the most recent CDC Surveillance and epidemiologic data to identify the target populations. The second method was to review Statewide Needs Assessment data collected for the JTGA/Partnership 4 in 2013, and data collected from PLWHA lost and returned to care in 2015 to decide if additional information was needed. It was decided that additional information would be useful so the Committee developed and distributed a brief, two page anonymous client needs assessment survey for completion by PLWHA. Surveys were given to all prevention and patient care service providers, consumer advocacy boards and committees, PLWHA members of FCCAPP, and PLWHA members of the Planning Council to be completed and returned in a 30 day period (the month of February 2016). The third method was to review 2015 Youth Risk Behavior Survey data (YRBS). The fourth method was to conduct focus groups with Ryan White service providers, FCCAPP members, and PLWHA lost and returned to care. The fifth method was to review HIV Care Continuum data to identify gaps in services.

Surveillance data tells us that the most at risk populations are African-American MSM, White MSM, African-American women, injecting drug users, transgendered people and youth. The number and percentage of new cases of HIV and AIDS are among these groups making them the target populations of the IHPCP Plan. Survey questions were developed to solicit responses to why some populations are more likely than others to become infected with HIV, not access medical care, and more likely to convert to and die of AIDS. Other questions dealt with

what prevented PLWHA from accessing care, and perceptions of stigma and discrimination. More than 274 surveys were returned in the 30 day survey period. Findings from the needs assessment surveys and focus groups were the following:

Sexual Health Behavior – Among the sexually active, one in five engaged in unprotected sex. Of this group, condom despicability meaning either sex partner does not like a condom or they are not comfortable with it personally, accounted for three in ten respondents who had unsafe sex. Sexual diversity, which is multiple sex partners, also emerged as a component of sexual health behavior, with seven of ten sexually active respondents reporting at least one sex partner. There was also the factor of non-disclosure of HIV status to sex partners for fears associated with personal and psychological well-being.

Client's Barriers to Access Care and Services – A client's sense of service needs span four domains covering nine factors. Those domains and factors are: 1) Health system (could not get an appointment and lack of transportation); 2) Personal knowledge (don't know where to get services and could not pay for services); 3) Survival (from homeless to could not get time away from work); and 4) Psychological (depression, not feeling sick, and not wanting people to know I have HIV).

Client's Perceptions of HIV Service Priorities – A client's sense of service needs span four domains covering ten services. Those domains and services are: 1) Biomedical (outpatient medical care and dental/oral health); 2) Financial (payment for medications and health insurance premiums and copayments); 3) Survival (housing, food bank/food voucher, transportation, and retention in care); and 4) Psychological (mental health services and substance abuse treatment).

Medication Adherence Status – Some 87% of respondents provided data on adherence to medications. A little more than one in 10 (11.3% or 27) PLWHA have medication compliance dissociation, meaning not taking antiretrovirals as prescribed by a medical professional. When asked about reasons for medication noncompliance, three things stood out: 1) feeling healthy; 2) forgetting to take medications; and 3) not liking to take medications. These factors accounted for almost 25% of medication non-compliance.

Needs of PLWHA upon Release from Incarceration or Detention – A minority of the region's PLWHA spent time in the penal system. According to survey respondents, only one of five PLWHA at the exit from jail, received referrals to HIV medical care and had a supply of ART, and even fewer had transportation assistance or information about housing. A little more than 38% (14 out of 37) accessed HIV outpatient medical care within two weeks of release. The same is not true for access to ancillary services. For example, food bank and housing services reached only 1 in 5 within two weeks of release.

b. HIV prevention needs of persons at risk for HIV and PLWH were assessed in focus groups asking the following questions:

1. *Why are some populations more likely than others to become infected with HIV, not access medical care, and more likely to convert to AIDS?* Answers included: 1) stigma and fear of judgment; 2) mental health and substance abuse issues; 3) illiteracy; 4) belief they will live forever; 5) providers unwilling to talk about safe sex; 6) low self-esteem; 7) social pressure to fit in; 8) lack of access to protection; 9) hidden self/on the down low; and 10) cultural norms.
2. *What keeps HIV positive people from disclosing their HIV status to their sex partner?* Answers included fear of rejection by sex partner (42%), fear of being hurt by others (35%), and fear of rejection by family and friends (23%).

From these responses, it would appear that the HIV prevention needs of persons at risk for HIV would be increased access to HIV testing venues, greater access to condoms, educational messages through social media, development and implementation of evidenced-based interventions, and promotion of PrEP/nPEP programs. These initiatives are addressed in Goal 1 of this plan to reduce new HIV infections.

Care service needs were prioritized in the needs assessment survey (respondents were asked to prioritize the top five) as: 1) outpatient medical care (66%); 2) medications (66%); 3) dental/oral health (50%); 4) housing (48%); 5) mental health services (40%); 6) food bank/food vouchers (40%); 7) transportation to appointments (38%); 8) health insurance premiums & co-payments (37%); 9) substance abuse treatment (20%); and 10) outreach to HIV patients out of care (17%). These needs are addressed in Goal 2 of this plan to increase access to care and improve health outcomes for people with HIV as well as by the Planning Council in prioritizing services and allocating Part A and B Ryan White and General Revenue funds to meet the needs.

c. HIV prevention service gaps have been identified as: 1) lack of adequate funding for HIV/STD education and health promotion programs in the community; 2) challenges reaching youth with effective prevention programs (lack of comprehensive sex education in most schools); 3) lack of PrEP availability; 4) stigma concerns; and 5) lack of education and testing by primary care providers and emergency room providers. Implementing the objectives and strategies of Goal 1 of the plan will address many of the issues raised in the needs assessment. Care service gaps have been identified as: 1) lack of consistently available transportation resources; 2) stigma concerns affect client engagement; 3) lack of stable housing; and 4) limited mental health/substance abuse care resources.

d. *Barriers* to HIV prevention and care services identified in the needs assessment survey and focus groups include:

- i. Social and structural barriers such as stigma concerns that limit the effectiveness of linkage efforts (fear of being recognized as a person with HIV), high rates of poverty among PLWHA, system is too hard to navigate, and significant travel required to medical care for many individuals in outlying counties of the JTGA/Area 4;
- ii. Program barriers such as lack of funding for HIV/STD education and health promotion programs in the community, lack of PrEP availability, and lack of standard HIV screening and testing protocols in Emergency Departments;
- iii. Service provider barriers that involve the movement of care providers from one agency to another, some perception of lack of welcoming clinic environment, too little time with provider (feeling of being rushed), rudeness at the front desk, provider hours of operation; lack of education and testing by primary care providers; and
- iv. Client access barriers such as homelessness/housing instability, inability to navigate the system of care, comorbid conditions, limited mental health/substance abuse care.
- v. There are no significant federal, state, or local legislative/policy barriers. In fact, the Florida Legislature recently passed legislation for the Opt-Out for HIV testing bill. The law allows Florida doctors, in healthcare settings, to offer HIV testing as part of all routine medical tests given by physicians. Patients will still be informed that the test is being provided.

Written consent forms will continue in non-healthcare settings, such as health fairs and testing conducted at community-based organizations.

E. Data, Access, Sources, and Systems

a. The main data system utilized for data collection, monitoring and reporting in the region is CAREWare. It is a server based, centralized, but scalable software application for evaluating the impact of HIV clinical and supportive care. On the end-user side of the application, client level data are entered using editors, whereas, on the administrative side of the application, client level data are imported or exported to or from other data management information systems. After CAREWare has been populated with data, data elements are examined for completeness and accuracy, and predefined end-user interfaces, accessible by point-and-click functionalities, allow the system's administrator to produce Ryan White HIV/AIDS Service Reports (RSR), demographic reports, clinical performance measures reports or other queried reports based on end-user needs, which are queried using filters. These and other CAREWare outputs are both tabular and graphic, and are available on both the end-user side and the system's administrator side. On the end-user side, a user has access only to his/her domain, but on the system's administrator side, data outputs are extracted from all domains (sub-recipients). CAREWare generates data for development of the HIV Care Continuum (linked to care, in care, on ART, and viral load suppression by funded service provider), HAB Performance Measure compliance, unmet needs assessment, lost to care report, and re-linked to care through outreach report.

The various types of reports that the Planning Council uses for the Needs Assessment and the HIV Continuum of Care include: Client Demographic Reports, Clinical Encounter Reports, Financial Reports; HAB Performance Measures; Lab Reports; Medication Reports; Service Utilization Reports; and WICY Reports.

Epidemiologic, surveillance, counseling and testing, and unmet need data was also provided via the FDOH, HIV/AIDS Reporting System (eHARS). Using Florida data instead of data from the Centers for Disease Control (CDC) provides the Planning Council access to more timely and comprehensive data specifically tailored to the area. Florida has had HIV reporting since July 1, 1997. The Florida eHARS data provides exposure status for adults by sex and with risks redistributed according to the history of the local area. eHARS data is more precise than the CDC's protocol which uses history of risk reclassification of the entire southeast quadrant of the United States.

b. HRSA's Client Level Data (CLD) capture policies mandate that all RWHAP service providers collect all of HAB's required RSR data elements and enter the data into the CAREWare system. The data policies facilitate the data capture required to generate the Needs Assessment and the HAB Performance Measures. Two of the area's service providers capture CLD using disparate data systems. The CLD captured by these disparate systems is exported from these systems and imported into CAREWare in order to obtain a complete client record that is imperative to accurate reporting the planning group uses to conduct the Needs Assessment, generate the HAB Performance Measures, and the HIV Continuum of Care data.

c. There are PLWHA eligible and enrolled in the region's Ryan White Program that receive core medical services funded by non-Ryan White payer sources. These PLWHAs' medical data are not captured in CAREWare as the out-of Ryan White Network medical providers do not and will not use CAREWare as they are not providing or receiving any Ryan White funded services or funds. Presently, the only avenue of capturing this data is for the Part A and B Medical Case

Managers to obtain the medical information from their clients and manually enter the data into CAREWare to complete the client record. The absence of this data under-reports the services utilized and generates lower HAB Performance Measure and HIV Continuum of Care percentages.

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

The JTGA/Partnership 4 Plan was developed by the Metropolitan Jacksonville Area HIV Health Services Planning Council (Planning Council) in collaboration with the First Coast Community AIDS Prevention Partnership (FCCAPP), RWHAP Parts A, B, C, and D grantees, mental health and substance abuse treatment providers, community leaders, and PLWHA in care and lost to care. This group of stakeholders met as part of the Planning Council's Coordination Committee to achieve a more coordinated jurisdictional response to the local HIV epidemic. Members developed goals and objectives that responded to the needs identified in Section I of the Integrated HIV SCSN/Needs Assessment and align with the three NHAS goals: (1) reducing new HIV infections; (2) increasing access to care and improving health outcomes for PLWH; and (3) reducing HIV related disparities and health inequities.

All but two objectives describe at least two strategies that correspond to each objective. Each strategy is further defined by activities/interventions, targeted populations, responsible parties, time-phased, and resources needed to implement the activity. Activities are specifically aimed at addressing gaps along the HIV Care Continuum. Responsible parties include all stakeholders and RWHAP funded service providers in the planning and implementation process to include the FCCAPP planning group, Planning Council EIIHA Committee, Planning Council Coordination Committee, FDOH AIDS Program Office Surveillance Unit, Minority AIDS Coalition (MAC), medical case managers and supervisors, mental health and substance abuse treatment agencies, outpatient medical care providers, RWHAP Part A and B Administrative/Lead Agencies, RWHAP Part C grantee, Jail Link staff, peer navigators, retention in care coordinators, and the TOPWA grantee. Target populations include African-American MSM, African-American women, transgendered people, injection drug users, and youth between the ages of 18 and 24 years. See Appendix 1, Integrated Prevention and Care Plan Goals, Objectives, Strategies and Activities. Included in this narrative are the Goals, Objectives, Strategies, and Activities:

Table 10: Goals, Objectives, Strategies, and Activities of IHPCP 2017 - 2021
NHAS Goal 1: Reduce new HIV infections.
<u>Objective 1.1:</u> By December 2021, increase the number of health care providers that offer routine HIV testing by 1 per year (from 0 new to 5 new).
<u>Strategy 1.1.1:</u> Develop and implement plan for identifying and promoting routine testing with a broad spectrum of health care providers in a variety of areas.
<u>Activities</u> aimed at increasing the number and percentage of persons infected with HIV who are aware of their status: (1) develop list of potential health care providers who offer routine HIV testing; and (2) distribute routine testing guidance and related marketing materials, including EIIHA routine testing packet developed in 2015 and model protocol approved in 2016, to listed providers.
<u>Strategy 1.1.2:</u> Provide annual face-to-face follow-up contacts with providers to ensure progress of implementation.

<u>Activities</u> aimed at increasing the number and percentage of persons infected with HIV who are aware of their status: Include routine testing follow-up during HIV surveillance site visits to providers to determine implementation.
<u>Objective 1.2:</u> By December 2021, increase the number of testing events in Partnership 4 counties outside of Duval by 1 per year (from 0 new to 5 new). <u>Strategy 1.2.1:</u> Develop and implement testing plan for Partnership 4 counties outside of Duval. <u>Activities</u> aimed at increasing the number and percentage of persons infected with HIV who are aware of their status: (1) identify list of existing test sites in outlying counties; (2) identify list of new potential test sites in outlying counties; and (3) provide support to testing events in Area 4 counties outside of Duval to include National Awareness days. <u>Strategy 1.2.2:</u> Draft new High Impact Prevention (HIP) contracts to include HIV testing in the outlying counties. <u>Activities</u> aimed at increasing the number and percentage of persons infected with HIV who are aware of their status and preventing new infections are: (1) develop plan to identify agencies with the ability to provide testing in Area 4 counties outside of Duval County; and (2) enter into HIP contracts.
<u>Objective 1.3:</u> By December 2021, ensure that at least 90% of social marketing materials developed by publicly funded HIV providers contain at least 1 of the following: an HIV testing message, information about where to get free condoms, where to go for information about PrEP and PEP, retention/re-engagement, or a message to eliminate stigma. <u>Strategy 1.3.1:</u> Pilot and update early iterations of youth-centric, social marketing materials. <u>Activity</u> aimed at preventing new infections: (1) develop youth-centric messages; and (2) pilot test in venues where high risk youth congregate. <u>Strategy 1.3.2:</u> Develop and disseminate inventory of appropriate prevention messages for youth and adults. <u>Activity</u> aimed at preventing new infections: (1) compile a list of prevention messages from state and national sources for review and approval; (2) provide examples of messages to local publicly funded HIV providers; and (3) facilitate provider forums to share social marketing content.
<u>Objective 1.4:</u> By December 2021, establish at least 1 PrEP/nPEP medical provider (including local DOH) per year (from 0 to 5). <u>Strategy 1.4.1:</u> Develop plan to identify existing and new PrEP/nPEP Partnership 4 providers. <u>Activity</u> aimed at preventing new infections is to develop local guidance of statewide PrEP/nPEP plan. <u>Strategy 1.4.2:</u> Disseminate PrEP/nPEP guidance to healthcare providers (including local DOH). <u>Activity</u> aimed at preventing new infections is to distribute CDC and/or DOH PrEP/nPEP guidance. <u>Strategy 1.4.3:</u> Provide face-to-face follow-up contacts with providers to ensure progress of implementation. <u>Activity</u> aimed at preventing new infections is to include PrEP/nPEP follow-up during HIV surveillance site visits to providers to determine implementation.
<u>Objective 1.5:</u> By December 2021, increase non-traditional venues for condom distribution by 5 per year (from 0 new to 25 new). <u>Strategy 1.5.1:</u> Create an inventory of events and locations where condoms are or could be routinely distributed. <u>Activities</u> aimed at preventing new infections are: (1) map existing distribution of condoms by

publically funded HIV and other service providers; and (2) disseminate maps/records of current and potential condom distribution locations and partners to FCCAPP membership. <u>Strategy 1.5.2:</u> Facilitate capacity building outreach to potential condom distribution partners. <u>Activity</u> aimed at preventing new infections is to conduct site visits or other activities to provide capacity building for condom distribution.
<u>Objective 1.6:</u> By December 2021, identify and implement 1 evidence based intervention for high risk negatives and/or HIV positives by 1 per year (from 0 to 5). <u>Strategy 1.6.1:</u> Identify evidence based interventions for high risk populations. <u>Activity</u> aimed at preventing new infections is to conduct a gap analysis for evidence based interventions. <u>Strategy 1.6.2:</u> Seek funding opportunities for implementing evidence based interventions identified in gap analysis. <u>Activity</u> aimed at preventing new infections is to develop an inventory of funding opportunities for evidence-based interventions needed in JTGA/Partnership 4. <u>Strategy 1.6.3:</u> Coordinate local training for evidence based interventions. <u>Activities</u> aimed at preventing new infections are: (1) identify local training resources; (2) identify national training resources; and (3) provide training for HIV prevention providers.
NHAS Goal 2: Increase access to care and improve health outcomes for people with HIV (PLWH).
<u>Objective 2.1:</u> By December 2021, assess 95% of all Ryan White enrolled clients for barriers to care (from 0 to 3022). <u>Strategy 2.1.1:</u> Develop and implement a plan to assess barriers to care. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) develop barrier assessment tool (possibly MMP protocol); and (2) utilize the tool developed. <u>Strategy 2.1.2:</u> Use a strengths-based approach for securing client’s involvement in care. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) identify positive activities in the lives of clients and offer positive praise and/or encouragement; and (2) co-create a care journey (map) with clients for reliable access to care. <u>Strategy 2.1.3:</u> Provide agency guidance for client-centered approaches to care—client feels more like a person than a patient. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) provide technical assistance to promote client-centered approach to services including soliciting questions and sharing decision-cost; and (2) share examples of different modalities of client encounters such as face-to-face, text, phone calls, email, post-cards, small group bag lunches, and so on.
<u>Objective 2.2:</u> By December 2021, ensure 95% of diagnosed PLWHA enrolled in medical case management have Individualized Service Plans (ISPs) that address barriers to care (from 0 to 3022). <u>Strategy 2.2.1:</u> Develop ISPs that identify barriers to care. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) determine indicators of lost-to-care and include in ISP; and (2) conduct review of client’s barriers profile in CAREWare. <u>Strategy 2.2.2:</u> Utilize peer navigators and retention in care coordinators in barrier reduction activities. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) relink clients lost to care by utilizing barrier’s profile; and (2) conduct barrier reduction case conferencing. <u>Strategy 2.2.3:</u> Document Ryan White funded medical case manager annual review of the effectiveness of planned activities to reduce barriers to care.

<u>Activities</u> aimed at linking and retaining PLWH in care are: (1) create standardized barrier reduction evaluation form for documenting client feedback; and (2) evaluate client feedback and share with all stakeholders.
<u>Objective 2.3:</u> By December 2021, link 90% of HIV positive pregnant women to prenatal care including HIV treatment (from 0 to 61). <u>Strategy 2.3.1:</u> Assure linkage of HIV positive pregnant women in care. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) refer pregnant women to Targeted Outreach for Pregnant Women Act (TOPWA); and (2) conduct targeted outreach to identify previously undiagnosed HIV positive pregnant women and refer to TOPWA. <u>Strategy 2.3.2:</u> Assess maternal barriers to prevention of perinatal transmission of HIV. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) develop brief pregnancy expectations and/or attitudes survey and include as a link to CAREWare eligibility determination tab (http://iussp2009.princeton.edu/papers/91126); and (2) assess housing status, residential mobility, and co-occurring conditions that pose barriers to care. <u>Strategy 2.3.3:</u> Assure community awareness of TOPWA services and other resources. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) distribute TOPWA program referral materials to all prenatal service providers; and (2) implement medication adherence and counseling programs to prevent perinatal transmission.
<u>Objective 2.4:</u> By December 2017, refer 75% of HIV infected inmates in the Duval County Jail, incarcerated for 14 days or more, to medical care upon release from the Duval County Jail (from 0 to 140). <u>Strategy 2.4.1:</u> Fully implement Jail Linkage Demonstration Project Protocol. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) implement and monitor protocol, including staffing and cost; (2) evaluate protocol; and (3) determine sustainability of protocol.
<u>Objective 2.5:</u> By December 2017, develop and disseminate a fast track linkage protocol to all funded providers (from 0 to 9). <u>Strategy 2.5.1:</u> Review and implement linkage protocols. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) review rapid linkage protocols such as the Connecticut Department of Public Health (DPH), Early Referral and Linkage Initiative (ERLI) Protocol; and (2) develop and implement rapid linkage protocol to meet the needs of PLWHA in the Jacksonville Transitional Grant Area (JTGA)/Partnership 4. <u>Strategy 2.5.2:</u> Evaluate effectiveness of the fast track linkage protocol during the first implementation year. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) create an online survey for provider and client comments; and (2) review and share provider and client comments, if any, at quarterly provider meetings and semi-annually with Planning Council Coordination Committee for consensus on adaptations, if indicated.
<u>Objective 2.6:</u> By December 2021, expand jail linkage protocol to 1 of the 4 outlying county jails (from 0 to 1). <u>Strategy 2.6.1:</u> Quantify staffing and health care system requirements in outlying county jails. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) identify average time and staff needed for preparing HIV positive inmate for connectivity to community HIV care and services; and (2) identify health system infrastructure needed to transition inmates into first outpatient medical care post release appointment. <u>Strategy 2.6.2:</u> Develop a recruitment package for stakeholders in outlying counties. <u>Activities</u> aimed at linking and retaining PLWH in care are: (1) draft summary guidance for

dissemination; (2) identify required commitments for successful implementation; and (3) distribute recruitment package.
NHAS Goal 3: Reduce HIV-related disparities, (difference in the burden of disease), and health inequities (preventable unjust differences in health status).
<u>Objective 3.1:</u> Beginning March 2017, assess nature and extent of HIV health disparities in JTGA/Partnership 4. <u>Strategy 3.1.1:</u> Collect data from epidemiologic profiles, gap analyses, needs assessments, focus groups and other methods. <u>Activities</u> aimed at preventing new infections, retaining PLWHA in medical care, on ART, and suppressing viral load: (1) develop and disseminate a dashboard of client's perceptions of their health disparities; (2) develop and disseminate a dashboard of providers' perceptions of client health disparities; and (3) analyze data and report trends in HIV health disparities.
<u>Objective 3.2:</u> By December 2018, develop at least two (2) strategies for providing client-centered care that promotes human dignity, and supports understanding diversity in order to address stigma and discrimination in at least 90% of service providers. <u>Strategy 3.2.1:</u> Integrate client-centered approaches into HIV prevention and care services. <u>Activities</u> aimed at preventing new infections, retaining PLWHA in medical care, on ART, and suppressing viral load: (1) develop and promote use of health literacy assessment tool in health care settings; (2) develop training modules to help staff examine individual characteristics, identify and remove barriers, and identify key cultural differences to eliminate gaps in services; and (3) utilize health literacy assessment findings to involve clients in making choices about their health care alternatives. <u>Strategy 3.2.2:</u> Advance human dignity in service delivery system. <u>Activities</u> aimed at preventing new infections, retaining PLWHA in medical care, on ART, and suppressing viral load: (1) research, identify, and develop best practices for enhancing client self-esteem and self-worth; (2) train service providers in the implementation of client confidence building; and (3) implement services that promote client self-worth. <u>Strategy 3.2.3:</u> Raise awareness of the ethnic, racial, geographic, social, and other issues that define and/or characterize clients' service needs. [As used here, issues denote communication styles, non-verbal behaviors, expectations, stereotypes, challenges engaging health care, customs, beliefs, preferences, and so on.] <u>Activities</u> aimed at preventing new infections, retaining PLWHA in medical care, on ART, and suppressing viral load: (1) identify cultural and linguistic skills of service providers relative to target populations; (2) develop cultural and linguistic competency (CLC) training modules for presentations in public meetings; and (3) develop CLC training modules that clients and service providers can access electronically—webinars, and other methods.
<u>Objective 3.3:</u> By December 2021, increase access to food and nutritional services for at-risk clients. <u>Strategy 3.3.1:</u> Identify nutritional needs of PLWHA in JTGA/Partnership 4. <u>Activities</u> aimed at retaining PLWHA in medical care, on ART, and suppressing viral load: (1) identify or develop a tool to assess nutritional needs and food services access; and (2) conduct client-centered nutritional needs assessment including food insecurity and comorbidities. <u>Strategy 3.3.2:</u> Identify and promote food pantry linkages. <u>Activities</u> aimed at retaining PLWHA in medical care, on ART, and suppressing viral load: (1) identify linkages, barriers, and gaps in service delivery; and (2) stock food pantries to address client needs.

Objective 3.4: By December 2021, implement a comprehensive integrated media campaign to address stigma and discrimination (from 1 to 4).

Strategy 3.4.1: Begin to construct social norms for fairness and respect for all marginalized people in JTGA/Partnership 4.

Activities aimed at preventing new infections, retaining PLWHA in medical care, on ART, and suppressing viral load: (1) assemble coalition to track, organize, and catalog examples of fair treatment and respect, or the lack thereof; for marginalized people in Northeast Florida; and (2) identify a collaboration partner for the design and dissemination of a digital storyboard that shows the status of fair treatment and respect for marginalized people in Northeast Florida.

Strategy 3.4.2: Establish a plan to educate elected officials, business, and other community leaders about HIV health disparities.

Activities aimed at preventing new infections, retaining PLWHA in medical care, on ART, and suppressing viral load: (1) develop a plan to recruit opinion leaders to help educate other leaders; (2) compile critical information and messages for dissemination to leaders; and (3) implement periodic communication with leaders at such events as town hall meetings, lunch-and-learn events, and briefing events.

B. Collaborations, Partnerships, and Stakeholder Involvement

a. Collaborations, partnerships, and stakeholder involvement include a network of prevention and service planning bodies and service providers. The stakeholders are the FCCAPP, the Part A/B Planning Council, the City of Jacksonville Ryan White Part A Administrative Agency, the State of Florida Department of Health Area 4 AIDS Program Office, and core medical and support service providers in the five county area. The Metropolitan Jacksonville Area HIV Health Services Planning Council (Part A) and the First Coast CARES (Part B) Consortium fostered collaborative work for many years that culminated in consolidation of the two bodies in 2009. The consolidated body is known as “the Part A/B Planning Council.” This merger facilitates increased coordination in needs assessments, service planning, service prioritization, resource allocation, and monitoring of prevention and patient care services and funding. Coordination among stakeholders is critical to maximizing resources and efficiencies in serving PLWHA and effectively improving outcomes along the HIV Care Continuum. All stakeholders were involved in the planning process. Specific contributions of stakeholders and key partners to the development of the plan are as follows:

Part A: The City of Jacksonville, FL is the grantee of RWHAP Part A funds. The City’s Division of Social Services is the Part A Administrative Agency responsible for contracting with community-based and hospital-based organizations in Duval County to provide HIV health and support services to PLWHA. The Mayor of the City of Jacksonville is responsible for appointing members to the Metropolitan Jacksonville Area HIV Health Services Planning Council. The Planning Council is responsible for determining the size and demographics of the population of individuals with HIV disease, determining the needs of such populations, establishing priorities for the allocation of Part A and B funds, developing the comprehensive plan for the organization and delivery of health and support services, participating in the development of the statewide coordinated statement of need initiated by the State public health agency, establishing methods for obtaining input on community needs and priorities which may include public meetings, conducting focus groups, and convening ad-hoc panels, and coordinating with Federal grantees that provide HIV-related services within the eligible area. Active members of the Planning

Council include persons filling mandated categories, FDOH representatives from the five counties, as well as other community representatives. In addition to RWHAP Parts A and B, the Planning Council includes PLWHA, representatives from Medicaid, Part C, Part D, private providers including Baptist Medical Center (a large regional hospital), substance abuse treatment providers, the Jacksonville Sheriff's Office Corrections Division, and UF CARES (the major provider of HIV/AIDS care for children and adolescents). The Planning Council has allocated funds to outpatient medical care, medications assistance, mental health, substance abuse treatment, medical and non-medical case management, oral health, medical nutrition therapy, health insurance premium assistance, transitional housing for recently incarcerated PLWHA, outreach, clinic based child care, medical transportation, and food assistance. The City of Jacksonville has awarded these funds to nine community and clinic-based organizations in Duval County.

Part B: The State of Florida is the Ryan White Part B grantee responsible for the AIDS Drug Assistance Program (ADAP) and distributing RWHAP Part B and Florida General Revenue Patient Care Assistance funds to areas throughout the State. The AIDS Program Office (APO) is the Part B Lead Agency responsible for contracting with the county health departments to provide HIV services to PLWHA. The health departments are funded to provide outpatient medical care, medical and non-medical case management, oral health, mental health, medical nutrition therapy, health insurance premium assistance, outreach, and medical transportation. The FDOH in Duval County manages the ADAP and ADAP Premium Assistance Programs.

Part C: FDOH in Duval County, FDOH in St. Johns County, AIDS Healthcare Foundation (AHF), and UF CARES receive Part C funding. Their roles include HIV counseling and testing, linking to services and provision of outpatient medical care. Each entity has an active HIV testing and linkage pathway to medical providers at the point of HIV diagnosis. Each county health department (CHD) offers HIV testing and linkage to care through the HIV and sexually transmitted disease (STD) programs. Program staff directly contact people diagnosed with HIV and offer linkage to care shortly after confirmation of HIV status. In contrast, UF CARES focuses on access to medical care and retention-in-care through collaboration with UF Health Disparity Clinics that offer access to comprehensive primary care. A monthly HIV specialty clinic, led by a Nurse Case Manager is held at UF CARES to monitor impact of this coordinated effort on scheduling, follow-up and care management of identified HIV infected patients.

Part D: UF CARES also receives Part D funding. Their role is provision of outpatient family-centered primary medical care and support services to women, infants, children and youth with HIV/AIDS. The program combines medical care, medical case management, health services research, nutrition counseling, psychological and psychiatric assessments and referral services. Additionally, the program uses a medical home model to serve single HIV+ women, and HIV+ women with children across their life- spans. Under this model, the UF CARES program has successfully achieved Level 3 Patient-Centered Medical Home Recognition through the National Committee for Quality Assurance (NCQA) which recognizes programs that facilitate partnerships between the individual patient, personal physician, physician specialist and when appropriate, the patient's family. As the only Part D provider and comprehensive pediatric HIV program in Northeast Florida, UF CARES offer a full slate of services, which are as follows:

- Participation in National Institute of Health (NIH) sponsored International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT) network.

- Active involvement in research opportunities for women, children, adolescents and families living with and affected by HIV/AIDS.
- Pursuit of national research grants and clinical trials in multiple areas that impact HIV/AIDS care and service delivery.
- Partnership for Access to Treatment and Housing (PATH) grantee collaborating with River Region Human Services to provide outpatient medical care and residential substance abuse treatment.

HOPWA: The City of Jacksonville is the grantee of Housing Opportunities for People with AIDS (HOPWA) funding every year because it has a population of over 500,000 persons and more than 1,500 cumulative cases of AIDS. Agencies receiving HOPWA funding in Jacksonville include Catholic Charities, Lutheran Social Services, Northeast Florida AIDS Network, and River Region Human Services. HOPWA funding provides short-term, transitional housing. Some programs target women with children and others target recovering substance abusers.

TOPWA: UF CARES, under contract with FDOH, manages the Targeted Outreach for Pregnant Women Act (TOPWA). The outreach team identifies women at risk of HIV infection or substance abuse, HIV positive women early in their pregnancy who fell-out of HIV care, and re-link them to care to reduce mother to child HIV transmission. Team members also follow the mother and child after delivery for up to 6 months to ensure access to and retention in care. Referrals of all HIV exposed infants are made to UF CARES for HIV testing and follow-up.

Jacksonville Sheriff's Office: The Jacksonville Sheriff's Office (JSO) is a partner in the Part A and B funded Jail Link Program. A medical case manager works with JSO medical staff in the Duval County Detention Center in assessing medical and support needs and determining eligibility of HIV+ inmates who are housed in the facility for 7 to 14 days. Based on the needs assessment, appointments for medical care are scheduled, prescriptions written for 30 days of medications, referrals for substance abuse treatment, mental health, and medical case management are made, and transitional housing arranged if inmate is not going home or directly to substance abuse residential treatment. Upon release, inmates are picked up by a Retention in Care Coordinator and either taken to substance abuse residential treatment, transitional housing, or their home. The Retention in Care Coordinator accompanies inmates to appointments for up to 90 days and then refers them to a designated medical case manager for continued care management.

Substance Abuse Treatment Programs/Facilities: Agencies providing substance abuse treatment services include River Region Human Services (RRHS) and Gateway Community Services (GCS). Both agencies receive Part A funding as well CDC and Substance Abuse and Mental Health Services Administration (SAMHSA) funding. Their services include substance abuse and mental health assessments, individual therapy, group counseling, residential treatment, and medication management. River Region Human Services received an Integrated Needs Treatment and Care (INTAC) grant to provide HIV, medical, mental health, and social services to African-American men and women at risk for HIV, STDs, substance abuse, or mental health problems. Partners on the INTAC grant include UF CARES and Department of Health in Duval County. Coordination occurs through the area's referral and linkage process implemented by all RWHAP funded agencies.

Prevention Programs: The region is implementing a host of prevention programs targeting all identified risk groups. FDOH is funded to provide HIV testing services to targeted populations within Area 4 under the Expanded Testing Initiative (ETI). CDC prevention

services funding includes HIV counseling and testing, health education and risk reduction, and partner notification services for Duval County. In an effort to increase the percentage of homeless persons who are aware of their HIV status and refer them to medical care, the FDOH AIDS Program Office (APO) in Duval County partnered with the Sulzabacher Center for the homeless. The HRSA/CDC initiative known as Partnerships for Care (P4C) expands the provision of HIV prevention and care services to the homeless population because homelessness is a huge social problem in Florida and Duval County.

Another health department initiative expands prevention education to youth in an after school program called the Teen Health Center (THC). The Jacksonville Partnership for Promoting Health for Emerging Adults (JPPHEA) is a partnership between the Duval County Public Schools (DCPS), Full Service Schools of Jacksonville (FSSJ), the Florida Department of Health in Duval County (DOH-Duval), the Jacksonville Area Sexual Minority Youth Network (JASMYN), the University of North Florida (UNF), and many other partners. During September 2015, the THC provided services at four schools in Duval County. The program provides group education, HIV counseling and testing, STI screening, and pregnancy testing. In addition, staff at the THCs make referrals for HPV vaccine at DOH, prenatal care/WIC/Healthy Start for pregnant teens, and contraception services at DOH Duval Woman and Children Center.

In addition to FDOH, there are other nonprofit organizations in the region that work closely with the patient care and prevention planning bodies to provide prevention services. JASMYN offers HIV prevention services designed to provide a comprehensive, multi-intervention approach to ending the HIV/AIDS epidemic among gay, bisexual, and other YMSM in northeast Florida. Services include: recruitment and outreach to YMSM through community events, social media, and club outreach; *HIV Counseling, Testing and Linkages* (CTL) and evidence-based interventions such as *Healthy Relationships*, a group intervention adapted for HIV+ youth to support healthy disclosures of HIV status to friends, partners, and family; PrEP, a comprehensive sex education intervention for teens; and ARTAS, a behavioral model for linking HIV+ youth to care. Safety net services include: a STD clinic where almost 30% of clients tested positive in the last year; case management services including follow-up and linkages to care for youth who test positive for HIV and other STDs; and case coordination services and linkages for homeless youth and substance abuse treatment. Retention in care, medication adherence, and viral load suppression are the primary focus for all case management with HIV+ youth. JASMYN provides youth development programs that include a drop-in center, support groups, youth council, leadership development programs, and support for high school and transgender youth. Community education and advocacy are also activities provided by JASMYN to include training, and consultation with an HIV+ youth panel to educate and address structural interventions for HIV prevention.

APEL Health Services' "Project YouthLink" Straight Talk Program is a youth empowerment initiative for teens and young adults in Northeast Florida. Youth are afforded the opportunity to participate in activities designed to increase effective decision making skills, hone good judgement, develop leadership skills, increase self-esteem, and build character through community outreach and social networking. Project YouthLink started as an HIV/STD awareness and pregnancy prevention program of APEL Health Services Center dedicated to health education and street outreach. Teens make connections with others like themselves and participate in activities and events designed to create awareness and prevention messages surrounding sexual health, teen pregnancy and STD/STI prevention.

Gateway Community Services was funded by SAMSHA for a High Impact Project for Men (HIP for Men) to improve health related outcomes for racial and ethnic minorities. This project is in partnership with APEL Health Services, JASMYN and the FDOH in Duval County targeting young (18 to 29 years) minority men (racial and/or ethnic minorities) who have sex with men (MSM) in order to reduce HIV and hepatitis transmission and increase access to care.

STD Programs: The FDOH in Duval County created *The Interdiction Project* (TIP) that provides intensive education to HIV+ person with a recent STD infection. In addition, the area's county health departments routinely screen for and treat Sexually Transmitted Diseases (STDs). STD testing takes place in public and private primary care clinics, family planning clinics (including federally funded Title X), and hospital emergency departments. Testing strategies are included in community STD outreach programs conducted on mobile health vans, bathhouses, jails, and substance abuse treatment facilities. Most FCCAPP member organizations also provide STD screening, and the Planning Council's Women, Adolescent and Children's Committee partners with private and public health care providers to provide STD screening as part of their outreach activities.

b. Stakeholders and partners not involved in the planning process but who are needed to more effectively improve outcomes along the HIV Care Continuum include private providers, **Medicare** and **Medicaid**, and community health centers. Private providers coordinating HIV health and support services in the JTGA/Partnership 4 include private physicians, all major hospitals, and the Sulzbacher Center for the Homeless. These agencies provide HIV testing venues within the emergency rooms, the county jail, and the homeless shelter. Other private agencies and local churches located in the targeted service area coordinate counseling and testing activities at popular community sites such as malls, flea markets, and private clinical settings.

Coordination is enhanced with Medicare and Medicaid by utilization of uniform consent forms, referral policies and unique client identifiers to limit duplication of services and define expectations for standards of Medical Case Management services and program eligibility. The JTGA/Partnership 4 has implemented a centralized eligibility process that requires eligibility staff to screen for other payer sources. Eligibility staff also refer potential candidates for other programs to case management agencies for assistance in filling out application forms. The RWHAP funded agencies assist eligible clients in receiving assistance with Medicare co-payments for doctor visits and medications.

The Sulzbacher Center for the Homeless provides medical and oral health care to homeless persons as a FQHC. The Center has an active HIV counseling and testing program, an established referral system, and a very successful linkage program. In addition, the Center has a cooperative agreement with the FDOH in Duval County to treat and refer all newly diagnosed persons with HIV/AIDS to appropriate health and support services.

The Planning Council and FCCAPP coordinating efforts include maintenance of existing mechanisms and creation of new innovative approaches to strengthen the HCC. The Joint Coordination Committee will meet bi-annually to address the goals, objectives, strategies, and activities identified in the IHPCP. Status of implementing the goals will be reported to both the Planning Council and FCCAPP. Adjustments to the IHPCP will be made by the Planning Council in collaboration with the FCCAPP to reflect local needs, changes in the HIV epidemic, and changes in the health care delivery system.

c. Letters of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the chair of the Metropolitan Jacksonville Area HIV Health

Services Planning Council and chair of the First Coast Community Prevention Partnership are included in Appendices 2 and 3.

C. People Living with HIV (PLWH) and Community Engagement

a. People Living with HIV (PLWH) were involved in the coordination and development of the IHPCP. PLWH members of the FCCAPP and Planning Council Coordination Committee were fully engaged in development of the Needs Assessment as well as the goals, objectives, strategies, and activities of the plan. Eight PLWHA participated on the 22-member Coordination Committee. Of the eight PLWHA, three were African-American females, four were white MSM, and one was an African-American MSM. Five PLWHA attended and participated in all of the meetings, and the remaining three participated in at least 50% of the meetings. PLWHA members were fairly representative of the epidemic in that 50% were African-American, 62% were MSM, and 37% were female.

b. All data were reviewed with the same scrutiny by PLWHA as other committee members. As each section of the IHPCP was discussed, PLWHA expressed their opinions and counter opinions about the importance or lack of importance of each section in the context of subpopulation members represented.

c. Methods used to engage communities, PLWH, those at substantial risk of acquiring HIV and other impacted population groups were numerous. Methods included announcements about development of the IHPCP at monthly FCCAPP meetings, service provider meetings and Planning Council PLWHAA Committee meetings, discussions at PLWHA luncheon and Consumer Advisory Board (CAB) meetings, medical and support service providers speaking with clients about involvement in the planning process. Public notices and flyers were distributed designating the day, time and location of meetings.

d. The impacted communities were most engaged in the needs assessment process and development of the goals, objectives, strategies, and activities of the plan providing critical insight into developing solutions to health problems to assure the availability of necessary resources. In particular, the consumer members of FCCAPP, members of the Peer Navigator Cooperative and the Planning Council's PLWHAA Committee members provided the focus of the planning effort by emphasizing the need to overcome barriers to accessing medical care. There were many questions regarding perinatal transmission of HIV, health literacy, stigma, and mental illness. Objectives, strategies, and activities were developed to address all of the issues raised by the impacted communities.

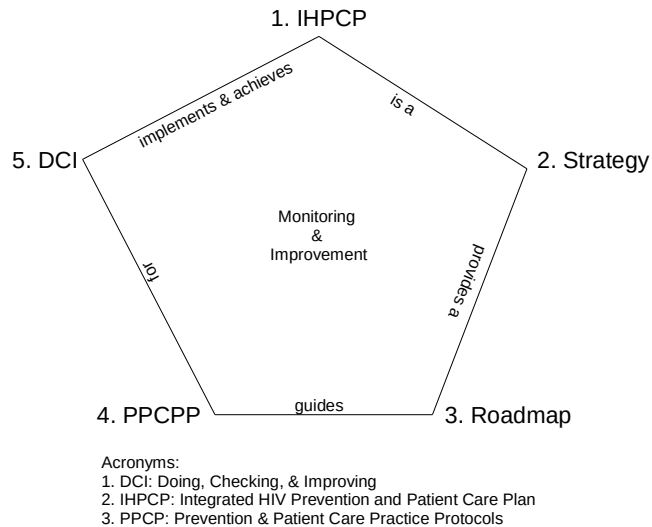
Section III: Monitoring and Improvement

A. Plan to Monitor and Evaluate Progress in Achieving Proposed Goals and Identified Challenges.

A system for monitoring implementation of the IHPCP objectives is pivotal to assuring stakeholders that the plan will translate into action. Assertions from page two, June 2015 Policy Guidance, sets the context. "The Integrated HIV Prevention and Care Plan (hereafter IHPCP) must cover calendar years 2017 [through] 2021, and serve as a jurisdictional HIV/AIDS Strategy. HIV planning bodies should use this living document as a roadmap to guide its HIV prevention and care planning throughout the year. Updates to the [IHPCP] can [proceed from] the [administrative] level [with submission] annually, if necessary, to reflect local needs and changes in the health care delivery system."

A visual depiction of the monitoring and improvement system components follow:

Monitoring & Improving the HIV Continuum of Care in the Jacksonville TGA/Partnership 4
(A Collaboration of All Ryan White Parts & Stakeholders in Northeast Florida)



The diagram makes transparent the two arms of the system. More specifically, the follow-up part of the evaluative system must ensure the transition from component one through five. Such movements hold promise to assist grantees and planning bodies with identifying gaps in implementing the IHPCP. Next, the improving part of the evaluative system must compare measured values against threshold values specified in IHPCP objectives to determine whether implementation task and activities are working as planned. These processes hold promise to assist grantees and planning bodies with data for assessing the meaningfulness of rates of change on baselines. The two arms of the monitoring and improvement system should be co-dependent in their capacities to inform the JTGA about the movement toward or away from targets, goals, and objectives. Given these aspirations, the section that follows will discuss three points: 1) Data collection; 2) Data analysis for decision-making; and 3) Processes for improving HIV prevention, care, and treatment within the jurisdiction.

Data Collection: This section outlines a plan to monitor and evaluate the implementation of objectives to achieve the IHPCP goals. The first goal aims to reduce new HIV infections, relying on six objectives (1.1 to 1.6), which point out data elements (1 to 6) for data collection. These elements include:

- 1.1: Provider offering routine HIV testing—PORT,
- 1.2: Testing events in outlying counties—TOC,
- 1.3: Thematic Social Marketing materials—TSMM,
- 1.4: Recruitment of PrEP/PEP medical providers—RPPMP,
- 1.5: Contemporary (non-traditional) condom distribution venues—CCDV, and
- 1.6: Evidence-based interventions for high-risk negatives and HIV positives—EBI-HRNP.

These six data elements will use thresholds established in their respective prevention objectives to develop an online survey with a binary (yes, no) response format, which indicates either attainment or non-attainment of the outcome in the respective objectives. Prevention staff will use checklists, event calendars, established protocols, work-plans, video recordings, still pictures, sign-up sheets, and so on to document activities associated with goal one objectives. First Coast Community AIDS Prevention Partnership will take the lead in developing a validation/verification system for assuring strong data collection activities. Florida Department Health, Duval, Part B, HIV/AIDS Prevention Coordinator will assign responsibilities for raw data capture, organization, and format for submission to a single database manager for data entry within seven working days of receipt of the raw data. Table 11 below shows what the TGA expects for Goal 1 during each year of the IHPCP implementation.

Table 11: Monitoring IHPCP 2017 – 2021 Goal 1 Objectives						
Data Elements	Dec. 2017	Dec. 2018	Dec. 2019	Dec. 2020	Dec 2021	Σ Thresholds
PORT	1	1	1	1	1	5
TOC	5	5	5	5	5	25
TSM	10%	25% (Δ15%)	45% (Δ20%)	70% (Δ25%)	90% (Δ20%)	> 90%
RPPMP	1	1	1	1	1	5
CCDV	5	5	5	5	5	25
EBI-HRNP	1	1	1	1	1	5
Objectives (%)	N ₁ /6	n/6	n/6	n/6	N ₅ /6	Σ(n ₁ ...n ₅)/30

Δ means change

Full attainment of each prevention objective is pivotal to the success of the IHPCP. Hence, a binary system of measurement appears warranted. Mid-year meetings for updates and course-correction, if indicated, will use data to assess the adequacy of planned activities to determine whether IHPCP revisions or maintenance should occur. If at year-end, results indicate less than 100% attainment of objectives, then reporting will follow a qualitative paradigm to account for what happened and what lessons emerged. Because the ultimate aim of IHPCP goal one objective is to reduce the spread of new HIV infections in the TGA, the Planning Council Coordination Committee proposes two hypothesis. In 2019, the TGA expects a decline in the year 2018 incident HIV positivity rate per 1,000,000 tests. In 2019, the TGA expects a drop in the year 2018 new HIV diagnosed cases after adjusting for annual population increases and immigration. The TGA's Coordination Committee will use FDOH as a data source for results to test the hypotheses above.

The second goal aims to increase access to care and improve health outcomes for PLWH, using seven objectives (2.1 to 2.7), which point out data elements (1 to 7) for data collection. These elements include:

1. 2.1: Assess in-care PLWHA barriers to care and services—AIPBCS,
2. 2.2: PLWHA MCM ISPs address barriers—PMI_ABC,
3. 2.3: Dual linkage to OAMC and TOPWA for pregnant HIV+ females—DLOT,
4. 2.4: Zero or near-zero mothers to child transmission—ZNZ_MTCT,
5. 2.5: Link formerly detained PLWHA to OAMC—LFDPTO,

6. 2.6: Migrate Jail Link Project to outlying counties—MJLP_TOC, and
7. 2.7: Deploy a fast track OAMC linkage protocol—DFTLP.

These seven data elements will use thresholds established in their respective patient care objectives to develop an online survey with a binary (yes, no) response format, which indicates either attainment or non-attainment of the outcome in the respective objectives. Responsibilities for completing the online survey items distribute accordingly:

- a. Part A site visit team, has responsibility for completion of survey items for objectives 2.1 to 2.3. The team will request a purposive sample of clients records for inspection to identify progress toward the respective IHPCP objectives. Sample size will be 61, where the standard deviation equals 8 and margin of error equals 4. If 95% and 90% of the records meet the IHPCP objective, the Coordination Committee will infer attainment of the objective.
- b. HIV primary medical care Medical Case Management Supervisors and CAREWare Systems Administrator have responsibility for survey items for objective 2.4.
- c. Part A Retention-in-Care Coordinator and Jail Link Medical Case Managers have responsibility for survey items for objective 2.5.
- d. The Jail-Link Task Force co-chair has responsibility for survey items for objective 2.6.
- e. Ryan White Part A Administrative Agency has responsibility for survey items for objective 2.7.

Table 12 below shows expectations for Goal 2 during each year of the IHPCP implementation.

Data Elements	Dec. 2017	Dec. 2018	Dec. 2019	Dec. 2020	Dec 2021	Σ Thresholds
AIPBCS	Δ10%	24% (Δ14%)	48% (Δ24%)	70% (Δ22%)	95% (Δ25%)	95%
PMI_ABC	Δ10%	24%	48%	70%	95%	95%
DLOT	Δ10%	25% (Δ15%)	45% (Δ20%)	70% (Δ25%)	90% (Δ20%)	90%
ZNZ_MTCT	< 1%	< 0.75%	< 0.5%	< 0.25%	0	0
LFDPTO	75%	77% (Δ2%)	80% (Δ3%)	83% (Δ3%)	85% (Δ2%)	85%
MJLP_TOC	1	1	1	1	0	4
DFTLP	4	-	-	-	-	4
Objectives (%)	N₁/7	n/7	n/7	n/7	N₅/7	Σ(n₁...n₅)/35

Δ means change

The third goal aims to reduce HIV-related disparities and health inequities, relying on six objectives (1.1 to 1.6) and point out data elements (1 to 6) for data collection. These elements include:

1. 3.1: Inter-agency cultural competency curricula development and revisions—IA3CsD,
2. 3.2: Providers host annual cultural competency training—PHACCT,
3. 3.3: Black MSM medical visit frequency—BMSM_MVF,
4. 3.4: Assessment and linkage to food pantry service—ALFPS,
5. 3.5: Assessment and linkage to medical nutrition therapy for multiple chronic diseases—LMNT, and

6. 3.6: Message HIV conversations in specific target audiences—MHCISTA.

Possible Disparities Reduction Objective: By December 2021, deploy five integrated media campaigns through historically inaccessible or previously unused information channels accessed by particular groups for addressing HIV stigma and discrimination.

These six data elements will use thresholds established in their respective community impact objectives to develop an online survey with a binary (yes, no) response format, which indicates either attainment or non-attainment of the outcome in the respective objectives.

Responsibilities for completing the online survey items distribute accordingly:

- a. The co-chair of a Culturally Competency Work Group, to be identified by the IHPCP Coordination Committee in fall 2016, will assume responsibility for completing survey items for objectives 3.1 and 3.2.
- b. HIV primary medical care Medical Case Management Supervisors and CAREWare Systems Administrator have responsibility for survey items for objective 3.3 to 3.5.
- c. The co-chair of an Integrated Media Campaign Work Group, to be identified by the IHPCP Task Force in fall 2016, will assume responsibility for completing survey items for objectives 3.6.

Table 13 below shows expectations for Goal 3 during each year of the IHPCP implementation.

Data Elements	Dec. 2017	Dec. 2018	Dec. 2019	Dec. 2020	Dec 2021	Σ Thresholds
IA3CsD	1	1	1	1	1	5
PHACCT	1	1	1	1	1	5
BMSM_MVF	Δ1%	3% (Δ2%)	5% (Δ2%)	7% (Δ2%)	10% (Δ3%)	10%
ALFPS	Δ1%	3% (Δ2%)	5% (Δ2%)	7% (Δ2%)	10% (Δ3%)	10%
ALMNT	Δ1%	3% (Δ2%)	5% (Δ2%)	7% (Δ2%)	10% (Δ3%)	10%
MHCISTA	1	1	1	1	1	5
Objectives (%)	N₁/6	n/6	n/6	n/6	N₅/6	Σ(n₁...n₅)/30

Δ means change

For data management and quality control, electronic copies consisting of survey items germane to each group of goal related objectives will transmit to the in-box of persons responsible for data gathering. Emails, sent 30-days ahead of due dates, will give instructions and return dates for completing the items. Follow-up phone calls and/or text messages will also prompt response rates so that by the close of business on the first working day of June and December of each year, from 2017 through 2021, the Part A Administrative Agency data entry operator can populate an online database. During fall 2016, after submission of the IHPCP, the Coordination Committee will develop and pilot test survey questions for all objectives in the IHPCP.

Qualitative Component: The description of monitoring and improvement, thus far, has been largely quantitative. Here, the plan proposes a collection of histories for assessment of implementation fidelity. Making no previous assumptions about what the field experiences of

persons implementing the IHPCP will be; a collection of individual and team stories, and field notes, if available, will capture the implementation experiences, unbiased by preconceived notions. Each year, two focus groups, convened during June and December, will provide the vehicle for qualitative data collection. The Joint Coordination Committee wants to learn about implementation integrity. Therefore, questions will seek why and how answers. Verbatim responses documented in participants native language and dialect, preferably English, will comprise the raw data for thematic analyzes. Subsequent data analysis, data organization and data interpretation should offer insights for understanding how to create a context for using the IHPCP as both a strategy and a roadmap for linkage to and closing gaps in the HIV Continuum of Care.

Table 14 below summarizes key aspects of the quantitative and qualitative data collection plan scheduled for June and December of each year, during the IHPCP life cycle.

Table 14: Synopsis of Key Aspects of the IHPCP Data Collection Tasks for Creating a Monitoring Gantt Chart at Inauguration					
IHPCP Objectives	Owners	Targets	Implementers	Follow-Up	Status
1.1 Providers offering routine HIV testing	DOH Prevention	Community	Medical Provider	Secret Shopper	
1.2 Testing events in outlying counties	DOH Prevention	Community	Prevention Staff	Secret Shopper	
1.3 Thematic social marketing materials	DOH Prevention	Community	CBO Developer	Auditor-TBD	
1.4 Recruitment of Prep/Pep medical provider	DOH Prevention	Physicians	DOH Leadership	Admin Agency	
1.5 Contemporary condom distribution venues	DOH Prevention	Community	Prevention Staff	FCCAPP	
1.6 EBIs for high-risk negatives and HIV+	DOH Prevention	Community	Prevention Staff	FCCAPP	
2.1 Assess in-care PLWHA barriers to care	Admin Agency	Providers	Part A Monitors	FCCAPP	
2.2 PLWHA MCM ISPs address barriers to care	Admin Agency	Providers	Part A Monitors	FCCAPP	
2.3 Dual linkage to OAMC & TOPWA	Admin Agency	Providers	Part A Monitors	FCCAPP	
2.4 Zero/near zero mother to child transmission	Medical Provider	Female & +	Medical Provider	Auditor-TBD	
2.5 Link formerly detained PLWHA to OAMC	Consortia	Detainees	Jail Link MCM	LSS	
2.6 Spread Jail-Link Project to outlying	Consortia	Jails	Consortia	LSS	

counties					
2.7 Deploy fast track OAMC linkage protocol	Admin Agency	Providers	Admin Agency	DOH Prevention	
3.1 Inter-agency cultural competency curricula	Admin Agency	Providers	Providers	FCCAPP	
3.2 Providers annual cultural competency training	Admin Agency	Providers	Providers	FCCAPP	
3.3 Black MSM medical visit frequency	Medical Provider	Black MSMs	MCM	Auditor-TBD	
3.4 Assessment & linkage to food pantry services	Admin Agency	PLWHAs	MCM/Providers	Part A Monitors	
3.5 Assessment & linkage to nutrition services	Admin Agency	PLWHAs	MCM/Providers	Part A Monitors	
3.6 Message HIV conversations in... audiences	DOH Prevention	Community	Work Group	Auditor-TBD	
Get insights from staff implementing the IHPPCP	Admin Agency	Implementers	Admin Agency	DOH Prevention	

Legend:

1. FCCAPP is First Coast Community AIDS Prevention Partnership, a Northeast Florida community-planning group.
2. LSS is Lutheran Social Services, a Northeast Florida non-profit that operates four major programs for disadvantaged people.
3. Auditor-TBD is someone that the IHPCP Task Force will ask to volunteer in a particular role for a limited duration of time.
4. Secret Shopper is a PLWHA, recruited by the IHPCP Task Force to engage in legitimate, clandestine surveillance.
5. ISP is individualized service plan, meaning tailoring a client's plan of care to his/her unique needs.
6. MCM is medical case manager; DOH is Department of Health; Administrative Agency is the Ryan White, Part A federal grantee.

Status is whether the objective is **complete, (C), in-progress, (IP), or not complete, (NC)** at mid-year or year-end.

Data Security: The duration and complexity of this project requires risk mitigation and management to be measured by implementation data. The electronic dataset that will store IHPCP implementation data will reside on the network server, which is backed-up locally and out-of-state. Access to data will require authentication, for a limited number of end-users, N=3, with restrictions on view, edit, and delete roles.

Data Analysis for Decision-Making: This section outlines the strategy—action plan or policy—to use surveillance and program data to assess and improve health outcomes along the

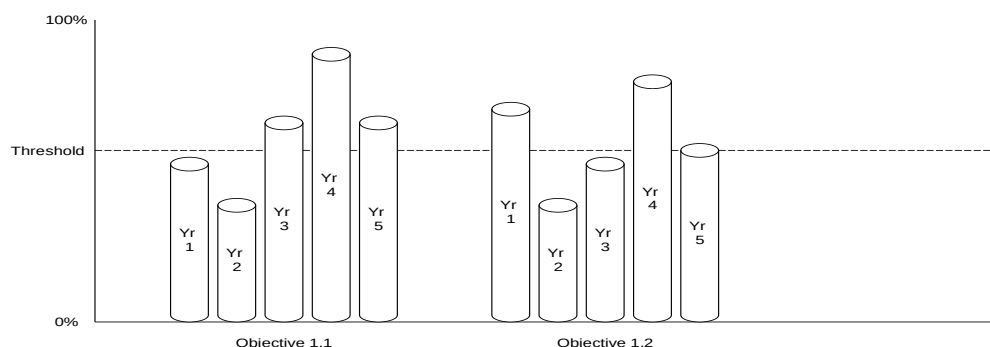
HCC. FDOH provides data on an annual basis. These data present HCC outcomes at the aggregate and disaggregate levels of analysis. Levels of data disaggregation have historically included divisions based on race. Using the year 2016 HCC outcomes as a baseline, the Joint Committee will review outcomes in subsequent years to assess the impact of IHPCP implementation. The Part A Administrative Agency also has access to FDOH unmet needs data that identify trends associated with no receipt of viral load testing, CD4 count, or provision of anti-retroviral therapy in a defined 12-month period. Thus, comparisons of unmet needs before and during IHPCP implementation will allow for decision making about additional steps to improve the system of care and services for PLWHA. Turning attention to program data, the Table below presents a framework for examining progress fulfilling the IHPCP objectives, years 2020 and 2021, and most objectives not shown. For each implementation year, the Joint Coordination Committee can identify specific levels of attainment by objectives to spot gaps in attainment and develop strategies for closing identified gaps.

Table 15 : Monitoring IHPCP Objectives through 2021

Data Elements & Objectives	Dec. 2017		Dec. 2018		Dec 2019	
	Planned	Achieved	Planned	Achieved	Planned	Achieved
1.1.1						
2.1.2						
1.2.1						
2.2.2						
3.2.3						
1.3.1						
2.3.2						

Tables are an excellent aid for data compacting, but may obscure patterns in the data that lie buried in the deluge of information. Thus, decision-making will include graphics. Figure 7 presents an alternative framework for examining progress fulfilling the IHPCP objectives. For each implementation year, the quantifying estimator (either percentages or counts) will group objectives by years of data collection so that the task force can identify specific levels of attainment in relationship to thresholds. A sample bar graph follows that can readily pinpoint departures from expectations.

Figure 1: Annual Trends in Percentages of Objectives that Fell Below and Exceeded Thresholds



Processes for Improving HIV Prevention, Care, and Treatment within the Jurisdiction:
This section outlines how the IHPCP Joint Coordination Committee will advance HIV

prevention, care, and treatment in the jurisdiction. All processes will have nexus in open, transparent dialog; critical analysis, consensus development; and intelligent compromise that does no harm to PLWHA. Thus, key stakeholders will have a role in system improvement, and will include:

1. The Metropolitan Jacksonville Area HIV Health Services Planning Council,
2. First Coast Community AIDS Prevention Partnership,
3. The IHPCP Joint Coordination Committee,
4. RWHAP Parts A through D funded service providers,
5. Invited members of the affected community, and
6. Consumers of Ryan White services.

All stakeholders will receive written summaries and oral explanations of content in the summaries on a semi-annual basis. Publicized meeting dates and venues will go out two weeks in advance to allow for scheduling. The Joint Coordination Committee will provide light refreshment, meet at convenient times, and provide transportation as needed to maximize participation at data briefings. During the first quarter of each subsequent implementation year, all stakeholders, previously identified, will receive an annual report of past 12-months implementation progress. Request for feedback will include both written and oral and in-person or private, such as letter or postcard. The Part A Administrative Agency will conveniently locate a locked box in an area to be determined to receive anonymous feedback. The Administrative Agency's experience in presenting data shows that providing context, discussing expectations, clarifying what was planned and attempted, and showing accomplishments or underachievements in succinct but easily comprehensible ways, aid stakeholder's comprehension. Therefore, the staff will follow that format as a precursor to soliciting stakeholders' feedback. Data briefing staff will catalog and submit all stakeholder's feedback to the IHPCP Committee, unedited, for review, evaluation, synthesis, and adoption. Where indicated, if the IHPCP Committee has difficulty making sense of feedback, the group will request in-person audiences from feedback contributors to answer questions or make clarifying remarks, before the adoption of recommendations.

Acronyms List: Abbreviations

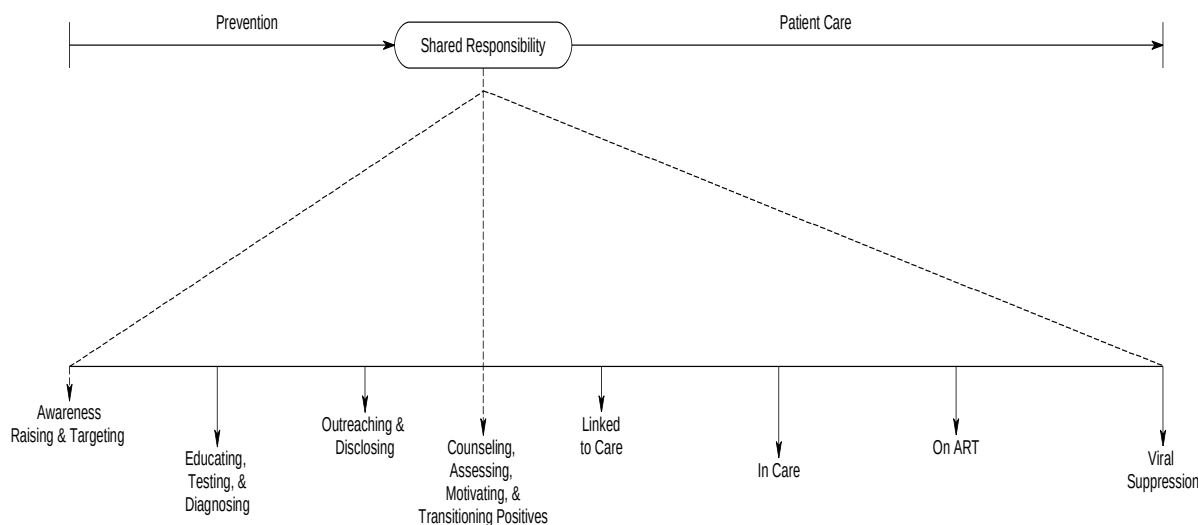
1. ACA: Affordable Care Act
2. ADAP: AIDS Drug Assistance Program
3. AETC: AIDS Education and Training Centers
4. AHCA: Agency for Healthcare Administration
5. AHF: AIDS Healthcare Foundation
6. ART: Antiretroviral Therapy
7. BMSM: Black men who have sex with men
8. CCC: Comprehensive Care Center
9. CAREWare: "...[A] free, scalable software for managing and monitoring HIV clinical and supportive care
10. CBO: Community Based Organization
11. CD4: Cluster of differentiation 4 is a glycoprotein expressed on the surface of T helper cells, monocytes, macrophages and dendritic cells
12. CDC: Centers for Disease Control and Prevention
13. CLC: Cultural and Linguistic Competency
14. CPM: Clinical Performance Measures
15. CRC: Community Rehabilitation Center
16. DCF: Department of Children and Families
17. eHARS: Electronic HIV/AIDS Reporting System
18. EIIHA: Early Identification of Individuals with HIV/AIDS
19. EIS: Early Intervention Services
20. ETI: Expanded Testing Initiative
21. FCCAPP: First Coast Community AIDS Prevention Partnership
22. FDOH: Florida Department of Health
23. FDOHB: Florida Department of Health in Baker County
24. FDOHC: Florida Department of Health in Clay County
25. FDOHD: Florida Department of Health in Duval County
26. FDOHN: Florida Department of Health in Nassau County
27. FDOHSJ: Florida Department of Health in St. Johns County
28. FHAB: Florida Department of Health, HIV/AIDS Bureau

29. FSSJ: Full Service Schools of Jacksonville
30. GCS: Gateway Community Services
31. HAB/HRSA: HIV/AIDS Bureau, Health Resources and Services Administration
32. HCBS: Home and Community Based Services
33. HIP: High Impact Prevention
34. HIPAA: Health Insurance Portability and Accountability Act
35. HIV/AIDS: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
36. HMS: Health Management System
37. HOPWA: Housing Opportunities for People with AIDS
38. HP 2020: Healthy People 2020 (National Health Objectives for the United States)
39. HPCNEFL: Health Planning Council of Northeast Florida
40. IDU: Injecting Drug User
41. IMPAACT: International Maternal Pediatric Adolescent AIDS Clinical Trials
42. IMSCH: I.M. Sulzbacher Center for the Homeless
43. INTAC: Integrated Needs Treatment and Care
44. IOM: Institute of Medicine
45. JALA: Jacksonville Area Legal Aid
46. JASMYN: Jacksonville Area Sexual Minority Youth Network
47. JPPHEA: Jacksonville Partnership for Promoting Health for Emerging Adults
48. LSS: Lutheran Social Services of Northeast Florida
49. MAC: Mycobacterium Avium Complex
50. MAI: Minority AIDS Initiative
51. MCM: Medical Case Management/Manager
52. MJAHSPC: Metropolitan Jacksonville Area HIV Health Services Planning Council
(Planning Council)
53. MSA: Metropolitan Statistical Area
54. MSM: Men who have sex with men
55. NASTAD: National Alliance of State and Territorial AIDS Directors
56. NCHD: Nassau County Health Department
57. NFAN: Northeast Florida AIDS Network
58. NHAS: National HIV/AIDS Strategy

- 59. NIDCR: National Institute of Dental and Craniofacial Research
- 60. NWBHS: Northwest Behavioral Health Services
- 61. OAMC: Outpatient Ambulatory Medical Care
- 62. P4C: Partnerships for Care
- 63. PCP: Pneumocystis Carinii Pneumonia
- 64. PLWA: People living with AIDS
- 65. PLWH: People living with HIV
- 66. PLWHA: People living with HIV/AIDS
- 67. PMC: Primary Medical Care
- 68. RRHS: River Region Human Services
- 69. RWHAP: Ryan White HIV/AIDS Program
- 70. SAORT: Substance Abuse Outpatient and Residential Treatment
- 71. SCSN: Statewide Coordinated Statement of Need
- 72. SMART: Specific, Measureable, Attainable, Realistic and Time bound
- 73. SSD: Social Security Disability
- 74. SSI: Supplemental Security Income
- 75. STD: Sexually Transmitted Diseases
- 76. STI: Sexually Transmitted Infections
- 77. TGA: Transitional Grant Area
- 78. THC: Teen Health Center
- 79. UF CARES: University of Florida Center for AIDS/HIV Research, Education and Service
- 80. VA: Veterans Administration
- 81. WAC: Women, Adolescent and Children
- 82. WICY: Women, Infants, Children and Youth

Appendix 1

Framework for Integrated Prevention and Care Plan Implementation, Monitoring, and Evaluation



Without the skeletal system, a body would not move and the entire mass of matter will pile like a glob of water-filled balloons. Prevention and patient care also need a skeletal, organizing structure. Thus, the Jacksonville TGA/Partnership 4 proposes a skeletal framework intended to serve as a pathway of defined steps to illuminate the crosswalk from prevention to patient care. Clearly, in the global space, this idea may have existed in some form before its appearance here; therefore, the originator (Graham Watts, Sr.) does not make a claim to novelty. However, what is new about this proposed framework is that it explicitly denotes an active and shared responsibility for a triad of formative activities—counseling, assessment, and motivational interviewing—to ease transition of newly diagnosed people from the larger, general population to the smaller, ambulatory care population where Peer Navigation and Retention in Care Coordination become critical for HIV viral suppression.

Table 1: Prevention Activities for Early Treatment for HIV to Reduce Risk of Viral Transmission.

NHAS Goal 1: Reduce new HIV infections				
Objective 1.1: By December 2021, increase the number of health care providers that offer routine HIV testing by 1 per year (from 0 new to 5 new).				
Strategy 1.1.1: Develop and implement plan for identifying and promoting routine testing with a broad spectrum of health care providers in a variety of areas.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop list of potential health care providers who could offer routine HIV testing.	12/1/2016 to 5/31/2017	Early Identification of Individuals with HIV/AIDS (EIIHA) Committee and	Doctors, Hospitals	Provider list

		First Coast Community AIDS Prevention Partnership (FCCAPP)		
Distribute routine testing guidance and related marketing materials, including EIIHA routine testing packet developed in 2015 and model protocol approved in 2016, to listed providers.	6/1/2017 to 6/30/2017	EIIHA Committee and AIDS Program Office (APO) Surveillance Unit	Doctors, Hospitals	Distribution logs maintained by EIIHA Committee, APO Surveillance Unit
Strategy 1.1.2: Provide annual face-to-face follow-up contacts with providers to ensure progress of implementation.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Include routine testing follow-up during HIV surveillance site visits to providers to determine implementation status.	7/1/2017 to 7/31/2017 and annually thereafter	APO Surveillance Unit and EIIHA Committee	Doctors, Hospitals	Provider Response Log
Objective 1.2: By December 2021, increase the number of testing events in Area 4 counties outside of Duval by 1 per year (from 0 new to 5 new).				
Strategy 1.2.1: Develop and implement testing plan for Area 4 counties outside of Duval.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Identify list of existing test sites in outlying counties.	8/1/2017 to 10/31/2017 and annually thereafter	Early Intervention Coordinator (EIC)	Existing test sites	Registered Public Test Site certification
Identify list of new potential test sites in outlying counties.	8/31/2017 to 10/31/2017 and annually thereafter	Minority AIDS Coordinator (MAC), EIC and Prevention Coordinator	New test sites	New test site development requests
Provide support to testing events in counties outside of Duval to include National Awareness days.	11/1/2017 to 11/30/2017 and annually thereafter	MAC, EIC and Prevention Coordinator	All identified sites	Test site reports

Strategy 1.2.2: Draft new High Impact Prevention (HIP) contracts to include HIV testing in outlying counties.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop plan to identify agencies with the ability to provide testing in counties outside of Duval County.	12/31/2016 to 1/31/2017	DOH APO Contract Manager	HIP providers	Plan to identify agencies
Enter into HIP contracts.	1/31/2017 to 4/1/2017	DOH APO Contract Manager	HIP providers	HIP contracts
Objective 1.3: By December 2021, ensure that at least 90% of social marketing materials developed by publicly funded HIV providers contain at least 1 of the following: an HIV testing message, information about where to get free condoms, where to go for information about PrEP and PEP, retention/re-engagement, or a message to eliminate stigma.				
Strategy 1.3.1: Pilot and update early iterations of youth-centric, social marketing materials.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop youth-centric messages.	6/1/2017 to 7/30/2017	FCCAPP and APO	Publicly funded HIV providers	List of messages
Pilot test in venues where high risk youth congregate.	8/1/2017 to 9/30/2017	EIIHA, FCCAPP, and APO	Publicly funded HIV providers	Distribution logs, email distribution list
Strategy 1.3.2: Develop and disseminate inventory of appropriate prevention messages for youth and adults.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Compile a list of prevention messages from state and national resources for review and approval.	6/1/2017 to 7/30/2017	FCCAPP and APO	Publicly funded HIV providers	List of messages
Provide examples of messages to local publicly funded HIV providers.	8/1/2017 to 9/30/2017	FCCAPP and APO	Publicly funded HIV providers	Distribution logs, email distribution list
Facilitate provider forums to share social marketing content.	9/30/2017 and annually thereafter	FCCAPP	Publicly funded HIV providers	FCCAPP meeting minutes
Objective 1.4: By December 2021, establish at least one PrEP/nPEP medical provider (including local DOH) per year (from 0 to 5).				
Strategy 1.4.1: Develop plan to identify existing and new PrEP/nPEP Area 4 providers.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop local guidance of	10/1/2017	FCCAPP and	Healthcare	Local version of

statewide PrEP/nPEP plan.	to 11/30/2017	APO Prevention Coordinator	providers	statewide PrEP/nPEP Plan
Strategy 1.4.2: Disseminate PrEP/nPEP guidance to healthcare providers (including local DOH).				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Distribute CDC and/or DOH PrEP/nPEP guidance	12/1/2017 to 12/31/2017	FCCAPP and APO	Healthcare providers	Distribution logs, email distribution list
Strategy 1.4.3: Provide face-to-face follow-up contacts with providers to ensure progress of implementation.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Include PrEP/nPEP follow-up during HIV surveillance site visits to providers to determine implementation.	12/31/2018 and annually thereafter	APO Surveillance Unit, FCCAPP, and EIIHA Committee	Healthcare providers	PrEP/nPEP Provider Response Log
Objective 1.5: By December 2021, increase non-traditional venues for condom distribution by 5 per year (from 0 new to 25 new).				
Strategy 1.5.1: Create an inventory of events and locations where condoms are or could be routinely distributed.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Map existing distribution of condoms by publically funded HIV and other service providers.	6/1/2017 to 7/31/2017	MAC, EIC, APO Prevention Team, and FCCAPP	Publically funded HIV service providers	GIS mapping products and regional condom distribution log
Disseminate maps/records of current and potential condom distribution locations and partners to FCCAPP membership.	8/1/2017 to 9/30/2017 and annually thereafter	MAC, EIC, APO Prevention Team, and FCCAPP	Publically funded HIV service providers	GIS mapping products and regional condom distribution log
Strategy 1.5.2: Facilitate capacity building outreach to potential condom distribution partners.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Conduct site visits or other activities to provide capacity building for condom distribution	12/1/2017 to 12/31/2017	MAC, EIC, APO Prevention Team, and FCCAPP	Potential condom distribution providers	Resource center MOA on file with DOH.
Objective 1.6: By December 2021, identify and implement 1 evidence based intervention for high risk negatives and/or HIV positives by 1 per year (from 0 to 5).				

Strategy 1.6.1: Identify evidence based interventions for high risk populations.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Conduct a gap analysis for evidence based interventions.	3/1/2017 to 3/30/2017	FCCAPP planning committee	HIV prevention providers	FCCAPP report
Strategy 1.6.2: Seek funding opportunities for implementing evidence based interventions identified in gap analysis.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop an inventory of funding opportunities for evidence-based interventions needed.	4/1/2017 to 5/30/2017	FCCAPP	HIV prevention providers	Inventory, FCCAPP meeting minutes.
Strategy 1.6.3: Coordinate local training for evidence based interventions.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Identify local training resources.	6/1/2017 to 6/30/2017	FCCAPP	HIV prevention providers	Inventory, FCCAPP meeting minutes.
Identify national training resources.	6/1/2017 to 6/30/2017	FCCAPP/DOH	HIV prevention providers	Inventory, FCCAPP meeting minutes.
Provide training for HIV prevention providers.	8/1/2017 to 9/30/2017	FCCAPP/DOH	HIV prevention providers	Number of training sessions.

Table 2: Patient Care Activities for Retention in Care to Support Viral Suppression.

NHAS Goal 2: Increase access to care and improve health outcomes for people with HIV.				
Objective 2.1: By December 2021, assess 95% of all Ryan White enrolled clients for barriers to care (from 0 to 3022).				
Strategy 2.1.1: Develop and implement a plan to assess barriers to care.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop barrier assessment tool (possibly MMP protocol).	3/1/2017 to 5/30/2017	Medical Case Management (MCM) Supervisors, and Ryan White Part A	HIV positive clients	Assessment tool in CAREWare
Utilize tool.	6/1/2017 to 6/30/2017 and on-	MCM, Mental Health and Substance Abuse	HIV positive clients	Percentage of clients assessed

	going thereafter.	service providers		
Strategy 2.1.2: Use a strengths-based approach for securing client's involvement in care.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Identify positive activities in the lives of clients and offer positive praise and/or encouragement.	3/1/2017 to 3/30/2017 and on-going thereafter.	HIV service providers	HIV positive clients	Number of clients involved in strengths-based approach
Co-create a care journey (map) with clients for reliable access to care.	3/1/2017 to 3/30/2017 and on-going thereafter.	MCM, Mental Health and Substance Abuse service providers	HIV positive clients	Number of clients involved in care journey
Strategy 2.1.3: Provide agency guidance for client-centered approaches to care—client feels more like a person than a patient.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Provide technical assistance to promote client-centered approach to services including soliciting questions and sharing decision-cost.	7/1/2017 to 7/30/2017	Part A and B administrative agencies	Service providers and staff.	Number of training materials
Share examples of different modalities of client-encounters such as face-to-face, text, phone calls, email, post-cards, small group bag lunches, and so on.	8/1/2017 to 8/31/2017	Part A and B administrative agencies and successful HIV service providers	Service providers and staff.	Number of training materials
Objective 2.2: By December 2021, ensure 95% of diagnosed PLWHA enrolled in medical case management have Individualized Service Plans (ISPs) that address barriers to care (from 0 to 3022).				
Strategy 2.2.1: Develop ISPs that identify barriers to care.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Determine indicators of lost-to-care and include in ISP.	12/1/2016 to 12/31/2016	MCM Supervisors, Mental Health and Substance Abuse providers	HIV positive clients	List of indicators
Conduct review of client's	Semi-	MCM	HIV positive	Number of client

barriers profile in CAREWare.	annually beginning 12/1/2017	Supervisors	clients	reviews in CAREWare
Strategy 2.2.2: Utilize peer navigators and retention in care coordinators in barrier reduction activities.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Relink clients lost to care by utilizing barrier's profile.	7/1/2017 to 7/31/2017 and ongoing thereafter	MCM, Peer Navigators, and Retention in Care Coordinators	HIV positive clients lost to care	Number of clients relinked to care
Conduct barrier reduction case conferencing.	Quarterly beginning 7/1/2017	MCM, Peer Navigators, and Retention in Care Coordinators	HIV positive clients lost to care	Number of case conferences
Strategy 2.2.3: Document Ryan White funded Medical Case Manager annual review of the effectiveness of planned activities to reduce barriers to care.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Create standardized barrier reduction evaluation form for documenting client feedback.	10/1/2017 to 10/31/2017	MCM Supervisors	HIV positive clients lost to care	Barrier reduction evaluation form
Evaluate client feedback and share with all stakeholders.	12/1/2017 to 12/31/2017	MCM Supervisors, Peer Navigators and Retention in Care Coordinators	HIV positive clients lost to care and HIV service providers	Evaluation report
Objective 2.3: By December 2021, link 90% of HIV positive pregnant women to prenatal care including HIV treatment (from 0 to 61).				
Strategy 2.3.1: Assure linkage of HIV positive pregnant women in care.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Refer pregnant women to Targeted Outreach for Pregnant Women Act (TOPWA) Program.	3/1/2016 and daily thereafter	HIV service providers	Pregnant women	Number of referrals
Conduct targeted outreach to identify previously undiagnosed HIV positive pregnant women and refer to TOPWA.	3/1/2016 and daily thereafter	TOPWA grantee	Previously undiagnosed HIV positive pregnant women	Number of women identified

Strategy 2.3.2: Assess maternal barriers to prevention of perinatal transmission of HIV.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop a brief pregnancy expectations and/or attitudes survey and include as a link to CAREWare eligibility determination tab (http://iussp2009.princeton.edu/papers/91126).	3/1/2017 to 3/31/2017	TOPWA grantee	HIV positive pregnant women	Completed survey
Assess housing status, residential mobility, and co-occurring conditions that pose barriers to care.	3/1/2017 and daily thereafter	TOPWA grantee and MCM	HIV positive pregnant women	Number of assessments
Strategy 2.3.3: Assure community awareness of TOPWA services and other resources.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Distribute TOPWA program referral materials to all prenatal service providers.	3/1/2017 and weekly thereafter	TOPWA grantee	HIV positive pregnant women	Number of materials distributed
Implement medication adherence and counseling programs to prevent perinatal transmission.	3/1/2017 and daily thereafter	MCM and Outpatient Medical Care (OAMC) providers	HIV positive pregnant women	Number of medication adherence and counseling programs
Objective 2.4: By December 2017, refer 75% of HIV infected inmates in the Duval County Jail, incarcerated for 14 days or more, to medical care upon release from the Duval County Jail (from 0 to 140).				
Strategy 2.4.1: Fully implement Jail Linkage Demonstration Project Protocol.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Implement and monitor protocol, including staffing and cost.	3/1/2016 and semi-annually thereafter	Part A and B administrative agencies, Lutheran Social Services, and Jail Link staff in jail	HIV positive inmates of Duval County jail	Implementation and monitoring dates
Evaluate Protocol.	3/1/2017 to 3/31/2017	Part A and B administrative agencies, Lutheran Social Services, Jail Link staff in jail,	HIV positive inmates of Duval County jail	Evaluation report

		and recently released inmates		
Determine sustainability of protocol.	4/1/2017 to 4/30/2017	Part A and B administrative agencies, Lutheran Social Services, Jail Link staff in jail, and HIV Health Service Planning Council	HIV positive inmates of Duval County jail	Decision to proceed or abort
Objective 2.5: By December 2017, develop and disseminate a fast track linkage protocol to all funded providers (from 0 to 9).				
Strategy 2.5.1: Review and implement linkage protocols.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Review rapid linkage protocols such as the Connecticut Department of Public Health (DPH), Early Referral & Linkage Initiative Protocol (ERLI)	3/1/2017 to 3/30/2017	Part A administrative agency	HIV positive clients	Linkage protocol
Develop and implement rapid linkage protocol to meet the needs of PLWHA.	7/1/2017 to 7/30/2017 and daily thereafter	MCM and Part A and B administrative agencies	HIV positive clients	Linkage protocol
Strategy 2.5.2: Evaluate effectiveness of the fast track linkage protocol during the first implementation year.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Create an online survey for provider and client comments	1/1/2018 to 1/31/2018	Part A administrative agency	HIV service providers and clients	Survey
Review and share provider and client comments, if any, at quarterly provider meetings and semi-annually with Planning Council Coordination Committee for consensus on adaptations, if indicated.	3/1/2018 to 3/31/2018	Part A administrative agency	HIV service providers and clients	Summary of survey findings
Objective 2.6: By December 2021, expand jail linkage protocol to 1 of the 4 outlying county jails (from 0 to 1).				
Strategy 2.6.1: Quantify staffing and health care system requirements in outlying county jails.				
Activity	Timeframe	Responsible	Target	Data Indicators

		Parties	Population	
Identify average time and staff needed for preparing HIV positive inmates for connectivity to community HIV care and services.	4/1/2018 to 5/30/2018	DOH APO	HIV positive inmates of Area 4 jails	Cost effectiveness analysis
Identify health system infrastructure needed to transition inmates into first OAMC post release appointment.	6/1/2018 to 7/31/2018	DOH APO	HIV positive inmates of Area 4 jails	Infrastructure availability
Strategy 2.6.2: Develop a recruitment package for stakeholders in outlying counties.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Draft summary guidance for dissemination.	10/1/2018 to 11/30/2018	Part A and B administrative agencies	Jails in outlying counties	Completion of summary guidance
Identify required commitments for successful implementation.	12/1/2018 to 2/28/2019	Part A and B administrative agencies	Jails in outlying counties	Commitments report
Distribute recruitment package	3/1/2019	DOH APO	Jails in outlying counties	List of persons receiving recruitment package

Table 3: Programmatic Activities for Supporting Delivery of Quality HIV Care.

NHAS Goal 3: Reduce HIV-related disparities, (differences in the burden of disease), and health inequities (preventable unjust differences in health status).				
Objective 3.1: Beginning March 2017, assess nature and extent of HIV health disparities in JTGA/Partnership 4.				
Strategy 3.1.1: Collect data from epidemiologic profiles, gap analyses, needs assessments, focus groups and other methods.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop and disseminate a dashboard of clients' perceptions of their health disparities.	3/1/2017 to 5/30/2017	MCM Curriculum Development Committee, UF Center for Health Equity and Quality Research (CHEQR), and	MSM of Color, youth, Transgender, Injection-drug users (IDU), other high risk populations	Dashboard of client perceptions

		FCCAPP		
Develop and disseminate a dashboard of providers' perceptions of client health disparities.	6/1/2017 to 8/30/2017	MCM Curriculum Development Committee, UF CHEQR, and FCCAPP	HIV prevention and care providers	Dashboard of provider perceptions
Analyze data and report trends in HIV health disparities.	9/1/2018 to 9/30/2018	Part A Administrative Agency	HIV prevention and care providers, prevention and care planning bodies.	Reports
Objective 3.2: By December 2018, develop at least two (2) strategies for providing client-centered care that promotes human dignity, and supports understanding diversity in order to address stigma and discrimination in at least 90% of service providers.				
Strategy 3.2.1: Integrate client-centered approaches into HIV prevention and care services.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop and promote use of health literacy assessment tool in health care settings.	12/1/2017 to 12/31/2017	MCM Curriculum Development Committee, UF CHEQR, FCCAPP, and peer navigator cooperative	HIV prevention and care providers	Assessment tool
Develop training modules to help staff examine individual characteristics, identify and remove barriers, and identify key cultural differences to eliminate gaps in services.	3/1/2018 to 6/30/2018	MCM Curriculum Development Committee and peer navigator cooperative	HIV prevention and care providers	Training modules
Utilize health literacy assessment findings to involve clients in making choices about their health care alternatives.	7/1/2018 to 7/31/2018	Medical case managers, and funded service providers	HIV prevention and care providers	Periodic audits with standardized checklist
Strategy 3.2.2: Advance human dignity in service delivery system.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Research, identify, and	8/1/2018 to	IHPCP	MSM of	Best practices

develop best practices for enhancing client self-esteem and self-worth.	12/31/2018	Committee and core service providers	Color, youth, Transgender, IDU, other high risk populations	documented
Train service providers in the implementation of client confidence building	2/1/2019 to 2/28/2019	Best practices service providers, for example AETC, HIVQUAL, CHEQR	MSM of Color, youth, Transgender, IDU, other high risk populations	Provider self-reports, training logs and percent of clients retained in care
Implement services that promote client self-worth	3/1/2019 to 3/31/2019	Core, funded service providers	MSM of Color, youth, Transgender, IDU, other high risk populations	Implementation variables, monitoring reports, and quality plans that lead to changes in percent of clients retained in care
Strategy 3.2.3: Raise awareness of the ethnic, racial, geographic, social, and other issues that define and/or characterize clients' service needs. [As used here, issues denote communication styles, non-verbal behaviors, expectations, stereotypes, challenges engaging health care, customs, beliefs, preferences, and so on].				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Identify cultural and linguistic skills of service providers relative to target populations.	1/1/2019 to 1/31/2019	All Ryan White Parts	HIV prevention and care providers, MSM of Color, youth, Transgender, IDU, other high risk populations	Inventory of written and spoken languages, dialects, and slangs
Develop cultural and linguistic competency (CLC) training modules for presentations in public meetings.	6/1/2019 to 10/31/2019	All Ryan White Parts	HIV prevention and care providers, MSM of Color, youth, Transgender, IDU, other high risk populations	Training modules

Develop CLC training modules that clients and service providers can access electronically—webinars, and other methods.	12/1/2019 to 4/30/2020	All Ryan White Parts	HIV prevention and care providers, MSM of Color, youth, Transgender, IDU, other high risk populations	Multiple modalities
Objective 3.3: By December 2021, increase access to food and nutritional services for at-risk clients (from 2 access points to 4 access points).				
Strategy 3.3.1: Identify nutritional needs of PLWHA in JTGA/Partnership 4				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Identify or develop a tool to assess nutritional needs and food services access.	1/1/2019 to 2/28/2019	Part A funded nutritionists	MSM of Color, youth, Transgender, IDU, other high risk populations	Assessment tool CAREWare service unit
Conduct client-centered nutritional needs assessment including food insecurity and comorbidities.	4/1/2019 to 6/30/2019	Medical case managers and Part A funded nutritionists	MSM of Color, youth, Transgender, IDU, other high risk populations	Needs assessment report or Individualized Service Plan (ISP)
Strategy 3.3.2: Identify and promote food pantry linkages.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Identify linkages, barriers, and gaps in service delivery	8/1/2019 to 8/30/2019	Network nutritionists	MSM of Color, youth, Transgender, IDU, other high risk populations	Inventory of linkages
Stock food pantries to address client needs.	9/1/2019 to 11/30/2019	Network funded food pantries	MSM of Color, youth, Transgender, IDU, other high risk populations	List of foods available in food pantry
Objective 3.4: By December 2021, implement a comprehensive integrated media campaign to address stigma and discrimination (from 1 to 4).				
Strategy 3.4.1: Begin to construct social norms for fairness and respect for all marginalized people in JTGA/Partnership 4.				

Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Assemble coalition to track, organize, and catalog examples of fair treatment and respect, or the lack thereof; for marginalized people.	3/1/2020 to 4/30/2020	All Parts, FCCAPP, and other community partners	MSM of Color, youth, Transgender, IDU, other high risk populations	Stakeholder involvement Affected people Logs Issues identification Proposed solutions
Identify a collaboration partner for the design and dissemination of a digital storyboard that shows the status of fair treatment and respect for marginalized people in Northeast Florida.	5/1/2020 to 6/30/2020	All Parts, FCCAPP, and other community partners	MSM of Color, youth, Transgender, IDU, other high risk populations	Stakeholder involvement Affected people
Strategy 3.4.2: Establish a plan to educate elected officials, business, and other community leaders ^e about HIV health disparities.				
Activity	Timeframe	Responsible Parties	Target Population	Data Indicators
Develop a plan to recruit opinion leaders to help educate other leaders.	8/1/2020 to 8/30/2020	FCCAPP and Planning Council	Elected officials, business and other community leaders	Plan
Compile critical information and messages for dissemination to leaders.	9/1/2020 to 10/31/2020	FCCAPP and Planning Council	Elected officials, business and other community leaders	Number of messages
Implement periodic communication with leaders at such events as town hall meetings, lunch-and-learn events, and briefing events.	11/1/2020 to 12/31/2020	FCCAPP and Planning Council	Elected officials, business and other community leaders	Transcripts of meetings

Notes: ^e includes a balance of opinion leaders, religious advocates, educators, etc.

Miami (Miami-Dade County)



September 19, 2016

LCDR Anderson A. Tesfazion, US Public Health Service
Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, 09W-13D
Rockville, Maryland 20857

Re: Miami-Dade HIV/AIDS Partnership Concurrence with Miami-Dade County's Chapter of the 2017-2021 CDC/HRSA Integrated HIV/AIDS Prevention and Care Plan (Miami Integrated Plan); and Concurrence with Reservations with the Florida Combined Integrated HIV/AIDS Prevention and Care Plan (Florida Integrated Plan)

Dear Lt. Tesfazion:

The Miami-Dade HIV/AIDS Partnership (Partnership), local HIV/AIDS planning council, concurs with the attached Miami Integrated Plan chapter to accompany the Florida Integrated Plan. The attached submission by the Florida Department of Health in Miami-Dade County and the Miami-Dade County Part A/MAI Recipient is the culmination of a strong, year-long, local and statewide collaborative effort in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV/AIDS Prevention and Care Plan.

The Partnership, as well as its Prevention and Strategic Planning Committees, concurs that the Miami Integrated Plan chapter describes how program activities and resources are being directed toward the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease in this jurisdiction. The Partnership concurs that the Miami Integrated Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance. However, the Partnership concurs with reservations that the Florida Integrated Plan submission also fulfills the requirements of FOA PS12-1201. Concurrence with reservations for the statewide plan is because, as of this date, the Partnership has only reviewed and commented on a prior version of the statewide plan and not the final version.

Development and review of the local and statewide plans were accomplished through a series of stakeholder input meetings, presentations to the Partnership and its standing committees and work groups, community input sessions with persons who are living with HIV/AIDS in the jurisdiction, and reviews by a joint workgroup including senior personnel from both the Miami-Dade County Ryan White Part A/MAI Program Recipient and the Florida Department of Health in Miami-Dade County. The National HIV/AIDS Strategy (NHAS) goals and Miami-Dade County-specific objectives, strategies, and activities were reviewed and approved in separate meetings of the Prevention Committee and Strategic Planning Committee, both of which will be closely monitoring progress of the plan's implementation from 2017 through 2021. The Partnership will oversee this monitoring process.



By my signature below, I confirm that the Partnership fully concurs with the Miami Integrated Plan; and concurs with reservations as stated above with the Florida Integrated Plan.

Please do not hesitate to contact us with any questions or concerns you may have about this process. The Partnership can be reached at (305) 445-1076.

Sincerely yours,

Date:

9-19-16

Eddie Orozco, Chair
Miami-Dade HIV/AIDS Partnership

Attachments

c: Miami-Dade HIV/AIDS Partnership members
Daniel T. Wall, Assistant Director, OMB
Carla Valle-Schwenk, Program Administrator, OMB
Kira Villamizar, Public Health Services Manager, FDOH-MDC
Robert Ladner, President, Behavioral Science Research Corporation

2017-2021 CDC/HRSA INTEGRATED HIV/AIDS PREVENTION AND CARE PLAN

MIAMI-DADE COUNTY, FLORIDA

I. STATEWIDE COORDINATED STATEMENT OF NEEDS/NEEDS ASSESSMENT

While the Florida Department of Health in Miami-Dade County (FDOH-MDC) and the Miami-Dade County Ryan White Part A Program both have participated in the development of and concur with the State of Florida's CDC/HRSA Integrated HIV Prevention and Care Plan (hereafter, Florida Integrated Plan), there are some very important differences that must be highlighted. This narrative reflects the unique characteristics HIV/AIDS incidence and prevalence in the Miami-Dade County Eligible Metropolitan Area (EMA) as they relate to specific vulnerable populations. The data presented here are intended to provide a context for the objectives, strategies, and activities outlined in this jurisdiction's chapter of the Florida Integrated Plan, and are detailed in the accompanying 2017-2021 CDC/HRSA HIV Prevention and Care Plan for Miami-Dade County (hereafter, Miami Integrated Plan). Therefore, the following narrative is intended as a supplement to the Florida Integrated Plan, which addresses all components of the CDC/HRSA Integrated Plan guidance.

Unless otherwise specifically noted, the source of epidemiology data in this narrative comes from the Florida Department of Health, HIV Surveillance Data through December 31, 2015, as reported in 2016, through its electronic HIV/AIDS reporting system (eHARS). Miami-Dade County Ryan White Program Part A/MAI Program data comes from service utilization data for grant Fiscal Year (FY) 2015 (March 1, 2015 through February 29, 2016), as reported in the Ryan White Program Service Delivery Information System (SDIS), the EMA's comprehensive client data management and billing system.

A. EPIDEMIOLOGIC OVERVIEW

The Miami-Dade County EMA is not like the rest of the State of Florida, nor is the HIV/AIDS epidemic in Miami-Dade County like the HIV/AIDS epidemic throughout the rest of the State. Note that while Miami-Dade County occupies only 3.7% of the total land area of Florida, in the southeastern tip of the State, and represents only 13.2% of Florida's population, Miami-Dade County accounts for 23.7% of the total number of persons living with HIV in the State, and leads the United States in the rate of new HIV cases each year. Overall, 26,042 people were living with HIV/AIDS (PLWHA) in Miami-Dade County in 2015, 1% of the entire population. ***Miami-Dade County has the highest number of PLWHA in Florida.***

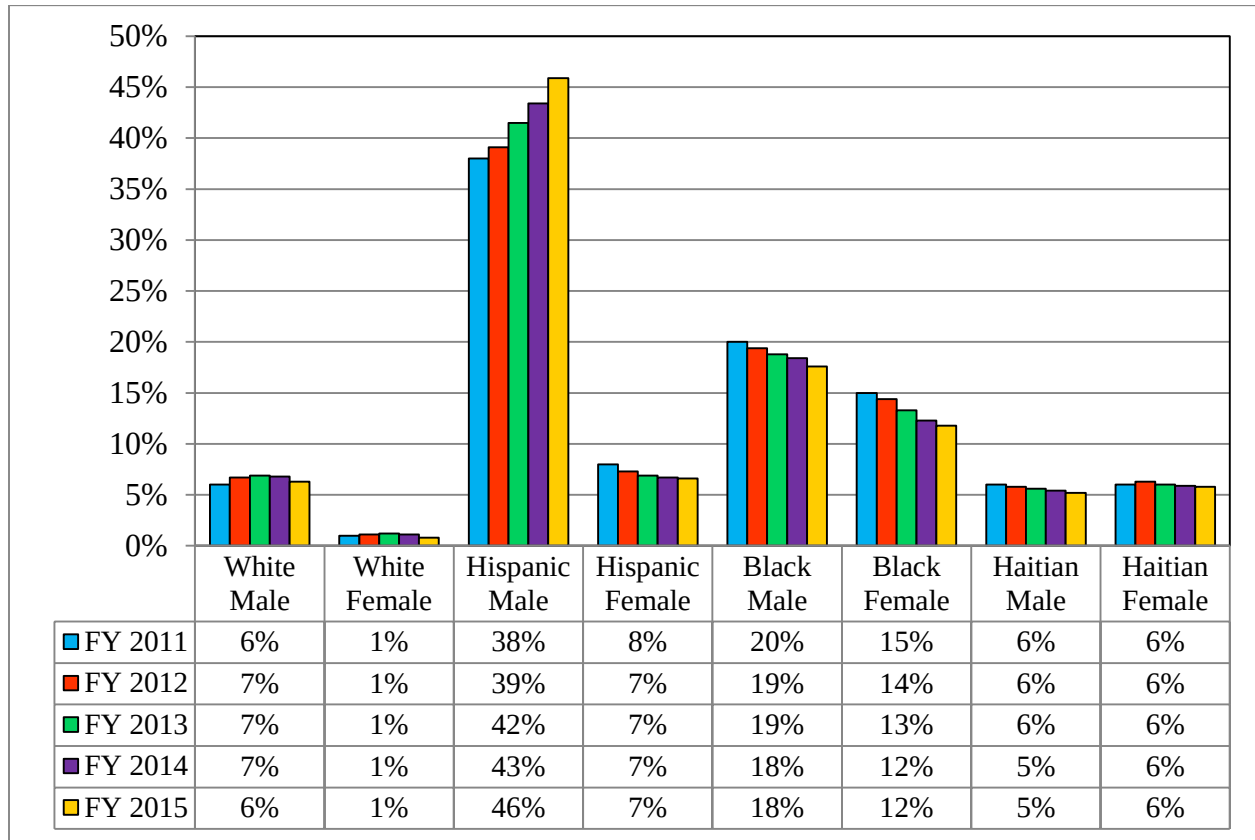
In addition to Miami-Dade County's high HIV/AIDS incidence levels, Miami-Dade County's racial/ethnic composition differs from the rest of Florida, both in the composition of its residential population and in the composition of the populations of persons living with HIV or AIDS. Table 1, below, illustrates the demographic differences between Florida's overall population and a breakdown of the HIV/AIDS epidemic throughout the state, as compared to the racial/ethnic composition within the Miami-Dade County EMA.

Table 1:
Differences between the Ethnic/Racial Composition of Miami-Dade County and Florida,
with Particular Reference to Ethnic Differences among PLWH and PLWA

Racial/Ethnic Groups in Florida	Racial/Ethnic % Across Florida and Within Miami-Dade		Racial/Ethnic % Among Persons With HIV		Racial/Ethnic % Among Persons With AIDS	
	State of Florida	Miami-Dade	State of Florida	Miami-Dade	State of Florida	Miami-Dade
White Non-Hispanic	59%	14%	26%	13%	25%	13%
Black/African American	14%	17%	44%	41%	51%	50%
Hispanic	23%	67%	28%	44%	21%	35%
Other	4%	2%	2%	1%	3%	2%

- o The defining characteristic of Miami-Dade County's population, compared to the State of Florida, is the low percentage of White Non-Hispanics coupled with a high percentage of Hispanics. White Non-Hispanics represent almost 60% of Florida's population, but only 14% of the population in Miami-Dade County. Hispanics comprise less than a quarter of the population of the State as a whole, but approximately 67% of the population in Miami-Dade County, 44% of the persons diagnosed with HIV (vs. 28% for the State as a whole), and 35% of the persons diagnosed with AIDS (vs. 21% for the State as a whole). The high proportion of Hispanics in the Miami-Dade County EMA, along with the high incidence of HIV/AIDS in this population, is the basis for the designation of Hispanics as a target population for prevention efforts (see NHAS 2020 Goal #3: Disparities in Prevention, Strategy DP 1.2, for Hispanics/Latinos in the Miami Integrated Plan).
- o Blacks/African Americans (which includes African Americans, Black Caribbeans, and Black Haitians) comprise 17% of Miami-Dade County's population, comparable to the 14% shown across the State of Florida; but, based on FDOH-MDC's data for 2015, comprise 41% of the persons living with HIV in Miami-Dade County and 50% of the persons living with AIDS. This pattern of low percentages of Black/African Americans in the population at large, but much higher percentages of Black/African Americans living with HIV and AIDS in both the State and Miami-Dade County demographics, is the basis for designating Blacks/African Americans as a target population for prevention efforts (see NHAS 2020 Goal #3: Disparities in Prevention, Strategy DP 1.1, for Blacks/African Americans in the Miami Integrated Plan).
- o Altogether, 85% of the PLWHA in Miami-Dade County are from ethnic minority groups. The proportion of minorities in care in the local Ryan White Part A/Minority AIDS Initiative (MAI) Program's system of care is even higher – approximately 93%, a percentage that has remained almost unchanged over the last five years. During the same five year period, the Miami-Dade County EMA has experienced a trend towards having more Hispanic males and fewer Black/African American males and females in care. Figure 1 below presents the racial/ethnic and gender breakdown of PLWHA served in the jurisdiction over the past five years.

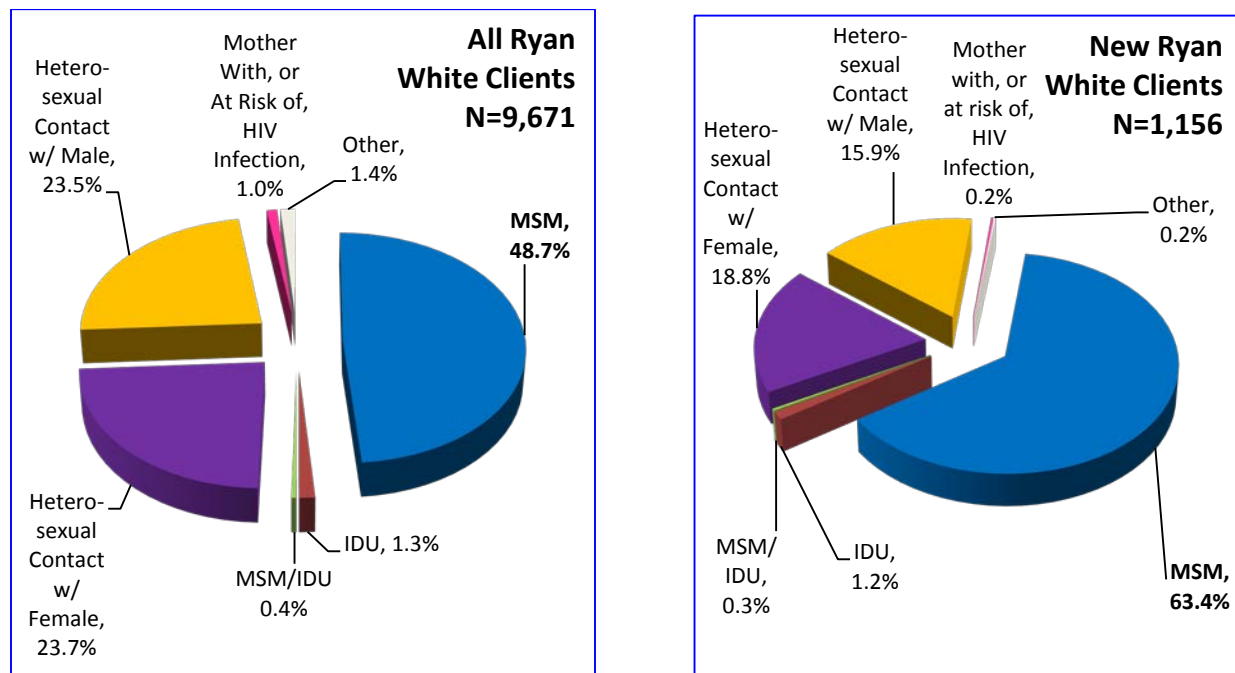
**Figure 1:
Race/Ethnicity of PLWHA in Care in the
Miami-Dade County Ryan White Part A/MAI Program**



INDICATORS OF RISK FOR HIV INFECTION –

The chief exposure category for PLWHA in Miami-Dade County continues to be men who have sex with men (MSM), who comprise 47% of living AIDS cases and 56% of living HIV cases in Miami-Dade County (FDOH-MDC data, 2015), and who comprise the largest single risk category for new cases in the local Ryan White Part A/MAI Program system of care (see **Figure 2** below). In FY 2015-2016, MSMs comprised 63.4% of new Ryan White Program clients in care and 48.7% of the total PLWHA in care. Among male PLWHA in care, 75.6% of the new male PLWHA in care were MSM, and 64.7% of the total male PLWHA in care were MSM. These statistics impacted several decisions in the Miami Integrated Plan, from identifying MSM as a target population for disparity-reduction prevention efforts (see NHAS 2020 Goal #3: Disparities in Prevention, Strategy DP 1.3 in the Miami Integrated Plan), and focusing on the MSM population as a target for HIV testing and provision of PrEP by the FDOH-MDC (see NHAS 2020 Goal #1, Prevention, Strategy P 1.2 and P 1.3 in the Miami Integrated Plan).

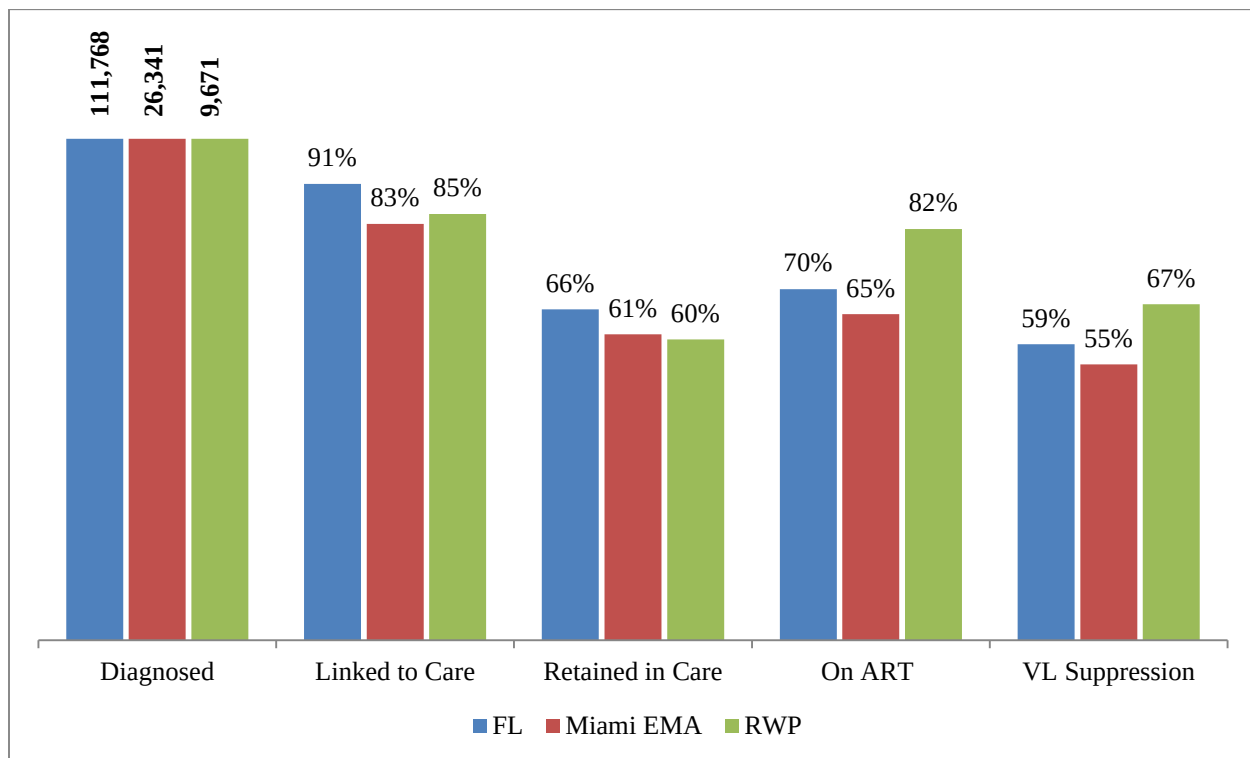
Figure 2:
Risk Categories for Persons in Care in the
Miami-Dade County Ryan White Part A/MAI Program, FY 2015-2016



B. HIV CARE CONTINUUM

Miami-Dade County uses the diagnosis-based approach to the HIV Care Continuum, where each step of the continuum is represented as a percentage of the total number of PLWHA who were diagnosed in the jurisdiction. **Figure 3** below depicts the Miami-Dade County EMA's HIV Care Continuum through calendar year (CY) 2015 (as reported in 2016 for the entire HIV+ population in the jurisdiction) and for the clients in care under the Ryan White Program in FY 2015-16. The data presented in this graph were made available by the FDOH, through its electronic HIV/AIDS reporting system (eHARS), and through the Ryan White Service Delivery Information System, the EMA's comprehensive client data acquisition and tracking system. Despite the fact that Miami-Dade County ranks high in new infections in the US, the EMA in general and the Ryan White Program specifically show high levels of linkage to medical care (83% and 85%, respectively).

**Figure 3:
HIV Care Continuum in Florida (FL; 2015), Miami-Dade County EMA (2015),
and the Miami-Dade County Ryan White Part A/MAI Program (FY 2015)**



There are two areas in the HIV Care Continuum where the Miami-Dade County Ryan White Program has identified weaknesses in provision of care to persons with HIV/AIDS: retention in care and viral load suppression. These areas are specifically addressed in the Miami Integrated Plan.

- o "Retained in care" is defined as a PLWHA having at least two medical encounters at least 90 days apart during a 12-month period. The Miami-Dade County EMA in general and the Ryan White Program specifically show a similar retention in care percentage, 61% and 60% respectively, both slightly below the 66% reported at the state level. For clients in the Ryan White Program, the lowest levels of retention in care were reported among specific groups (see **Table 2**, below), including Blacks/African Americans (52%), clients under 25 years of age (52%), clients older than 65 years of age (49%), and individuals who reported injection drug use (IDU) (43%) as their primary HIV exposure category. Similar disparity trends were reported for these groups across the EMA.

Note that the Miami Integrated Plan addresses both the general issue of improvement for rates of retention in care (NHAS 2020 Goal #2: Retention in Care, Objective R1) and reduction of disparities in retention rates for Blacks/African Americans and Hispanics under 25 years of age (NHAS 2020 Goal #3: Disparities in Retention in Care, Objective DR1).

- o The Miami-Dade Ryan White Part A/MAI Program reported a higher level of viral load (VL) suppression (67%) than the EMA as a whole (55%) and the State (59%). However, the proportion of PLWHA with suppressed VL is substantially lower than the proportion of PLWHA who are on antiretroviral therapy (see **Figure 3**, above), indicating a problem with adherence in the treatment regimen. In addition, there are important disparities in VL suppression that parallel the disparities shown in the figures for retention in care: for clients in care in the Miami-Dade County Ryan White Part A/MAI Program, Blacks/African Americans (58%) and clients under 25 years of age (47%) reported the lowest viral load suppression percentages of any demographic group (see **Table 2**, below). Similar disparity trends were reported across the EMA in general.

Note that the Miami Integrated Plan addresses both the general issue of improvement in VL suppression in the EMA (see NHAS 2020 Goal #2: Viral Load Suppression, Objective V1) and reduction of disparities in VL levels for Blacks/African Americans and Hispanics under 25 years of age [see NHAS 2020 Goal #3, Disparities in Treatment Outcomes (Suppressed/Undetectable), Objective DV1)].

Table 2:
Variations in HIV Care Continuum Engagement and Health Outcome
for Clients in the Miami-Dade County Ryan White Part A/MAI Program, 2015

Characteristic	Linked to Medical Care	Retained in Care	Suppressed/ Undetectable VL
Race/Ethnicity			
White, non-Hispanic	84%	54%	68%
Black/African American	82%	52%	58%
Hispanic	86%	63%	72%
Haitian	89%	67%	68%
Other	90%	63%	80%
Gender			
Male	85%	60%	68%
Female	85%	59%	65%
Transgender	91%	61%	67%
Age			
<25	88%	52%	47%
25-34	87%	57%	63%
35-49	87%	62%	70%
50-64	84%	61%	70%
65+	76%	49%	62%
HIV Exposure			
Heterosexual	85%	60%	66%
IDU	75%	43%	53%
Mother with/at risk of HIV	93%	60%	35%
MSM	86%	61%	71%
MSM/IDU	81%	46%	57%
Other	67%	44%	52%

USE OF HIV CARE CONTINUUM FOR PLANNING AND IMPROVING OUTCOMES

The HIV Care Continuum is utilized in the EMA for **planning, prioritizing, and monitoring available resources** in response to needs of PLWHA and for improving engagement at each stage of the continuum. These activities are reflected in several ways.

- **First**, the HIV Care Continuum has been instrumental in enhancing the cooperation and collaboration among the Florida AIDS Drug Assistance Program (ADAP), the Florida Department of Health in Miami-Dade County (FDOH-MDC), the Ryan White Part A/MAI Program Recipient, and the Miami-Dade HIV/AIDS Partnership (local planning council). For example, the Linkage to Care Quality Improvement Workgroup, organized and hosted by the FDOH-MDC in 2015, has been instrumental in monitoring and making recommendations towards improving the linkage to care rate in the EMA. In fact, the consistent, increased attention and focus has yielded notable success in this area with a linkage to care rate of **83% within 90 days of diagnosis**; 80% for newly diagnosed and 88% for previous positive PLWHAs (Source: FDOH, 2016). Although the linkage rate target goal has been achieved (80%), moving forward the effort will focus on reducing the days of linkage to ultimately achieve 80% or better linkage **within 30 days of diagnosis**.
- **Second**, review of the HIV Care Continuum has been a critical tool in identifying areas or demographics requiring special attention. Despite the achievement in linking newly-diagnosed clients with RWP services (in FY 2015, 1,156 clients entered the Miami-Dade County Ryan White Part A/MAI Program for the first time), a substantial number of clients drop out of the Part A/MAI Program every year (in FY 2015, the number of clients receiving Part A/MAI Program services of any kind rose from 9,655 to 9,671, a net increase of only 26 clients).

Clearly, the most serious challenge facing the EMA is Retention in Care, reported in **Figure 3** above as the largest gap in the EMA's HIV Care Continuum. In this regard, important steps have already been taken to address retention in care in the local Ryan White Program and in the Miami Integrated Plan. As part of the Ryan White Part A/MAI Program's continuous quality improvement (CQI) efforts, Part A Recipient and its contracted quality management service provider have conducted an analysis of dropout rates for the overall program and specific demographic and co-morbidity subgroup, in order to better understand the factors impacting retention in care. In response to the CQI research, the Miami-Dade HIV/AIDS Partnership authorized the establishment of the Retention in Care Workgroup under its Strategic Planning Committee to explore all factors affecting retention in care and make recommendations for future interventions or directives for program improvements.

- **Third**, the HIV Care Continuum encourages data sharing across prevention, care, and treatment entities to improve the accuracy of the local and State's HIV surveillance systems and data management systems. The ability to exchange and compare data – while ensuring client confidentiality, restricted access to client-specific data for authorized persons, and HIPAA compliance – continues to enhance both Ryan White

Part A/MAI Program and FDOH program effectiveness. Expanding on a data-sharing agreement between FDOH and the local Part A/MAI Program that has been in place for several years, the Part A/MAI Program currently provides monthly data files from its client data management system to the FDOH, to ensure that data on Part A/MAI clients in care, clients on antiretroviral therapy (ART), and clients with reported VL data are included in the FDOH HIV/AIDS Surveillance system. Overall, the above mentioned efforts as well as other systematic approaches are critical as greater emphasis is placed on the HIV Care Continuum to guide local efforts to improve the quality of care and client health outcomes.

Systematic approaches have been developed and implemented **to address gaps** (less than 100%) in the following stages of the HIV Care Continuum: Linkage to Care, Retention in Care, ARV Use, and VL Suppression.

Part of the **gap in Linkage to Care** is believed to be a product of under-reporting of connections to medical care (i.e., medical visits) to FDOH of newly diagnosed persons. Although FDOH testing and counseling staff members have a direct connection to Part A/MAI outreach workers, as a result of the Early Identification of Individuals with HIV or AIDS (EIIHA) Initiative, to ensure that newly diagnosed clients have a direct connection to Part A/MAI-funded outpatient medical care, visits to a medical provider are not always being captured in FDOH's data system. The connection from HIV testing/counseling to the Part A/MAI outreach worker is facilitated through a formal referral process. In FY 2015, through the aforementioned data sharing agreement, the FDOH's HIV/AIDS Surveillance Team in Miami-Dade County began reporting higher linkage to care numbers after they were granted access to the data system for the purpose of confirming medical visits received by newly diagnosed clients who received the service from the local Part A/MAI Program.

In response to the **Retention in Care gap**, in July 2015, the Miami-Dade HIV/AIDS Partnership voted to establish the aforementioned seven-member Retention in Care Workgroup. The group was commissioned to examine issues related to retention in Ryan White Part A/MAI Program care, the development or modification of protocols for adjusting care to improve retention, and the evaluation of the retention success of specific demographic subgroups. Specific attention is given to examining the effect of minority status as a complicating factor for retention in care. The efforts of this workgroup are complemented by the analysis of RWP data for the past three years. The objective of workgroup is to identify patterns, both positive and negative, that can help improve retention in care by identifying and addressing lost-to-care risk/protective factors as clients enroll in and drop out of the RWP. To identify lost-to-care risk factors, detailed service utilization analyses are supported with chart reviews.

Two systematic approaches to the **gap in ARV use** have been implemented as well. First, through the aforementioned data sharing agreement, the Florida ADAP and the Part A/MAI Recipient match clients against one another's data systems to confirm which clients are enrolled in the local ADAP [whose services are limited to ARV and opportunistic infection (OI) medications] to identify the actual number of clients on ARV

therapy. Second, review and discussion of the current Department of Health and Human Services (DHHS) treatment guidelines for HIV are conducted regularly by the Partnership's Medical Care Subcommittee (MCSC). Based on this regular review, the MCSC then revises and disseminates the local Primary Medical Care Standards in accordance with the HHS treatment guidelines to subrecipients of outpatient medical care to ensure clients begin ARV therapy according to the guidelines.

The gap in the final stage, **Viral Load Suppression**, is expected to improve with the aforementioned improvements in linkage, retention, and ARV use.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

See corresponding sections in the Florida Integrated Plan.

D. ASSESSING NEEDS, GAPS, AND BARRIERS

In addition to the gaps in care shown in the HIV Care Continuum analysis, several additional key gaps in care or treatment issues were identified by the FDOH-MDC, the Miami-Dade County Ryan White Part A/MAI Program, and community stakeholders who were part of the development of the respective Florida and Miami Integrated Plans. Some of these are directly reflected in the Miami Integrated Plan; others are reflected in the prevention, diagnosis and linkage efforts of the FDOH-MDC and the quality of care, retention in care and VL suppression efforts of the Miami-Dade County Ryan White Part A/MAI Program. These include:

- o **Needs of women who are living with HIV:** As part of the NHAS 2020 Goal #1 (Reducing New HIV Infections) efforts under the Miami Integrated Plan, the FDOH-MDC is seeking to reduce the number of HIV-infected infants born in Miami-Dade County from five (5) per year to zero (Objective P 2), through a combination of community services, public relations campaigns and interface with non-HIV OB/GYN medical providers, and to create an electronic direct observation system for pregnant women living with HIV who are in danger of dropping out of ARV care (NHAS 2020 Goal #2, Viral Load Suppression, Objective V1). Concurrently, the Miami-Dade County's MAI Program specifically is engaging in focus groups and survey research directed toward identifying the dynamics of initial HIV infection and patterns of abusive/exploitive relationships with infected men, to raise retention in care rates for Black/African American, Hispanic, and Black Haitian women who are living with HIV or AIDS, and to identify strategies that may reduce disparities.
- o **Addressing housing problems for PLWHA:** as reported by over 75 PLWHA respondents in Miami-Dade County Ryan White Program needs assessment and client satisfaction surveys in 2015 and 2016, and responses to open-ended questions about unmet need in needs assessment focus groups held in 2014, 2015, and 2016 – and in light of the demonstrated negative impact of housing insecurity on adherence to ARV treatment regimens (and subsequent impairment of VL suppression) – the Miami-Dade County Ryan White Part A/MAI Program is conducting a qualitative and quantitative study of the dimensions of housing insecurity among Ryan White Program clients.

Because the impact of housing insecurity spans numerous HIV Care Continuum issues – linkage to medical care, retention in care, ARV use – this activity is not reflected in a single outcome-based strategy or activity, but is intended to form the basis for future services planning.

- o **Continuous improvement in service quality, access to care and sensitivity to PLWHA needs in delivery of services.** Throughout the Integrated Plan, the MDC-RWP has identified areas of service quality improvement, improving the RWP's existing Client-Centered Care program to generate increased retention in care, treatment adherence and VL suppression. Many of these initiatives are reflected in NHAS 2020 Goal #2, Retention, (see Objective R1, Strategies R 1.1 – R1.4).

E. DATA: ACCESS, SOURCES, AND SYSTEMS

As previously stated, FDOH uses eHARS to track and report HIV/AIDS Surveillance data. The Miami-Dade County Ryan White Part A/MAI Program uses Automated Case Management Systems' proprietary software known as Casewatch Millennium® (or known locally as the Service Delivery Information System). A fully functioning Business Agreement/Data Sharing Agreement is in effect between FDOH, FDOH-MDC, and the Ryan White Part A/MAI Program, to coordinate services, eliminate duplication, and track and report client outcomes along the HIV Care Continuum.

II. INTEGRATED HIV PREVENTION AND CARE PLAN

A. INTEGRATED HIV PREVENTION AND CARE PLAN

See the accompanying “2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan Provided by the Florida Department of Health in Miami-Dade County and the Miami-Dade County Ryan White Part A/MAI Program.”

B. COLLABORATIONS, PARTNERSHIPS, AND STAKEHOLDER INVOLVEMENT

See related section in Florida Integrated Plan.

C. PLWH AND COMMUNITY ENGAGEMENT

Miami-Dade County's chapter of the Florida Integrated Plan was constructed with extensive attention to the needs of the PLWHA community and the ability of the FDOH-MDC and Miami-Dade County Ryan White Part A/MAI Programs (MDC-RWP) to work together in an integrated fashion. Beginning with a series of six cross-organizational planning meetings by FDOH-MDC and MDC-RWP managers and planners, major issues linking prevention, diagnosis, linkage, retention and treatment outcome were outlined; eight (8) meetings were held with PLWHA and outside community stakeholders (e.g., community town hall meetings, meetings with the FDOH MSM Collaborative), service providers (at scheduled Partnership and Quality Management committee meetings and provider forums), and Partnership Committee and Subcommittee meetings. A checklist of over 40 potential areas of future activity was reviewed by the cross-

organizational team, and concentrated in the objectives, strategies and activities found in the Integrated Plan. Drafts of this plan were reviewed by the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee, Medical Care Subcommittee and Retention in Care Workgroup, and detailed reviews of the Plan were conducted with the Prevention Committee (principally an FDOH-MDC entity, concentrating on objectives and strategies related to prevention and diagnosis) and the Strategic Planning Committee (principally a Partnership entity, concentrating on objectives and strategies linked to linkage, retention and treatment outcomes) prior to its ratification by the Partnership and submission to the State for inclusion in the Statewide Integrated Plan.

III. MONITORING AND IMPROVEMENT

IMPLEMENTATION, MONITORING AND COMMUNITY INPUT

As a means of managing the implementation and evaluation of the Miami Integrated Plan, the Partnership's Prevention Committee, Strategic Planning Committee, and Retention in Care Workgroup will oversee specific objectives, strategies and activities in monthly meetings. These meetings will be publicly noticed (i.e., following Florida Sunshine Law, will be open to all interested parties including stakeholders, involved community members, and PLWHA) to ensure maximum transparency with the implementation of the Miami Integrated Plan. Once per quarter, the Partnership's Prevention Committee, Strategic Planning Committee, PLWHA, and other stakeholders will meet together in a collective process to evaluate progress of Integrated Plan implementation, as well as to ensure that the Miami Integrated Plan is truly integrated and does not devolve into separate planning and implementation "silos." During the October-December 2016 quarter, a summary "dashboard indicator" system will be drafted and will become the basis for tracking, reporting, disseminating, and evaluating the implementation of the Miami Integrated Plan.

Data on the selected performance measures will be collected by the MDC-RWP and the FDOH-MDC, will be shared at these quarterly meetings, and will be disseminated on a semiannual basis. As the activities under the Miami Integrated Plan develop and evolve, additional strategies and activities may be added to the plan by the Strategic Planning Committee, Prevention Committee, and the Partnership, which will have final approval of any changes. This collaboration allows for consensus on the goals and SMART objectives. Local progress will also be reported through the Florida Integrated Plan process.

Meaningful measures and indicators will be used to monitor both operational performance and progress on initiatives in the Integrated Plan. Data is used to make program decisions, direct efforts to assure the program achieves the intended results, and help identify additional operational and process improvement opportunities. This approach will align, support and advance the goals of National HIV/AIDS Strategy, the Florida Department of Health in Miami-Dade County, and the Miami-Dade County Ryan White Part A/MAI Program, to ensure improvement in the access and quality of HIV services and overall improvements in client health outcomes.

IV. ADDITIONAL NARRATIVE DISCUSSION OF INTEGRATED PLAN OBJECTIVE AND STRATEGIES

The following section outlines the objectives, strategies and activities of the “2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan” (i.e., the Miami Integrated Plan), focusing on unique aspects of the HIV/AIDS epidemic in Miami-Dade County and the community’s response.

The Miami Integrated Plan draws heavily on the unique characteristics of the population living with HIV/AIDS in Miami-Dade County, and those HIV+ persons in the population that are connected to medical care and support services. For example:

- Prevention programs under NHAS 2020 Goal #1 (e.g., condom distribution, PrEP) are directed toward HIV-vulnerable populations identified in the FDOH-MDC and MDC-RWP data, with particular emphasis on injection drug users, Trans-identified persons and gay/bisexual men.
- Prevention activities focused on reducing disparities (NHAS 2020 Goal #3: Objective DP 1) are directed toward Blacks/African Americans (because of their disparate representation among the PLWHA throughout the state and in Miami-Dade County in particular), toward Hispanics (because of the high representation in the Miami-Dade County population, relative to the rest of the State, and because of the growing number of Hispanic men in the MDC-RWP treatment population as shown in **Figure 1**) and toward men who have sex with men.

The narrative descriptions below refer to the specific objectives and strategies of the corresponding Miami Integrated Plan, and are intended to provide context for the plan strategies and activities in the Miami Integrated Plan itself. Please refer to the Miami Integrated Plan for specific activities and measurements associated with the strategies outlined below.

A.1. NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS

A.1.1 PREVENTION

OBJECTIVE P 1: By 2021, reduce new HIV infection rate by at least 25%, from 54.4 per 100,000 population in 2015 to 40.8 per 100,000 population in 2021, so that Miami-Dade County is no longer among the top three metropolitan areas with the highest incidence of new HIV infections.

Strategy P 1.1 Increase access to and use of condoms by HIV positive persons and HIV-vulnerable populations, including but not limited to injection drug users, Trans-identified persons, gay and bisexual men. *The Florida Department of Health-Miami Dade County (FDOH-MDC) provides over two million condoms a year through a variety of channels, through the Business Responds to AIDS (BRTA) project, partnering with businesses in neighborhoods with high-risk local populations as condom distribution centers. By 2021, the*

BRTA program will have been expanded to 300 commercial sites in Miami-Dade County and will have distributed a cumulative total of 12 million condoms in the five year time frame.

Strategy P 1.2 Increase availability of – and access to -- PrEP/nPEP programs. *In conjunction with the Ryan White Part A/MAI (RWP) Grantee, the FDOH-MDC will generate and distribute a local directory of providers prescribing PrEP and nPEP. By 2021, FDOH-MDC will effectively double the number of medical providers providing PrEP and nPEP.*

Strategy P 1.3 Implement combined STD/HIV education and testing to raise HIV prevention awareness among HIV-vulnerable populations, including but not limited to injection drug users, Trans-identified persons, gay and bisexual men. *FDOH-MDC implements and promotes integrated STD/HIV testing and educational services with its testing providers. This effort increases access, improves the timeliness of service delivery, and increases the effectiveness of efforts to prevent infectious diseases and disorders that share common risk factors, behaviors, and social determinants.*

Strategy P 1.4 Achieve a more coordinated local response to the HIV epidemic. *Coordination of community resources beyond the FDOH-MDC and the MDC-RWP is an essential component of the Integrated Plan. One element of this enhanced coordination is the implementation of a HIV/AIDS “Getting to Zero” Task Force, appointed by the Mayor of Miami-Dade County to collectively create a community plan that will invoke county-wide systems change and help eliminate HIV. This task force will operate hand-in-hand with the FDOH-MDC, and the Miami-Dade HIV/AIDS Partnership, and will use the Miami Integrated Plan as the skeleton and guide for the mayoral initiative.*

OBJECTIVE P 2: Reduce the number of HIV-infected infants born in Miami-Dade County each year from five (5) HIV+ newborns each year to zero (0) HIV+ newborns by 2021.

Strategy P 2.1 Increase number of OB/GYN healthcare providers engaging in HIV prevention activities with pregnant women. *In FY 2015-16, the MDC-RWP initiated an outbound direct mail campaign to local OB-GYN providers, informing them of the need for testing pregnant women for HIV and referring them to supportive care if they tested positive. This activity will be expanded in the five years of the Plan.*

Strategy P 2.2 Create an action-oriented community process to improve service systems and community resources for women and infants. *FDOH-MDC is partnering to create a case review team and a community action team that will address perinatal transmission cases and initiate change based on the case review recommendations.*

Strategy P 2.3 Conduct targeted public information campaigns toward pregnant women at risk of HIV, to have access to OB/GYN providers, HIV prevention materials and information on community services for women with HIV/AIDS. *FDOH-MDC will expand its “Protect Yourself, Protect Your Baby” campaign to encourage health care providers and pregnant women to follow the CDC’s HIV testing recommendations. A key element in this*

strategy is aggressively partnering with a growing network of private obstetric medical providers throughout the Miami-Dade County EMA.

A.1.2 DIAGNOSIS

OBJECTIVE D 1: Increase the percentage of people living with HIV/AIDS (PLWHA) who know their serostatus from 84.9% in 2014 to at least 90% by 2021.

Strategy D 1.1 Partner with healthcare settings (e.g., hospitals, health centers, emergency departments), to increase the provision of routine HIV testing as part of medical care. *Routinized HIV testing is a vital part of HIV diagnosis, leading to linkage to care for persons who are unaware of their HIV status and reducing new infections. In 2015, Florida mandated primary care providers, as well as hospitals and emergency departments, to offer HIV testing to all persons between the ages of 13 and 64 years, removing written consent but allowing opt-out testing. FDOH-MDC has been exploring partnerships with local hospitals and non-traditional health care providers to encourage HIV prevention, incorporate routinized HIV testing, and educate on implementing third party billing for testing.*

Strategy D 1.2 Intensify HIV testing efforts in high impact areas. *The Take Control program utilizes non-clinical venues in high-prevalence areas providing HIV/STD screenings and outreach information to the appropriate high-risk populations.*

Strategy D 1.3 Increase the number of HIV tests conducted, effectively identifying and testing individuals at highest risk, including but not limited to injection drug users, Trans-identified persons, gay and bisexual men. *Registered counseling and testing sites are required to maintain a desired level of testing excellence. FDOH-MDC provides technical assistance and capacity building to increase and effectively identify target populations.*

A.2 NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

A.2.1 LINKAGE

OBJECTIVE L 1: Increase the percentage of PLWHA linked to medical care [at least one outpatient medical care visit, as documented by a billed OMC encounter, or a CD4 or VL test] within 30 days post-diagnosis from 55% in 2015 to at least 85% by 2021.

Strategy L 1.1 Improve existing FDOH-Part A diagnosis-to-linkage client management process. *Since 2012, the FDOH-MDC and MDC-RWP have worked together to create a seamless diagnosis-to-care process, continually identifying areas to strengthen cooperation, referral and data capture. The strong partnership between the FDOH-MDC and MDC-RWP is part of an ongoing monitoring and improvement process to enhance the linkage to care systems and outcomes. Activities include (but are not limited to): a shared State and County approved consent/referral form, collaborative monitoring and trainings activities, and a dynamic data sharing agreement supporting joint reporting efforts.*

Strategy L 1.2 Provide Partner Services to identified HIV+ individuals, allowing for the notification, screening and referral to appropriate services for partners of newly-diagnosed PLWHA. *Partner services are offered to individuals who are infected with HIV/STDs, to their partners, and to other persons who are at increased risk for infection in an effort to prevent transmission of these diseases. The focus is to identify and locate the sexual contacts of infected persons and other persons at risk for behavioral or other factors, and then refer them for medical examination and, as appropriate, for treatment.*

Strategy L 1.3 Identify and link to medical care at least 25% of the HIV-infected persons identified through the FDOH-MDC "Data to Care" (DTC) initiative. *The "Data to Care" program uses laboratory reports received by FDOH-MDC's HIV surveillance program and analyzes them to identify individuals who were either never linked to care after diagnosis or did not continue to receive care. The program then offers individuals on this list assistance with getting into HIV care.*

A.2.2 RETENTION IN CARE

OBJECTIVE R 1. Increase the percentage of PLWHA in the RWP who had at least two medical visits [or CD4/VL lab tests, or ARV prescriptions filled, or any combination of two or more of these metrics] at least 90 days apart within a 12 month period, from 60% in 2015 to at least 90% by 2021.

Strategy R 1.1 Identify PLWHA who are at greatest risk for dropping out of care. *Through the efforts of the MDC-RWP Quality Management Program, the MDC-RWP will engage in a systematic statistical analysis of the factors affecting retention in care among the 9,600+ PLWHA in care through the RWP. This analysis will be combined with a quality improvement initiative to identify client-based warning signs. The systematic analysis will focus on identifying risk as well as protective factors associated with retention in care. The results will inform initiatives and interventions to increase access and retention in care.*

Strategy R 1.2 Enhance the RWP Client-Centered Care quality improvement system that focuses on reduction of barriers to continued care, identification of best practices, and implementation of system-wide service quality improvement. *The MDC-RWP Quality Management Program will generate a five-year systematic analysis of its Client Centered Care program, looking at program-based quality improvement opportunities, and creating at least one intervention implementation per year throughout the five years of the Miami Integrated Plan.*

Strategy R 1.3 Enhance the RWP Client-Centered Care quality management protocols for (1) reducing lagtime to first or repeat appointments; (2) reducing wait time in lobby for appointments; and (3) reducing hold time reaching live help by telephone, for Ryan White Program outpatient medical care (OMC), oral health care (OHC) and medical case management (MCM) providers. *The MDC-RWP Quality Management Program will monitor non-clinical program-based wait-time indicators to identify opportunities, and creating at least one time-saving initiative per year throughout the five years of the Miami Integrated Plan.*

Strategy R 1.4 Provide continuous improvements in outpatient medical care that meets the needs and identified vulnerabilities of PLWHA in care. *Through the efforts of the MDC-RWP Quality Management Program, the MDC-RWP will monitor the quality and appropriateness of OMC clinical care to identify patterns of high quality of care delivery as well as areas of improvement. Specific efforts will be made to integrate lessons learned from providers delivering high quality of care with providers in need of technical assistance to enhance quality of care delivery.*

Strategy R 1.5 Track and assess the quality of care provided to MDC-RWP clients who transition to ACA-provided outpatient medical care. *The MDC-RWP Quality Management Program will conduct an annual assessment of clients who transition to an ACA Marketplace health insurance plan (both ADAP and non-ADAP ACA transitioned) and clients who remained in the Ryan White Program (non-ACA transitioned). The purpose of this analysis is to assess and identify differences in service utilization and health outcomes that may be associated with retention in care and overall quality of care of clients in the MDC-RWP.*

A.2.3 VIRAL SUPPRESSION

OBJECTIVE V 1. Increase the percentage of people living with HIV who are virally suppressed (<200 copies/mL) from 67% in 2015 to at least 80% by 2021.

Strategy V 1.1 Provide immediate access to antiretroviral therapy through timely linkage to medical care, expanding the FDOH-MDC Test and Treat model of care. *The Test and Treat Model provides early treatment initiation, which is linked to improved health outcomes. FDOH-MDC is working with local hospitals and healthcare providers to expand this model of care, and will effectively double the number of Test and Treat sites by the close of the planning period.*

Strategy V 1.2 Enhance support for FDOH-MDC treatment adherence initiatives. *Optimizing treatment adherence reduces viral transmission. FDOH-MDC understands that utilizing peer educators and interventions is an opportunity to suppress HIV and raise the continuum of care bars.*

Strategy V 1.3 Expand role of MDC-RWP Medical Case Management (MCM) and Outpatient Medical Care (OMC) providers in detecting lapses in adherence or persistent viremia, and initiate appropriate responses. *The MDC-RWP Quality Management Program will conduct quarterly assessments to identify detectable viral loads patterns in the RWP and at the provider level. The “Quality Assurance Report Card” will serve as the primary tracking mechanism for monitoring and reporting viral load as a quality of care measure for the entire MDC-RWP and each provider.*

A.3 NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES

A.3.1 DISPARITIES IN PREVENTION

OBJECTIVE D P1. By 2021, reduce number of persons in key disparate minority health groups who are newly-diagnosed with HIV/AIDS by 15%, relative to 2015 levels.

Strategy DP 1.1-1.3 Enhance HIV prevention, testing, communication and community mobilization efforts in Miami-Dade County towards the following groups, reducing the numbers of newly-diagnosed:

- DP 1.1 Blacks/African Americans: from 464 diagnosed in 2015 to 394 in 2021. Note that in Miami-Dade, as throughout the State of Florida, the incidence of HIV/AIDS is disproportionately high in this population (see Epidemiological Profile, above).
- DP1.2 Hispanics: from 659 diagnosed in 2015 to 560 in 2021. Note that in Miami-Dade County, the proportion of Hispanics in the general population is substantially higher than the Hispanic proportion throughout the state (Table 1), as is the proportion of Hispanics among persons with HIV or AIDS. Note also that the proportion of Hispanic males in Ryan White Program-funded medical care has been growing steadily (Figure 1).
- DP1.3 Gay and bisexual men: from 678 diagnosed in 2015 to 576 in 2021.

A.3.2 DISPARITIES IN RETENTION

OBJECTIVE DR 1. By 2021, increase the percentage of clients in three (3) key disparate minority health groups who are retained in RWP outpatient medical care [at least two medical visits, or CD4/VL lab tests, or ARV prescriptions filled, or any combination of two (2) or more of these metrics, at least 90 days apart within a 12 month period], to 90%.

Strategy DR1.1-1.3 Identify risk factors associated with retention in the Ryan White Part A/MAI network of care for the special populations listed below, and address them with specific interventions:

- DR1.1 Black/African American males, from 53% retained in care in 2015 to 90%.
- DR1.2 Black/African American females, from 52% retained in care in 2015 to 90%.
- DR1.3 Hispanics under 25 years of age, from 49% retained in care in 2015 to 90%.

A.3.3 DISPARITIES IN TREATMENT OUTCOMES

OBJECTIVE DV1. By 2021, increase the percentage of clients in RWP care among three (3) key disparate minority health groups with suppressed viral loads to 80%, to match overall PLWHA levels.

Strategy DV1.1 -1.3 Identify risk factors associated with having high VL (low proportions of suppressed or undetectable VL) within the Ryan White Part A/MAI network of care for the special populations listed below, and address them with specific interventions:

DV 1.1 Black/African American Males: from 57% suppressed VL in 2015 to 80%.

DV 1.2 African American Females: from 60% suppressed VL in 2015 to 80%.

DV 1.3 Haitians: from 68% suppressed VL in 2015 to 80%.

2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan
Provided by the Florida Department of Health in Miami-Dade County
and the Miami-Dade County Ryan White Part A/MAI Program

Acronyms and Abbreviations Used In This Document

ADAP	AIDS Drug Assistance Program
BRTA	Business Responds to AIDS, a program of the Florida Department of Health in Miami-Dade County
DIS	Disease Intervention Specialist, within the Florida Department of Health in Miami-Dade County
FDOH-MDC	Florida Department of Health in Miami-Dade County
FIMR	Fetal Infant Monitoring Review
IDU	Injection Drug Use / Injection Drug User
MCM	Medical Case Management, provided by the Ryan White Program
NHAS	National HIV/AIDS Strategy
OHC	Oral Health Care, provided by the Ryan White Program
OMC	Outpatient Medical Care, provided by the Ryan White Program
Part A/MAI	Part A and the Minority AIDS Initiative of the Ryan White Program in Miami-Dade County
PrEP/nPEP	Pre-Exposure Prophylaxis /non-occupational Post-Exposure Prophylaxis
PRIM	Pre-Natal Immunology Clinic, within the University of Miami
QM	The Ryan White Program's Quality Management Contractor
RWP	Miami-Dade County Ryan White Program, both Part A and MAI (Minority AIDS Initiative)
VL	Viral Load

2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan
Provided by the Florida Department of Health in Miami-Dade County
and the Miami-Dade County Ryan White Part A/MAI Program

NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS								
PREVENTION								
Objectives	Strategies	Activities / Measurements	Responsible Entities	2017	2018	2019	2020	2021
P1. By 2021, reduce new HIV infection rate by at least 25%, from 54.4 per 100,000 population in 2015 to 40.8 per 100,000 population in 2021, so that Miami-Dade County is no longer among the top three metropolitan areas with the highest incidence of new HIV infections.	PROGRESS TOWARD OBJECTIVE: Baseline 54.4 per 100,000 population in 2015, reduced to 40.8 per 100,000 in 2021.			53	50	47	44	41
	P1.1 Increase access to and use of condoms by HIV positive persons and HIV-vulnerable populations, including but not limited to injection drug users (IDU), Trans-identified persons, gay and bisexual men . ¹	P1.1a Increase the number of businesses recruited through BRTA to 300 sites (baseline: 115 in 2015).	FDOH-MDC and Partners	152	189	226	263	300
		P1.1b Provide four (4) educational sessions per year on condom use targeted towards HIV-positive and high risk negative persons, for a cumulative total of 20.	FDOH-MDC	4	8	12	16	20
		P1.1c Distribute 2 million condoms per year, for a cumulative total of 12 million condoms (baseline: 2,245,986 in 2015).	FDOH-MDC and Partners	4.0 mill	6.0 mill	8.0 mill	10.0 mill	12.0 mill
	P1.2 Increase availability of – and access to – PrEP/nPEP programs.	P1.2a Conduct 15 PrEP awareness webinars and presentations in the Miami-Dade County community per year, for a cumulative total of 75 presentations.	FDOH-MDC	15	30	45	60	75

¹ Unless otherwise specified in the text of a strategy or activity, all strategies and activities are continuous progressive activities from January 1, 2017 to December 31, 2021. Where appropriate, interim benchmark metrics are shown, either with a specific value (percentages, numbers of activities engaged in, etc.) or a check mark to indicate a process is underway through that year.

**NHAS 2020 GOAL #1:
REDUCE NEW HIV INFECTIONS**

PREVENTION

Objectives	Strategies	Activities / Measurements	Responsible Entities	2017	2018	2019	2020	2021
		P1.2b By December 31, 2017 (First Year) , create a local directory of providers prescribing PrEP and nPEP, disseminate same on Part A and FDOH-MDC websites, and update annually thereafter.	FDOH-MDC and Part A/MAI	Create	Up-date	Up-date	Up-date	Up-date
		P1.2c By December 31, 2019 (Third Year) , facilitate establishment of six (6) new PrEP/nPEP medical providers (baseline: 3 in 2015).	FDOH-MDC and Partners	4	5	6		
		P1.2d Raise proportion of clients identified through the FDOH-MDC PrEP Clinic who are prescribed PrEP to 70% (no baseline).	FDOH-MDC	10%	25%	40%	55%	70%
	P1.3 Implement combined STD/HIV education and testing to raise HIV prevention awareness among HIV-vulnerable populations, including but not limited to injection drug users (IDU), Trans-identified persons, gay and bisexual men.	P1.3a Identify/recruit additional sites to increase the number of HIV testing programs offering integrated STD testing from 12 to 15 sites.	FDOH-MDC and Partners	13		14		15
		P1.3b Conduct 15 testing events per year with integrative screenings of HIV, STD, and viral hepatitis in high prevalence areas of Miami Dade County (baseline: 18 in 2015).	FDOH-MDC	30	45	60	75	90
		P1.3c Organize 50 cycles per year of STD education, targeting high risk negative individuals (baseline: 53 cycles in 2015).	FDOH-MDC	100	150	200	250	300
	P1.4 Achieve a more coordinated local response to the HIV epidemic.	P1.4a By January 1, 2017 (First Year) , publish the Integrated Plan on Test Miami and Part A websites, promoting awareness of this plan.	FDOH-MDC and Part A/MAI	✓				

NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS								
PREVENTION								
Objectives	Strategies	Activities / Measurements	Responsible Entities	2017	2018	2019	2020	2021
		P1.4b By January 1, 2017 (First Year) , implement a short-term intensive "Getting to Zero" Task Force, appointed by the Mayor, to generate high-level community commitment to actions consistent with the Integrated Plan, to eliminate HIV/AIDS in Miami-Dade County.	FDOH-MDC Part A/MAI	✓				
		P1.4c By January 1, 2017, 2017 (First Year) , implement a joint mechanism for the FDOH-MDC and Part A/MAI to measure, track, review, evaluate and disseminate information on progress toward achieving the Integrated Plan's metrics.	FDOH-MDC Part A/MAI	✓	✓	✓	✓	✓

NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS								
PREVENTION								
Objectives	Strategies	Activities / Measurements	Responsible Entities	2017	2018	2019	2020	2021
P2. Reduce the number of HIV-infected infants born in Miami-Dade County each year from five (5) HIV+ newborns each year to zero (0) HIV+ newborns by 2021.	PROGRESS TOWARD OBJECTIVE: Continual reduction of live HIV+ births from 5 per year to zero by 2021.			4	3	2	1	0
	P2.1 Increase number of OB/GYN healthcare providers engaging in HIV prevention activities with pregnant women.	P2.1a Use Miami-Dade County OB/GYN physician/clinic address data from FDOH-MDC (1) to conduct an annual outbound direct mail and e-mail awareness campaign to inform them of state law 64D-3.042, the local protocol of High Risk Pregnancy Notification and encourage awareness of their responsibility to act on behalf of the HIV infected pregnant women in their care, and (2) to include bounce-back cards to enumerate level of cooperation, number of HIV infected pregnant women in care, and to request more information.	Miami-Dade HIV/AIDS Partnership Staff Support	✓	✓	✓	✓	✓
		P2.1b Conduct four (4) in-person educational sessions per year directed toward medical professionals, who participate in the care of HIV infected pregnant women, educating them about the requirements of Florida law and ensuring they are aware of community services available for HIV infected women and HIV infected or exposed infants.	FDOH-MDC	4	8	12	16	20

**NHAS 2020 GOAL #1:
REDUCE NEW HIV INFECTIONS**

PREVENTION

Objectives	Strategies	Activities / Measurements	Responsible Entities	2017	2018	2019	2020	2021
		P2.1c Conduct one (1) educational round per year with emergency rooms, urgent care centers, and classified high-risk delivery hospitals, to increase provider awareness of their responsibility to utilize the <i>High Risk Pregnancy Notification</i> and <i>Newborn Exposure Notification</i> forms and act on behalf of the HIV infected pregnant women and their HIV infected or exposed babies.	FDOH-MDC	1	2	3	4	5
	P2.2 Create an action-oriented community process to improve service systems and community resources for women and infants.	P2.2a Organize four (4) Fetal Infant Monitoring Review (FIMR-HIV) meetings per year to review all information gathered on perinatal transmission cases, identify system issues, and make recommendations for improvement.	FDOH-MDC Healthy Start	4	8	12	16	20
		P2.2b Organize four (4) Community Action Team meetings per year to initiate systems change based on FIMR-HIV recommendations for improvement.	FDOH-MDC Healthy Start	4	8	12	16	20
	P2.3 Conduct targeted public information campaigns toward pregnant women at risk of HIV, to have access to OB/GYN	P2.3a Disseminate a minimum of 1,000 units of educational materials per year, promoting the “Protect Yourself, Protect Your Baby” awareness campaign, encouraging women of childbearing age who are pregnant or considering pregnancy to get tested for HIV (no baseline).	FDOH-MDC	1,000	2,000	3,000	4,000	5,000

NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS								
PREVENTION								
Objectives	Strategies	Activities / Measurements	Responsible Entities	2017	2018	2019	2020	2021
	providers, HIV prevention materials and information on community services for women with HIV/AIDS.	P2.3b Create memorandum of agreement with at least five (5) obstetric healthcare providers per year, who agree to show the “Protect Yourself, Protect Your Baby” DVD in patient waiting rooms (no baseline).	FDOH-MDC	5	10	15	20	25
		P2.3c Create linkage services assuring at least 85% of HIV-infected post-partum women have access to contraceptive/family planning and preconception care services after delivery (no baseline).	FDOH-MDC	65%	70%	75%	80%	85%

NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS								
DIAGNOSIS								
Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
D1. Increase the percentage of people living with HIV/AIDS (PLWHA) who know their serostatus from 84.9% in 2014 to at least 90% by 2021.	PROGRESS TOWARD OBJECTIVE: Increase from 85% of PLWHA who know their status in 2016 to 90% in 2021.			86%	87%	88%	89%	90%
	D1.1 Partner with healthcare settings (e.g. hospitals, health centers, emergency departments), to increase the provision of routine HIV testing as part of medical care.	D1.1a By December 31, 2017, create a program to enroll, support and evaluate healthcare providers to implement routinized HIV testing in their facilities.	FDOH-MDC	Create				
		D1.1b Conduct fifteen (15) educational visits per year to healthcare providers to disseminate information regarding the importance of routine HIV screening.	FDOH-MDC	15	30	45	60	75
		D1.1c Enroll six (6) new healthcare providers per year in the routinized HIV testing program.	FDOH-MDC	6	12	18	24	30
		D1.1d Provide education, training and technical assistance to six (6) healthcare providers per year enrolled in the routinized HIV testing program.	FDOH-MDC	6	12	18	24	30
	D1.2 Intensify HIV efforts in high impact areas.	D1.2a Increase the number of registered testing sites by six (6) per year to ensure that HIV testing is more readily available and accessible (baseline: 118 sites in 2015)	FDOH-MDC	124	130	136	142	148
		D1.2b Conduct thirty (30) Take Control events per year in high impact areas (i.e., FDOH-MDC Life Zones II, III, IV and V).	FDOH-MDC	30	60	90	120	150

**NHAS 2020 GOAL #1:
REDUCE NEW HIV INFECTIONS**

DIAGNOSIS

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
		D1.2c Document effective strategies in the execution of Take Control activities and host a quarterly debriefing to address barriers to successful implementation.	FDOH-MDC and Partners	4	8	12	16	20
	D1.3 Increase the number of HIV tests conducted, effectively identifying and testing individuals at highest risk including but not limited to injection drug users (IDU), Trans-identified persons, gay and bisexual men.	D1.3a Provide registered testing sites with a quarterly "report card" identifying areas of success and opportunities for improvement in testing.	FDOH-MDC	4	8	12	16	20
		D1.3b Provide technical assistance to registered testing agencies not meeting the standards of the quarterly "report card."	FDOH-MDC	✓	✓	✓	✓	✓
		D1.3c Host an annual 501 Update for HIV Testing Counselor's education on testing technologies and emerging testing trends.	FDOH-MDC	1	2	3	4	5

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

LINKAGE TO CARE

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
L 1. Increase the percentage of PLWHA linked to medical care [at least one (1) outpatient medical care visit, as documented by a billed OMC encounter, or a CD4 or VL test] within 30 days post-diagnosis from 55% in 2015 to at least 85% by 2021.	PROGRESS TOWARD OBJECTIVE: Baseline linkage rate of 55% in 2015 increased to 85% by 2021.		FDOH-MDC Part A/MAI	65%	70%	75%	80%	85%
	L 1.1 Improve existing FDOH-Part A diagnosis-to-linkage client management process.	L 1.1a FDOH-MDC and Ryan White Part A/MAI will jointly identify and address at least one (1) Linkage to Care Quality Improvement Opportunity per year (identify, pilot-test, evaluate, implement), for a total of five (5).	FDOH-MDC Part A/MAI	1	2	3	4	5
		L 1.1b FDOH-MDC and Ryan White Part A/MAI will hold four (4) training events per year with FDOH Disease Intervention Specialists (DIS), Part A outreach workers and FDOH peers to address identified linkage to care gaps and quality improvement initiatives.	FDOH-MDC Part A/MAI	4	8	12	16	20
		L 1.1c Guarantee flexible after-hours and weekend availability at Ryan White Part A/MAI MCM, OMC and Outreach provider agencies, ensuring that at least one (1) MCM provider, one (1) OMC provider and one (1) Outreach provider will offer after-hours service five (5) weeknights per week and will offer four (4) hours of service availability one (1) weekend day, to reduce or eliminate barriers to Part A/MAI program linkage once a PLWHA has been diagnosed at an FDOH-MDC site.	Part A/MAI	✓	✓	✓	✓	✓
	L 1.2 Provide Partner Services to identified HIV+ individuals, allowing for the notification, screening	L 1.2a At least 75% of newly-diagnosed PLWHA eligible for services in Miami-Dade County will be offered Partner Services counseling interviews within thirty (30) days of the positive HIV test (baseline: 68% in 2015).	FDOH-MDC DIS	69%	71%	73%	74%	75%

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

LINKAGE TO CARE

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
	and referral to appropriate services for partners of newly-diagnosed PLWHA.	L 1.2b At least 75% of the partners of newly-diagnosed PLWHA interviewed through Partner Services (L1.2a) will be tested for HIV (baseline: 48% in 2015).	FDOH-MDC DIS	55%	60%	65%	70%	75%
		L 1.2c At least 75% of the HIV negative Partners identified through Partner Services will be offered a referral to the FDOH-MDC PrEP clinic (no baseline).	FDOH-MDC DIS	55%	60%	65%	70%	75%
	L 1.3 Identify and link to medical care at least 25% of the HIV-infected persons identified through the FDOH-MDC "Data To Care" (DTC) initiative.	L 1.3a Increase by 5% per year the percentage of DTC clients with a positive diagnosis, but without CD4/VL data, who are contacted to determine eligibility for linkage to care in Miami-Dade County.	FDOH-MDC	60%	65%	70%	75%	80%
		L 1.3b Through FDOH-MDC and Part A/MAI cooperation, link 25% of DTC clients identified as eligible for linkage in Miami-Dade County to care within sixty (60) days of identification.	FDOH-MDC Part A/MAI	5%	10%	15%	20%	25%

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

RETENTION IN CARE

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
R1. Increase the percentage of PLWHA in the RWP who had at least two medical visits [or CD4/VL lab tests, or ARV prescriptions filled, or any combination of two (2) or more of these metrics] at least 90 days apart within a 12 month period, from 60% in 2015 to at least 90% by 2021.	PROGRESS TOWARD OBJECTIVES: Baseline retention rate of 60% in 2015 increased to 90% by 2021.		Part A/MAI QM	66%	72%	78%	84%	90%
	R1.1 Identify PLWHA who are at greatest risk for dropping out of care.	R1.1a By December 31, 2017 (First Year) , identify PLWHA demographic background factors associated with dropping out of Ryan White Program OMC care, and track retention annually thereafter.	Part A/MAI QM	Identify	Track	Track	Track	Track
		R1.1b By December 31, 2017 (First Year) , develop, test and implement assessment measurements of HIV-related comorbidities and acuity levels associated with dropping out of Ryan White Program OMC care; track and refine measurements in subsequent years.	Part A/MAI QM	Identify	Track	Track	Track	Track
		R1.1c Beginning January 1, 2018 (Second Year) , identify at least one (1) client characteristic-based Retention In Care Quality Improvement opportunity per year (identify, pilot-test, evaluate, implement improvement).	Part A/MAI QM		1	2	3	4
	R1.2 Enhance the RWP Client-Centered Care quality improvement system that focuses on reduction of barriers to	R1.2a By December 31, 2017 (First Year) , identify OMC providers with outstanding retention in care rates, independent of client demographics, comorbidities or special need characteristics. Determine best program practices.	Part A/MAI QM	✓				

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

RETENTION IN CARE

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
	continued care, identification of best practices, and implementation of system-wide service quality improvement.	R1.2b Expand implementation of 2016-17 RWP Texting Intervention Project protocols to PLWHA at five (5) MCM sites per year to apply intervention protocols to improve PLWHA retention in care.	Part A/MAI QM	5	10	15	20	25
		R1.2c Beginning January 1, 2018 (Second Year) , identify at least one program-based Retention In Care Quality Improvement Opportunity per year (identify, pilot-test, evaluate, implement improvement).	Part A/MAI QM		1	2	3	4
		R1.2d Review and update Client-Centered Care standards for Ryan White Program-funded OMC, OHC and MCM services, and evaluate (track) providers' compliance with these standards annually thereafter.	Part A/MAI QM	Review and Up-date	Track	Track	Track	Track
	R1.3 Enhance the RWP Client-Centered Care quality management protocols for (1) reducing lagtime to first or repeat appointments; (2) reducing wait time in lobby for appointments; and (3) reducing hold time reaching live help by telephone, for Ryan White Program OMC,	R1.3a By December 31, 2017 (First Year) , identify and review existing provider-based processes for monitoring lagtime, wait time and hold time in 100% of Part A/MAI-funded OMC, OHC and MCM providers; develop and implement system-wide protocols for measurement and reporting.	Part A/MAI QM	Implement				
		R1.3b Beginning January 1, 2018 (Second Year) , track lagtime, wait time and hold time performance of Ryan White Program OMC, OHC and MCM providers.	Part A/MAI QM		Track	Track	Track	Track
		R1.3c Reduce average lagtime, average wait time and average hold time by 25%, relative to standards updated in R1.2c and tracked in R1.3a and R1.3b.	Part A/MAI QM		-10%	-15%	-20%	-25%

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

RETENTION IN CARE

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
	OHC and MCM providers.	R1.3d Identify at least one (1) program-based Retention In Care Quality Improvement Opportunity per year (identify, pilot-test, evaluate, implement improvement).	Part A/MAI QM	1	2	3	4	5
	R1.4 Provide continuous improvements in outpatient medical care that meets the needs and identified vulnerabilities of PLWHA in care.	R1.4a Monitor quality and appropriateness of OMC clinical care through client satisfaction surveys, focus groups, targeted reviews of SDIS data and clinical record reviews and improve through various technical assistance methods (on site QM TA, AETC, etc.). Require corrective actions for providers with identified deficiencies.	Part A/MAI QM	✓	✓	✓	✓	✓
		R1.4b Monitor quality and appropriateness of prescription of non-ARV medication, to identify unusual prescription drug patterns reflecting problems in quality of care, through statistical analysis of prescribing frequency and/or desk audits of prescription patterns for particular providers and improve prescribing patterns of these non-ARV medications as needed for appropriateness and cost effectiveness. Require corrective actions for providers with identified deficiencies.	Part A/MAI QM	✓	✓	✓	✓	✓

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

RETENTION IN CARE

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
		R1.4c Monitor and improve clinical and administrative proficiency among outreach workers, medical case managers and peers, through systems of proficiency development and enhanced clinical training. Require corrective actions for providers with identified deficiencies.	Part A/MAI QM	✓	✓	✓	✓	✓
	R1.5 Track and assess the quality of care provided to RWP clients who transition to ACA-provided outpatient medical care.	R1.5a Revise and streamline ACA enrollment and re-enrollment processes to increase the proportion of ACA-eligible RWP clients transitioned to ACA from 50% to 70% (2015 baseline: 50%).	Part A/MAI QM	54%	58%	62%	66%	70%
		R1.5b Increase the percentage of eligible clients transitioned from Ryan White Part A/MAI-funded outpatient medical care to ACA medical care who are retained in ACA-provided medical care for two (2) years after enrollment from 45% to 65%.	Part A/MAI QM	45%	50%	55%	60%	65%
		R1.5c Require that all clients receiving Part A/MAI assistance with the ACA report VL levels at a minimum once every six (6) months, in order to assess and track clinical health outcomes of RWP clients receiving OMC through an ACA Marketplace insurance plan. Compare VL levels among PLWHA treated through ACA with VL levels of PLWHA receiving OMC through the RWP to identify disparities.	Part A/MAI QM	Check	Track	Check	Track	Check

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

VIRAL LOAD SUPPRESSION

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
V1. Increase the percentage of people living with HIV in the EMA who are virally suppressed (<200 copies/mL) from 67% in 2015 to at least 80% by 2021.	PROGRESS TOWARD OBJECTIVES: baseline viral suppression in the EMA overall from 67% in 2015 to 80% by 2021.		FDOH MD-C	71%	73%	75%	77%	80%
	V1.1 Provide immediate access to antiretroviral therapy through timely linkage to medical care, expanding the FDOH-MDC Test and Treat model of care.	V1.1a Develop capacity for increased Test and Treat sites, setting a goal of one (1) new site identified and in development every 18 months, including: (1) identifying potential new Test and Treat sites; (2) determining what the sites need to become “Test and Treat”-ready; and (3) provide technical assistance to the sites to assure Test and Treat readiness and success (baseline: 1).	FDOH M-DC and Partners		2	3		4
		V1.1b At least 80% of clients identified through the “Test and Treat” model will have received antiretroviral therapy within the seven (7) day time period.	FDOH M-DC and Partners	60%	65%	70%	75%	80%
	V1.2 Enhance support for FDOH-MDC treatment adherence (FDOH-MDC initiatives).	V1.2a By December 31, 2018 (Second Year) , create an Electronic Direct Observation Therapy system for ARV non-compliant pregnant women.	FDOH-MDC and UM PRIM clinic		✓			
		V1.2b Beginning in January 1, 2019 (Year Three) , at least 75% of women using the electronic direct observation therapy will be treatment compliant.	FDOH-MDC and UM PRIM clinic			65%	70%	75%

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

VIRAL LOAD SUPPRESSION

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
		V1.2c By December 31, 2017 (Year One) , establish a referral service between ADAP and FDOH Peer Educators and Linkage staff to target ADAP clients not achieving viral suppression, and maintain throughout following years.	FDOH-MDC ADAP FDOH Peer Educators	Estab- lish	Main- tain	Main- tain	Main- tain	Main- tain
		V1.2d By December 2018 (Year Two) , at least 55% of HIV+ persons enrolled in peer navigation programs will receive treatment adherence education, rising to 70% by 2021. (No baseline)	FDOH-MDC FDOH Peer Educators		55%	60%	65%	70%
		V1.2e By December, 2018 (Year Two) , 45% of the PLWHA who fail to pick up medications through ADAP will be contacted and efforts made to diagnose barriers and move them to compliance, rising by 5% per year thereafter.	FDOH-MDC ADAP		45%	50%	55%	60%
	V1.3 Expand role of Part A/MAI MCM and OMC providers in detecting lapses in adherence or persistent viremia, and initiate appropriate responses.	V1.3a Hold quarterly meetings between ADAP and Part A/MAI MCM supervisors during MCM supervisor trainings to find ways to increase awareness of early detection of lapses in adherence and persistent high viremia.	Part A/MAI ADAP	4	8	12	16	20
		V1.3b Expand implementation of 2016-17 RWP Texting Intervention Project protocols to PLWHA at five (5) MCM sites per year to apply intervention protocols to improve PLWHA viral load suppression.	Part A/MAI	5	10	15	20	25

NHAS 2020 GOAL #2:

INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

VIRAL LOAD SUPPRESSION

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
		V1.3c On a monthly basis, detect PLWHA with persistently high viremia and notify OMC and MCM providers to enable targeted response. Monitor improvement in VL levels to ensure efficacy of provider response.	Part A/MAI	✓	✓	✓	✓	✓
		V1.3d Beginning January 1, 2018 (Second Year), identify at least one (1) Viral Load (non)Suppression Quality Improvement opportunity per year (identify, pilot-test, evaluate, implement improvement).	Part A/MAI		1	2	3	4

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN PREVENTION								
Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
DP1. By 2021, reduce number of persons in key disparate minority health groups who are newly-diagnosed with HIV/AIDS by 15%, relative to 2015 levels.	PROGRESS TOWARD OBJECTIVES: a. Blacks/African Americans: from 464 in 2015 to 394 in 2021. b. Hispanics: from 659 in 2015 to 560 in 2021. c. Gay and bisexual men: from 678 in 2015 to 576 in 2021.		FDOH-MDC	a. 450 b. 639 c. 657	a. 436 b. 619 c. 637	a. 422 b. 600 c. 617	a. 410 b. 582 c. 598	a. 394 b. 560 c. 576
	DP1.1-1.3 Enhance HIV prevention, testing, communication and community mobilization efforts in Miami-Dade County towards the following groups:							
	DP1.1 Blacks/African Americans	DP1.1a FDOH-MDC in collaboration with local community based organizations, will annually organize sixty (60) community mobilization events engaging Blacks/African Americans in HIV prevention, harm risk reduction, and addressing stigma (baseline: 73 events in 2015).	FDOH-MDC and Partners	60	120	180	240	300
		DP1.1b FDOH –MDC will mobilize leaders and the Black/African American community by hosting quarterly meetings to invigorate HIV prevention efforts, support the reduction of risky behavior, and address stigma.	FDOH-MDC and Partners	4	8	12	16	20
		DP1.1c FDOH-MDC and non-clinical HIV counseling and testing sites will educate the Black/African American community about the importance of getting an HIV test, increasing the number of HIV tests by at least 10% (Baseline: 34,860 tests in 2015)	FDOH-MDC and Partners	35,557	36,268	36,993	37,732	38,486

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN PREVENTION								
Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
	DP1.2 Hispanics/Latinos	DP1.2a FDOH-MDC will mobilize leaders and the Hispanic/Latino community by hosting quarterly meetings to invigorate HIV prevention efforts, support the reduction of risky behavior, and address stigma.	FDOH-MDC and Partners	4	8	12	16	20
		DP1.2b FDOH-MDC will partner with community based organizations and host at least one (1) annual <i>Iniciativa Hispana</i> activity engaging the Hispanic community in HIV prevention.	FDOH-MDC and Partners	1	2	3	4	5
		DP1.2c FDOH-MDC will have implemented fifty (50) cycles of educational sessions, including harm risk reduction methods targeting positive and high risk negative Hispanic persons.	FDOH-MDC	10	20	30	40	50
		DP1.2d FDOH-MDC and non-clinical HIV counseling and testing sites will educate the Hispanic/Latino community about the importance of getting an HIV test, increasing the number of tests by at least 10% (baseline: 40,741 tests in 2015).	FDOH-MDC and Partners	41,555	42,386	43,233	44,097	44,978
	DP1.3 Gay and bisexual men	DP1.3a FDOH-MDC will have coordinated fifteen (15) outreach/testing events targeting high risk gay and bisexual men.	FDOH-MDC and Partners	3	6	9	12	15

**NHAS 2020 GOAL #3:
REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES**

DISPARITIES IN PREVENTION

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
		DP1.3b FDOH –MDC will mobilize leaders and the gay and bisexual community by hosting quarterly meetings to invigorate HIV prevention efforts, support the reduction of risky behavior, and address stigma.	FDOH-MDC and Partners	4	8	12	16	20
		DP1.3c FDOH-MDC and non-clinical HIV counseling and testing sites will mobilize and educate the gay and bisexual community about the importance of getting an HIV test, increasing the number of tests by at least 10%, compared to 2015 baseline of 16,711 tests.	FDOH-MDC and Partners	17,045	17,385	17,732	18,086	18,447

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN RETENTION IN CARE								
Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
DR1. By 2021, increase the percentage of clients in three (3) key disparate minority health groups who are retained in RWP outpatient medical care [at least two (2) medical visits, or CD4/VL lab tests, or ARV prescriptions filled, or any combination of two (2) or more of these metrics, at least 90 days apart within a 12 month period] to 90%, to match overall PLWHA levels.	PROGRESS TOWARD OBJECTIVES: a. Black/African American males: from 53% retained in care each year to 90%. b. Black/African American females: from 52% retained in care each year to 90%. c. Hispanics under 25 years of age: from 49% retained in care each year to 90%.		RWP Part A QM	a. 65% b. 65% c. 63%	a. 71% b. 71% c. 70%	a. 77% b. 77% c. 77%	a. 83% b. 83% c. 84%	a. 90% b. 90% c. 90%
	DR1.1-1.3 Identify risk factors associated with retention in care for the specialty groups listed below, and address them with specific interventions:							
	DR1.1 Black/African American males	DR1.1a By December 31, 2017 (First Year) , determine (1) best practices of Part A/MAI agencies with higher than average PLWHA retention rates for Black/African American males; and (2) risk factors contributing to low Black/African American male PLWHA retention rates.	RWP Part A	✓				
		DR1.1b By December 31, 2018 (Second Year) , design, pilot-test and evaluate interventions to improve retention of Black/African American male PLWHA in Part A/MAI-funded services.	RWP Part A QM		✓			
		DR1.1c By December 31, 2019 (Third Year) , implement interventions directed to Black/African American male PLWHA throughout the RWP Part A/MAI networks of care, thereby reducing lost-to-care rates for Black/African American males. Evaluate annually thereafter.	RWP Part A QM			✓	✓	✓

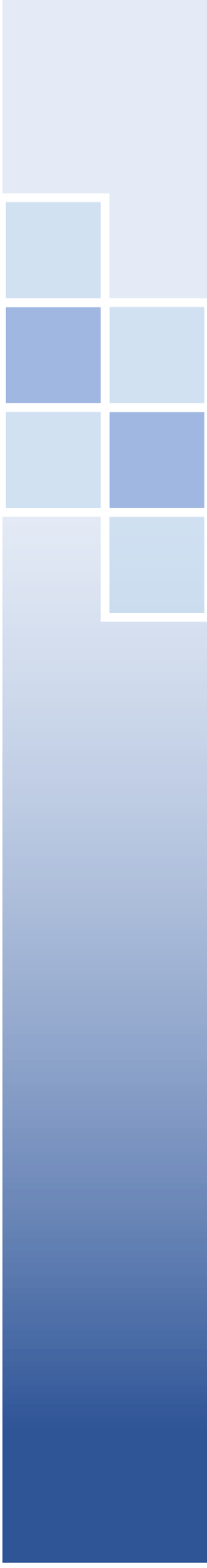
NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN RETENTION IN CARE								
Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
	DR1.2 Black/African American females	DR1.2a By December 31, 2017 (First Year), determine (1) best practices of Part A/MAI agencies with higher than average PLWHA retention rates for Black/African American females; and (2) risk factors contributing to low Black/African American female PLWHA retention rates.	RWP Part A QM	✓				
		DR1.2b By December 31, 2018 (Second Year), design, pilot-test and evaluate interventions to improve retention of Black/African American female PLWHA in Part A/MAI-funded services.	RWP Part A QM		✓			
		DR1.2c By December 31, 2019 (Third Year), implement interventions directed to Black/African American female PLWHA throughout the RWP Part A/MAI networks of care, thereby reducing lost-to-care rates for Black/African American female PLWHA. Evaluate annually thereafter.	RWP Part A QM			✓	✓	✓
	DR1.3 Hispanics under 25 years of age	DR1.3a By December 31, 2017 (First Year), determine (1) best practices of Part A/MAI agencies with higher than average PLWHA retention rates for Hispanics under 25 years of age; and (2) risk factors contributing to low young Hispanic PLWHA retention rates.	RWP Part A	✓				

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN RETENTION IN CARE								
Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
		DR1.3b By December 31, 2018 (Second Year), design, pilot-test and evaluate interventions to improve retention of young Hispanic PLWHA in Part A/MAI-funded services.	RWP Part A QM		✓			
		DR1.3c By December 31, 2019 (Third Year), implement interventions directed to young Hispanic PLWHA throughout the RWP Part A/MAI networks of care, thereby reducing lost-to-care rates for young Hispanic PLWHA. Evaluate annually thereafter.	RWP Part A QM			✓	✓	✓

NHAS GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN TREATMENT OUTCOMES (SUPPRESSED / UNDETECTABLE VL LEVELS)								
Objective	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
DV1. By 2021, increase the percentage of clients in RWP care among three (3) key disparate minority health groups with suppressed viral loads to 80%, to match overall PLWHA levels.	PROGRESS TOWARD OBJECTIVES: a. Black/African American Males: from 57% suppressed VL in 2015 to 80%. b. Black/African American Females: from 60% suppressed VL in 2015 to 80%. c. Haitians: from 68% suppressed VL in 2015 to 80%.		RWP Part A QM	a. 60% b. 64% c. 72%	a. 65% b. 68% c. 74%	a. 70% b. 72% c. 76%	a. 75% b. 76% c. 78%	a. 80% b. 80% c. 80%
	DV1.1 Identify risk factors associated with Black/African American male clients within the Ryan White Part A/MAI networks of care having high VL, and address them with specific interventions.	DV1.1a By December 31, 2017 (First Year) , determine best practices of Part A/MAI agencies with high proportions of Black/African American male PLWHA with undetectable VL.	RWP Part A QM	✓				
		DV1.1b By December 31, 2018 (Second Year) , design and pilot-test interventions to improve Black/African American male PLWHA undetectable VL levels.	RWP Part A QM		✓			
		DV1.1c By December 31, 2019 (Third Year) , implement Black/African American male VL suppression interventions throughout the RWP Part A/MAI networks of care, thereby increasing undetectable VL rates for Black/African American males.	RWP Part A QM			✓	✓	✓
	DV1.2 Identify risk factors associated with Black/African American female PLWHA clients within the Ryan White	DV1.2a By December 31, 2017 (First Year) , determine best practices of Part A/MAI agencies with high proportions of Black/African American female PLWHA with undetectable VL.	RWP Part A QM	✓				

NHAS GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN TREATMENT OUTCOMES (SUPPRESSED / UNDETECTABLE VL LEVELS)								
Objective	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
	Part A/MAI networks of care having high VL, and address them with specific interventions.	DV1.2b By December 31, 2018 (Second Year) , design and pilot-test interventions to improve Black/African American female PLWHA undetectable VL levels.	RWP Part A QM		✓			
		DV1.2c By December 31, 2019 (Third Year) , implement VL suppression interventions for Black/African American females throughout the RWP Part A/MAI networks of care, thereby increasing undetectable VL levels for Black/African American female PLWHA.	RWP Part A QM			✓	✓	✓
	DV1.3 Identify risk factors associated with Haitian clients within the Ryan White Part A/MAI networks of care having persistently high VL, and address them with specific interventions.	DV1.3a By December 31, 2017 (First Year) , determine best practices of Part A/MAI agencies with high proportions of Haitian PLWHA with undetectable VL.	RWP Part A QM	✓				
		DV.3b By December 31, 2018 (Second Year) , design and pilot-test interventions to improve Haitian PLWHA undetectable VL levels.	RWP Part A QM		✓			
		DV1.3c By December 31, 2019 (Third Year) , implement Haitian VL suppression interventions throughout the RWP Part A/MAI networks of care, thereby increasing undetectable VL levels for Haitians.	RWP Part A QM			✓	✓	✓

Orlando (Lake, Orange, Osceola, and Seminole Counties)



2017-2021

INTEGRATED HIV PREVENTION AND CARE PLAN

Orlando Service Area

The 2017-2021 Integrated HIV Prevention and Care Plan for the Orlando Service Area follows the guidance set forth by the Center for Disease Control (CDC) and the Health Resources and Services Administration (HRSA) and will accelerate reaching the goals in the **NATIONAL HIV/AIDS STRATEGY**.





Orlando EMA HIV Health Service Planning Council 2015-2016

Shirley Lanier, Chairperson



Central Florida AIDS Planning (CFAP) Consortium 2016 – 2017

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SECTION I

Statewide Coordinated Statement of Need/Need Assessment



SECTION I: Statewide Coordinated Statement of Need/Need Assessment**SECTION I: Statewide Coordinated Statement of Need/Need Assessment****A. Epidemiological Overview****a. Geographic Region of the Jurisdiction**

The Orlando Service Area consists of five counties in East Central Florida: Brevard, Lake, Orange, Osceola and Seminole. The service area includes the four counties that comprises the Orlando EMA (Lake, Orange, Osceola and Seminole) three of which overlaps with the Part B Consortium or Area 7 (Orange, Osceola and Seminole). The fifth county of the Service Area, Brevard County, completes the four counties that comprise Area 7. Lake County, an EMA County, is one of 15 counties of Area 3/13. Together the five counties represent 14.8% of the total population of Florida. Orange County is home to 42.8% of the population of the Orlando Service Area with a population density of 1,268 persons per square mile. Brevard County has 19.2% of the Orlando Service Area population; Seminole County at 15.1%; Lake County at 10.7%; and Osceola County at 10.3%. Seminole County is the most densely populated at 1,367 persons per square mile. Population density ranges from 202.4 to 535.0 persons per square mile for Osceola, Lake and Brevard counties.

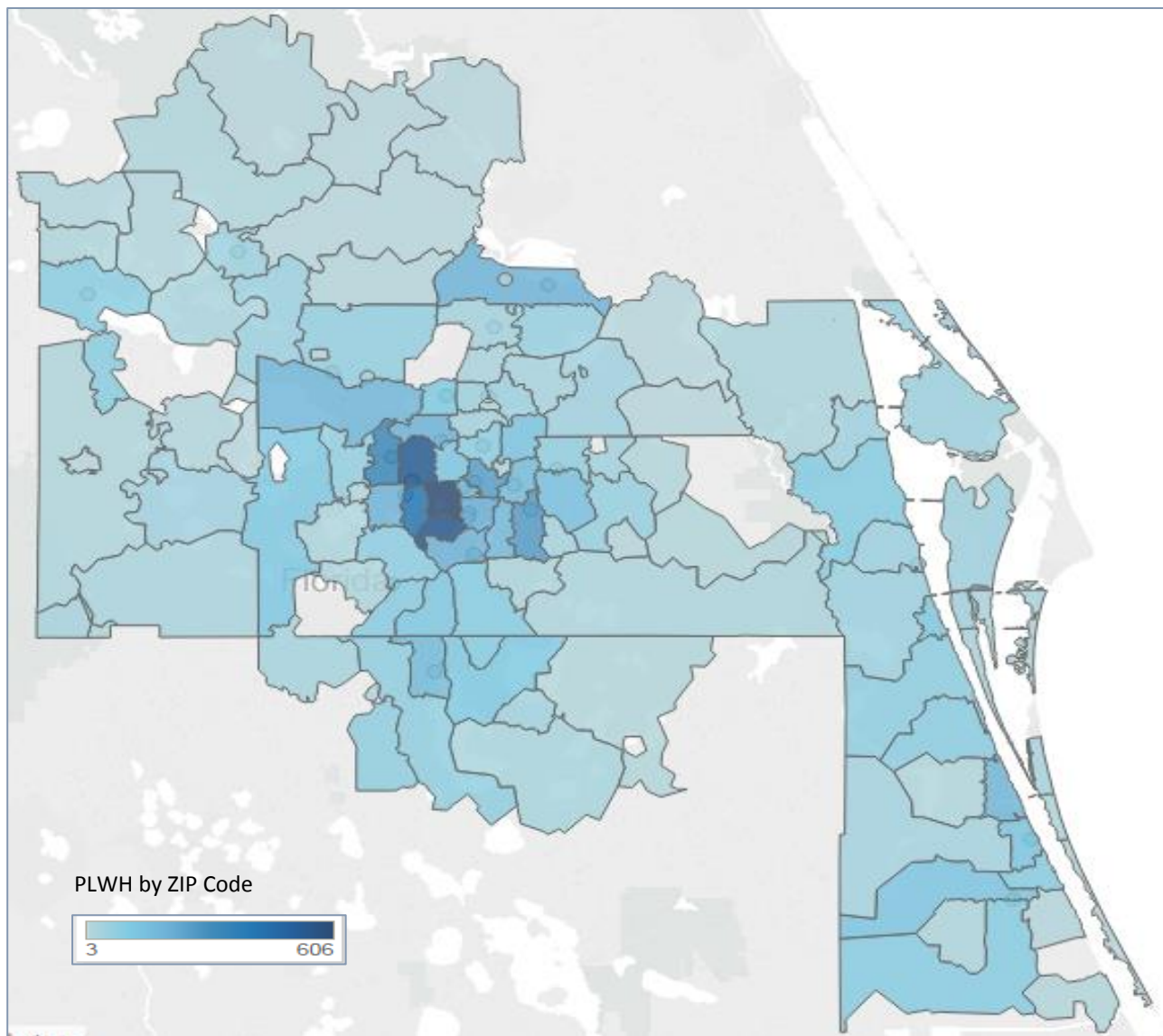
Population estimates from the Florida Department of Health, Office of Health Statistics estimated the total population of the Orlando Service Area at 2,884,534 persons, with 71.0% of the population identifying as White; 18.6% Black, and 29.4% Hispanic. By age, 15.9 percent are 0-12 years; 16.6% are 13-24 years; 26.4% are 25-44 years and 41.2% of the population is 45+ years of age. The general population is younger when compared to the PLWHA population where 60.0% are at least 45 years or older.

Population growth among the five counties in the Orlando Service Area was greatest in Osceola, at 11.3% from 2010 to 2014. Brevard County's population is older when compared to other counties in the service area. By gender, females represented a slightly larger percentage of the population when compared to their male counterparts, but still well within the 1:1 ratio.

Osceola County had the highest percentage of those living in poverty (2014) in the Orlando Service Area at 19.3%. Orange County, with poverty at 18.2% was higher than the poverty rates in Brevard County at 14.5%, Lake County at 13.8% and Seminole County at 11.8%.

According to the American Community Survey (2010-2014), Osceola County had the highest rate of uninsured adults at 23.3%, while Lake County adults were the lowest at 15.7%. Uninsured among adults in Brevard County, at 16.0% was lower than the percentages in Orange, at 21.6% and Seminole, at 16.6%.

The number of PLWHAs by zip code was mapped to depict the geographical areas where there were high concentrations of HIV prevalence. Each county had several zip codes where the rates of PLWHA were very high when compared to other zip codes within the Orlando Service Area. The map below highlights the number of PLWHA by zip code for the five-county area. The very dark shaded areas are located in Orlando and had the highest rates of PLWHA in the Orlando Service Area.

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 1: PLWH by ZIP Code for the Orlando Service Area**

Source: eHARS

b. Socio-Demographic Characteristics

As of 2014, a total of 12,659 persons were living with HIV/AIDS in the Orlando Service Area. PLWHA are predominately Black males, ages 45+ years with a transmission exposure of MSM. The Black population is disproportionately represented as they account for 39% of PLWHA but only comprise 18.6% of the general population. The White and Hispanic populations are underrepresented as they account for 71.6% and 29.4% of the general population, respectively, but 35.0% and 24.0% of the PLWHA population. Among the PLWHA population, 66% are below the age of 45 years, with 16% between 13-24 years.

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 2: Number and Percent of HIV, AIDS, and PLWHA in the Orlando Service Area (as of 12/31/2014)**

Indicator	HIV Incidence		AIDS Incidence		PLWHA	
	Number	Percent	Number	Percent	Number	Percent
Total	845	100%	381	100%	12,659	100%
White, Non-Hispanic	280	33%	107	28%	4,405	35%
Black, Non-Hispanic	279	33%	173	45%	4,925	39%
Hispanic	259	31%	90	24%	3,056	24%
Other	27	3%	11	3%	273	2%
Male	667	79%	267	70%	9,174	72%
Female	192	23%	114	30%	3,485	28%
0-12 yrs.	4	0%	0	0%	24	0%
13-24 yrs.	138	16%	33	9%	527	4%
25-44 yrs.	419	50%	185	49%	4,504	36%
45+yrs.	284	34%	163	43%	7,604	60%
MSM	537	64%	196	51%	6,781	54%
IDU	47	6%	37	10%	1,373	11%
MSM/IDU	26	3%	15	4%	464	4%
Hetero	224	27%	133	35%	3,804	30%
Other	9	1%	0	0%	215	2%

Source: eHARS

According to the CDC, individuals with sexually transmitted diseases and TB are at a higher risk of HIV infection than that of the general population who are disease-free. The table below contains the number of individuals in the Orlando Service Area who had been diagnosed with an STD in 2014.

Figure 3: Persons at Higher Risk for HIV Infection

	Syphilis	Gonorrhea	Chlamydia	TB	Hepatitis A	Hepatitis B	Hepatitis C
Total	231	2,503	10,917	84	5	16	2,246
White, Non-Hispanic	81	404	1,912	14	3	12	430
Black, Non-Hispanic	69	1,097	3,095	26	1	1	87
Hispanic	58	230	1,345	22	1	2	62
Other	23	772	4,565	22	0	1	1,667
Male	223	1,426	2,922	57	1	12	1,350
Female	8	1,076	7,979	27	4	4	891
0-12 yrs.	0	0	0	1	0	0	6
13-24 yrs.	56	1,369	7,064	6	1	0	150
25-59 yrs.	173	1,119	3,831	57	5	13	1,552
60+yrs.	2	15	22	20	0	3	538

Source: Florida Department of Health, Bureau of Communicable Disease, HIV/AIDS Section

SECTION I: Statewide Coordinated Statement of Need/Need Assessment

The clients in the Ryan White system of care tend to have lower employment rates, live in poverty, have unstable housing, and higher than average rates of poverty. The socioeconomic data that was reported by the RSR is found in the table below. It should be noted that Insurance Status was unknown/not reported for 1,283 clients.

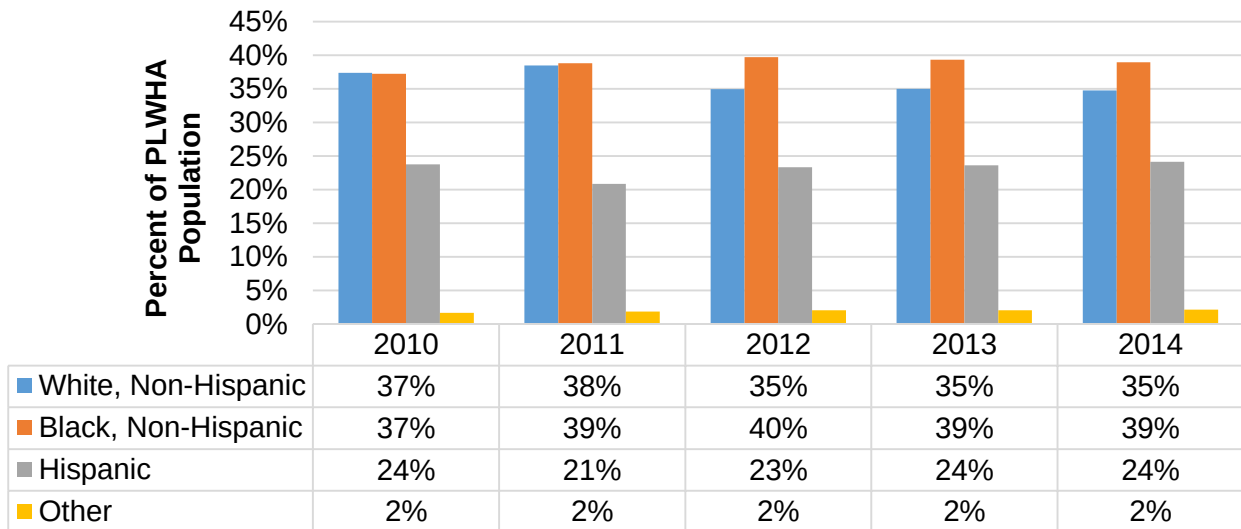
Figure 4: Ryan White Clients by Health Insurance Status and Poverty

Socioeconomic Indicator	Number	Percent
Medicaid	106	5.4%
Medicare	23	1.2%
Marketplace Exchanges	181	9.3%
Uninsured	527	27.0%
138% FPL	232	12.6%
400% FPL	644	34.9%

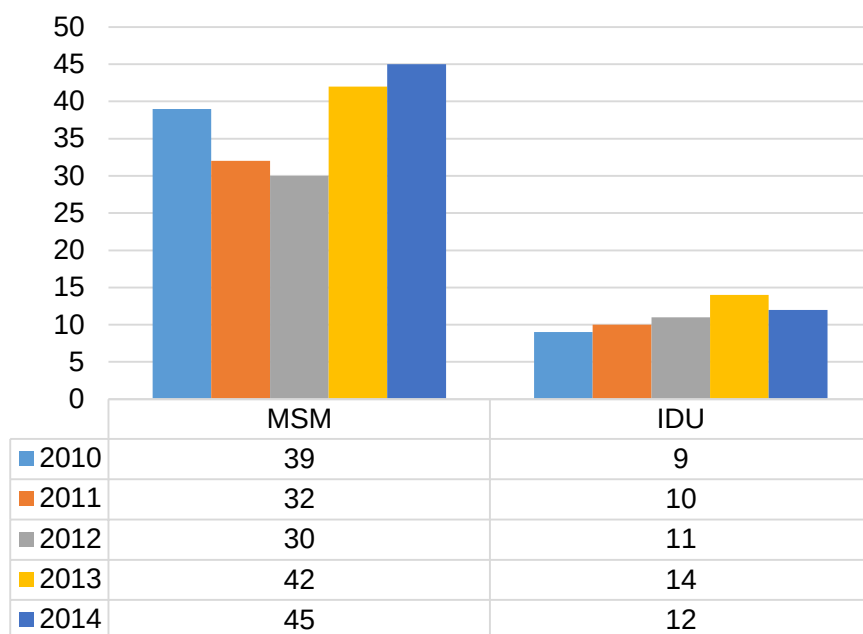
Source: RSR Clinical Summary Report FY 2014

c. Describe the Burden of HIV

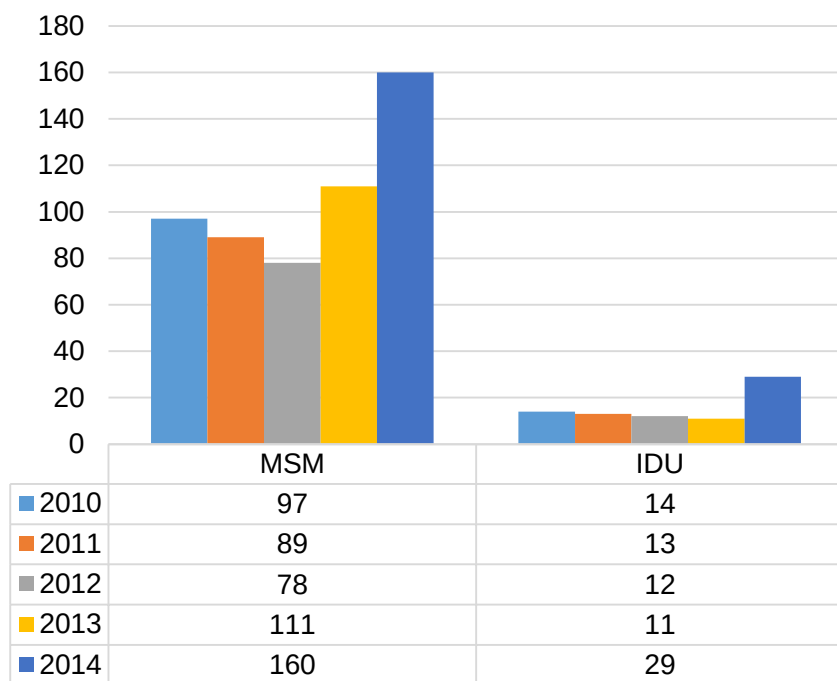
The number of PLWHA grew from 10,548 in 2010 to 12,659 in 2014, which represented an 18.5% increase of those living with HIV infection. Among population groups, Blacks represented 18.6% of the Orlando Service Area population. However, they represented 33.0% of the new HIV cases, 45.0% AIDS cases, and 38.9% of PLWHA in the Orlando Service Area. Hispanics represented 27% of the general population and comprised 29% of the new HIV cases and 26% of new AIDS cases. The most significant increases were among new AIDS and HIV cases in the Hispanic population when comparing eHARS data from 2012 to 2014. They are as follows: among Hispanic MSM new AIDS cases increased 52% and new HIV cases 106.2%; HIV cases among Hispanic male IDU increased 141.7%; HIV case among Hispanic male youth (13-24 years) increased 45%; HIV cases among Hispanic female youth increase from 1 case in 2012, to 5 cases in 2014 (400%); and new AIDS cases among Hispanic Women of Childbearing Age (WCBA) were up 85.7% while new HIV cases for this population increased 181.8%.

Figure 5: PLWH by Race/Ethnicity, 2010-2014

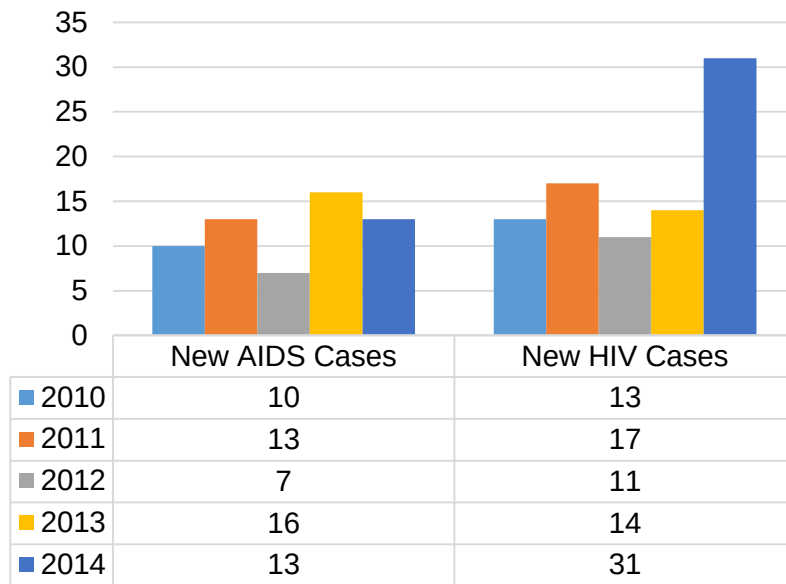
Source: eHARS

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 6: New AIDS Cases for Hispanic MSM and Hispanic Male IDU, 2010-2014**

Source: eHARS

Figure 7: New HIV Cases for Hispanic MSM and Hispanic Male IDU, 2010-2014

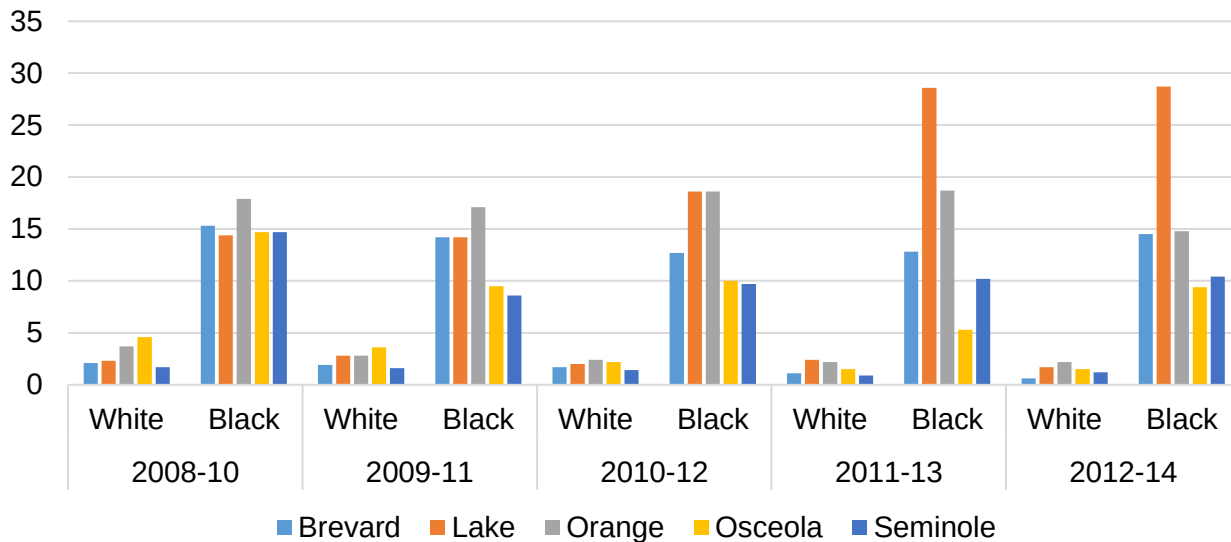
Source: eHARS

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 8: Hispanic WCBA New AIDS and HIV Cases, 2010-2014**

Source: eHARS

There were ten communities within the Service Area that experienced a disproportionate share of infection in 2014. They are as follows: Melbourne and Palm Bay in Brevard County; Leesburg, Mt. Dora, and Clermont in Lake County; Parramore, Pine Hills, and Holden/Oakridge in Orange County; Kissimmee in Osceola County; and Altamonte Springs and Sanford in Seminole County. A county health department provider of Outpatient Ambulatory Health Services (OAHS) is located within each county in the zip code with the highest HIV/AIDS population, with the exception of Osceola County where the health department is located in a contiguous zip code and Brevard County where the health department is located in a zip code with the second highest PLWHA population. Providers of other health services are all located in Orange County zip codes with a disproportionate share of PLWHA.

An analysis of death rates from HIV/AIDS revealed the rates among those in the Black population was at least three times the rates among Whites. In 2012-14, deaths rates among Whites ranged from 0.6/100,000 in Brevard County to 2.2/100,000 in Orange County. Among the Black population, rates ranged from 9.4/100,000 in Osceola County to 28.7/100,000 in Lake County. HIV/AIDS deaths rates by county among Hispanics were very similar to those of Non-Hispanics with the exception of Orange County where Hispanic deaths were twice the rate of Non-Hispanics.

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 9: Deaths from HIV/AIDS by Race by County, 2008-10 to 2012-14 (rate per 100,000 population)**

Source: Florida CHARTS, Office of Vital Statistics

d. Indicators of Risk for HIV Infection

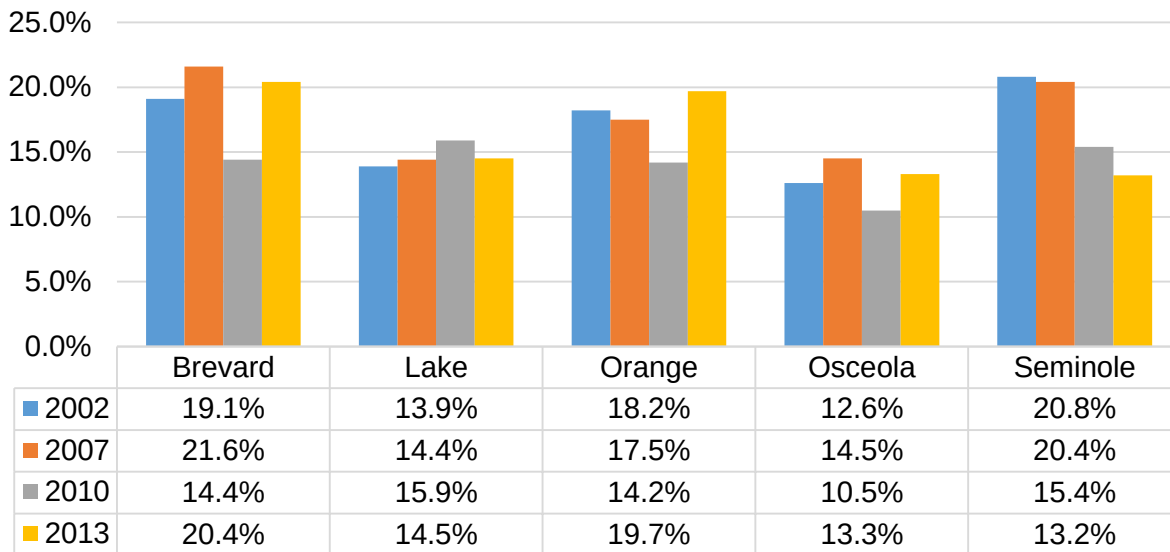
The Youth Risk Behavioral Surveillance System (YRBSS) is administered to Orange County, Florida high school students. Although Orange County is the only county in the Orlando Service Area to participate in the survey, the data is relevant as Orange County bears the larger burden of disease when compared to the other four counties.

Figure 10: YRBSS 2013 Orange County, Florida Students

YRBSS Question	Percent	Sample
Ever taken any illegal drug	2.0%	1,625
Had sexual intercourse before age 13 years	6.2%	1,509
Had sexual intercourse with 4 or more persons (Lifetime)	9.4%	1,501
Did not use a condom before last sexual intercourse	37.4%	334
Did not use both a condom and birth control before last sexual	97.6%	329
Drank alcohol or used drugs before last sexual intercourse	21.8%	340
Were never taught in school about HIV/AIDS infection	16.0%	1,597

Source: YRBSS 2013 Orange County, Florida

The 2013 Behavioral Risk Factor Surveillance System (BRFSS) did not contain any questions related to the risk for HIV/AIDS infection, testing, sexual orientation or gender identity. Information was available for adults who engaged in binge drinking, which is defined as consuming 5 alcoholic drinks for men or four alcoholic drinks for women in one session. According to the Center for Disease Control and Prevention (CDC), binge drinking is associated with sexual disease transmission.

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 11: Adults who engaged in binge drinking, 2007-2013**

Source: BRFSS 2013

The estimated number of people who are HIV positive and are unaware of their status is based on a methodology created by the Centers for Disease Control and Prevention (CDC). According to the CDC, 15.8% of people who are living with HIV/AIDS do not know their status nationally. In Florida, the percentage is between 10 and 12% due to the number of tests conducted in the state.

Based on this estimate, the following is a calculation of people living in the service area who are HIV+ and unaware of their status:

- National Proportion Undiagnosed HIV (21%) = p
- Number of individuals diagnosed with HIV and living per FDOH = 11,186
- Local Undiagnosed = $p/1-p$ multiplied by the number of diagnosed living (11,186 in the Orlando Service Area) = the number of people living in the Orlando unaware of their HIV positive status.

According to this calculation, 2,973 people are living in the Orlando Service Area unaware of their HIV+ status.

Figure 12: Newly Diagnosed Positive at HIV Testing Events

Population	Total HIV Tests	Reactive	Confirmed New Positive	Linked to Care	Referred Partner Services	Rec'd Partner Services	Referred Prevention Services	Rec'd CD4 & VL tests
Black/AA, Females 15-44 Yrs.	1,585	8	8	7	8	6	2	7
White MSM	1,155	25	25	17	24	20	14	17
Black/AA, MSM	429	35	35	21	33	31	14	21
Total	3,169	68	68	45	65	57	30	45

Source: Florida Department of Health

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 13: Previously Diagnosed Positive at HIV Testing Event**

Population	Total HIV Tests	Reactive	Confirmed Positive	Linked to Care	Referred Partner Services	Rec'd Partner Services	Referred Prevention Services	Rec'd CD4 & VL tests
Black/AA, Females 15-44 Yrs.	1,585	10	10	7	10	10	5	7
White MSM	1,155	7	6	3	7	6	2	3
Black/AA, MSM	429	4	4	3	4	4	1	3
Total	3,169	21	20	13	21	20	8	13

Source: Florida Department of Health

The Recipients continue to support testing activities at health fairs, awareness days, festivals, etc. The majority of Part A and B providers offer rapid testing. Their efforts help provide a seamless transition from Prevention to Patient Care activities (Referring and Linking to care) in the event of an individual testing HIV positive. Regularly scheduled EIIHA strategy meetings are convened to identify possible strategies and collaborative partnerships to enhance service delivery.

The target populations for the Early Identification of Individuals with HIV/AIDS (EIIHA) Plan are based on epidemiological data made available from the Florida Department of Health (FDOH). Data made available from FDOH was used to trend mode of exposure, age, gender, race, ethnicity, and county of residence, with some of it cross tabulated to identify target populations. Based on the available data, the following target populations have been identified for the FY16 EIIHA Plan: (1) White MSM, (2) Black Heterosexual both male and female and (3) Black MSM. These groups were selected based on several sources of information available. The first data source was recent epidemiological data, which showed these groups as having higher rates of infection compared to other groups, as well as being more likely to be out of care compared to other groups. Other data sources which were used in identifying these target groups originated from reports developed by the FDOH regarding certain populations, among them the African American community (“Silence is Death”), men (“Man Up: The Crisis of HIV/AIDS Among Florida’s Men”), and women (“Organizing to Survive: The HIV/AIDS Crisis Among Florida’s Women”). They were also selected in part due to historical data, trending out prevalence and incidence rates over the last five years.

The Orlando Service Area continues to respond to the epidemic by supporting initiatives such as:

1) The Test Orlando Campaign which aims to:

- Promote Routine HIV Testing
- Improve Orange, Osceola, Seminole and Brevard Counties resident's understanding of HIV
- Reduce the transmission of HIV by knowing your status – Getting to Zero

2) The Black Treatment Advocates Network (BTAN) – Melbourne Chapter which aims to:

- Link individuals with HIV into care and treatment
- Strengthen local leadership
- Connect influential peers
- Raise HIV science and treatment literacy in the community

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- Advocate for policy change and research priorities

In September 2006, CDC released *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings*. These revised recommendations advise routine HIV screening of adults, adolescents, and pregnant women in health care settings in the United States.

Many infected persons decrease behaviors that transmit infection to sex or needle-sharing partners once they are aware of their positive HIV status. HIV-infected persons who are unaware of their infection do not reduce risk behaviors. Because medical treatment that lowers HIV viral load might also reduce risk for transmission to others, early referral to medical care could prevent HIV transmission in communities while reducing a person's risk for HIV-related illness and death.

In addition to the target populations selected for the EIIHA plan, all proposed activities are intended to reach all newly infected individuals, as well as those who are high risk negatives.

Activities to be implemented begin in collaboration with the counseling and testing sites to support targeted testing activities. It is critical to expand activities and look for novel ways to identify and test them. In addition, both the Part A and B Recipients will be funding linkage coordinators through Early Intervention Service (EIS) funds beginning in FY 2016 in order to assist newly diagnosed people to get linked into primary medical care, to reach heterosexual men and women, encourage testing and promote safe behavior, initiatives must focus less on prevalence and zip code data, to locations where socialization occurs. To reach White MSM, similar efforts must be made. To reach Hispanic MSM, expanded testing efforts, the increase of rapid testing sites in addition to targeted testing would reduce environmental barriers in high prevalence zip code areas.

The Orlando Service Area continues to partner with Prevention. Last year 41,378 tests were conducted in the Orlando Service Area. The state of Florida, the Part B Recipient, consistently tests more individuals than any other state. They have been EIIHA partners from the inception of the initiative, and continue to work with Part A to develop a seamless system from testing to whatever service is most appropriate for the individual. Several counseling and testing agencies within the Orlando EMA are now active partners in the EIIHA efforts: (1) Miracle of Love, (2) Hope and Help Center of Central Florida, Inc., (3) Healthcare Center for the Homeless, and (4) The Gay, Lesbian, Bisexual, Transgender Center. Each of these agencies provides linkage between prevention programs and patient care programs. While the Brevard County providers do not currently participate in EIIHA, DOH-Brevard, Comprehensive Healthcare and Project Response offers HIV testing and provides linkage between prevention and care. Many of the Orlando Service Area providers receive funding from other sources to offer testing, providing a natural connection between counseling, testing, referral, and linkage. An overwhelming majority of the testing and counseling providers hire diverse staff, which helps reach more diverse populations. The Recipients (Parts A and B) will begin funding linkage coordinators through EIS funds in FY 2016 in order to assist newly diagnosed people with getting linked into primary medical care.

Governor Rick Scott of Florida signed legislation into law effective July 1, 2015 that makes HIV testing an opt-out component of routine testing, thereby removing a tremendous legal barrier.

Multiple agency representatives have collaborated since the inception of the EIIHA Plan. Chief among them have been individuals from Part A, Part B, Part C, Part D, Prevention, Counseling and Testing staff, and members of the planning bodies. All have been instrumental in implementing the

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EIIHA Plan, primarily the counseling and testing sites, Part A, Part B, and Prevention. FDOH staff has assisted in developing reports to share with the Orlando Service Area to identify the number of individuals linked to care.

The primary outcome of the EIIHA plan has been to create a seamless system of access to and retention in-care among the different Ryan White entities in the Orlando Service Area with the ideal goal of viral suppression for all PLWHA. Collaboration among the Parts, as well as Prevention has been a main driving force behind the EIIHA Plan. A major objective in the Plan has been to work among the different Ryan White Parts and Prevention to develop a data collection strategy to determine the rates at which newly diagnosed individuals are referred and linked into care and support efforts to determine the rates at which high risk negatives are referred to services that keep them from becoming infected. Thanks to collaborative efforts with Prevention and FDOH, reports are available that provide counseling, testing, referral, and linkage information.

One of the outcomes of the EIIHA Plan is to continue to have all of the Parts and Prevention to meet regularly together to discuss collaboration and data collection efforts across the board. A second outcome is to fund linkage coordinators throughout the Orlando Service Area, thereby increasing the overall number of people linked into medical care. These linkage coordinators will be located at each of the five health departments throughout the Orlando Service Area. A third outcome is to communicate EIIHA activities to the Planning bodies and CFAP to keep them informed, whether it is data being collected or on the activities of the linkage coordinators. This ensures the Planning bodies can make decisions based on data. In addition to the funding of Linkage Coordinators, another outcome in the EIIHA Plan will be continuing to partner with the Part B funded Anti-Retroviral Treatment and Access to Services (ARTAS) program to receive EIIHA-related referrals for newly identified positives as well as those positives who have fallen out of care. Finally, the fifth outcome will be the continued support of counseling and testing site activities throughout the Orlando Service Area.

The number of homeless among PLWHA has decreased 14.8% over the past two years. Data from eHARS indicated that 75 homeless PLWHA were living in the Central Florida service area in 2014. Of these 58.7% were Black, 21.3% White and 16.0% Hispanic. The rate of homelessness among those living with HIV/AIDS, at 670.5/100,000 is more than six times that of the general population at 104.6/100,000 as reported by the *Council on Homelessness 2015 Report* prepared by the Department of Children and Families. Providers within the service area are challenged by the complexities of retaining homeless PLWHA in care. One of the reasons that it has been such a daunting task is the lack of housing units as well as not capturing all of the data regarding this sub-populations' need. With the new PROVIDE ENTERPRISE software system, as well as the high priority that is being given to this sub-population, the system will be more capable of meeting their needs.

According to the Department of Corrections, 2,707 offenders returned to the Orlando EMA in 2014. Of these, 73 (2.7%) were HIV positive. This was an increase from HIV positive offenders released in 2013 (2.2%) but still less than 3.0% in 2012. The number of HIV positive inmates released from area jails has yet to be estimated. In Brevard County, there are approximately 58 clients in treatment who had been previously incarcerated. Some of these clients were in the Part B system of care before incarceration while others were new to the system. The 2013 Ryan White Consumer Survey data showed that 80 respondents reported living in jail and/or prison in the past 12 months. Providers in each county have developed processes to link individuals to care prior to their release.

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Whenever possible, jail staffers try to alert the provider representative when an inmate identified as one needing care is about to be released. In addition, funded programs in all four counties of the EMA send staff to the jails to provide assistance with linking released PLWHA to care. In Area 7, when a prisoner with HIV is released, personnel at the prison will contact the Area 7 (Part B) Linkage staff member to schedule the client's appointment prior to their release. The Linkage staff member maintains contact with the prisoner upon release and provides follow-up to ensure that appointments are kept. When appointments are not kept, the staff member determines the barrier(s) that prevented the missed appointment and works with the client to remove/reduce the barrier in order to facilitate linkage.

Mental health problems usually predate substance use activity which can interfere with HIV/AIDS treatment adherence. In the Orlando Service Area, the rate of PLWHA with chronic mental illness is 1,868.4/100,000 (16.7%) which is significantly higher when compared to the general population at 4.1 percent.

Substance abuse (including binge drinking and illicit drug use) is also more prevalent among PLWHA than the general population. Data from eHARS indicate the rate of substance abuse among the PLWHA population at 13,239.83/100,000 is more than 1.5 times the rate in the general population at 8,200/100,000. Active substance abusers are more likely to engage in risky behaviors that can have a negative effect on overall health. The interaction of illegal substances and HIV medications can diminish an individual's ability to adhere to proper HIV treatment. IDU is the second most common exposure category for both male and female PLWHA in the Orlando Service Area. eHARS data indicate that in the Service Area, the rate of IDU for PLWHA is 14,357.2/100,000. According to the 2013 National Survey on Drug Use and Health (NSDUH) report, the IDU rate for the general population is 2,600/100,000.

To reach high risk women of child-bearing age (WCBA), the Targeted Outreach for Pregnant Women Act (TOPWA) was implemented in Orange County (the county bearing the burden of the epidemic). The mission of TOPWA is to reach high-risk women or HIV-infected pregnant women not receiving services. Since 1999, TOPWA has maintained the goal of assisting under-served women in accessing prenatal care and other services that lower their risk for HIV infection or substance abuse.

Women encountered by a TOPWA outreach worker can receive:

- HIV testing
- Pregnancy testing
- Referrals for substance abuse testing and treatment
- HIV prevention education and condoms

Pregnant women enrolled in TOPWA can receive:

- Assistance getting Medicaid coverage
- Assistance getting prenatal care
- HIV testing
- Referrals for substance abuse testing and treatment
- HIV prevention education and condoms
- Referrals for family planning services

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- Referrals for other services in the community,

Many women are encountered by TOPWA through street outreach in housing projects, laundromats, bars, or public places. TOPWA has served thousands of women over the past 10 years, and many pregnant women are brought to TOPWA by previous clients, who are their sisters, neighbors, or friends. TOPWA works closely with high-risk obstetrical clinics to locate and assist women who miss scheduled prenatal appointments. Pregnant women living with HIV receive added support, encouraging them to keep taking medications to prevent transmission of the virus to their baby. Due to medical advances, if a woman follows all medically directed protocols; the baby will be free of HIV over 98% of the time. The number of babies born healthy as a result of TOPWA will never be known, but we know the number of babies born with HIV has dropped dramatically. We look forward to the next 10 years as we continue to reach out to women who may fall through the cracks of our system of care.

Provider Survey: The Ryan White Part A Provider Survey was commissioned as part of the Needs Assessment for the 2015 Data Presentation for the Orlando Eligible Metropolitan Area HIV Health Services Planning bodies (the Planning bodies). The Ryan White Part A 2015 Needs Assessment Provider Survey was administered to Ryan White Part A providers.

This survey results provided data regarding where services were being provided, how client and provider needs are being met and what services are of core importance. The data were gathered in an effort to gain a better understanding of the capacity and delivery of services provided by all participating agencies.

The 2015 Provider Survey was administered to 12 Ryan White Part A providers as a link to an online version of the survey sent via email in May 2015. The survey was also provided as an attachment in the email to allow providers the option of completing a hard copy instead of the online version. Eleven (11) surveys were completed and returned, resulting in a 92 percent response rate. Clarification was obtained via telephone or email as needed.

Similar to the 2014 survey, non-medical case management remained the most frequently reported service provided, approximately two-thirds of respondents provide HIV/AIDS care-related services as a component of a larger services program, one-third are solely HIV/AIDS care-related service providers, and most providers have offered services for 15 years or more. According to 2015 responses, service categories with the most employees and volunteers were medical professionals (13 full-time and 11 part-time) and mental health/substance abuse counselors (15 full-time, 1 part-time and 3 volunteers). The service categories with the greatest reported capacity were non-medical case management, OAHS, and HIV education.

As in the previous survey, over 80 percent of providers offer HIV counseling and testing; most providers that conducted HIV testing utilized rapid testing, followed closely by OraSure; all providers offer walk-in or same-day appointments and over half provide 24-hour coverage.

All 2015 respondents reported that they hire multi-lingual staff, compared to 92% in 2014. The percentage of providers that translate patient materials increased from 33% in 2014 to 54.5% in 2015 and the percentage of agencies that ensure translators or interpreters are available decreased from 75% in 2014 to 63.6 percent in 2015. As in the previous survey, most providers reported that they did not have problems meeting any language needs of their clients. The only languages

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presenting challenges to providers were Creole (27.3%) and sign language (9.1%); Creole was also noted in the previous year's survey. Hiring staff of different cultures and basic diversity/cultural competency training continue to be the most frequently reported methods of addressing cultural diversity in both the 2014 and 2015 surveys. The percentage of providers who hire peer educators/counselors of different cultures decreased from 33% in 2014 to 18.2% in 2015. Programs targeting specific populations include Extended Testing Initiative ETI's (Targeted MSM as well as African-American men and women), Willow (HIV+ women), Mpowerment Prevention Program (MSM and transgender, ages 14-29 years), ARTAS Project testing and education (incarcerated individuals), substance abuse and mental health (homeless, injection drugs users and individuals in recovery), and programs for MSM population.

While Part B did not conduct a formal Provider survey, the Part B providers within the Tri-County area of Orange, Osceola and Seminole Counties, who were also Part A providers were respondents of the Part A Survey, thus the above responses also reflects the Part B provider system.

Similar to the 2014 Provider Survey, the most frequently cited funding sources in 2015 were Part A, Part B in Brevard County, Medicaid, and state funding.

When asked about barriers to service provision, the most frequently reported challenges were similarly distributed in the 2014 and 2015 surveys. Consumer distrust/suspicion as a barrier increased from 42% (2014) to 64% (2015). The most frequently requested capacity building trainings were motivational training for staff/clients (45%) and HIV/AIDS general training (45%). In 2014, the most frequent responses were staff and volunteer recruitment training, which decreased from 50% in 2014 to 36% in 2015 and program evaluation, which decreased from 42% in 2014 to 36% in 2015.

Additionally, anecdotal information from the Brevard County providers indicates that they are experiencing similar challenges as the Part A providers. Brevard providers however are experiencing challenges in meeting the needs of their creole-speaking clients and due to the length of the county, transportation also present a challenge for clients as the public transportation system in Brevard is inadequate.

Out-of-Care Survey: The survey instrument used for this assessment was designed by members of the Ryan White Planning bodies. The survey was translated from English into Spanish and Creole in an effort to capture specific at-risk population groups. Surveys were distributed on May 1, 2015 to all Ryan White providers in the Part A Service Area. On July 27, 2015, the survey was available to be administered in the Orange County Jail.

The survey process was expanded in October 2015, which included training fifteen individuals representing several Ryan White agencies, to administer the survey at locations outside of the provider network. Surveys were also sent to the Health Care Center for the Homeless in Orange County.

A total of 172 completed surveys were collected from May 1, 2015 to December 7, 2015. Only 17 respondents met the out-of-care definition of not having had medical care for the past 12 months. Although individuals received training to administer the survey, no completed surveys were collected.

The most important services for the out-of-care population were access to care, medications, housing and mental health services. This aligns with the results of the most recent consumer survey

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conducted in 2013. HIV stigma is still a very big barrier for those currently diagnosed and not in care. Efforts should be made to incorporate inquiries via the primary or chronic disease care assessment processes to help bring people into care or return clients who have dropped out of the health care system.

Focus Group: On January 19, 2016, the Health Council of East Central Florida conducted a focus group to identify potential strategies to increase access to and retention in HIV care. The group focused on three questions during the discussion period. They were as follows:

- How can the Orlando Service Area increase the number of individuals seeking and actually being tested for HIV?
- For those individuals who learn that they test positive for HIV, how can the Orlando Service Area improve the ability to link them to care?
- What would improve the likelihood that once diagnosed as HIV positive, an individual linked to care will follow-through and continue to receive that care?

In an effort to increase the number of individuals seeking and actually being tested, the group defined ten possible strategies. These ranged from engaging the faith-based community to reducing the length of surveys. It was felt that increasing access to testing at locations frequented by gay populations, engaging peers, and offering an incentive would help to accomplish this goal. Stigma still remains a big issue as well as misconceptions regarding risk and treatment protocols. Addressing these through marketing and education were suggestions made by the group.

Once individuals learn their status and need to seek care, the linkages within the system may not be fully integrated. To improve these linkages, the group focused on education. It is important that the messages are clear, consistent, and available to everyone, from RW providers to private physicians, and locations where social services are accessed. It was felt that peers can play an important role by engaging the client before the daunting task of completing the required paperwork.

Retention in care has always been challenging due to a myriad of factors. The focus group members felt that the client should be empowered by making them part of the process, teaching them to be their own advocate, and encouraging them to get involved in community organizations where policy change can happen to benefit those diagnosed with HIV disease. The group suggested using current technology to streamline the processing time for clients. Using IT technology would also be helpful with the younger population who rely on social media for most of their information. Education was also cited as an integral component for conveying knowledge that will help the client understand the importance aspects of the disease and treatment adherence. The group suggested bringing all services under one roof in a ‘one-stop shop’ model would be effective for those accessing multiple services and could help alleviate some of the transportation issues within the community.

B. HIV Care Continuum

a. Descriptive Narrative of HIV Care Continuum

The HIV Care Continuum is a model that is used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to PLWH across the entire HIV Continuum of Care. The HIV Care Continuum has five main “steps” or stages including: HIV

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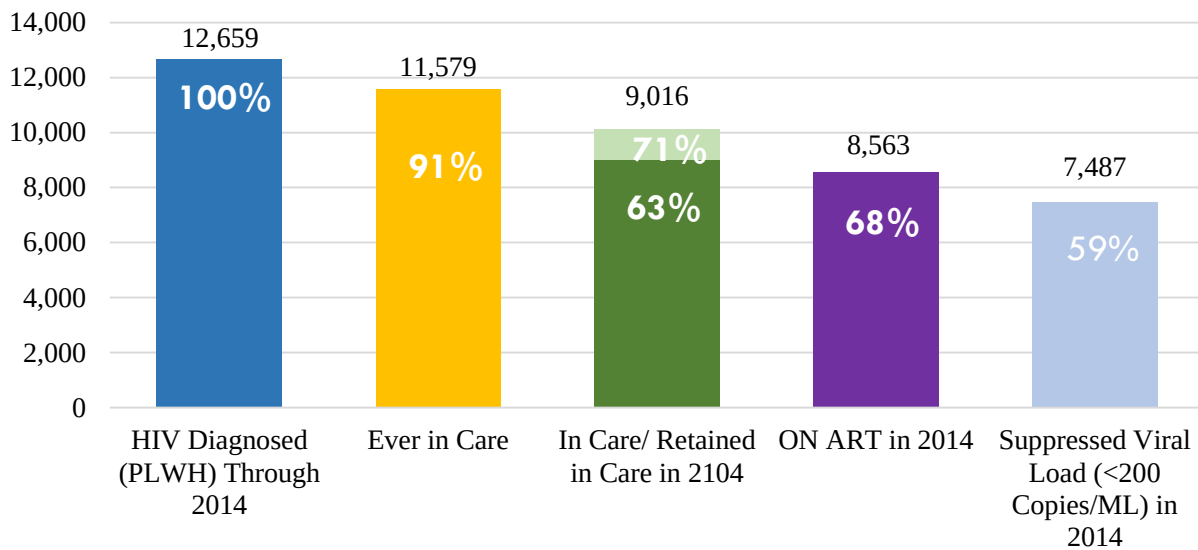
diagnosis, linkage to care, retention in care, antiretroviral use, and viral suppression. The State of Florida has developed a diagnosis-based model to identify issues and opportunities related to improving the delivery of services to high-risk, uninfected individuals. Since the Orlando Service Area's HIV Continuum of Care chart is developed by the Florida Department of Health, it uses a diagnosis-based model.

The diagnosis-based model of the HIV Care Continuum allows the service area to display each step of the continuum as a percentage of the number of PLWH who were only diagnosed. The diagnoses-based continuum directs steps that can be taken to get individuals with HIV into care and virally suppressed (<200 copies/ml).

The HIV Care Continuum depicted below illustrates the HIV epidemic for the Orlando Service Area.

Please note that in order to be considered "Retained in Care," an individual must have gone to two medical visits at least three months apart during 2014.

Figure 14: 2014 HIV Care Continuum of the Orlando Service Area



- 82% of those diagnosed with HIV in 2014 had documented HIV-related care within 3 months of diagnosis
- 83% of PLWHA in care had a suppressed viral load in 2014

An individual does not need to be "Retained in Care" in order to be prescribed ART, thereby showing a higher number of people prescribed ART than those considered to be "Retained in Care." Definitions for numerators and denominators are as follows:

I. HIV Diagnosed: Number of reported cases of HIV Infection regardless of AIDS

II. Ever in Care: PLWHA with at least 1 documented viral load (VL) or CD4 lab, medical visit or prescription since HIV diagnosis.

Linkage to Care: Numerator is the number of clients who have received at least one medical visit during 2014; Denominator is the total number of reported HIV cases

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III. Retained in Care: Numerator is the number of clients who have received two or more visits three months apart during 2014; Denominator is total number of reported HIV cases

IV. Antiretroviral Use: Numerator is the number of clients with access to prescribed HIV medications according the PHS treatment guidelines; Denominator is the total number of reported HIV cases for 2014.

V. Viral Load Suppression: Numerator is clients with viral load <200; Denominator is total reported HIV cases for 2014.

The data used by the State to develop the diagnosis-based HIV Care Continuum stems from the merging of the following databases:

- HIV/AIDS Reporting System (eHARS) database
- Florida's CAREWare database
- Miami's SDIS database (Miami's CAREWare)
- ADAP database

The analysis of data from the latter databases depends on:

- the completeness of laboratory reporting in eHARS,
- the maintenance of timely death reporting, and
- the accurate maintenance of current PLWH addresses, accommodating for in and out migration

All of the bars in the HIV Care Continuum reflect actual data, analyzed from the matched databases with the exception of the ART bar. The data for ART was estimated based on Florida's Medical Monitoring Project (MMP) data.

As previously mentioned, the merging of the latter databases facilitated the data necessary to develop a diagnosis-based HIV Care Continuum in alignment with any data policies protecting the identity of PLWH living in the service area of Florida. At the present time, since there are no formal policies and procedures serving as barriers for developing the HIV Continuum of Care model, the significant limitation results in assuming that persons not in care (based on the listed data matches above) are truly not in care. The upcoming challenges will be to develop policies and procedures, with available staff at the state health office and in the Orlando Service Area,

- to evaluate those cases not in care,
- specify who will be responsible for trying to locate those persons not in care and
- ascertain how staff will carry out this process.

Legal agreements may need to be drawn up if non-DOH staff needs to be contracted to perform some of these duties.

Additionally, continued efforts will be made to further improve the completeness of state and local data elements. Moreover, facilitating data agreements with local IT departments will allow for greater development of the HIV Care Continuum.

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**b. Description of Disparities in Engagement**

The Orlando EMA's sub-recipients utilize Minority AIDS Initiative (MAI) funding to enhance the quality of care and health outcomes in minority communities disproportionately impacted by HIV/AIDS in the Orlando Service Area. Brevard County does not have MAI funds. MAI funds support OAHS and specialty care, as well as associated laboratory services, and will begin funding four linkage coordinators through MAI dollars beginning in FY 2016. The Orlando Service Area continues to experience a disproportionate amount of African American and Hispanic populations living with HIV. The Orlando Service Area identified Blacks, Hispanics, and those with more than one race as the target populations. Blacks represented 18.6% of the population; however, they represented 33% of the new HIV cases and 45% AIDS cases in the Orlando Service Area. Hispanics represented 27% of the general population and comprised 31% of the new HIV cases and 24% of new AIDS cases. The most significant increases were among new AIDS and HIV cases in the Hispanic population when comparing eHARS data from 2012 to 2014. They are as follows: among Hispanic MSM new AIDS cases increased 52% and new HIV cases 106.2%; HIV cases among Hispanic male IDU increased 141.7%; HIV case among Hispanic male youth (13-24 years) increased 45%; HIV cases among Hispanic female youth increased from 1 case in 2012, to 5 cases in 2014 (400%); and new AIDS cases among Hispanic WCBA were up 85.7% while new HIV cases for this population increased 181.8%. Therefore, it is critical that MAI support these and other vulnerable populations.

Trended data support the need to continue the allocation of MAI funds in the Orlando Service Area for critical core medical services, especially to African Americans and Hispanic/Latino Americans.

The plan to address disparities focused on developing and implementing individualized treatment plans that include strategies for medication and treatment adherence for disproportionately impacted/underserved communities. The goal of this plan is to reduce the disparity in access to care for HIV+ minority consumers in the rural counties of the Orlando Service Area, by increasing access to culturally appropriate medical services. Primary care services also include the provision of specialty care services through Memoranda of Understanding (MOU) with specialty care providers.

In addition, medical case managers from eleven (11) diverse racial and ethnic cultures are located at all clinics that provide OAHS through Part A and Part A MAI funds. When consumers representing minority groups access medical care at these clinics, they have access to medical case management and are linked to all other available Part A services. The activities described in this MAI plan provide increased access to the HIV continuum of care for minority communities.

c. HIV Care Continuum Planning

The measures utilized in the HIV Care Continuum table underscore the most vital components in HIV care. OAHS, Pharmaceutical services, the Insurance Services Program, as well as Medical Case Management, are four service categories directly impacted by the measures included within the Care Continuum table. The Planning bodies consistently prioritizes these categories for funding, understanding the importance of ensuring individuals are obtaining access to and receiving critical medical care and medications, oftentimes coordinated through the medical case managers operating within the Orlando Service Area. In addition, several performance measures tied in to these service categories are tracked within the Clinical Quality Management program among Part A/Part B funded providers and reported back to them to identify possible service improvement activities. These HIV HAB measures have been measured and benchmarks are in development to strengthen PLWHA care. Several providers within the Orlando Service Area also receive Part B and/or

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General Revenue funds, thereby eliminating possible gaps in patient care. In addition, several of the Part A funded case management providers are also counseling and testing sites, allowing for a smooth transition between prevention and patient care in the event an individual tests positive.

The Orlando Service Area has engaged in several activities to ensure PLWHA are linked into care in addition to retaining them in care. Beginning in FY 2016, the Orlando Service Area and CFAP will begin funding Early Intervention Services in the form of linkage coordinators to help link newly diagnosed individuals into medical care. The intent is to decrease the number of people not receiving medical care, which will in turn increase the number of people prescribed ART and hopefully add to the number of people with a suppressed viral load. The Part A and Part B Recipients will begin revising its quality management plan in early 2016 in order to reconfigure the data that is currently collected to identify and address possible gaps in care with providers, particularly retained in medical care, prescription of ART, and viral load suppression. Thirdly, the Orlando Service Area continues to engage representatives from Prevention, Part B, Part C, and Part D to identify strategies to remove barriers to care and ensure a seamless system for all individuals regardless of their status.

a. Funding Sources

* Includes Program Income; **Indicates funding for all 67 counties.

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NOTE: Data based on CAREWare and Health Management Services via the Florida Department of Health.

Stages of the HIV Care Continuum	Goal	Outcome		Service Category (One or more may apply)
I. Diagnosed	Maintain the percentage of people who know their HIV+ status.	HIV Positivity* Late HIV Diagnosis*		Counseling and Testing (Part B and General Revenue) not funded by Part A Early Intervention Services
		Baseline: Numerator/Dominator, % 11,186/11,186, 100%	Target: Numerator/Dominator, % 11,745/11,745, 100%	
II. Linked to Care	Increase the percentage of people who go to at least one medical visit.	Linkage to HIV Medical Care*		Outpatient Medical Care Medical Case Management Medical Transportation
		Baseline: Numerator/Dominator, % 7,841/11,186, 70%	Target: Numerator/Dominator, % 8,809/11,745, 75%	
III. Retained in Care	Increase the percentage of people who receive medical care twice a year at least three months apart.	Retention in HIV Medical Care* HIV Medical Visit Frequency**		Outpatient Medical Care Medical Case Management Medical Transportation Treatment Adherence Health Insurance Premium
		Baseline: Numerator/Dominator, % 6,852/11,186, 61%	Target: Numerator/Dominator, % 7,634/11,745, 65%	
IV. Prescribed ART	Increase the percentage of clients with access to prescribed HIV/AIDS medications consistent with PHS Treatment Guidelines.	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care* Prescription of HIV Antiretroviral Therapy **		Outpatient Medical Care Medical Case Management Medical Transportation Local Pharm. Assistance Program
		Baseline: Numerator/Dominator, % 7,449/11,186, 67%	Target: Numerator/Dominator, % 8,456/11,745, 72%	
V. Virally Suppressed	Increase in the percentage of clients with a viral load of <200	Viral Load Suppression Among Persons in HIV Medical Care* HIV Viral Load Suppression**		Outpatient Medical Care Medical Case Management Local Pharm. Assistance Program
		Baseline: Numerator/Dominator, % 6,495/11,186, 58%	Target: Numerator/Dominator, % 7,399/11,745, 63%	

* HHS Measures can be found at <http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf>** HAB Core performance measures can be found at: <http://hab.hrsa.gov/deliverhivaidscore/coremeasures.pdf>

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**b. HIV Workforce**

The HIV prevention and care service delivery systems must share a firm foundation to maximize the impact of the Orlando Service Area response to the HIV/AIDS epidemic. Coordination of these efforts is necessary to accomplish the goals as set by planning bodies.

The Orlando Service Area has a responsibility to administer public health activities and to oversee the coordinated efforts of all agencies receiving Ryan White funding. We are also charged with a responsibility of bringing all stakeholders to the table regardless of funding, for the benefit of the consumers. This process strengthens our efforts to develop a coordinated HIV prevention and care program.

The Orlando Service Area workforce is comprised of many facets of care. This includes prevention, linkage, treatment, education and support services. HIV services are accessed through different means. Consumers may enter care via key points of entry, health fairs, clinics, private practice and community linkage programs to name just a few.

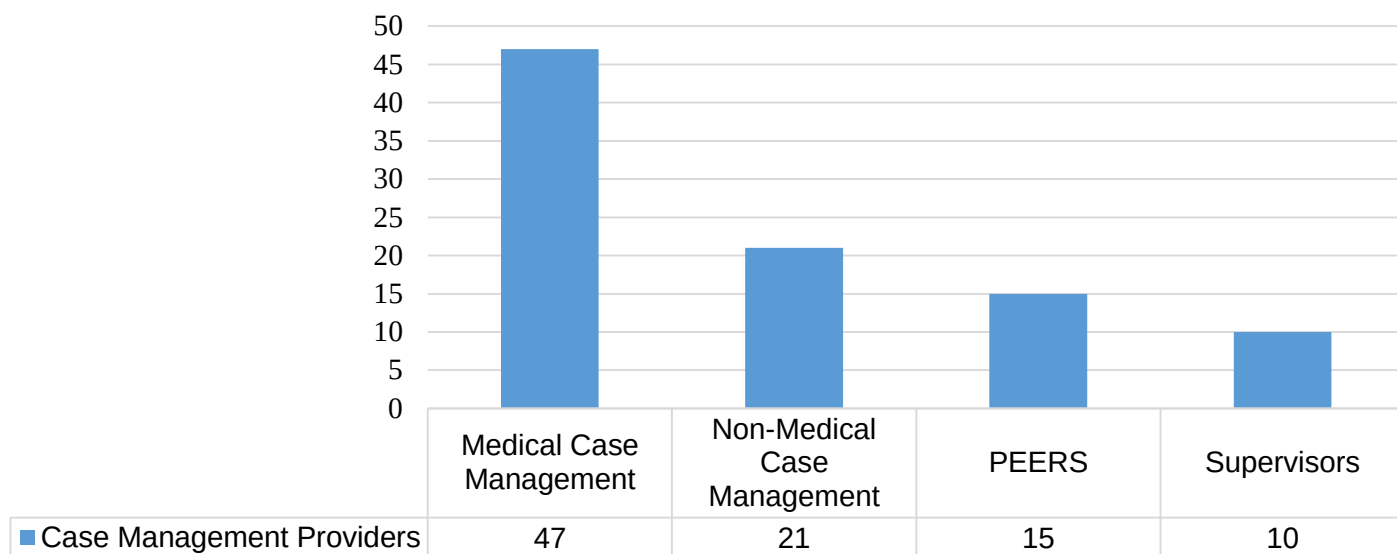
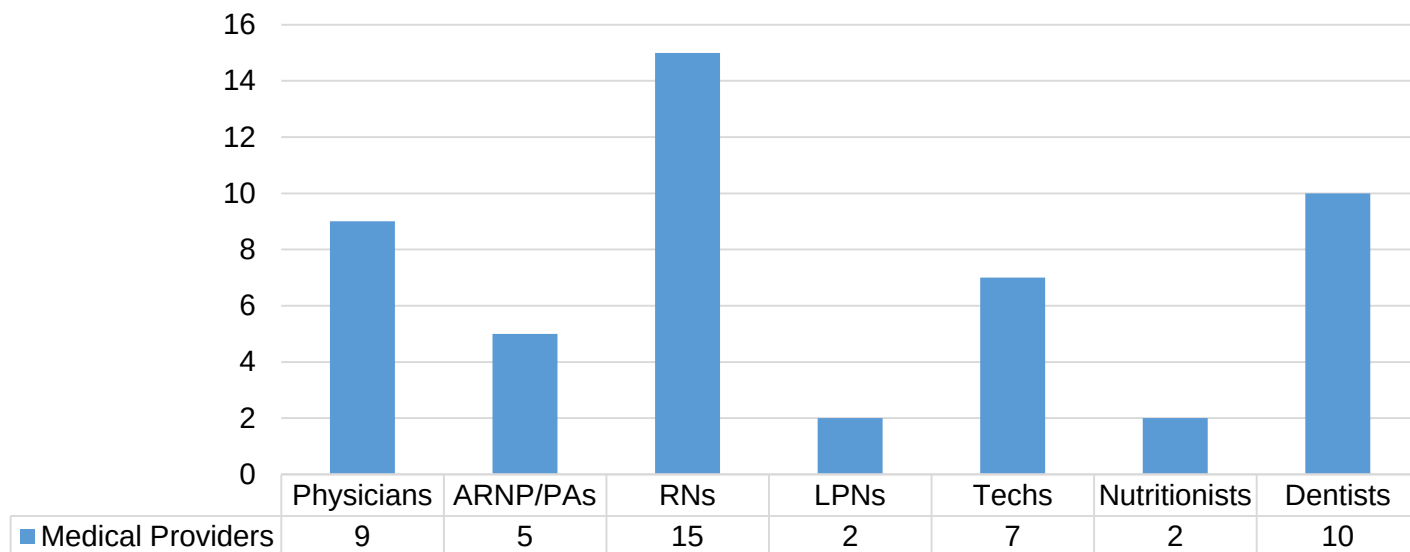
A high quality HIV/AIDS continuum of care is maintained through collaboration among all Ryan White Parts and non-Ryan White service providers to ensure seamless delivery of essential services. The continuum of care incorporates the core services of primary medical care (including outpatient ambulatory medical care), medical case management, pharmacy services, substance abuse and mental health services (outpatient), medical nutrition therapy, oral health care services, housing services, the payment of health insurance premiums and the addition of early intervention services. This jurisdiction's primary focus is getting people into care, ensuring that they remain in treatment and reducing disparities in health care.

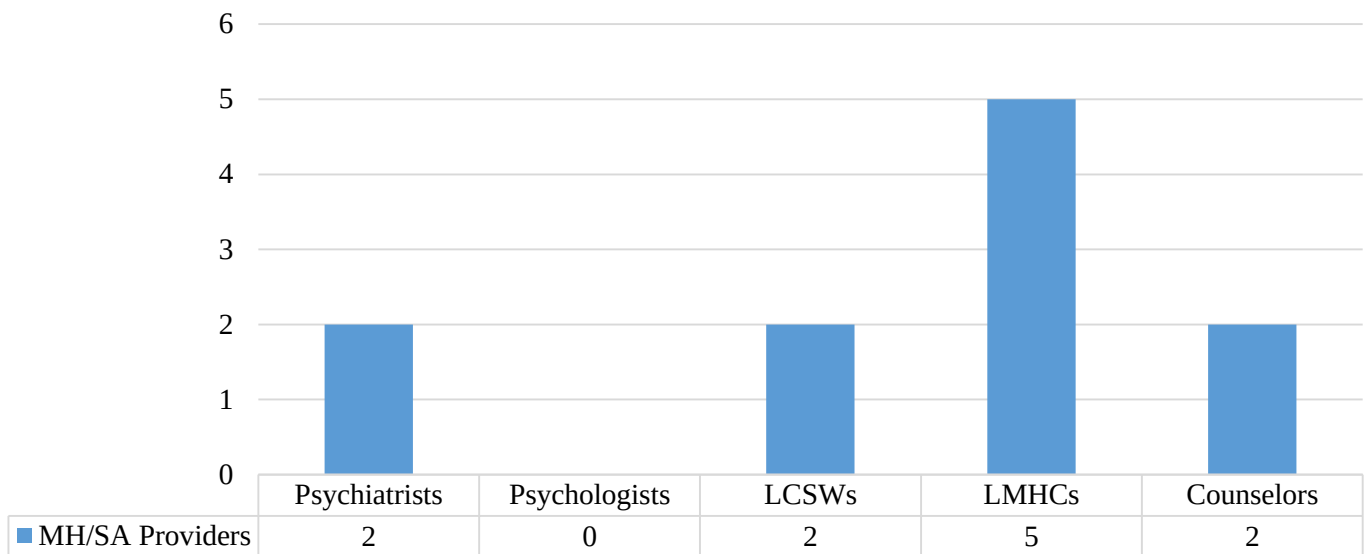
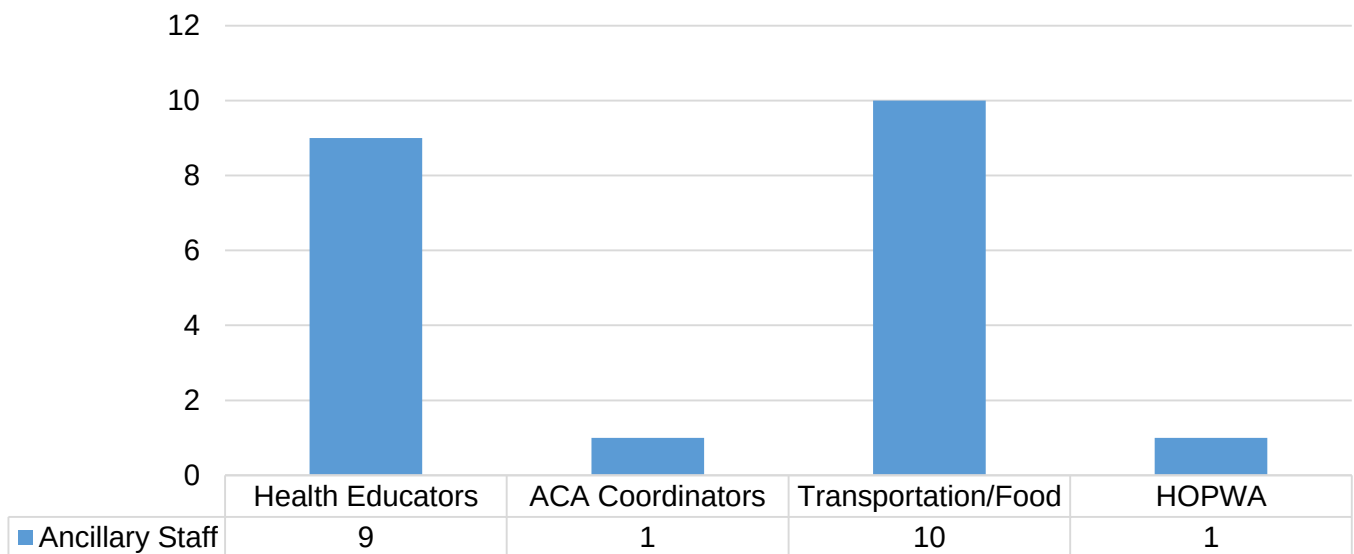
Our jurisdictional workforce includes agencies supporting the above core and support services. Prevention and educational programs are available as are testing initiatives. Linkage programs are in place to allow for crossover between the differently funded programs. This allows the consumer to access a broader continuum of care for their individual health needs.

Care and support is provided by physicians, nurse practitioners (ARNP), Physician Assistant's, licensed social workers, licensed mental health workers, and staff with experience in their field of expertise. Nearly all positions require a Baccalaureate degree and/or experience. Supervisory levels and above require an advanced degree.

By establishing high educational and work experience standards, this jurisdiction is able to provide consumers with the highest standards in care. Ongoing education relating to job performance is a requirement of all funded agencies.

A firm foundation is built with the needs of the consumer being placed first. Oversight and management expertise guide our agencies as they support and provide services to consumers, reaching not only those in care but reaching out to those that have fallen out of care or have never accessed care.

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 15: Orlando Service Area Case Management Providers****Figure 16: Orlando Service Area Medical Providers**

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 17: Orlando Service Area Mental Health and Substance Abuse Providers****Figure 18: Orlando Service Area Ancillary Staff****c. Funding Sources to Ensure Continuity of Care**

The Orlando Service Area consists of five counties in which the state managed health department is a provider. The health departments are the medical homes for individuals living within their respective jurisdiction and various service providers are co-located to provide parity in access to care and support services through geographic location and comprehensiveness of services. Services are provided using a client centered holistic approach to addressing the wellbeing of the consumers. The Orlando Service Area provides services that are culturally and linguistically relevant to the population served, including sign language, and the use of providers that reflect the dominant culture of that specific geographic location. Quality of services is maintained by the use of national monitoring standards, adherence to Public Health Service guidelines, local Standards of Care and HAB Outcome Measures.

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Service providers are required to participate in diversity training on an annual basis, as well as to have culturally reflective staff of the target population. The majority of sub-recipients/service providers in the Orlando Service Area hire people from various ethnic and racial backgrounds, mirroring the PLWHA population, ensuring that the entities offering services can meet the unique cultural and linguistic needs of historically underserved populations. The Orlando Service Area contracts with providers in communities where PLWHA who have been historically disadvantaged can obtain services to increase access to care and health outcomes.

The State of Florida Legislation opted not to expand Medicaid, however the Orlando Service Area, through Case Management services, constantly review the consumer's eligibility for Medicaid services and enroll all those who meet the qualifications. Also, the Orlando Service Area increased the number of consumers that enrolled in ACA plans in 2015 and is working on the enrollment for 2016; these strategies have reduced the need in funding for OAHS compared with previous years. The Orlando Service Area changed the pharmacy provider and brought it in house to a County operated pharmacy. The pharmacy, a 340B entity, is able to bill insurance companies and generate revenue, including rebates, that is utilized as program income. Program income generated reduces the amount of funding needed from the grant for the Local AIDS Pharmaceutical Assistance program.

The Orlando Service Area requires that service providers expend funds and provide services in proportion to the epidemic; also the providers are required to submit monthly reports of their compliance with same and if necessary make the appropriate adjustments by targeting populations and engaging in outreach activities.

The needs assessments are related to the HIV Care Continuum as it reflects consumers' ability to link to care, their retention in care, as well as their compliance with ART resulting in suppressed viral loads. Based on the unmet need data there are 4,334 consumers within the service that are aware of their status but not in care. The Orlando Service Area encouraged service providers to engage in outreach activities and to establish appropriate relationships & coordination with the established Key Points of Entry as part their contractual requirements. In addition, the Orlando Service Area is working on increasing the awareness of the availability of services provided by engaging consumer to be ambassadors to those unaware though education of case managers, peers and other network service providers in collaboration with other local and state programs. The Orlando Service Area is working on the comprehensive plan in collaboration with prevention and patient care programs. The comprehensive plans goals are overarching and related to access to and retention in-care. The relevant performance measures are recommended by HAB/HRSA as part of the HHS Core Metrics which are recommended for HHS funded HIV programs and services. Performance measures are also related to service categories funded as reflected in the compressive plan to monitor service delivery. The action items are reviewed collaboratively by the Planning bodies and Recipients to determine if specifically assigned goals and objectives have been met or are pending.

d. Identify Needed Resources

The need for early intervention specialists (EIS)/Linkage Coordinators were identified last year and from that need both Part A and Part B funded a total of eight positions starting in March and April 2016, respectively.

With the five service counties that sprawl from the space coast to below Disney and into the rural counties to the west a continued need is a better mass transit system. It is difficult for the consumers to get to their primary care physicians, Infectious disease and specialty providers.

Affordable housing is a continued need in all of the service counties. With the restrictions and waiting lists for Housing Opportunities for Persons with AIDS (HOPWA), Section 8 and other government housing programs it limits our consumers who do not have the funds, the credit or other hindrances to obtaining suitable housing.

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**D. Assessing Needs, Gaps and Barriers****a. Process to Identify HIV Prevention and Care Service Needs**

Health care providers indicate that their consumers have increasingly complex medical needs including the co-morbidities and co-factors identified previously. Co-morbidities require more complex medical and psychosocial interventions than standard HIV care. Providers must be vigilant regarding medication interactions when treating multiple conditions, nutritional needs, housing situation, side effects management and other quality of life issues. The aging population will continue to pose new challenges as medical providers account for the additional concerns of older adults and the aging process. As a result, the Recipients have implemented key cost containment measures for specialty care referrals to reduce the likelihood of these additional factors driving up the cost-of-care per client.

The Orlando Service Area community input process is structured to afford an opportunity for consumers to provide written feedback on their level of satisfaction with services and/or the system in general at all funded sites. As outcome data is generated from the implementation of the HIV Care Continuum it is shared with the Planning bodies and community members. The Planning bodies' methods through the use of contracted agencies include: focus groups; in-depth interviews; surveys; monthly Ryan White Community Meetings; newsletters; and the Orlando Service Area websites. These data collection methods are designed to gather input from the consumer in the HIV Care Continuum of Care to provide direction on future planning considerations for the Orlando Service Area. The results of all methods are used to guide future planning considerations.

The Planning bodies utilizes established principles and criteria based on the Ryan White HIV/AIDS Program Part A and B Manual <http://hab.hrsa.gov/manageyourgrant/files/happartamanual2013.pdf> and <http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf> throughout the entire priority setting and resource allocation process, as agreed upon by its members and in accordance with the existing and emerging needs of PLWHA, as identified by the comprehensive needs assessment. The process is data driven by examining the epidemiological profile of PLWHA; assessing service utilization; reviewing available funding streams by service category; and evaluating survey data gathered from consumers and providers within the Orlando Service Area.

The Planning bodies focus efforts on addressing the HIV Care Continuum outcomes by evaluating and coordinating with other Ryan White-funded Parts (C and D) and local, state, and federal resources. This is an ongoing practice that includes the priority setting and resource allocation processes.

The Planning Committee of the Planning Council (EMA) developed the process, with input from consumers during PLWHA Caucus and committee meetings and through the newsletter, website and focus groups, to ascertain consumer needs and concerns with the existing system of care. In open community meetings, the Planning bodies approved the priority setting and resource allocation processes prior to implementation and adhered to the process throughout. The priority setting and resource allocation process was conducted during several public meetings spanning one month. First, a data presentation was conducted over the course of one day, providing epidemiological data, funding streams, expenditures and utilization, resources maps, provider survey data, consumer survey data, barriers to care surveys, and unmet need data to all Planning bodies and community members attending. A priority setting meeting was conducted one week later and a slate of service category priorities was developed and approved by the Planning bodies. A resource allocation meeting was conducted one week later where actual funding amounts were assigned and approved by the planning bodies. An evaluation assessment for each component of the process was completed by members of the planning

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bodies. Finally, a debriefing meeting was added to gather additional information on how the process went and what changes were needed to improve it.

The Lead Agency for the Ryan White Part B recipient conducts the data presentation, priority setting and resource allocation for Tri-County (Osceola, Orange and Seminole) in one setting and the Brevard County process in a separate setting in Brevard. The Lead Agency provides the same data to the CFAP members as their Part A counterparts. Brevard County receives 72% of the RW Part B dollars with the remaining used to fill any gaps in services in the combined Part A and Part B service counties.

b. HIV Prevention and Care Service Needs of Persons at Risk for HIV and PLWH

According to the HRSA/HAB Unmet Need Framework, the Florida HIV/AIDS and Hepatitis Program estimated for CY 2014 there were 4,334 (39%) PLWHA who were not in-care. EIIHA efforts focus on post-test counseling, referrals and linkage into appropriate services for individuals. Activities related to those who are HIV+ but not in care are similar, although the key difference is that these individuals know their status. The overall goal is the same though, which is to identify people who are HIV+ and bring them and/or retain them in care.

The Orlando Service Area will begin funding linkage coordinators in FY 2016 to assist with linking newly diagnosed individuals into primary medical care, designed to decrease the number of people who know their status but are not in care. The Recipients will begin allocating dollars into Early Intervention Specialist (EIS) in FY 2016 in order to fund eight (8) linkage coordinators, four (4) each from Ryan White Part A and B respectively.

In an effort to address unmet need, the Orlando Service Area moved to a case management model four years ago, in order to more aggressively bring people into care and keep them in care. The Planning bodies continue to dedicate funding to both medical and non-medical case management for this purpose. They use data made available to them from the EIIHA workgroup to dedicate funding to assist in bringing newly diagnosed positives into medical care. The Planning bodies considered the needs of historically underserved populations during the priority setting and resource allocation meetings and continues to support the proactive stance taken by the Recipient's to test and link people into care. Many of the testing and counseling sites are also Ryan White Part A and Part B patient care providers. The Planning bodies considered the funding of services located near or in disproportionately impacted communities in order to meet the HRSA goals of increasing access to quality primary medical care and other services and decreasing HIV health disparities among infected and affected subpopulations in historically underserved communities. In addition, the Planning bodies implemented an "Out-Of-Care" survey to determine why individuals drop out of care. The goal was to determine the barriers that cause individuals to fall out of care and address and decrease those barriers.

The Anti-Retroviral Treatment and Access to Services (ARTAS) funded through the Ryan White Part B MAI program actively re-links people who have fallen out of medical care back into care. This program, along with other outreach efforts, are aggressively implemented to successfully link HIV+ individual to the system of care and case managers regularly interact with site staff. Several Counseling and Testing sites engage in aggressive marketing campaigns to encourage people to get tested to learn their status.

A primary care facility providing services for the homeless (Health Care Center for the Homeless - HCCH) was awarded a Bureau of Primary Care grant Partnership 4 Care grant to expand and integrate medical care with the PLWHA population. The EMA provides them with detailed information on resources available and the process to link individuals testing positive to the system of care. HCCH is also an Expanded Testing Initiative site and

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has implemented routine HIV testing into their primary medical care which identifies homeless HIV-infected individuals and links them to care within their facility.

Planning body members and consumers participate throughout the year as information concerning the service delivery system, unmet needs and gaps in care as well as any real or perceived barriers is collected and reviewed. Participation is facilitated through the monthly PLWHA Caucus meeting, CFAP general membership meetings, representation at various Consumer Advisory Board (CAB) meetings held by providers, special focus groups and interview sessions, and participation with support groups by Planning Council and Consortia members. Information from each of these sources is brought back monthly to the Council for review and action as needed.

The Planning bodies continue to adhere to the HRSA mandate that 75% of service dollars be used to fund core medical services. The Part A and B planning bodies considered the Unmet Need Framework in the planning and decision making processes for setting priorities, resource allocations, and the system of care. The needs of those not in care and unaware of their status were considered based on barriers to care and unmet need data. It is estimated that 39% of PLWHA in the Orlando Service Area were not currently receiving primary medical care services in CY 2014. As such, approximately 85% of service dollars have been allotted to core medical services for the FY 2015.

MAI funds have historically been utilized to provide OAHS to racial and ethnic minorities. Trended epidemiological data support the need to continue allocating MAI funds in the Orlando Service Area for critical core medical services to Black, non-Hispanic, and Hispanic populations who are disproportionately impacted by HIV. Part A MAI funds are used to support OAHS, including the development and implementation of individualized plans of care that include strategies for adherence in the continuation of medical care for disproportionately impacted or underserved communities. For 2016, the planning bodies have allocated part of the MAI Funding to create and strengthen linkage to care for minorities who test positive. The linkage coordinators will work closely with the testing agencies to ensure the linkage. Part B MAI funds are used solely to identify consumers who have dropped out of care and re-link them to care via the ARTAS program.

The planning bodies examined epidemiological and utilization data to assess the needs of the community for priority setting and resource allocation. The group aligned the top five service categories to coincide with the top five needs identified in the Consumer Survey. As a result, the top five services in order of priority are as follows:

1. OAHS
2. AIDS Pharmaceutical Assistance (Local)
3. AIDS Drug Assistance Program
4. Oral Health
5. Medical Case Management.

Epidemiological data for the Orlando Service Area continues to show that new cases of HIV and AIDS are a disproportionate burden among the Black, non-Hispanic populations. There has also been a rise in new cases in the Hispanic population. Community input is continually sought through caucus meetings, health fairs, community gatherings, newsletters, website, focus groups and in-depth interviews in an effort to address the reasons for the continued spread of the disease among these populations. The information gathered is analyzed and presented to the Planning bodies and community members to aid in setting priorities and resource allocations and will be used to support the effectiveness of the HIV Care Continuum.

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The planning bodies utilized a trend analysis of expenditures and utilization to identify how and where funds were spent over the past five years along with epidemiology and unmet need data to determine the best methods for fund allocation. This data was shared with the Planning bodies and community members at the annual data presentation and proved instrumental in crafting funding slates for the upcoming fiscal year.

This planning effort requires an in-depth understanding of services as well as other publicly funded HIV services that are available to PLWHA. The Coordination of Services and Funding report includes funding source access details, broken out by service category, on the following programs: Part A, Part A MAI, Part B, Part B MAI, Part C, Part D, Part F, Substance Abuse and Mental Health Services Administration (SAMHSA) and Housing Opportunities for People with AIDS (HOPWA). All the recipients closely coordinate with other available programs and funding streams within the Orlando Service Area to enhance the HIV Care Continuum. This integration and coordination is achieved by regularly scheduled strategic planning meetings across all Ryan White Parts funded within the Orlando Service Area (Parts A, B, C and D). In addition, collaborative sessions are scheduled with prevention, housing, mental health and substance abuse to improve the current system of linkages and to strengthen the referral process. These efforts assure that Ryan White funds will always be utilized as the “Payer of Last Resort.”

A visual of the HIV Care Continuum was shared during the annual priority setting and resource allocation process as part of the Unmet Need presentation to assist in recognizing the possibility of health insurance coverage options and uncertain changes and how it would affect the most important needs of consumers. The planning bodies examined epidemiological and utilization data and reviewed the Orlando Service Area efforts to collaborate with other entities during the Affordable Care Act enrollment period to include the number of new and estimated enrollees. The planning bodies recognizes the importance of prioritizing and funding critical core medical services to ensure PLWHA receive appropriate care to ensure the quality of life.

Several strategies were considered during the priority setting and resource allocation process to make unaware consumers aware of their status and link them to care, including increased testing by reducing real and perceived barriers to HIV testing; ensuring that counseling, testing, and linkage services are provided to at-risk populations through our collaborations with Prevention, Counseling and Testing initiatives with other Ryan White entities and the Department of Health; increasing the percentage of persons who receive results after testing for HIV; linking all newly infected individuals to appropriate medical and support services; providing pre-release planning and linkage services in local jail facilities; ensuring newly identified HIV+ incarcerated persons are linked to appropriate community services prior to release; maintaining and expanding the network of providers willing and able to serve ex-offenders; and ensuring baseline data is collected and trends are monitored on an ongoing basis.

In support of our case management driven system, case managers are located in all clinics that provide OAHS and services funded through Part A and B and Part A and B MAI funds. It is anticipated that as outcome data is generated from the implementation of the HIV Care Continuum it will be shared with the planning bodies and community to help guide future planning considerations.

c. Describe Service Gaps

Florida, like many other states, has faced severe general revenue shortfalls since the economic downturn in 2006. Each year, as the legislature is forced to continue making funding cuts to balance an ever-demanding budget, services across the state have been curtailed and sometimes even eliminated. The Part B recipient has been successful in working creatively with the legislature, the governor’s office, and sub-recipients to ensure that the continuously shrinking allocation to HIV/AIDS care has been absorbed first at the administrative levels, before affecting direct client care. However, with ever deeper cuts in annual funding, eventually the effect is

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being felt at the client level, as evidenced by the ADAP wait list in 2010 (although no client had gone without life-saving medications), and diversion of federal Ryan White Part B allocations from local consortia areas to help keep ADAP afloat.

Florida has experienced nearly flat funding of its Ryan White Part B program for many years, despite growing incidence and prevalence of HIV. With reductions in local Ryan White Part B allocations across the state beginning in FY 2011-2012, many local regions including East Central Florida, have had to reduce funding for services from eligibility determination to medical case management to ambulatory care. These reductions have translated to a shrinking healthcare workforce, and in some areas, wait lists for newly HIV-diagnosed and identified individuals to enter care.

Besides HIV-specific funding cuts, local health departments have also experienced deep erosions in their state General Revenue funding and Medicaid reimbursement rates for the past four years. In many areas across the state, like in East Central Florida, local health departments are the medical homes for HIV ambulatory care, particularly for persons with no other funding sources besides Ryan White. Many health departments are now closing their primary care clinics and curtailing their HIV specialty activities. They simply cannot afford to continue to pay for the staff necessary to provide this complex and expensive care anymore. Private clinicians, for the most part, are not particularly interested in packing their practices with clients who have no insurance payers or who have only Medicaid.

Clients have indicated statewide as well as locally, a need for more HIV-competent and more culturally competent medical providers. The perfect storm of an economic downturn, with its resultant slashes in budgets and thus, reimbursements, has driven providers to reduce their workforces. New medical providers recognize the warning sign, and look elsewhere to establish their practices. Persons most in need of culturally competent providers are many times also persons who have no payer resources – they must rely on the governmentally funded networks of care, which right now are in funding turmoil. Many HIV-competent providers are beginning to age out of the care network. They have been the backbone of the area's network for many years. Some continue to practice beyond their anticipated retirements simply because there are few replacements for them. Others wearied by what seems an endless battle to fit more and more people into their already crowded practices, finally just move on to the private side or to an early retirement.

The simple math of an ever-increasing HIV-positive population trying to be served in a healthcare system whose funding cannot keep pace with the need and with rising costs yields an unfortunate product: shortfalls in care to a critically fragile community.

In the Orlando Service Area, a gap in service is defined when 30% or more consumers are unable to access a particular service. The Ryan White Orlando EMA Part A and Area 7 Ryan White Part B Recipient offices' in East Central Florida, utilized the Statewide Anonymous Ryan White Consumer Needs Survey in addition to service delivery information received from providers statewide to identify gaps in service. The survey consisted of 59 questions and offered HIV service providers an opportunity to describe service needs in their community. Questions assessed a range of variables, including respondent demographics, HIV/AIDS Medical Care, RW services that they may or may not have been able to receive, Jail/Prison Release services and Housing. They also had the opportunity to provide additional comments. There were 572 consumers that responded to the survey which included 266 from Brevard. The survey asks clients what services they needed but were unable to obtain from their service providers because they were not offered at all, were no longer being offered, or because of a wait list.

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On a local level, the gaps vary by area based on several factors, including availability of other funding sources, transportation issues, and availability of providers to deliver services. Overall, 72% of respondents to the consumer needs survey indicated they received all needed services that were listed in this survey tool. The majority of respondents indicated that they received specific services that they needed. Of the 18 services listed on the survey, more than 57% (4,000 respondents) needed each of six specific services (service gaps in parentheses): Food Bank (37%), Health Insurance (34%), Dental/Oral Health (31%), Case Management (11%), OAMC (5%), and Medications (5%). The latter two services are core services and fortunately, these needs are met for 95% of respondents.

The responses from the area providers were very similar to those of the clients in the Consumer Needs Survey. Each area was surveyed and asked to rank services in order by largest to smallest gaps. The gaps in services identified by the providers were then given a score based on the rank given by the provider. The largest gaps in services, in order from largest gap to smallest gap, according to the providers surveyed were as follows: Legal Services, Food Bank, Medical Transportation, Health Insurance, Rehabilitation Services, Dental/Oral Health, Substance Abuse Treatment, Mental Health Services, Home Health Care, Nutritional Counseling, Hospice, Outreach, Local AIDS Pharmaceutical Assistance, Housing Services, Early Intervention Services, OAMC, Medical Case Management, Emergency Financial Assistance, and Case Management (Non-Medical).

In addition to the consumer needs survey, ongoing focus group research as well as recent reports from the Centers for Disease Control and Prevention (CDC) has revealed that MSM are experiencing gaps in both patient care and prevention services. Some areas report these gaps for care are directly related to the client not receiving medical case management. This could be caused by lack of capacity to meet the growing demand, as well as simple lack of knowledge of the existence of the service by the consumer. In rural areas, support services such as transportation or other issues such as lack of proximate providers were identified as one of the causes for clients' not being connected. In urban communities, where access was not as prevalent an issue and more funding was available to support non-core services, MSM indicated that they relied heavily on peer networking for navigating through the healthcare system when difficulties engaging or obtaining medical case management were an issue.

Additionally, in both rural and urban communities, there were MSM who lacked awareness of the planning bodies, consortia and/or planning councils that could have served as a voice for this group. Contact with planning body members would have increased awareness of services and funding sources to needed health services for MSM. Service gaps for Women of Child Bearing Age include limited family-centered resources such as childcare, transportation, and treatment protocols. In some areas of the state, Minority AIDS Initiative resources are specifically targeted to this group in an effort to increase services for women and the RW Part A grantee office provides medications for pregnant infected women and their exposed newborn infants whenever there are barriers to accessing this service. The Part A grantee in the Orlando EMA/Area 7 has entered into an agreement with a local pharmacy to keep a supply of appropriate medications on hand for the following scenarios: a pregnant woman's Medicaid coverage is delayed approval or suspended and she is unable to obtain her medications; an infant is born and needs medications; mother and newborn are discharged over the weekend and unable to secure needed medications.

The service gaps were prioritized in accordance with the top five services identified in the 2013 Consumer Needs Survey as the most important for those with HIV/AIDS. For this reason, oral health and mental health were in the top seven prioritized core medical service categories.

Service gaps will be addressed through increased funding to case managers who will coordinate consumer's transportation and dental health service needs. Addition funding assistance will be provided to help consumers with enrollment into ACA programs. The Recipients' will continue to expand partnerships with local food

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banks, disburse copies of the Resource Directory to consumers which identifies local food programs respectively and eligibility criteria, and educate case managers to increase awareness of food resources for consumers. Increased funding was also provided to mental health services to cover the newly added psychiatric care services.

d. Describe Barriers to HIV Prevention and Care**Figure 19: Barriers to HIV Care**

Barriers to Care	Social & Structural Barriers	Legislative Barriers	Health Department Barriers	Program Barriers	Service Provider Barriers	Client Barriers
Policy implementation (e.g. Medicaid expansion, clean needle exchange programs, abstinence-based curriculum, etc.)	X	X		X	X	X
Significant budget cuts across the State – decreased funding at the local level			X	X	X	X
Federal, State and County contracting and procurement processes		X	X	X	X	X
Insufficient integration of cost data and service provision data to improve service delivery process.	X	X		X	X	
Limitations and delay on state epidemiological data				X	X	X
Delay in migration data (e.g. impact of consumers relocated from other states)		X		X	X	X
Insufficient communication protocols between prevention and patient care.	X	X	X	X	X	
Lack of integrated software system to share pertinent client information.	X	X	X	X	X	
Inadequate local public transportations systems	X	X				
Lack of dental providers in rural counties	X			X		X
Inadequate specialty care and primary care providers	X	X				X
Insufficient staff to client ratio					X	X
Lack of community partnerships/linkages		X	X	X	X	X
Lack of affordable housing	X	X		X		X
Lack of knowledge of the Ryan White service system by potential key points of entry	X		X	X	X	X
Low rate of health insurance coverage and declining coverage	X	X				
Lack of a functional, real time information system				X	X	X
Language and cultural barriers	X				X	X

SECTION I: Statewide Coordinated Statement of Need/Need Assessment**Figure 19A: Barriers to HIV Prevention – Service Gaps**

Barriers to Prevention	Social & Structural Barriers	Legislative Barriers	Health Department Barriers	Program Barriers	Service Provider Barriers	Client Barriers
Lack of Funding		X	X	X		
Federal Guidelines restricting bridging of programs		X	X	X		
Federal, State and Local policies not in alliance with community needs		X	X	X	X	
Agency turnover and lack of continuity of leadership			X		X	
Community Needs based on State Epidemiological data not necessarily on service area		X	X	X		
Weak or non-existent partnership and/or communication between agencies			X	X	X	
Community unaware of programs unavailability	X				X	X
Lack of community education leading to continued stigma			X	X	X	X
Inability to publicly educate due to local and state mandates	X	X				
Lack of staff training to understand cultural barriers			X	X	X	
Inadequate public transportation	X	X				

E. Data: Access, Source, and Systems**a. Describe Main Data Sources**

The Orlando Service Area received epidemiological data from the Florida Department of Health, Bureau of Communicable Disease, HIV/AIDS section. Data is primarily gleaned from Enhanced HIV/AIDS Reporting System. Population data was gathered from the Florida Department of Health, Office of Health Statistics. Data regarding health behaviors for adolescents and adults was provided by the Youth Risk Behavioral Surveillance System (YRBSS) and Behavioral Risk Factor Surveillance System, respectively. Additionally, qualitative data was gathered from focus groups and provider and client surveys.

b. Describe Data Policies that Served as Barriers

The merging of the databases discussed above facilitated the data necessary to develop the Orlando Service Area diagnosis-based HIV Care Continuum in alignment with any data policies protecting the identity of PLWHA living in the area. At the present time, since the State Health Office generates the Service Area's HIV Continuum of Care Model and there are no formal policies and procedures serving as barriers for developing model, the significant limitation results in assuming that persons not in care (based on the listed data matches

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above) are truly not in care. The upcoming challenges will be to develop policies and procedures, with available staff at the state health office and locally,

- to evaluate those cases not in care,
- specify who will be responsible for trying to locate those persons not in care and
- ascertain how staff will carry out this process.

Legal agreements may need to be drawn up if non-DOH staff needs to be contracted to perform some of these duties.

Additionally, continued efforts will be made to further improve the completeness of state and local data elements. Moreover, facilitating data agreements with local IT departments will allow for greater development of the HIV Care Continuum for the state, as demonstrated by the data agreement with Miami. Data sharing with the Ryan White Part A's around the state will be assessed to coordinate programs that target the care continuum.

c. Describe Any Data That Was Needed but Not Available

The data that the planning group would like to have used in conducting the needs assessment and in developing the HIV Care Continuum and the plan, but was not available were:

- Information from Medicaid regarding the amount of funds spent on providing HIV care and treatment
- Information from ADAP regarding the number and demographics of clients accessing medications
- Information from ADAP regarding the number of clients enrolled in ACA plans
- Actual information, not estimates, on the number of clients prescribed ART
- System wide unduplicated RSR data
- Community Health Center program data
- Vital statistics data

SECTION II

Integrated HIV Prevention and Care Plan



SECTION II: Integrated HIV Prevention and Care Plan**SECTION II: Integrated HIV Prevention and Care Plan****A. Integrated HIV Prevention and Care Plan****a-d Sections****Goal 1: Reduce New HIV Infections**

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%, from the baseline of 84%.

Strategy 1: Implement routine testing in applicable medical facilities.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of September 2017	Distribute the routine testing guidelines developed by the HIV/AIDS Section of the Florida Department of Health headquartered in Tallahassee to applicable medical facilities.	Ryan White Part A Planning bodies; Ryan White Part B/Prevention Consortium (CFAP) and the local Part B grant recipient office.	Medical Facilities such as primary care providers, emergency rooms, urgent care centers, etc.	Number of medical facilities in receipt of guidelines.
By the end of November 2018	Ensure training on implementation of the guidelines is provided to all medical facilities.	AETC (AIDS Education and Training Center)	Medical Facilities such as primary care providers, emergency rooms, urgent care centers, etc.	- Number of training sessions completed. - Number of facilities completing the training. - Number of facilities implementing routine testing.

Strategy 2: Increase outreach and targeted testing.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of December 2020	Deliver intensified outreach and testing to MSMs including young MSMs and heterosexuals of color.	Expanded Testing Initiative (ETI) sub-recipients, CBOs and ASOs.	MSMs (including young MSMs), heterosexuals of color.	- Number HIV tests performed. - HIV Positivity Rate. - Number of positives linked to care.

SECTION II: Integrated HIV Prevention and Care Plan**Strategy 3:** Increase post-test follow-up and coordination with DIS (Disease Intervention Specialists).

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2018	Designate individuals at testing sites to coordinate daily/weekly follow-up with DIS.	ETI sub-recipients, CBOs, ASOs, DIS/Linkage Coordinators, Medical Facilities.	MSMs (including young MSMs), heterosexuals of color.	• Number of positives referred and linked to DIS for Partner Services. • Number of positives linked to Case Management and/or Primary Medical Care.
By the end of March 2018	Determine a model to increase collaboration with DIS.	ETI sub-recipients, CBOs, ASOs, DIS/Linkage Coordinators, Medical Facilities.	MSMs (including young MSMs), heterosexuals of color.	• Identification of a best practice model. • Implementation of the best practice model. • Number of Memorandum of Agreements (MOAs) with Health Departments, DIS and Medical Facilities.
By the end of December 2020	Develop jurisdiction wide couples' counseling and testing protocols to include partner elicitation and notification.	CDC-funded Health Department.	ETI sub-recipients, CBOs, ASOs, DIS/Linkage Coordinators, Medical Facilities.	• Protocols developed. • Number of trainings. • Number of couples' counseling/testing sessions.

Objective 2: Reduce the number of new diagnoses by at least 10%, from the baseline of 845 to 760.**Strategy 1:** Increase Prevention for Positives Initiatives.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2021	Implement Effective Behavioral Interventions (EBIs) for Prevention for Positives/Treatment as Prevention (TaP).	Local Ryan White Part B recipients, Ryan White recipients.	Ryan White sub-recipients.	• Number of clients enrolled in interventions. • Number of clients completing interventions.

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Strategy 2: Increase knowledge and availability of Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post Exposure Prophylaxis (nPEP).

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of June 2019	Identify medical facilities and CBOs predisposed to implementing PrEP and nPEP.	Ryan White Part A Planning bodies, Ryan White Part B/Prevention Consortium, local Part B recipient, AETC.	Medical facilities, CBOs and ASOs.	Number of MOAs with Medical Facilities.
By the end of September 2020	Provide training on the implementation of PrEP and nPEP.	AETC	Medical facilities, CBOs and ASOs.	Number of CBOs and Medical Facilities that receive trainings.
By the end of March 2021	Implement PrEP and nPEP.	Medical Facilities, CBOs and ASOs.	High-risk HIV negative individuals, sexual assault victims, accidental exposures.	Number of individuals receiving PrEP and nPEP.

Strategy 3: Increase knowledge and availability of interventions for high-risk populations.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2017	Identify and apply for alternative funding sources for EBIs for target populations.	Ryan White recipients and sub-recipients, Prevention sub-recipients.	MSMs (including young MSMs), heterosexuals of color.	- Number of funding sources, other than Ryan White and CDC, identified. - Number of successful applications submitted.
By the end of June 2017	Implement training to CBOs, ASOs, medical facilities, etc. on EBIs for target population.	CDC-funded health departments.	MSMs (including young MSMs), heterosexuals of color.	- Number of training sessions completed. - Number of individuals receiving training.
By the end of December 2017	Implement appropriate EBIs.	Prevention sub-recipients.	MSMs (including young MSMs), heterosexuals of color.	- Number of individuals from target population enrolled and completed EBIs. - Number of individuals reporting reduced risk factors.

SECTION II: Integrated HIV Prevention and Care Plan**Goal 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV**

Objective 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 80%.

Strategy 1: Increase peer support services, linkage to care and case management services.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of September 2020	Identify funding resources to support expansion of: Early Intervention Services (EIS), linkage, peer support and case management services.	Ryan White recipients, planning bodies, and Prevention recipients.	CBOs and ASOs	Number of newly identified funding resources.
By the end of December 2021	Expand the aforementioned services.	Ryan White recipients, CBOs and ASOs.	MSMs (including young MSMs), heterosexuals of color.	Number of EIS, linkage, peer, and case management services provided.

Strategy 2: Increase uniformity in peer support, linkage to care and case management services.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of September 2018	Identify/develop standardized training for the provision of the aforementioned services.	Ryan White recipients and planning bodies.	EIS, peer, case management, linkage service providers.	Standardized training developed or identified.
By the end of February 2019	Implement the standardized training to CBOs, ASOs, etc.	Ryan White recipients.	EIS, peer, case management, linkage service providers.	- Number of standardized training sessions completed. - Number of service providers receiving training.

Strategy 3: Increase presence of peer support, linkage to care and case management services in the private sector.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of December 2018	Identify the models/best practices of aforementioned services that work in the private	Ryan White recipients and planning bodies.	Private sector ASOs.	Models/best practices identified.

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	sector.			
By the end of March 2021	Implement identified models/best practices.	Ryan White recipients and private sector ASOs.	HIV positive individuals receiving care in the private sector.	- Number of models/best practices implemented in the private sector. - Number of individuals receiving services in the private sector.

Objective 6: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 65% from the baseline of 59%.

Strategy 1: Increase the number and percentage of individuals on ARV (antiretroviral therapy).

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
Annually, by end of December	Educate clinical providers on the most current Public Health Service (PHS) Guidelines annually (within 90 days of update).	Ryan White recipients and planning bodies.	Clinical providers.	- Number of update sessions provided. - Number of clinical providers trained. - Number of individuals on ARV.
Annually, by end of December	Provide treatment updates in a Continued Medical Education/Continued Educational Units (CME/CEU) setting for clinical providers.	Ryan White recipients and planning bodies.	Clinical providers.	- Number of sessions receiving CME/CEUs. - Number of individuals on ARV.
By the end of August 2017	Identify and strengthen partnerships with key points of entry.	Ryan White sub-recipients, other CBOs and ASOs.	Key points of entry	Number of MOAs established.

Strategy 2: Increase adherence to treatment by promoting a consumer centered system focused on acceptance, trust and caring.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of May 2017	Provide system-wide standardized customer service training.	Ryan White and Prevention recipients and planning bodies.	Ryan White sub-recipients, other CBOs and ASOs.	- Number of training sessions completed. - Number of staff trained.
By the end of August 2018	Provide comprehensive cultural competency training reflective of consumers served.	Ryan White and Prevention recipients and planning bodies.	Ryan White sub-recipients, other CBOs and ASOs.	- Number of training sessions completed. - Number of staff trained.

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By the end of October 2018	Provide activities to decrease compassion fatigue across agencies and providers.	Ryan White and Prevention recipients and planning bodies.	Ryan White sub-recipients, other CBOs and ASOs.	- Number of activities provided. - Number and type of participants.

Strategy 3: Increase the awareness and the use of EBIs that address treatment adherence.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of February 2019	Provide information, resources and technical assistance to strengthen and increase delivery of EBIs that address treatment adherence.	Ryan White recipients and AETC.	Ryan White sub-recipients, other CBOs and ASOs.	- Number of EBIs that address treatment adherence implemented. - Number of virally suppressed individuals.

Goal 3: Reduce HIV-Related Disparities and Health Inequities

Objective 7: Reduce the percentage of persons in HIV medical care who are homeless (as defined by the HAB SPNS Initiative) to no more than 5%.

Strategy 1: Increase collaboration with organizations serving the homeless population.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of November 2017	Establish relationships/partnerships with Homeless Service Network (HSN), Housing Opportunities for Persons with AIDS (HOPWA) and other homeless service providers.	Ryan White recipients and planning bodies.	Ryan White sub-recipients and homeless service providers.	- Number of MOAs established with homeless service providers. - Number of HSN meetings attended.

Strategy 2: Align with the "Housing First" initiative.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of May 2018	Educate the Ryan White system of care on the "Housing First" initiative.	Ryan White recipients and HSN.	Ryan White sub-recipients.	Number of Ryan White service providers receiving training.
By the end of December 2021	Identify the number of homeless HIV positive individuals in medical care.	Medical providers.	Homeless HIV positive individuals.	Number of homeless HIV positive individuals who received medical care.
By the end of	Link homeless HIV positive individuals to	Ryan White recipients and HSN.	Homeless HIV positive	Number of homeless HIV positive

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December 2021	housing.		individuals.	individuals who received housing.

Strategy 3: Establish "out-call" (non-traditional) services to provide medical care in a non-clinical setting.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of October 2019	Identify current and potential providers of needed services.	Ryan White recipients and planning bodies.	Ryan White sub-recipients, other CBOs and ASOs.	Number of providers identified.
By the end of December 2021	Implement "out-call"/non-traditional services.	Ryan White sub-recipients, other CBOs and ASOs.	HIV positive homeless individuals.	- Number of services provided. - Number of individuals receiving services.

Objective 9: Reduce disparities in the rate of new diagnoses by at least 10% in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females.

Strategy 1: Expand available services to the aforementioned populations.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2017	Identify and strengthen relationships with key stakeholders in the aforementioned populations.	Ryan White recipients and planning bodies; Ryan White sub-recipients.	Key stakeholders of the sub-populations.	Number of MOAs established with key stakeholders.
By the end of November 2019	Increase mobile testing to address disproportionately affected populations as identified in epidemiological profile.	Ryan White recipients and planning bodies; Ryan White sub-recipients, and Prevention providers.	Gay and bisexual men, young Black gay and bisexual men, Black females.	- Number of mobile testing sessions conducted. - Number of individuals from the sub-populations tested.

Strategy 2: Promote a consumer-centered system focused on acceptance, trust, and caring.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of September 2018	Continue and improve education among clinical providers regarding current and updated modalities of treatment for the aforementioned populations.	Ryan White recipients and planning bodies; AETC.	Ryan White sub-recipients, other CBOs and ASOs.	- Number of training sessions provided. - Number and type of service providers trained.

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By the end of July of each year	Continue and improve cultural competency training for Provider staff.	Ryan White recipients and sub-recipients; AETC.	Ryan White sub-recipients, other CBOs and ASOs.	- Number of training sessions provided. - Number and type of service providers trained.

Strategy 3: Increase the availability of EBIs that target these populations.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2017	Identify best practices and successful techniques in existing EBIs.	Ryan White recipients and sub-recipients; Prevention service providers.	Gay and bisexual men, young Black gay and bisexual men, Black females.	Best practices identified.
By the end of March 2019	Standardize implementation of identified best practices and successful techniques for all EBIs.	Ryan White recipients and sub-recipients; Prevention service providers.	Gay and bisexual men, young Black gay and bisexual men, Black females.	- Number of individuals successfully completing EBIs. - Number of individuals reporting reduced risk behaviors.

Goal 4: Achieving a More Coordinated Local Response to the HIV Epidemic

Objective 1: Determine and develop mechanisms to improve coordination across all planning bodies.

Strategy 1: Investigate the feasibility of combining planning bodies.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of June 2019	Improve education regarding coordination of effort and system of care.	Ryan White recipients and planning bodies.	Planning bodies.	Number of educational sessions provided.
By the end of December 2019	Convene with all planning body stakeholders.	Ryan White recipients and planning bodies.	Planning bodies.	Number of meetings held.
By the end of June 2020	Update 2005 feasibility study.	Ryan White recipients and planning bodies.	Planning bodies.	Feasibility study updated.

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Strategy 2: Identify best practices for coordinating planning bodies based on the results of the investigation.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of December 2020	Develop and implement communication protocols between the planning bodies.	Ryan White recipients and planning bodies.	Planning bodies.	- Communication protocols developed. - Implement communication protocols.
By the end of December 2021	Implement the results of the feasibility study.	Ryan White recipients and planning bodies.	Planning bodies.	A more coordinated local response to the epidemic.

e. Challenges/Barriers in Implementing the Plan

The jurisdiction anticipates the following challenges/barriers in implementing the plan:

- The collection of data from the private sector, VA, Medicaid and Medicare
- The availability of housing units for homeless HIV positive individuals

B. Collaborations, Partnerships, and Stakeholder Involvement

a. Describe Specific Contributions

Both Planning bodies, the Planning Council (PC) and the Area 7 Consortium (CFAP) agreed to establish a collaborative Integrated Plan Writing Team which consisted of members of the Planning Committee of the PC, members of the CFAP Comprehensive Plan Committee, the Area 7 HIV/AIDS Program Coordinator (HAPC), the Part B Recipient Area Representative, representatives from the Part A Recipient's office, Ryan White Parts C and D representatives, Housing Opportunities for People with AIDS (HOPWA) representative, mental health and substance abuse providers and prevention providers as well as consumers. The composition of the Writing Team is reflective of the Central Florida epidemiology and is responsible for drafting the Plan. The Writing Team met monthly from June through November of 2015 and twice per month from December through February to draft the Plan.

To ensure that all members of both the PC and CFAP planning bodies were involved in the process both bodies included a report on the Progress of the Integrated Plan as a standing Agenda Item for their monthly meetings from the release of the Guidance in June 2015, to the completion and approval of the Plan in April 2016. During each report, Writing Team members presented the most recent draft of the Goals, Objectives, Strategies and Activities, obtained feedback from the membership, and revised the draft as necessary.

In addition to the monthly discussion and feedback sessions during the planning bodies meetings, Stakeholder meetings were held in each of the five (5) Orlando Service Area counties (Brevard, Lake, Orange, Osceola, and Seminole) to be impacted by the Plan. During these Stakeholder meetings representatives from the private sector, the clergy, law enforcement, education, public officials, and the general public were invited to discuss the draft goals, objectives, strategies and activities and provide feedback to the writing team for inclusion in the Plan.

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The final draft of the Plan was posted on each planning body's website for a two (2) week period during the month of March 2016 and emailed to all participants as well as invitees of the Stakeholder meetings to garner additional feedback from the wider community. All feedback was reviewed by the writing team and incorporated as applicable. The final document was then presented to both the PC and CFAP during the March meeting for a 30-day review per their Bylaws and approved during the April meeting. Once approved the letter of concurrence from the Chairs of both planning bodies were obtained (see Appendix A). The completed Orlando Service Area Integrated HIV Prevention and Care Plan was then submitted to the Department of Health's Headquarters in Tallahassee for inclusion into the Statewide Plan.

b. Describe Stakeholders and Partners Who Are Needed

Stakeholders from the private medical sector, public officials from each impacted County, representatives from the education sector and clergy were invited to participate in the planning process either as a member of the writing team or as a participant at the Stakeholder meetings. Since we were unable to attract their participation in the development process, the writing team decided and the planning bodies concurred to include these Stakeholders in the final solicitation for feedback. Both planning bodies also plan to continue to solicit participation from these Stakeholders as their input will be needed to more effectively improve the outcomes progress along the HIV Care Continuum.

c. Provide Letter of Concurrence

Please see the letter of concurrence from the PC Chairperson, and the CFAP Prevention and Patient Care Chairpersons in Appendix A.

C. People Living With HIV (PLWH) and Community Engagement

a. How Are People Involved in Plan Development

The Central Florida area, consisting of Brevard, Lake, Orange, Osceola and Seminole Counties, has a long history of both PLWHA and Community Engagement in developing plans for Prevention and Patient Care. This has been accomplished primarily through consumer representation on the Central Florida AIDS Planning Consortium (CFAP) and the Orlando Eligible Metropolitan Area HIV Health Services Planning Council (PC). Planning Council membership consists of approximately 50% individuals living with HIV and 45% being un-conflicted consumers. CFAP membership consists of 50% PLWHA with 27% un-conflicted. Additionally, the PC hosts a PLWHA Caucus a/k/a the Ryan White Community Meeting that attracts a larger number of consumers, including CFAP and PC members as well as non-members of both planning bodies. The purpose of the Ryan White Community Meeting is to serve as a venue for the HIV community to express feedback prior to decisions being made which impact both the prevention and patient care components of the service delivery system. Meetings of all three (3) groups are held monthly. Both the PC Support and the Lead Agency for CFAP are responsible for the group composition, ensuring that they are representative of the epidemic within the various geographic regions, Lake, Orange, Osceola and Seminole Counties for the PC and Brevard, Orange, Osceola and Seminole Counties for CFAP, utilizing the principles of Parity, Inclusion and Representation (PIR). The PC and CFAP, along with the Ryan White HIV/AIDS Program (RWHAP) Part A Recipient, PC Support, Lead Agency, and the HIV/AIDS Program Coordinator (HAPC), who is the RWHAP Part B Recipient Representative, are responsible for the development and implementation of this plan.

b. Describe the Inclusion of PLWHA with Plan Development

PLWHAs were well represented in the development of this Integrated HIV Prevention and Care Plan, as 25% of the members of the writing team self-identify as HIV Positive. PLWHAs have also contributed by participating

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in the Statewide Needs Assessment, on focus groups, serving on Consumer Advisory Boards, as well as participating at the Stakeholder meetings held in each of the five (5) Counties that will be affected by the plan. There are several robust peer-driven navigation and prevention programs as well as focus groups that contribute greatly to PLWH involvement on many different levels. These PLWHAs have helped us identify what is working well, areas for improvement, barriers to accessing prevention and patient care services, as well as helping to develop our Unmet Need matrix. Further, they have participated widely in providing feedback to the planning bodies by attending various “town hall” or Stakeholder meetings that have helped us develop goals and improve service delivery around Eligibility, Case Management, High-Impact Prevention, Pre-Exposure Prophylaxis (PrEP), ADAP and many of the other services that comprises the service delivery system. They have also played a key role in the success of the Medical Monitoring Project (MMP) in Florida by willingly volunteering their time to be interviewed for this significant program. Proposed changes in local policies are reviewed and feedback is provided by each of the planning bodies as well as the Caucus.

c. Describe Methods to Engage Communities

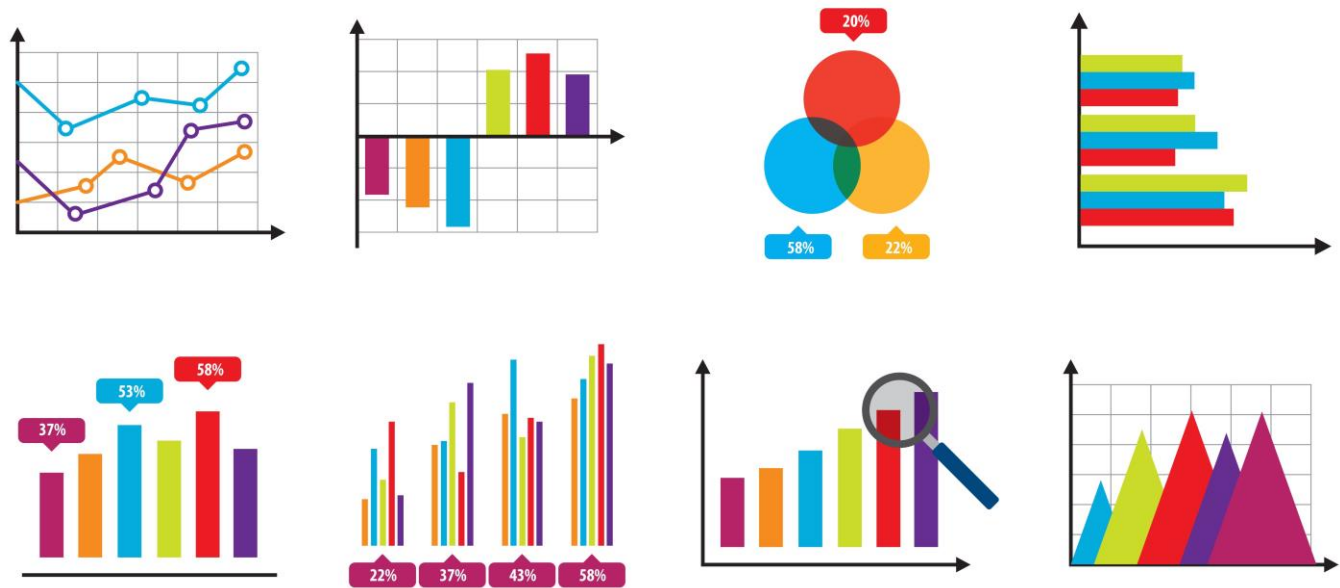
The development of a Workgroup/writing team that reflected the epidemic, the use of Stakeholder meetings in each of the five Counties as well as focus groups were different methods employed by the Orlando Service Area to engage all communities in the development of the Plan. The biggest challenge has been to engage PLWHA who are not in care or to find those who have tested positive but not entered care; but that is not unique to this area. Many areas of the state have dedicated staff to find those lost to care and we work closely with our surveillance specialists to identify and re-engage those individuals.

d. Describe How Impacted Communities Are Engaged in the Planning Process

The Orlando Service Area is a diverse area where we strive to reach even the most marginalized and underserved. A “one size fits all” approach is not very effective, due to the language and cultural challenges presented by such diversity; therefore, much effort and resources have been put forth to engage all PLWHA, those most at-risk for becoming infected, as well as their families and support systems. There have been a number of focus groups conducted across the area to identify the needs of specific populations, such as the MSM, Youth, and Transgender communities.

SECTION III

Monitoring and Improvement



SECTION III: Monitoring and Improvement**SECTION III: Monitoring and Improvement****a. Describe the Process for Reporting on the Progress of the Plan****Implementation**

The Orlando Service Area employs a multi-pronged approach in evaluating its progress towards achieving its goals in the Comprehensive Plan, assessing the impact of EIIHA, improving the usage of Ryan White client level data, using data to monitor service utilization, as well as an outline of the Clinical Quality Management program.

The Evaluation and Comprehensive Plan Committees of the Planning bodies monitor the Comprehensive Plan goals during their regularly scheduled meetings. Both Committees meet every month of the year, and both make review of the Comprehensive Plan a part of their regularly conducted business. Both request data from the Recipients on a frequent basis to ensure it has the most current information possible to assist them in their duties.

In addition, the Planning bodies utilize Ryan White HIV/AIDS Program Services Report (RSR) data in Priority Setting and Resource Allocation. The Planning bodies will be able to incorporate this data, along with the rest of the data used during this process, to paint a more complete picture of service utilization on a more detailed level to improve the process.

The Recipients and Planning bodies will continue to authorize special studies, in addition to the yearly needs assessment process, to identify gaps and barriers in care, assess service delivery, and offer recommendations on improving care. These activities commence on a yearly basis by the middle of the year, and this year will be no different. Data from these special studies is presented to the committees and the Planning bodies on a yearly basis during the Priority Setting and Resource Allocation processes.

b. Describe the Plan to Monitor and Evaluate the Implementation of Goals and SMART Objectives

Specific activities are monitored within each strategy for the specific object tied to each goal. The outcomes of these are reflected in the data indicators which measures the progress being made toward addressing the overall objectives. These indicators are analyzed through data collection from various sources. Specific numerators and denominators for each indicator have been developed and distributed to providers to ensure consistency in methodology. Performance data is obtained from Provide and CAREWare reported by each network provider. Provider data is aggregated into a summary report by the Recipients. This aggregate data is shared with the Planning bodies and the CQM Steering Committee, Network Providers and other stakeholders on a quarterly basis. Corrective action plans are required by the Recipients from providers whose quarterly performance did not meet or exceed the established targets. A follow-up session is scheduled with the provider to monitor implementation and anticipated improvement. Providers who meet the outcome measures are encouraged to identify and sustain the practices that produce positive results.

SECTION III: Monitoring and Improvement**Key Performance Indicators**

	Goal 1: Reduce New HIV Infections.		Goal 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV.		Goal 3: Reduce HIV-Related Disparities and Health Inequities.		Goal 4: Determine and develop mechanisms to improve coordination across all planning bodies by 2021.
Strategic Goal	Indicator 1: Increase the percentage of people living with HIV who know their serostatus to at least 90% from the baseline of 84%.	Indicator 2: Reduce the number of new diagnoses by at least 10% from 845 at baseline to 760.	Indicator 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 80%.	Indicator 6: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 65% from the baseline of 59%.	Indicator 7: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.	Indicator 9: Reduce disparities in the rate of new diagnoses by at least 10% in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States.	
Audience	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts
Key Performance Question	How effective is our screening process?	How effective is our prevention effort?	How effective are we in getting HIV+ individuals into care?	How effective are we in suppressing VL?	How effective are we in housing HIV+ individuals?	How effective are we in serving populations experiencing disparities?	How effective are we in coordinating our services?
How will this indicator be used?	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the National HIV Goals. Will be used to measure progress across all RW Parts.	Aligns with the National HIV Goals. Will be used to measure progress across all RW Parts.
Indicator Name	Know Status	Newly Diagnosed	Linked	Virally Suppressed	Homeless	Disparities	Coordination
Data Collection Method	Provider reporting statistics to	Provider reporting statistics to	Provider reporting statistics to	Provider reporting statistics to	Commission on Homelessness	Provider reporting statistics to	Coordination activities

b. Describe the Plan to Monitor and Evaluate the Implementation of Goals and SMART Objectives

SECTION III: Monitoring and Improvement

	FL DOH	FL DOH	FL DOH	FL DOH	surveys	FL DOH	
Assessment / Formula / Scale	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 1-6 scale.
Targets and Performance Thresholds	From 84% to 90% by 2021	From 845 to 760 by 2021	80% by 2021	From 59% to 65% by 2021	To no more than 5% by 2021	By at least 10% by 2021.	By at least 3 points achieved by 2021.
Source of Data	FL DOH data reports	FL DOH data reports	FL DOH data reports	FL DOH data reports	Commission on Homelessness	FL DOH data reports	Workgroup meeting minutes
Data Collection Frequency	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly
Reporting Frequency	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly
Data Entry	Work group	Work group	Work group	Work group	Work group	Work group	Work group
Revision Date	Annual	Annual	Annual	Annual	Annual	Annual	Annual

c. Describe the Strategy to Utilize Data and Improve Health Outcomes

To improve the HIV-related clinical quality health outcomes of PLWHA in the Orlando Service Area, the Recipients work with staff to ensure that the outcome data is coded correctly and that it accurately reflects the improvement trends in the data. In addition to the HAB core metrics, the Orlando Service Area will work with Recipient staff to customize outcome measurement reports so that aggregate reports can be obtained directly from the Provide ENTERPRISE and CAREWare databases. The QM team works to champion outreach coordination, increasing the visibility and access to care of hard to reach populations in our Orlando Service Area by developing and implementing specific targeted strategies.

The mission of the Clinical Quality Management (CQM) Program is to provide core medical and support services for eligible individuals with HIV/AIDS to achieve their medical outcomes as defined by Orlando Service Area. The program seeks to further develop and expand systems of care to meet the needs of PLWHA. The vision of the CQM Program is to be progressive, maximizing collaboration, efficiency and innovation in improving health outcomes to meet the needs of Persons Living with HIV/AIDS (PLWHA) within the Orlando Service Area with seamless access to quality care while reducing HIV infection, stigma and discrimination in high-risk communities against PLWHA. The goal of the CQM program is to provide the best care possible, for every consumer at every site, every day. Overall, the processes ensure that Primary Medical Care services are provided in accordance with the Department of Health and Human Services (DHHS) treatment guidelines and standards of care so that we may 1) reduce the number of people who become infected with HIV, 2) increase access to care and optimize health outcomes for people living with HIV, and 3) reduce HIV-related health disparities.

The overall responsibility for oversight and management of quality management (QM) activities rests with the Recipient's CQM team. This team is responsible for planning, directing, coordinating and improving healthcare services in the EMA. This CQM Team facilitates the implementation of the work plan associated with the QM Plan and relevant activities described in the Comprehensive Plan. This team is responsible for the development and deployment of system-wide quality initiatives and is responsible for conducting ongoing clinical quality

SECTION III: Monitoring and Improvement

assurance activities including programmatic and administrative reviews of service providers to ensure service delivery quality.

The Part A Recipient Administrator is the chairperson of the CQM Steering Committee, an advisory board directing and providing an oversight role in the implementation, monitoring and evaluation of the CQM Program and the development of the QM Plan. The Quality Management Steering Committee (QMSC) meets quarterly. The Recipient Administrator authorizes the Steering Committee to oversee the development of data-driven plans and measures prior to implementing performance improvement strategies throughout the provider network. The Recipient Administrator reports quality management findings, utilization data reports, special studies, evaluation of outcomes and indicators from all service categories, emerging issues and progress to the Planning bodies.

The internal process that assesses the Clinical Quality Management (CQM) Program is the “Quality Council” or Evaluation Committee of the Planning bodies and the CQM Steering Committee. Each of these committees consist of stakeholders and expert volunteers that provide oversight of the CQM Program by reviewing clinical outcome data and making recommendations and providing feedback during periodic scheduled reporting and update forums.

In addition, the QM team participates in a Regional Quality Management Meeting and facilitates the service coordination with emphasis on coordination with prevention, given new EIIHA requirements, with an EIIHA Strategy Meeting. The QM team participates in the Resource Allocation Process by providing outcome and utilization data for decision making.

SECTION IV

SECTION IV

Submission and Review Process



SECTION IV: Submission and Review Process

SECTION IV: Submission and Review Process

The Integrated HIV Prevention and Care Plan for the Orlando Service Area will be submitted to Tallahassee by May 16, 2016 to be included as a Chapter in the State Plan. Once the State Plan is completed then the Orlando EMA will submit the State Plan to HRSA for review.

APPENDIX A

APPENDIX A

Letter of Concurrence



LCDR Anderson A. Tesfazion, US Public Health Service
Public Health Analyst, Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, 09W-13D
Rockville, Maryland 20857

Dear Mr. Tesfazion:

The HIV Health Services Planning Council and the Central Florida AIDS Planning (CFAP) Consortium **concurs** with the following submission by the Orlando Service Area (Brevard, Lake, Orange, Osceola, and Seminole Counties) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Planning Council and Consortium have reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Planning Council and Consortium **concurs** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Consortium for Area 7 and the HIV Health Services Planning Council for the Orlando Eligible Metropolitan Area (EMA) established a collaborative Integrated Plan Writing Team which consisted of members of the Planning Council, CFAP members, the Area 7 HIV/AIDS Program Coordinator (HAPC) - the Ryan White Part B Recipient's Area 7 Representative, representatives from the Area 7 Lead Agency, representatives from the Ryan White Part A Recipient's office, Ryan White Parts C and D representatives, Housing Opportunities for People with AIDS (HOPWA) representative, mental health and substance abuse providers and prevention providers as well as consumers. The composition of the Writing Team was reflective of the East Central Florida epidemiology and was responsible for drafting the Integrated Plan. The Draft Plan was presented to the full Planning Council and Consortium membership monthly for discussion and feedback. Feedback received was incorporated into the Plan and the final draft of the Plan was presented to each body for a 30-day review at their respective March meeting and posted on each body's website. The 2017-2021 HIV Integrated Prevention and Care Plan for the Orlando Service Area was adopted on April 14, 2016 by the CFAP Consortium and by the Planning Council on April 27, 2016.

The signatures below confirm the **concurrence** of the planning bodies with the Integrated HIV Prevention and Care Plan.

Shirley Lanier, HIV Health Services Planning Council Chair

5/9/2016

Date

Karen Jaeger, CFAP Consortium Patient Care Chair

4-26-16

Date

John Curry, CFAP Consortium Prevention Chair

4-26-16

Date

Tampa/St. Petersburg (Hernando, Hillsborough, Pasco, and Pinellas Counties)



May 4, 2016

LCDR Daniel S. Baker, RD
Public Health Analyst
U.S. Department of Health and Human Services (DHHS)
Health Resources and Services Administration (HRSA)
HIV/AIDS Bureau (HAB)
Division of Metropolitan HIV/AIDS Programs (DMHAP) - Southern Branch
5600 Fishers Lane, Room 09W-13A
Rockville, Maryland 20852

Dear Mr. Daniel S. Baker:

The West Central Florida Ryan White Care Council (Care Council) **concurs** with the following submission by the Hillsborough County Board of Commissioners, as the Ryan White Part A Recipient for the Tampa-St. Petersburg EMA, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Care Council has reviewed the Integrated HIV Prevention and Care Plan Submission to the CDC, through its inclusion as a chapter of the *State of Florida Integrated HIV Prevention and Care Plan*, and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Care Council **concurs** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements set forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Care Council organized a writing team for the Integrated Plan, including Council members, Recipient staff, Part B lead agency staff, Care Council support staff, and the Co-Chairs of the Area 5, 6, and 14 HIV Planning Partnership (HPP). Sections of the Plan were presented at the Planning and Evaluation Committee, then sent to the full HPP membership for input and review, revised, and then presented to the full Care Council for approval. The Integrated Prevention and Care Plan was voted on for concurrence at today's full meeting of the Care Council.

The signature below confirms the **concurrence** of the West Central Florida Ryan White Care Council with the Tampa-St. Pete Integrated HIV Prevention and Care Plan.

Sincerely,

Martin Clemmons, Jr.
Chair, West Central Florida Ryan White Care Council

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

**Rick Scott**

Governor

Celeste Phillip, MD, MPH

Interim State Surgeon General

Vision: To be the Healthiest State in the Nation

May 4, 2016

LCDR Daniel S. Baker, RD
Public Health Analyst
U.S. Department of Health and Human Services (DHHS)
Health Resources and Services Administration (HRSA)
HIV/AIDS Bureau (HAB)
Division of Metropolitan HIV/AIDS Programs (DMHAP) - Southern Branch
5600 Fishers Lane, Room 09W-13A
Rockville, Maryland 20852

Dear Mr. Daniel S. Baker:

The Area 5, 6, and 14 HIV Planning Partnership (HPP) **concurs** with the following submission by the Hillsborough County Board of Commissioners, as the Ryan White Part A Recipient for the Tampa-St. Petersburg EMA, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The HPP has reviewed the Integrated HIV Prevention and Care Plan Submission to the CDC, through its inclusion as a chapter of the *State of Florida Integrated HIV Prevention and Care Plan*, and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Area 5, 6, and 14 HIV Planning Partnership **concurs** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements set forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The HPP members were sent draft sections of the Plan developed by the West Central Florida Ryan White Care Council for input prior to their being approved by the Care Council. The Co-Chairs of the HPP were also members of the Integrated Plan writing team for the Tampa-St. Pete EMA. The Integrated Prevention and Care Plan was voted on for concurrence at today's full meeting of the HPP.

The signatures below confirm the **concurrence** of the Area 5, 6, and 14 HIV Planning Partnership with the Tampa-St. Pete Integrated HIV Prevention and Care Plan.

Sincerely,

Michelle McKinney
Linkage to Care Coordinator
University of South Florida – Dept. of Pediatrics
and
Community Co-Chair
Area 5, 6, and 14 HIV Planning Partnership

Jim Roth
HIV/AIDS Program Coordinator
Florida Dept. of Health – Hillsborough County
and
Dept. of Health Co-Chair
Area 5, 6, and 14 HIV Planning Partnership

Florida Department of Health

Hillsborough County • HIV/AIDS Program Office
1105 E. Kennedy Blvd. • Tampa, FL 33602
PHONE: (813) 307-8015 • FAX: (813) 276-2839

www.FloridasHealth.com

TWITTER: HealthyFLA

FACEBOOK: FLDepartmentofHealth

YOUTUBE: fldoh

INTEGRATED HIV PREVENTION AND CARE PLAN
TAMPA- ST. PETERSBURG ELIGIBLE METROPOLITAN AREA
CY 2017-2021

SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED / NEEDS ASSESSMENT

Introduction

The Tampa- St. Petersburg Eligible Metropolitan Area (EMA) is located on the west central coast of Florida. It includes Hernando, Hillsborough, Pasco and Pinellas Counties.

Local partner agencies have a rich history of collaborating on HIV prevention, surveillance, care, and treatment issues throughout the Tampa-St. Petersburg EMA. This Integrated Prevention and Care Plan was written by the Tampa- St. Petersburg EMA in conjunction with the Part A Recipient, Part B Lead Agency, and the local prevention and patient care planning bodies. It will be included as a Chapter of the larger Integrated Plan for the State of Florida.

Subsequent to the writing of this Plan, the epidemiological data for 2014 was measurably adjusted (lowered) by the State of Florida. The data adjustment is currently under discussion between the State and the Federal Government. The Tampa- St. Petersburg EMA is using the un-adjusted data in the Plan. The EMA will update all epidemiological data, if needed, once a resolution is reached and all data is finalized.

A. Epidemiologic Overview

Geographic Region

The Tampa-St. Petersburg Eligible Metropolitan Area (EMA)'s total population is approximately 2.8 million, of which 66% are White (non-Hispanic), 18% are Hispanic and 12% are Black (non-Hispanic). Women represent 51.5% of the total population. The image below depicts the geographic layout of the EMA.

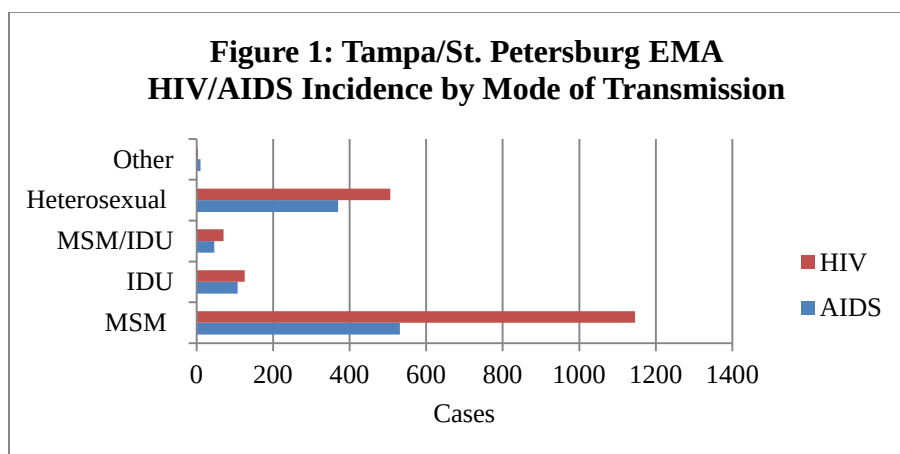


Socio-demographic Characteristics

The following data provides a description of the socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, and persons at higher risk for infection. This information is used by the local area to set priorities, identify interventions and services, and to allocate resources to HIV prevention to care. This overview focuses on the most recent year for which data is available.

The socioeconomic status of individuals living in the EMA varies greatly throughout the four county area. According to the Florida Department of Health's 2013 Division of Public Health Statistics and Performance Management Report, the median household income of residents living in Hillsborough and Hernando Counties is roughly \$35,500 compared to the higher median household income of Pinellas (\$45,500) and Pasco Counties (\$43,900). The percentage of individuals living below the federal poverty level ranges from 13.9% in Pasco County to 16.8% in Hillsborough County. The percentage of adults in each county who have any type of health care insurance ranges from 80.2% in Pinellas to 87.2% in Hernando. The percentage of EMA residents over the age of 25 with a high school diploma is 86.4% and 23% of persons over the age of 25 possess a bachelor's degree or higher.

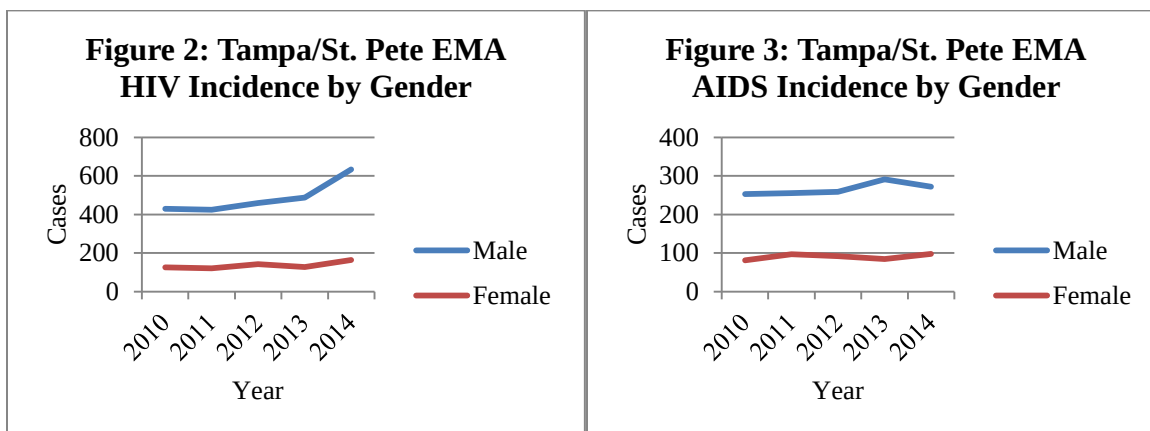
According to the Florida Department of Health's Epidemiological Profile, the incidence of HIV in the EMA has risen 44% since 2010. New cases of AIDS have increased 11% since 2010. The most common mode of transmission for HIV and AIDS in the EMA is men who have sex with men (MSM) followed by heterosexual transmission and, injection drug use (IDU). A visual account of the different modes of transmission of HIV and AIDS from 2012-2014 follows in Figure 1:



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

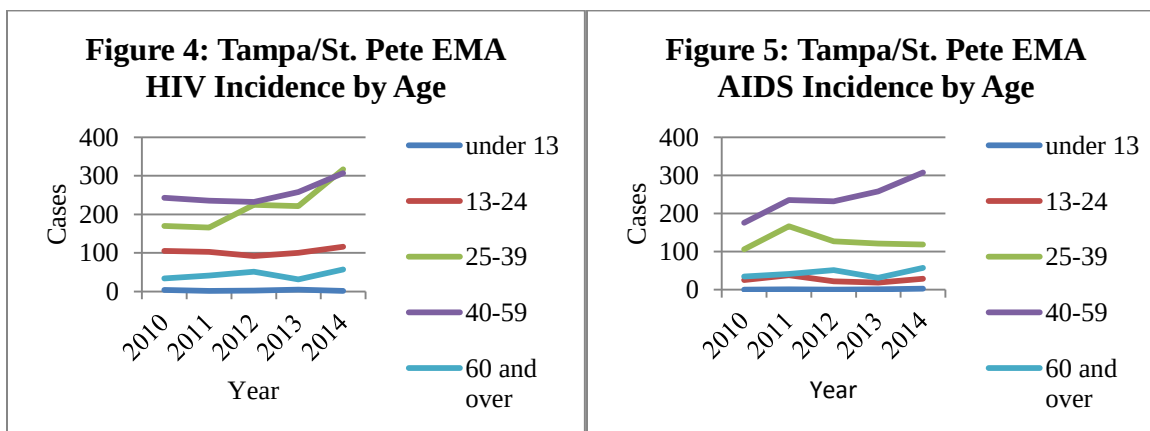
Figure 1 shows the highest mode of transmission for newly diagnosed individuals living with HIV/AIDS is MSM with 531 new cases of AIDS and 1,146 new cases of HIV. Heterosexual contact accounts for 370 new AIDS cases and 506 new HIV cases. IDU transmission is the third highest mode of transmission with 126 HIV cases and 107 AIDS cases.

The gender, age, and race/ethnicity of new HIV and AIDS cases in the EMA from 2010-2014 are detailed below in Figures 2-7:



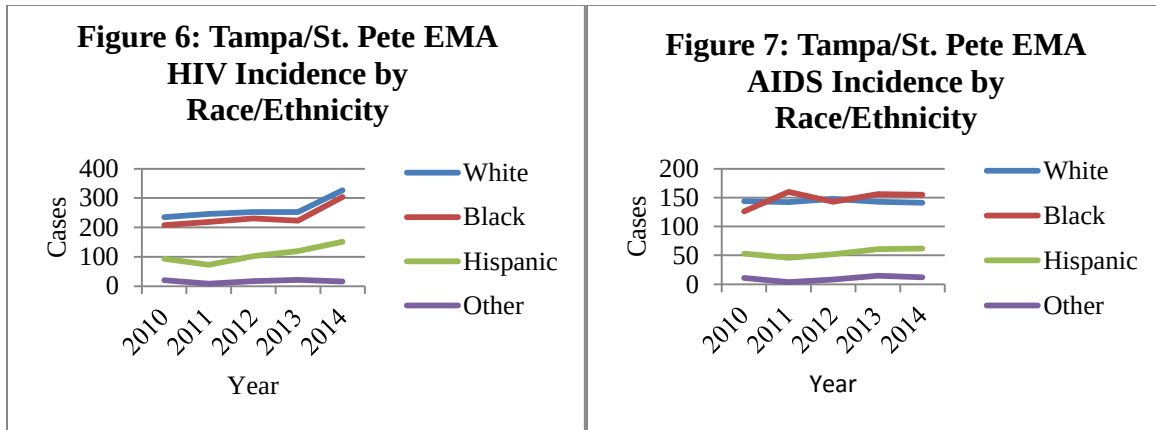
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

The incidence of HIV has increased from 430 cases in 2010 to 634 cases in 2014 among males in the EMA. This represents a 47% increase. During the same time frame, female cases increased from 126 to 164, a 30% increase. The incidence of male AIDS cases increased 7%, from 253 to 272 cases. The incidence of female AIDS cases increased 21% from 81 to 98 cases.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

The 40-59 age group experienced the highest increase in new AIDS cases from 2010 to 2014 at 75%. The same age group experienced a 26% increase in new HIV cases. The 25-39 age group had the highest rate of new HIV cases, increasing from 170 cases in 2010 to 317 cases in 2014. This represents an 86% increase.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

The past 5 years presented an increase in the incidence of HIV for Whites, Blacks, and Hispanics in the EMA. The incidence has risen 40%, 46%, and 62% respectively. From 2010 to 2014, the incidence of AIDS among Blacks in the EMA has risen 23%. The incidence of AIDS among Hispanics in the EMA has risen 17% during the same time from. The incidence of AIDS among Whites in the EMA has remained the same.

Burden of HIV

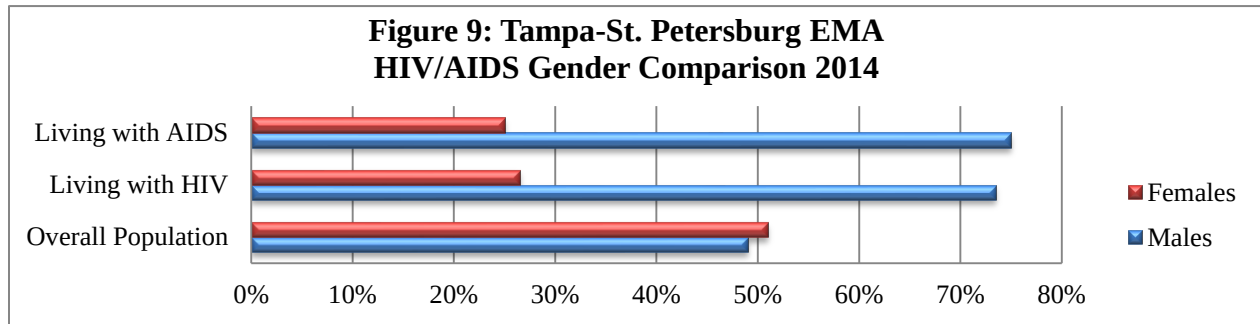
Total HIV and AIDS cases are on the rise in the Tampa/St. Petersburg EMA. The number of persons living with HIV in the EMA has increased 12% since 2010. The prevalence of AIDS has increased 15% since 2010. A table of the incidence and prevalence of HIV and AIDS in the EMA over the past five years is detailed in Figure 8.

Figure 8: Tampa/St. Petersburg EMA Epidemiological Profile

	CY 2010		CY 2011		CY 2012		CY 2013		CY 2014	
	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence
HIV	556	4,688	658	4,448	602	4,392	615	4,674	798	5,260
AIDS	334	5,986	352	5,820	351	5,953	375	6,187	370	6,898
TOTAL	890	10,674	1,010	10,268	953	10,345	990	10,861	1,168	12,158

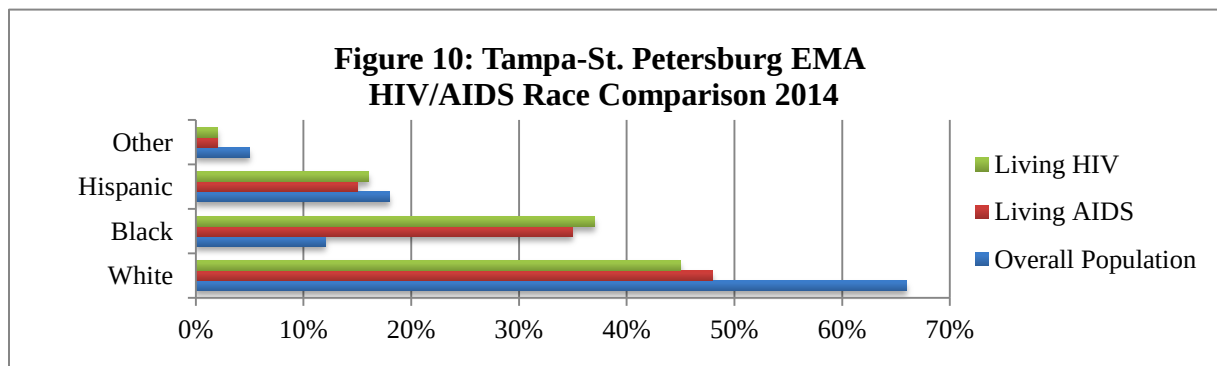
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

In 2014, men represented 73.5% and 75% of HIV and AIDS cases respectively. In the EMA, men comprise approximately 49% of the population but disproportionately represent a majority of HIV and AIDS cases. Women represented 26.5% and 25% of HIV and AIDS cases respectively.



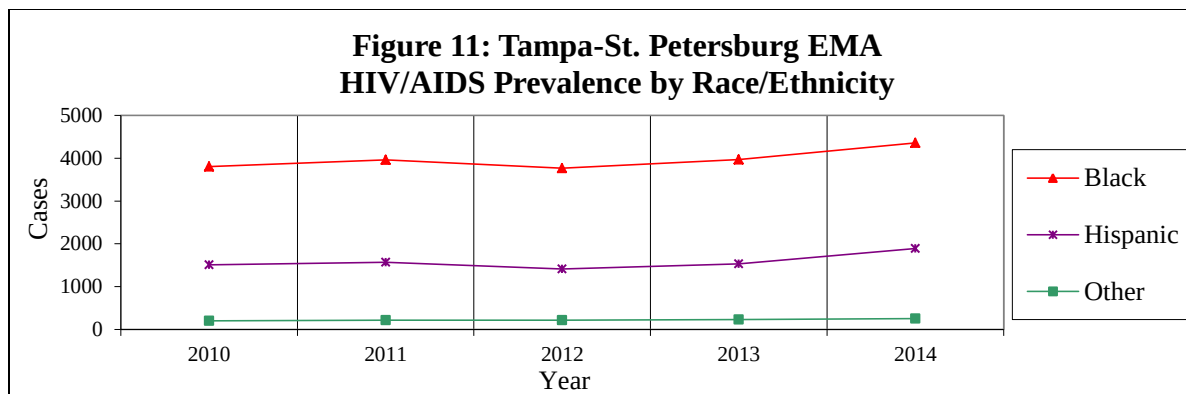
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

The 2014 calendar year saw only minor shifts in demographics of HIV and AIDS prevalence. Whites in the EMA represented two thirds of the population and have the highest percentage of HIV cases at 45%. Blacks account for 37% and Hispanics represent 16% of HIV cases. Whites represent the largest prevalence of AIDS cases in the EMA with 48% followed by Blacks with 35% and Hispanics with 15%. Blacks were disproportionately impacted by HIV/AIDS because although Blacks made up only 12% of the population within the EMA in 2014, they represented 37% of HIV cases and 35% of the AIDS cases.



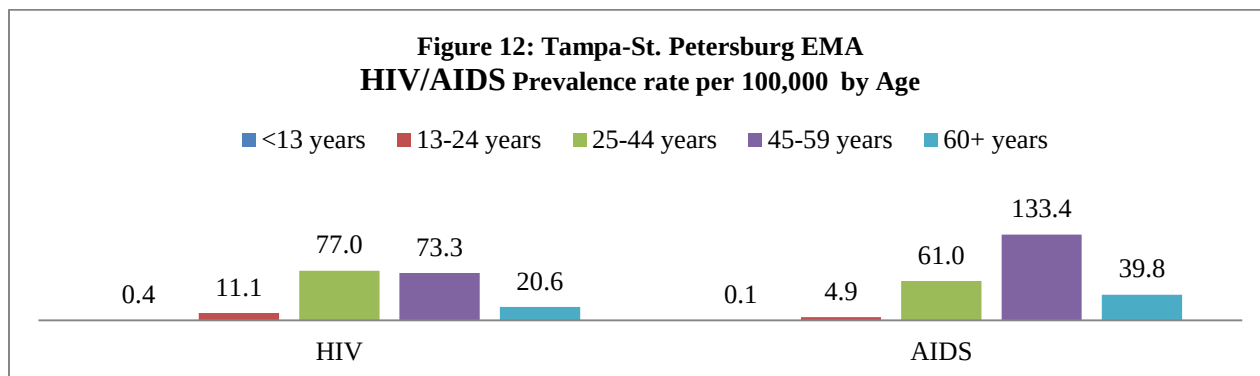
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Overall, the past 5 years presented an increase in HIV/AIDS prevalence in every race/ethnicity category. Hispanics in the EMA saw the greatest increase in HIV/AIDS prevalence, from 1,531 cases in 2010 to 1,892 cases in 2014.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

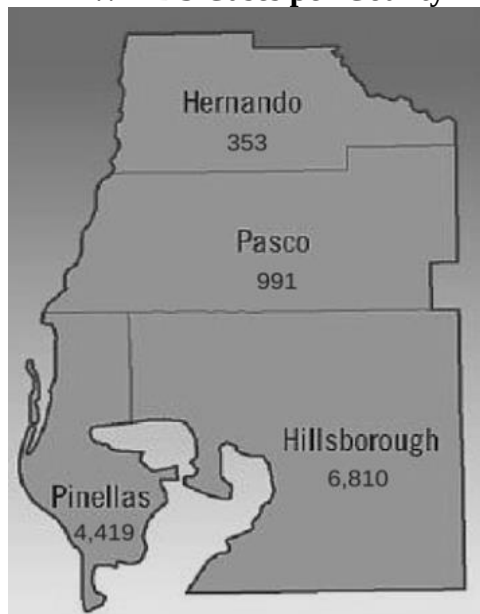
The 45-59 age group had the largest rate of AIDS prevalence reported at 133.4 per 100,000, followed by the 25-44 age group at 61.0. HIV prevalence rate was highest in the 25-44 age group at 77.0 per 100,000, followed by 45-59 age group at 73.3.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Figure 13 depicts the presumed living HIV/AIDS cases in each of the EMA's four counties as of 9/30/15. The EMA's urban counties (Hillsborough and Pinellas) experience a greater number of HIV/AIDS cases compared to the rural counties (Hernando and Pasco).

**Figure 13:
Tampa-St. Petersburg EMA
HIV/AIDS Cases per County**



Source: Florida Department of Health, Monthly Surveillance Report, October 2015

Indicators of Risk

The various indicators of risk for the EMA are identified by exposure category in Figure 14. Other indicators of risk are considered to be: HIV testing, unwanted sexual experiences, healthcare-seeking behaviors, and sexually transmitted infections such as Chlamydia, Syphilis and Gonorrhea.

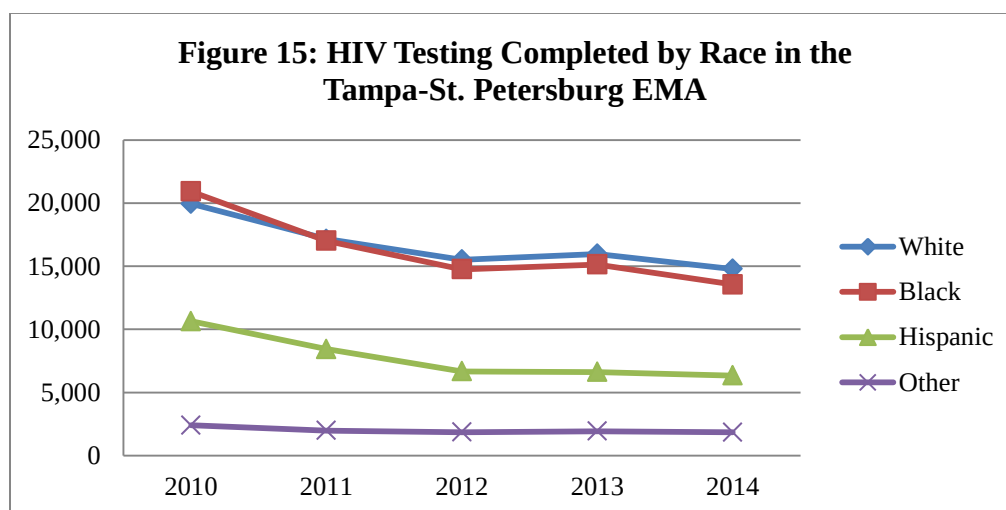
Figure 14 highlights possible HIV exposure categories as acknowledged by individuals while getting tested. Over a five year period (2010-2014), the highest tested exposure category is heterosexual contact. The second highest exposure category is STD diagnosis, followed by Men who have Sex with Men (MSM). Although the heterosexual exposure category had the highest number of tests, MSM had the highest number of positive tests in the 2010 – 2014 timespan.

Figure 14: Testing in the EMA by Possible Exposure Category

Exposure Category	2010		2011		2012		2013		2014	
	Number of Tests	Positive Tests	Number of Tests	Positive Tests	Number of Tests	Positive Tests	Number of Tests	Positive Tests	Number of Tests	Positive Tests
MSM/IDU	181	15	148	22	178	18	240	19	250	18
MSM	3,198	249	3,600	234	3,752	226	4,456	220	4,514	215
IDU	2,768	27	2,861	25	2,699	20	3,012	24	3,076	20
Sexual Partner at Risk	1,625	88	2,353	98	2,724	48	2,404	67	1,822	78
Child of Women with HIV/AIDS	142	2	122	1	89	4	54	0	10	0
STD Diagnosis	9,975	45	8,564	38	7,806	37	7,524	31	7,873	37
Sex for Drugs or Money	409	3	408	4	337	2	316	4	262	4
Hemophilia/ Blood Recipient	0	0	0	0	0	0	0	0	0	0
Victim of Sexual Assault	1,485	7	1,388	7	1,187	10	567	4	150	1
Health Care Exposure	900	7	0	0	0	0	0	0	0	0
Heterosexual	29,536	106	23,272	75	18,089	76	18,712	67	16,617	79
No Acknowledged Risk	700	0	421	1	384	5	413	4	1,491	8
Unknown	2,976	21	1,429	12	1,539	20	1,957	15	447	1
Total	53,895	570	44,566	517	38,784	466	39,655	455	36,512	461

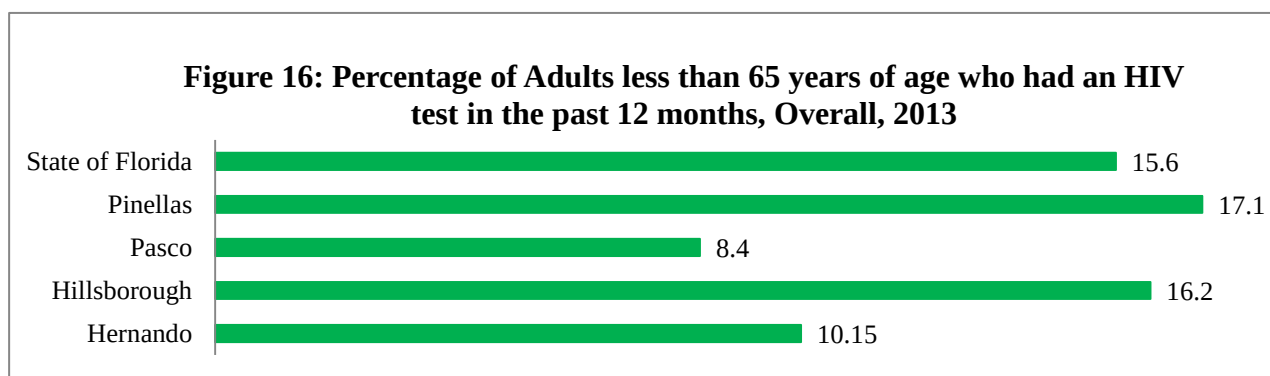
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Figure 15 depicts HIV testing in the Tampa- St. Petersburg EMA from 2010-2014. It indicates a general decrease in testing by all races. Although all races were tested in high numbers in 2010, there has been a decrease for the subsequent four years.



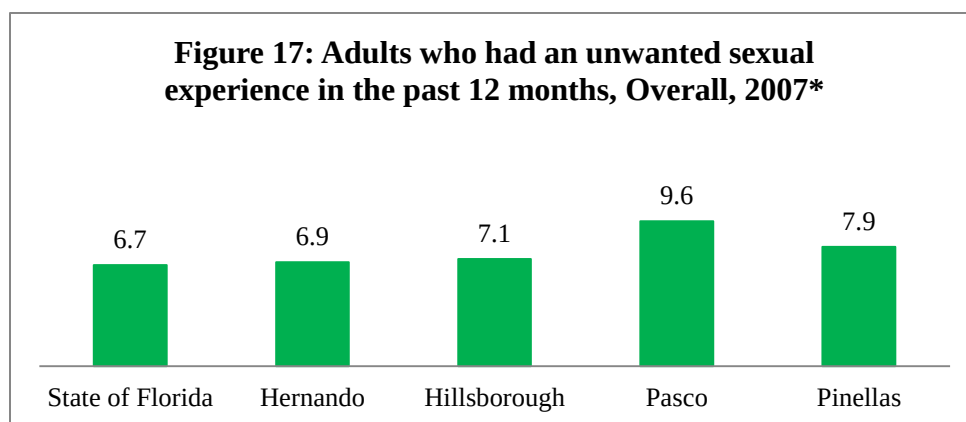
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Illustrated in Figure 16 is the percentage of adults less than 65 years of age who have had a HIV test in the past 12 months. Two of the counties in the EMA, Pasco and Hernando, have significantly lower testing rates compared to the state. Pasco County has a testing rate of 8.4% and Hernando County has a testing rate of 10.15% compared to the state's rate of 15.6%.



Source: Florida Behavioral Risk Factor Surveillance System County-level telephone survey conducted Centers for Disease Control and Prevention (CDC) and Florida Department of Health Bureau of Epidemiology.

Figure 17 shows that all parts of the Tampa – St. Petersburg EMA have higher rates than the State of Florida for Adults who had an unwanted sexual experience in the past 12 months in 2007. Pasco County has that highest rate at 9.6% almost a full 3% higher than the state of Florida.

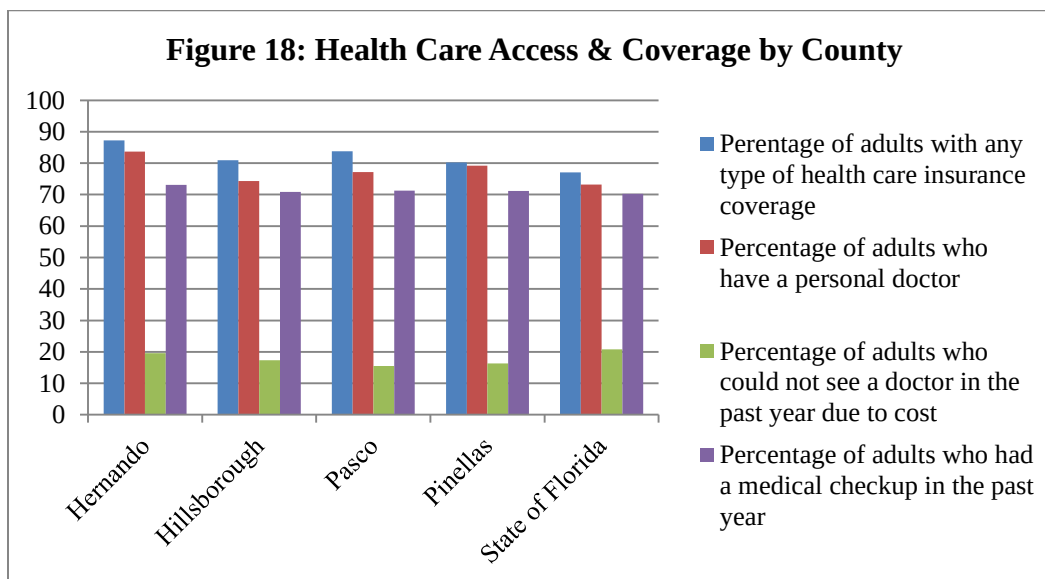


*2007 is the most current survey on unwanted sexual experience in the past 12 months.

Source: Florida Behavioral Risk Factor Surveillance System county-level telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Bureau of Epidemiology.

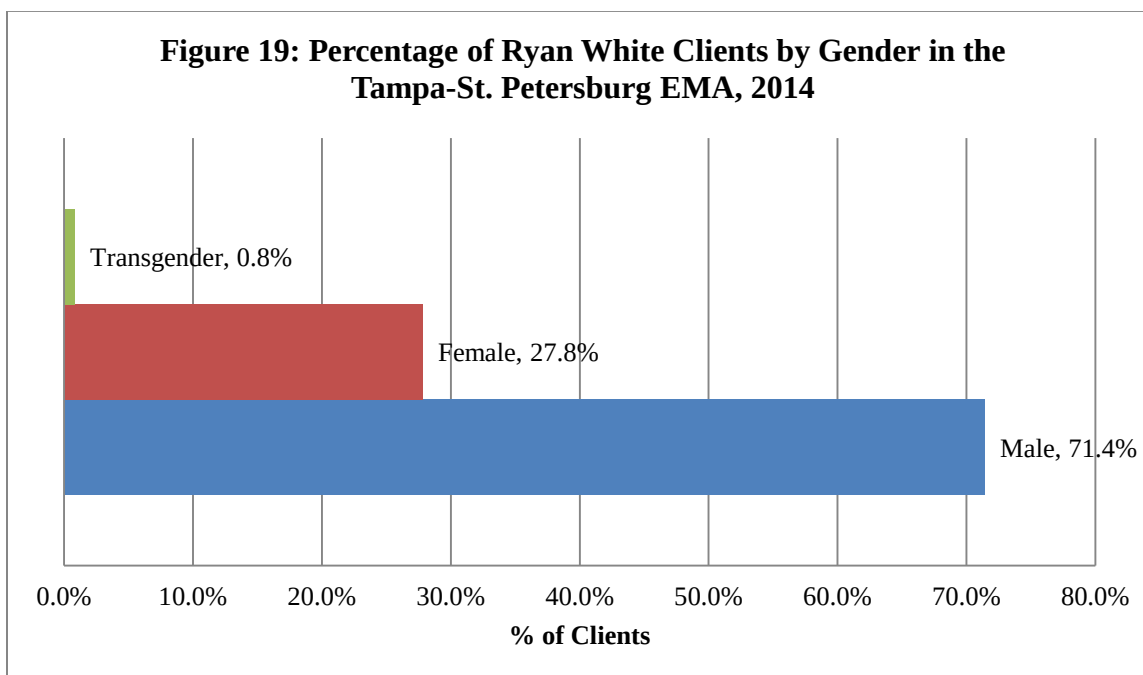
Figure 18 depicts the healthcare-seeking behavior for individuals in the EMA. All counties in the EMA are just above the State of Florida for adults with any type of health care insurance coverage. Although at least 80% of adults in the EMA have some type of health insurance,

15.5% - 19.6% of adults are not able to see a doctor due to cost, and 70.9% - 73.1% of adults have had a medical checkup in the last year.



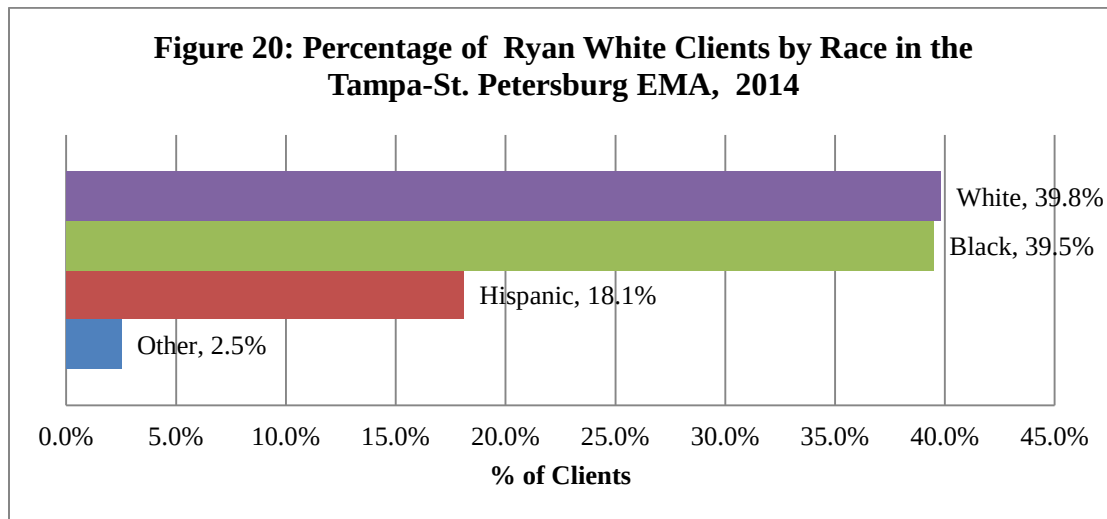
Source: Behavioral Risk Factor Surveillance System (BRFSS), 2013 County Level Reports.

Figures 19, 20, and 21 depict Ryan White HIV/AIDS Program Services Report (RSR) data for calendar year 2014. The data are representative of Ryan White providers in the Tampa – St. Petersburg EMA. The data are not Part-specific; that is, all tables include clients served across Ryan White HIV/AIDS Program (RWHAP) funding streams. These tables include RWHAP clients who are HIV-positive.



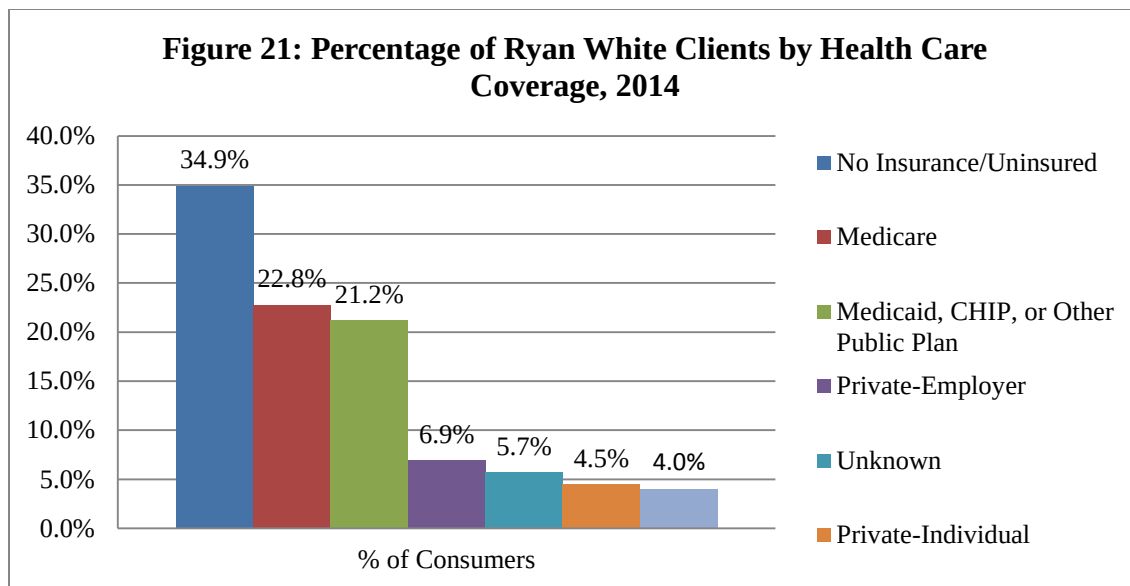
Source: Ryan White HIV/AIDS Program Services Report (RSR), Tampa-St. Petersburg EMA CY 2014.

The demographic characteristics of the EMA's RWHAP clients are similar to the overall prevalence of HIV/AIDS in the EMA by gender and race as highlighted in previous Figures 9 and 10. One disparity between those served by RWHAP and the HIV/AIDS prevalence in the community exists. Whites in the EMA account for 45% of HIV and 48% of AIDS cases yet are 39.8% of clients who receive RWHAP services. Ryan White utilization by gender as well as by Blacks and Hispanics are within 3.5% variance of the categories' respective prevalence in the EMA.



Source: Ryan White HIV/AIDS Program Services Report (RSR), Tampa-St. Petersburg EMA CY 2014.

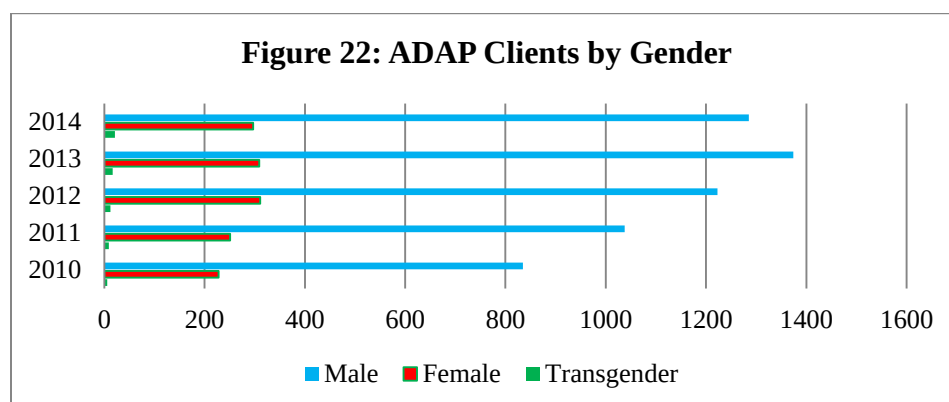
Figure 21 highlights RWHAP clients' health care coverage. Over one-third of clients have no health care coverage despite changes in the health care landscape in recent years. Over half of RWHAP clients are covered by some form of health care coverage.



Source: Ryan White HIV/AIDS Program Services Report (RSR), Tampa-St. Petersburg EMA CY 2014.

The percentage of Ryan White clients with a suppressed viral load (less than 200 ml/copies) in the EMA was 78% for calendar year 2015. The average viral load for clients in 2015 was 14,853 ml/copies. The average CD4 count was 588.74 cells/mm³. Approximately 57% of all RWHAP clients had a CD4 count of 500 cells/mm³ in 2015. This data was captured from Part A and Part B funded Outpatient Ambulatory Medical Care (OAMC) providers.

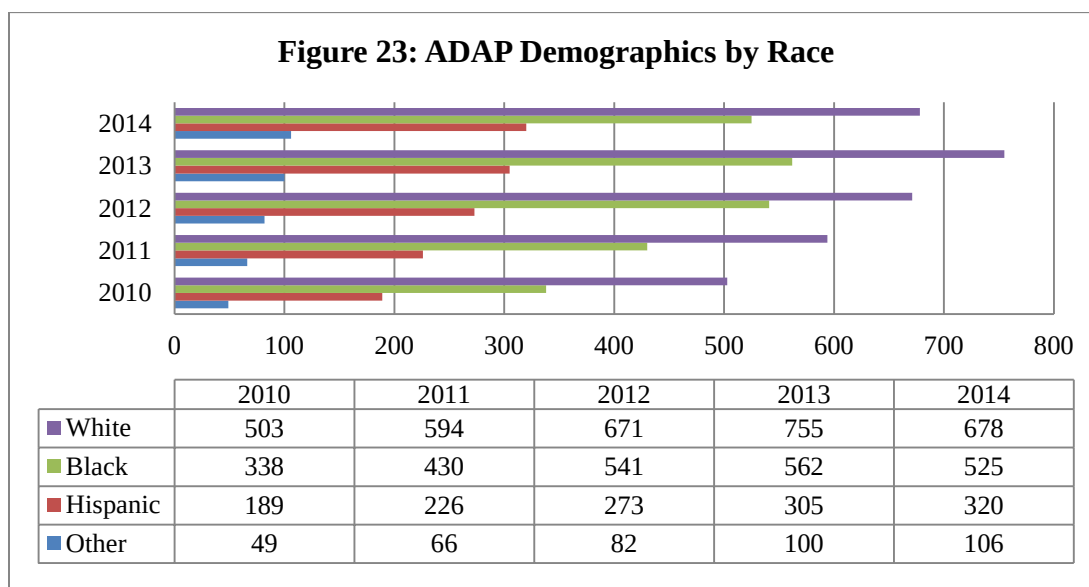
The Florida AIDS Drug Assistance Program (ADAP) provides AIDS-specific medications at no cost to residents who qualify. Figure 22 depicts ADAP clients by gender in the EMA. From 2010-2014 male clients are the majority of the clientele ranging from 78.11% - 80.82% of total clients. Females have ranged from 18.17% - 21.32% of clients and the remaining amount are Transgender. The transgender community utilizing ADAP services is slowly growing in the EMA from 0.56% - 1.31% of clients.



Source: Florida Department of Health, 2015.

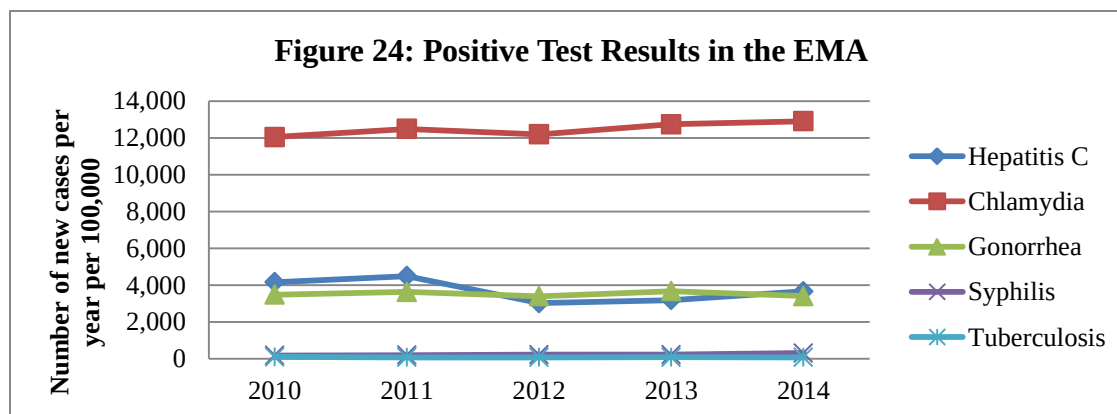
Demographic disparities exist in the EMA among racial and ethnic minorities with regards to accessing ADAP services. Minority populations represent a greater proportion of HIV/AIDS

cases within the EMA, but are accessing ADAP services in smaller numbers. Figure 23 shows the breakdown of ADAP clients by race. Since 2010 the number of Black clients enrolled in ADAP rose from 338 to 525, which is the largest increase among the races.



Source: Florida Department of Health, 2015.

Figure 24 shows that the EMA has had a steady increase of Chlamydia and Syphilis from 2010 – 2014. The rates have gone down for Tuberculosis, Hepatitis, and Gonorrhea in the same five year period. The positive test results indicate similar risky behaviors that have tested positive for HIV/AIDS.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Figure 25 represents the live births for the EMA. The Live Birth Rate is per 1,000 of the total population by year and separated by county of residence of the mother. The two counties that have the lowest birth rate in the EMA are Hernando and Pinellas with an average of 8.5 live births per 1,000 and 9.2 live births per 1,000.

Figure 25: Live Birthrate (per 1,000 of total population) for Tampa – St. Petersburg EMA, 2010-2014

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Hernando	8.5	9.0	7.9	8.5	8.4
Hillsborough	13.3	13.3	13.1	13.0	12.9
Pasco	10.3	10.1	10.0	10.1	10.0
Pinellas	9.2	9.0	9.2	9.3	9.2
State of Florida	11.4	11.3	11.2	11.1	11.2

Source: Florida Department of Health, 2015.

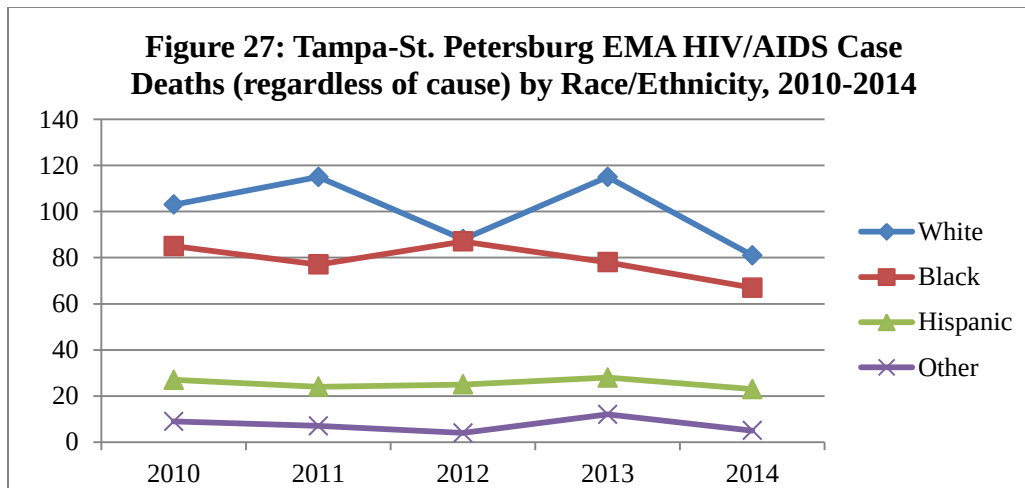
Figure 26 represents the Resident Age Adjusted Death rate per 100,000 population by year and by Residence County. In each year of the five year timespan the EMA has measured a higher age adjusted death rate than the state of Florida.

Figure 26: Resident Age Adjusted Death Rate (per 100,000 of total population) for Tampa – St. Petersburg EMA, 2010-2014

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Hernando	798.3	817.7	799.0	786.2	758.9
Hillsborough	735.3	723.0	748.7	750.3	745.8
Pasco	722.7	779.6	766.3	763.8	767.2
Pinellas	742.6	722.9	713.9	711.8	715.6
State of Florida	687.4	677.9	680.7	679.3	683.5

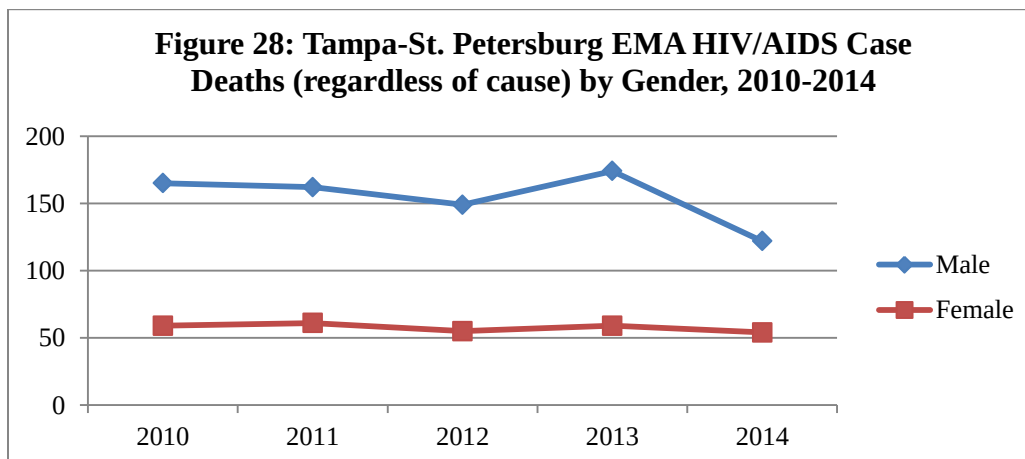
Source: Florida Department of Health, 2015.

Figure 27 shows the number of HIV/AIDS case deaths by race/ethnicity across the span of five years. All race/ethnicity categories experienced a lower number of deaths in 2014 compared to the preceding four years, with the exception of the year 2012 for the “Other” race/ethnicity category.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Figure 28 depicts the number of HIV/AIDS case deaths by gender across the span of five years. The largest drop in deaths for males occurred from 2013 to 2014, decreasing from 174 deaths in 2013 to 122 deaths in 2014. Female deaths have remained relatively stable among the last five years in the EMA.



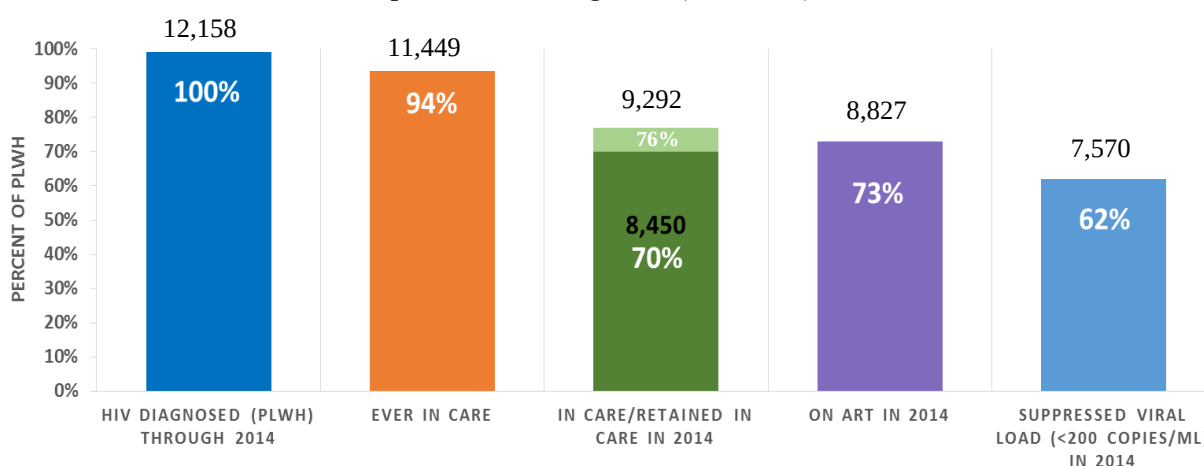
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Overall, the numbers of persons living with HIV have been on the rise in the Tampa – St. Petersburg EMA. Since 2010 the EMA’s incidence rate of HIV has risen 44% as previously indicated. By utilizing the indicators of risk the EMA can better plan where to focus its attention to decrease the number of persons living with HIV.

B. HIV Care Continuum

The following graph depicts the EMA’s HIV Care Continuum. The graph was developed using HIV/AIDS Surveillance data from the Florida Department of Health. Definitions and data sources for the Care Continuum are detailed in the “Data: Access, Sources, and Systems” section of this Integrated Plan. The diagnosed-based HIV Care Continuum approach was utilized as the estimated number of those who have not been diagnosed with HIV in the EMA is unavailable at this time.

**Figure 29: Number and Percentage of Persons Diagnosed and Living with HIV Engaged in Selected Stages of the Continuum of HIV Care
Tampa / St. Petersburg EMA (excl. DOC), 2014**

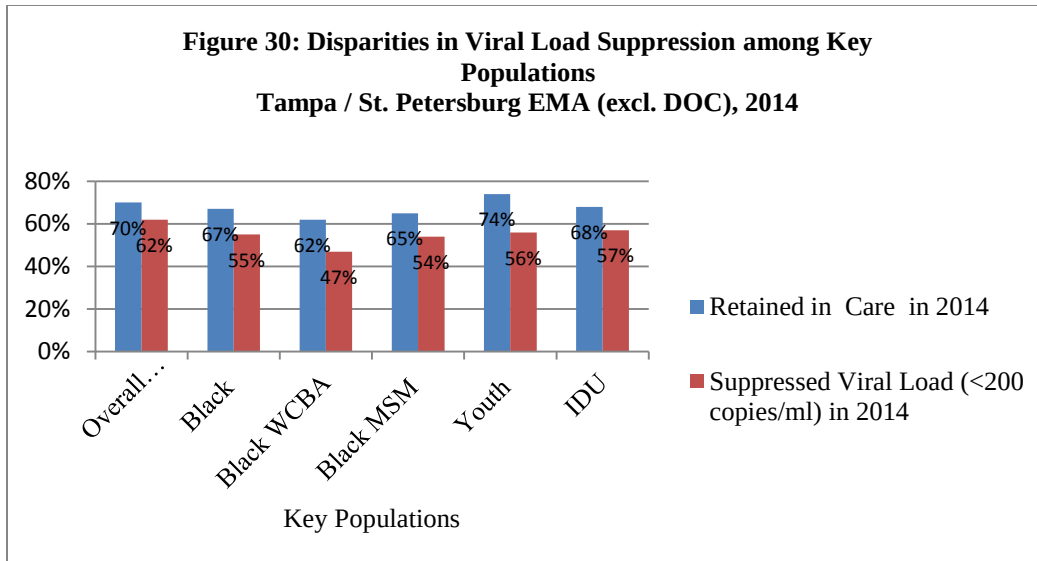


Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014.

*The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Disparities in Engagement among Key Populations

The EMA identified disparities among the following populations: Blacks, Black Women of Child Bearing Age (WCBA), Black Men who have Sex with Men (MSM), Youth 13-24 years old, and Injection Drug Users (IDU). When comparing the data for these populations to Tampa/St. Petersburg continuum of care data, it is apparent that these sub-populations have significantly lower rates of viral suppression. Data for subpopulations with very small numbers are not included in Figure 30 due to variability in percentages resulting from such small numbers. The EMA focuses resources on linkage, engagement, and retention in care programs for these populations. The EMA works with the local HIV Planning Partnership on joint efforts to address these disparities.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Using the Continuum in Planning, Prioritizing, Targeting, and Monitoring Resources

The EMA's Ryan White Planning Council incorporates the HIV Care Continuum into its prioritization and monitoring discussions. The Council's committees utilize the Care Continuum to assess community need and to analyze gaps in service. The Care Continuum is used as a reference tool in Planning Council meetings as well as its Planning and Evaluation, Resource Prioritization and Allocation Recommendations (RPARC), Women, Infant, Children, Youth and Families (WICY&F) committees. The planning process accentuates the need to fund categories such as medical case management that help navigate clients along the HIV Care Continuum. The Planning Council has full participation of those entities within the jurisdiction that constitute key points of access to the health care system for individuals with HIV/AIDS, from those that facilitate early intervention for individuals newly diagnosed with HIV/AIDS to those that reach out to individuals aware of their HIV status, but not in care. The EMA established linkages between the local HIV Planning Partnership and the Planning Council, which promotes comprehensive prevention and care planning activities.

Improving Engagement and Outcomes at Each Stage

The EMA utilizes an integrated service network that meets the following goals: coordination among service providers, seamless transition across levels of care and coordination of present and past treatment. The Ryan White Part A Program strives to accelerate improvements in HIV prevention and care and is firmly committed to improving access to all individuals living with HIV in the EMA. Without community partnerships, opportunities arise for clients to forgo HIV testing and engagement in care. Coordinated efforts address the needs of People Living with HIV/AIDS (PLWHA) across all life stages, from those unaware of their HIV status, through HIV counseling and testing, early intervention and linkage to care, retention in care, and treatment adherence to support improved health outcomes.

The following interventions are aimed at addressing the gaps along the HIV Care Continuum for each stage:

Diagnosed-

Public and private providers offer HIV testing to bring those unaware of their status into the continuum. Various coordinated Department of Health and Human Services (HHS) funding streams provide entry to the HIV Care Continuum in the EMA through any of the 57 Florida Department of Health licensed testing sites, hospital emergency rooms, private physician's offices, and outreach programs. Both confidential and anonymous testing are available. More than half of all HIV tests utilize rapid test technologies, allowing those clients who test preliminarily positive to learn their results in the same session.

Linked to Care-

The Florida Department of Health adopted a policy on April 11, 2013 to allow linking those clients testing preliminarily positive to a care provider without delay for confirmatory testing. For those sites not using rapid technologies, when a client returns for his or her lab confirmed results, the linkage to Ryan White eligibility and medical care begins. Ambulatory/outpatient medical care is available in all counties in the EMA. Early entry into care can have a positive impact on the overall length and quality of life of PLWHA. Each county in the EMA employs a Linkage to Care (LTC) Coordinator through the Department of Health to help address the needs of newly diagnosed individuals entering into the HIV Care Continuum. The LTC Coordinator receives a list of newly diagnosed individuals via the Patient Reporting Investigation Surveillance Manager (PRISM) database. The goal is to link these individuals to HIV care within 90 days of diagnosis. In addition, the LTC Coordinator works with the HIV Surveillance Data-to-Care project to determine if previously HIV positive individuals are engaged in medical care. The LTC Coordinator investigates whether or not the individual has received a CD4 count, Viral Load test, or HIV medical visit within the last year. If the person has no evidence of care, the LTC Coordinator contacts them and provides referrals for local providers and assistance with obtaining Ryan White eligibility.

Retained in Care-

Medical case management services are utilized to retain clients in care. These services are client centered with collaborations and linkages to health care, psychosocial, and other services to ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care. Services are available throughout the EMA and take place at the client's home, hospital, and clinic or provider offices.

Mental health services and substance abuse treatment are also utilized to keep clients retained in care. Feelings of anger, fear, guilt, denial and sadness can overwhelm a newly diagnosed person. Individuals who have lived with an HIV diagnosis for a long time also have to face additional stress in coping with the disease, and may have frequent episodes of bereavement following the loss of friends and family members. Pressure regarding who to disclose one's HIV status to, as well as the impact of HIV on establishing or maintaining close relationships can contribute to the need. Linkage to Care Coordinators throughout the EMA work to re-engage those clients who have fallen out of care through supported referrals and multi-session follow-up counseling for HIV-positive individuals.

Prescribed ART and Viral Load Suppression-

HIV-related medications are frequently accessed through the AIDS Drug Assistance Program (ADAP) and Medicaid. Ryan White also funds medication assistance, as do private insurance companies, the Veteran's Administration, and compassionate use programs provided by drug manufacturers. Policy changes, increased co-pays and formulary revisions make medications a service category with the potential for dramatic change and negative financial impact for the Ryan White program.

Ryan White Part A funds are utilized to cover HIV-related medications as well as other types of prescription drugs for treatment of various comorbidities. Regular adherence to ART is hindered if PLWHA are unable to treat comorbidities such as substance abuse, mental illness, and other chronic medical conditions. Regular adherence to medications play a significant role in maintaining health, quality of life, and achieving viral suppression for HIV infected individuals. Medications are the single largest expenditure in the treatment of HIV. In the EMA, medications represented 50.4% of the budgeted figures for all identified funding streams in 2013. This does not include payments for co-pays under the health Insurance Services Program (ISP) or the ADAP Premium Plus program.

The HIV Care Continuum model is used locally to identify issues and opportunities related to improving the delivery of services to PLWHA across the entire HIV Continuum of Care. The EMA utilizes the diagnosed-based HIV Care Continuum approach to capture a detailed image of where the EMA is in terms of moving PLWHA along the Continuum. The local area hopes to increase the overall percentage of persons with diagnosed HIV infection who are linked to care, retained in care, and virally suppressed.

C. Financial and Human Resources Inventory

This section provides an inventory of the financial and service delivery provider resources available in the Tampa-St. Petersburg EMA to meet the HIV prevention, care, and treatment needs of the population. The section describes CDC-funded high impact prevention services and HRSA-funded core medical and support services.

CDC-Funded High Impact Prevention Services

To ensure consistency throughout the state, the EMA implemented the *Florida Jurisdictional HIV Prevention Plan: 2015-2016 Update*. The target populations for high impact prevention interventions in the EMA include the following subset: White MSM 18-40, Black MSM 18-40, and Black Women of Childbearing Age (WCBA) 15-44. The primary interventions and activities include rapid HIV testing, active street outreach, condom distribution, testing in correctional facilities, faith-based initiatives, comprehensive prevention with positives, and prevention with high-risk negatives in the most populated areas. Testing in non-healthcare settings, behavioral interventions, social marketing, and partnerships with linkage to care programs are also direct and indirect prevention activities.

The three target populations were chosen by considering epidemiological data (both incidence and prevalence), unmet need estimates, and historical trending. In addition, the selection of these target groups was influenced by the Florida Department of Health's (FDOH) recent reports *HIV*

and AIDS Among Minorities in Florida; Man Up: the Crisis of HIV/AIDS Among Florida's Men; Organizing to Survive: the HIV/AIDS Crisis Among Florida's Women; and HIV and AIDS Among Adolescent and Young People in Florida. White MSM remain the largest special population in the EMA. From 2013 to 2014, White MSM showed a 39.7% increase in reported infections. FDOH estimates that 27% (n = 1,179) of White MSM PLWHA were not retained in care in the EMA in 2014.

Black MSM showed a 39.3% increase from 2013 to 2014 in reported HIV infection cases and a 6.6% increase in new AIDS cases during the same time period in the EMA. FDOH estimates that in 2014, 35% (n = 597) of this population were not retained in care. Black WCBA showed a 42.5% increase from 2013 to 2014 in reported HIV infection cases in the EMA. FDOH estimates that 38% (n = 287) of Black WCBA were not retained in care in the EMA in 2014.

One of the main opportunities for working with these populations is to improve linkage to care, engagement in care, and retention in care. Strengthening pre-test counseling sessions to make sure persons are ready for their results, to take action if positive, and educating on the benefits of early intervention are part of the plan to improve linkage to care rates and timeliness. FDOH has also dedicated a Linkage to Care Coordinator and a back-up in each county health department in the EMA. The FDOH in Hillsborough and Pinellas have also hired full-time HIV DIS (Disease Intervention Specialists) to improve the rates and timeliness.

Black MSM and WCBA benefit from the local MAI (Minority AIDS Initiative) programs which use the ARTAS (Anti-Retroviral Treatment and Access to Services) model to find strength-based approaches to move clients along the care continuum. This program is implemented by two agencies in Hillsborough County and one in Pinellas County.

All three target populations include adolescents. Specific challenges for working with adolescents include lack of transportation, stigma, fear of being found out by parents and friends, not feeling sick, and indifference/being unaware of the scope and severity of the epidemic. The EMA is fortunate to have the Connect to Protect Tampa Bay Coalition (C2P) focusing on the needs of adolescents, ages 13 to 24. C2P is a community coalition that works on structural changes that are linkable to HIV transmission and acquisition.

Among Black WCBA, the most common challenges include lack of childcare and lack of transportation. The most common mode of transmission for Black WCBA is heterosexual contact. Lack of healthcare, including contraception, high rates of STI's, and limited role models in the community continue to be challenges. The state and federal Healthy Start programs offer a prenatal screening of all pregnant women in the EMA. Women who are high risk are identified and targeted for services. Hillsborough County has a provider of TOPWA (Targeted Outreach to Pregnant Women Act) services funded by FDOH. Their target population also includes substance abusers and incarcerated women. The state requirement for universal prenatal screening offers the opportunity to identify women who are HIV+ and bring them into a home visiting program, facilitating linkage to care.

Challenges to working with MSM include a mistrust of the healthcare system, particularly for Black MSM, and a higher likelihood of engaging in unsafe sexual behaviors. Men having sex with men remains the highest mode of transmission in the EMA, and MSM continue to be the largest population of PLWHA.

HRSA-Funded Core Medical and Support Services

Due to the diverse nature of the Tampa-St. Petersburg EMA (two of the counties are urban and two semi-rural), the Planning Council and Recipient recognized that parity must be a primary consideration when allocating funds within the four-county area. All of the counties have the basic services provided, including outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), medical case management, oral health, and health insurance. MAI treatment adherence services are offered in all EMA counties, with this being especially important for the two outlying counties of Hernando and Pasco as they are geographically further from most services, with isolated pockets that have large numbers of targeted clients. Stigma and cultural barriers are more prevalent in these two counties, and there is limited public transportation.

There are five core services that are not funded with Ryan White HIV/AIDS Program funds, including medical nutrition therapy, early intervention services, home health, hospice services, and home/community based health services. These services are all prioritized by the Planning Council, with no allocations due to the fact that all of the services have other payer sources, such as Medicaid, including the various Medicaid waiver programs. In addition, Florida has not expanded Medicaid under the Affordable Care Act so clients are still receiving primary medical care and other basic services through Ryan White in the EMA and throughout the state. Due to the unmet need in the top priority categories such as outpatient/ambulatory medical care, the Planning Council cannot, with limited funding, expand beyond the top seven funding priorities. It has not funded other supportive services such as legal assistance, food bank, and housing for many years.

All of the planned services are delivered by providers who are culturally competent. This is examined and rated during the application process for all prospective providers. The procurement instrument has a key question for a prospective provider requiring a description of how they will deliver HIV services in a culturally competent manner, including the use of bilingual staff, and staff who culturally reflect the population they serve. This procurement standard, coupled with the Minimum Standards of Care adopted by the Planning Council, helps to ensure that all staff are governed by minimum core competencies and standards of care. In addition to Spanish-speaking staff, some agencies also have Haitian-Creole speaking medical case managers. As part of the ongoing quality management program, the EMA offers satisfaction surveys to clients in multiple languages due to the diverse cultures and populations within the EMA.

The EMA, including the Planning Council and the Recipient, review the annual Women, Infants, Children, and Youth (WICY) expenditure data to ensure that resource allocations to provide services to these subpopulations are consistent and in proportion to the percentages of the EMA's reported AIDS cases. Three Ryan White Parts are represented in the EMA: Parts A, B, and D, and all of them fund services for the WICY populations. Part A and Part B funds are planned concurrently through a combined planning body or Planning Council to ensure appropriate allocations, with Part D being represented on the Council and a well-established linkage and coordination of services.

a. Resource Inventory Tables

The following tables were developed for this plan with input and information from the Area 5, 6, and 14 HIV Planning Partnership (the local HIV prevention planning body), the West Central Florida Ryan White Care Council (or Planning Council), the Ryan White Part A, B, and D Recipients, and the Florida Department of Health. The first two tables are the Tampa-St. Petersburg EMA Prevention and Patient Care Dashboards. The Dashboard templates were developed by the Florida HIV/AIDS Prevention Planning Group's (PPG) Coordination of Efforts Committee and the Florida HIV/AIDS Patient Care Planning Group's (PCPG) Metrics Workgroup to be used in the integrated HIV plans for the resource inventory. The Dashboards relate to the HIV Continuum of Care in the EMA and list state and federal resources by amount. There is also a community resource section, listing providers and services offered but not specific monetary amounts. The PPG Committee and PCPG Workgroup discussed providers' potential reluctance to share specifics and decided to implement as presented. The PPG's Coordination of Efforts Committee started with the Prevention Dashboards and the stages of the HIV Care Continuum with the goal of individual areas being able to identify gaps in service.

The PCPG's Metrics Committee then developed the Patient Care Dashboard to compliment the Prevention version, with a major focus on the elements of the continuum related to linkage to care, engagement in care, and retention, rather than the HRSA-funded core service.

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Figure 31: Tampa-St. Petersburg EMA Prevention Dashboard

Area Profile - Prevention								
Tampa - St. Petersburg EMA: Hernando, Hillsborough, Pasco, and Pinellas Counties Living Cases HIV/AIDS 2014 = New Cases = Proportion of State Epidemic = 12,271 803 11.2% Total EMA Funding: \$2,227,946								
TAMPA-ST. PETERSBURG EMA PREVENTION DASHBOARD								
Local Grantee Resources (Health Department, Parts A, B, C, and D)								
Area Counties	Total HIV Funds	Funded PTC (yes or no)	Total Condom Sites	Total Test Sites	HIV-FUNDED DIS (FTE)	Funded Linkage Specialist (FTE)	Funded Peer Program (FTE)	Perinatal Nurse (FTE)
Hernando	\$ 83,669	YES	12	4	0	0	0	0
Hillsborough	\$1,174,530	YES	96	16	6	0.5	0.125	0.75
Pasco	\$ 213,226	YES	18	12	2	0.25	0	0
Pinellas	\$ 806,521	NO	96	25	7	0.5	0.125	1
EMA TOTAL	\$2,277,946		222	57	15	1.25	0.25	1.75

Agency	Funding Type	Target Population Served	Category of Service
DACCO	SAMHSA	MINORITIES WITH SA ISSUES	HIGH RISK HIV-, HIGH RISK HIV+, LINKAGE/RETENTION, SA PREVENTION
DACCO	TOPWA THRU FDOH	HIGH RISK WOMEN OF CHILDBEARING AGE	HIGH RISK HIV-, HIGH RISK HIV+, LINKAGE/RETENTION
METRO WELLNESS	DIRECT CDC	HIV+/- ;MSM; HIGH RISK HETERO MEN	PrEP, HIGH RISK HIV+/-, P4P, MEDICAL ADHERENCE, LINKAGE/RETENTION
METRO WELLNESS	OFFICE OF MINORITY HEALTH	RE-ENTRY HIV+/-	HIGH RISK HIV+/-, P4P, MEDICAL ADHERENCE, LINKAGE/RETENTION
METRO WELLNESS	SAMHSA	MINORITY YOUTH	HIGH RISK HIV-, HIGH RISK HIV+, LINKAGE/RETENTION, SA PREVENTION
UNIV. OF SOUTH FL - DEPT OF PEDIATRICS	RYAN WHITE PART D	AT RISK YOUTH	HIGH RISK HIV+/-, P4P, MEDICAL ADHERENCE, LINKAGE/RETENTION

Figure 32: Tampa-St. Petersburg EMA Patient Care Dashboard

Area Profile - Patient Care

Tampa - St. Petersburg EMA: Hernando, Hillsborough, Pasco, and Pinellas Counties

Living Cases HIV/AIDS 2014 = 12,271

New Cases = 803

Proportion of State Epidemic = 11.2%

Total EMA Funding: \$23,728,299

TAMPA-ST. PETERSBURG EMA PATIENT CARE DASHBOARD

Local Grantee Resources (Health Department, Parts A, B, C, and D)

Area Counties	Total HIV Funds	Early Inter- vention Services	ARTAS (or ARTAS Hybrid) FTE	Peer or Near Peer Subset	Outreach FTE	Funded Linkage Specialist (FTE)	Funded Peer Program (FTE)	Other Retention Services
Hernando	\$ 753,389	NO	0	0	0	0	0	YES
Hillsborough	\$ 11,405,909	NO	4.25	0	0	0.5	0.125	YES
Pasco	\$ 1,400,821	NO	0	0	2	0.25	0	YES
Pinellas	\$ 10,168,180	NO	0	0	0	0.5	0.125	YES
EMA TOTAL	\$ 23,728,299		4.25	0	2	1.25	0.25	

Community Resources

Agency	Funding Type	Target Population Served	Category of Linkage or Retention Service
AIDS HEALTHCARE FOUNDATION	PRIVATE	HIV+	PATIENT CARE, LINKAGE/RETENTION, TREATMENT ADHERENCE
HILLSBOROUGH COUNTY GOVT.	COUNTY HEALTH PLAN	HIV+ <100% FPL	PATIENT CARE, LINKAGE/RETENTION
METRO WELLNESS	GILEAD	HIGH RISK HIV-	PrEP

As mentioned above, the HIV Continuum of Care Dashboards have a major focus on linkage to, engagement in, and retention in care. Therefore, there is the inclusion of two additional tables. These tables help to complete the HIV picture for the area, with more detail as relating to the funding amounts, services delivered, and Ryan White funded full time employees.

Figure 33: Tampa – St. Petersburg EMA Ryan White Funded Human Resources

Tampa – St. Petersburg EMA Ryan White Funded Full Time Employees		
Service	Position	Number of Full Time Employees
Ambulatory/Outpatient Medical Care	Medical Doctor	12
	Nurse Practitioner	12
	Registered Nurse	10
	Nutritionist	4
	Med Assistant	21
	Lab Technician	2
	Total	61
AIDS Pharmaceutical Assistance (local)	Pharmacy Staff	5
	ADAP Staff	8
	Total	13
Oral Health Care	Dentist	7
	Hygienist	4
	Dental Assistant	5
	Total	16
Mental Health Services	Therapist	7
	Counselor	2
	Total	9
Medical Case Management (including Treatment Adherence)	Medical Case Manager	48
	Supervisors	5
	Program Specialist	7
	Educators	8
	Total	68
Substance Abuse Services Outpatient	Therapists	6
	Total	6
Case Management (non-medical)	Eligibility Specialist	4
	Total	4
Administration	Administration Staff	7
	Finance	4
	Management	8
	Total	19

Figure 34: Tampa – St. Petersburg EMA Coordination of Services and Funding Streams

Funding Source	2015 Budget (\$)	Anticipated 2016 Budget (\$)	Core Services	Outpatient/Ambulatory Medical	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Supportive Services	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing			
Part A	9,114,672	9,573,672		X	X	X		X					X		X	X		X		X													X				
Part B	1,134,216	1,505,605		X				X							X			X																			
Part C	0	0																																			
Part D	1,267,169	1,305,075		X									X		X							X				X	X	X	X				X	X			
Part F	0	0																																			
CDC	1,326,217	1,741,217						X														X												X			
SAMHSA	595,000	595,000														X																					
HOPWA	3,378,774	3,378,774											X			X		X			X		X			X											
ADAP	11,332,191	11,332,191			X																																
Medicaid/PA C Waiver	38,336,269	38,336,269		X	X	X		X	X	X	X	X	X		X			X			X	X				X				X							
State	1,988,594	2,052,273				X		X							X							X												X			
Local	220,404	220,404		X			X																														
TOTAL	68,693,506	70,040,480																																			

b. HIV Workforce Capacity

The HIV workforce in the EMA is extremely dedicated, compassionate, and robust. It is also quite diverse in its requirements dependent upon the position. There are licensed providers, community health and social workers, paraprofessionals, and administrators with roles and responsibilities in the local HIV workforce.

The licensed providers include the following: MD, DO, DDS, PA, ARNP, RN, LPN, PharmD, LCSW, and RD. The Quality Management provider along with the Health Services Advisory Committee of the Planning Council conducted a recent provider survey, with each of the previously named licensed providers being listed at least once in the responses. The top three were ARNP, MD, and RN with 20, 16, and nine listed respectively in the responses by the eight responding agencies in the EMA. The average amount of total experience was just under 19 years, with 12 ½ years of HIV experience. The licensed providers are primarily involved in the following Ryan White services: outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), medical case management, and oral health.

Community health and social workers primarily comprise the staff that provides medical and non-medical case management, eligibility determination, mental health, and substance abuse outpatient services through the EMA. The individuals in this category have extensive experience in the field of public health and social services, and the majority also have many years of HIV experience. These providers have at least a Bachelor's degree, with many having Master's degrees (e.g. MSW, MPH) and other certifications such as Certified Health Education Specialist (CHES) and Substance Abuse/Addictions Professionals. All of the case management staff are required to complete the state of Florida's HIV case management training and other HIV-specific trainings upon employment, with annual updates thereafter. Mental health and substance abuse providers complete HIV training and practice-specific continuing education courses annually as well.

Paraprofessional staff are generally those who provide HIV testing, outreach, education, high impact prevention, ADAP and other supportive services throughout the EMA. These staff have completed HIV/AIDS 500/501 (client-centered HIV pre- and post-test counseling) training and specialized training specific to their job duties. The educational requirements are dependent upon the position and the agency, but range from high school diploma/GED to college degrees. Some of these staff are PLWHA themselves and most have diverse and extensive experience working with the populations most affected by HIV.

Finally, administrative staff work to ensure that all providers are operating within CDC, HRSA, and Ryan White regulations. These individuals supervise, monitor, and manage the provision of direct prevention and care services, as well as data entry, fiscal oversight, and support services. The level of experience in administrative staff is based upon the specific role. However, many of these individuals have been working in their fields for more than 10 years, with a majority of them having experience in healthcare, if not in HIV, for most of that time. Educational levels vary from high school/GED (data entry clerks) to MBA (Director of Finance) to MD (Clinical Director) depending on the organization and the services provided.

c. Interaction of Funding Sources

Local partner agencies have a rich history of collaborating on HIV prevention, surveillance, care, and treatment issues throughout the EMA. This tradition continues as the networks implement a plan to incorporate early intervention services with the goal of ensuring 100% of HIV+ clients are linked to services with the local Ryan White programs. Bimonthly meetings of the Part A Recipient, the Part B Lead Agent, and the FDOH HIV/AIDS Program Coordinators (HAPC) occur to ensure optimal service delivery using limited federal, state, and local resources. Included in the agenda are discussions on linking HIV prevention and care services. Meetings focus on coordination between Ryan Part A and Part B (ADAP and Patient Care) programs to maximize funding as well as planning program integration (HIV, STI, TB, and Hepatitis) within the EMA. Collaborative partnerships also exist with local community-based organizations, researchers at the University of South Florida, and local health department officials.

The Planning Council serves as both the Ryan White Part B consortium and the Part A planning body for the EMA. The Planning Council also plans and prioritizes services for the Part A MAI program. Ryan White Parts A, B, and D are represented at the Planning Council and its committees. Membership also includes representatives from other federal, state, and local funding sources including the Veteran's Administration, State Medicaid Program, HOPWA grantees, and county health departments, who keep the Council apprised on related issues. The Area 5, 6, and 14 HIV Planning Partnership (HPP) covers the same eight counties as the Part B consortium, inclusive of the four EMA counties, for prevention planning. The HPP representatives include the Ryan White Part A Recipient, the Part B Lead Agent, the HAPCs, other health department staff, agencies receiving Ryan White Parts A, B, and D, HOPWA providers, Medicaid providers, SAMHSA providers, and consumers. The HPP works primarily on community engagement into the HIV planning process, sharing of best practices, training, and elects the members from this area to the PPG. The PPG in conjunction with FDOH produces a prevention funding analysis by area. FDOH produces the jurisdictional prevention plan, which is subject to concurrence by the PPG. FDOH also produces epidemiological profiles, as well as the annual HIV Continuum of Care documents by area and for the EMA.

For Ryan White, the service continuum in each county is assessed during the needs assessment process. A funding stream analysis is conducted to identify available funding sources to ensure that Ryan White funds are properly utilized as payer of last resort. Further, resources are analyzed to determine where the continuum of care contains gaps. This information is used to set funding priorities. The EMA has a mature planning process that coordinates Ryan White services with those available through other public sources in order to ensure payer of last resort and that there are no duplications of service.

d. Needed Resources and Services

A community assessment serves as the basis for identifying populations at risk for HIV infection in Florida, the prevention needs of those populations, activities/interventions being implemented to address those needs and service gaps. To help assess current needs for HIV prevention services in Florida, the PPG in collaboration with the prevention program conducted an HIV Provider Survey in July 2014. The HIV Provider survey was conducted as part of an ongoing

needs assessment process to identify emerging needs and service gaps related to the delivery of HIV services in Florida. The results of the survey were used to help the FDOH Prevention Program better understand the prevention need for persons living with HIV/AIDS and those at risk for HIV.

The survey was open from July 30, 2014-September 30, 2014. Survey responses were collected electronically utilizing Survey Monkey. In total there were 397 survey respondents. The survey consisted of 33 questions designed to gather information from providers about the types of HIV services provided statewide, access to services, coordination of HIV services, barriers to HIV services, and HIV service needs. Survey responses were summarized through Survey Monkey and subsequently reviewed by the PPG and Prevention Program staff. Analysis of data from the provider survey produced the following key findings related to barriers to HIV/AIDS services, unmet need, and technical assistance and training needs:

- Survey respondents identified the following as the top barriers that their organization faces when providing services to people living with HIV/AIDS or those at risk for acquiring HIV. The top three responses were: 1) inadequate funding resources, 2) stigma, mainly related to HIV status, and 3) inadequate transportation.
- When respondents were asked to identify the top three barriers that their organization faces when trying to find people who are unaware of their HIV status, the following barriers were identified: 1) stigma, mainly related to HIV status, 2) clients not ready to receive HIV test results/address health care, and 3) mistrust of the medical system or providers.
- The top three barriers that were identified as barriers to linking and retaining HIV-positive individuals were: 1) clients are afraid to disclose HIV status, 2) clients not ready to address health care, and 3) transportation.
- Respondents were asked to identify what they felt were the most common barriers that clients face when accessing services. Respondents were given a selection of common barriers from which to choose. The top three barriers that providers strongly agreed with were: 1) our clients are reluctant to seek services due to stigma and/or fear of disclosing HIV status, 2) our clients have difficulties getting transportation to our organization, and 3) our clients are unsure of how to navigate the care system.
- Respondents were asked to identify the three most important unmet needs for HIV prevention in their area. The top three identified unmet needs were: 1) mental health services, 2) substance abuse services, and 3) peer programs.
- Survey respondents were asked to identify training topics or technical assistance areas that would help them to better serve clients. The top three responses for training and technical assistance were: 1) recruiting hard-to-reach populations, 2) linkage to and retention in care, and 3) mental health.

The community also initiated a provider survey in 2016 to gather input on needed community services and human resources as well as funding and program opportunities providers are seeking to address the identified gaps. Identified community service needs are detailed in the Needs, Gaps, and Barriers section.

Identified human resource needs include:

- Spanish and Creole speaking staff
- Additional dentists
- Licensed Clinical Social Workers and mental health providers experienced with HIV/AIDS
- Trained peer educators

Funding and program opportunities that providers are pursuing to address the identified gaps include:

- Staff development
- Funding for Pre Exposure Prophylaxis (PrEP) clinics
- Expansion of oral health services
- Funding for Hepatitis C treatment

The services needed, barriers to prevention and care, and technical assistance and training needs identified through the prevention and care processes are being utilized by the HPP and the Planning Council in current and future planning.

D. Assessing Needs, Gaps, and Barriers

Process to Identify HIV Prevention and Care Service Needs

The Eligible Metropolitan Area (EMA) utilizes a variety of strategies to identify HIV prevention and care service needs of people at higher risk for HIV and people living with HIV/AIDS (PLWHA). These strategies include client and provider surveys, focus groups, and community forums. The surveys referenced in this needs assessment include the 2013 Anonymous Needs Survey, the 2015 Ryan White Client Satisfaction Survey, the 2016 Resource Survey, and the 2016 Linkage to Care Survey.

The 2013 Anonymous Needs Survey was distributed on paper to a total of 17 sites which were selected by Care Council staff across the Total Service Area (TSA) of the West Central Florida Ryan White Care Council to ensure diversity and representativeness in the sample. The TSA is comprised of the EMA in with the addition of Polk, Manatee, Highlands and Hardee Counties. The sites consisted of primary care providers (public and private) and HIV/AIDS case management agencies. A survey link was distributed through the Planning Council e-mail list serve and posted on the Planning Council's website. In addition, the survey link was posted on the Planning Council's Facebook page and on the pages of other providers. A postage paid return envelope was provided with all surveys at sites without a collection box. Key staff at several of the sites collaborated in the distribution by asking clients to complete the survey and by providing assistance with completing the survey as needed. Several agencies also distributed the survey by mailing copies with return envelopes to each client of record. A total of 1,154 surveys were returned.

The 2015 Ryan White Client Satisfaction Survey was originally developed to gather Ryan White client feedback regarding the quality of services rendered. The survey tool was developed

by referencing The AIDS Institute's *Patient Satisfaction Survey for HIV Ambulatory Care*. The ongoing administration of the survey allows for continuous monitoring of satisfaction among clients at the provider level as well as across the EMA. Surveys are distributed to each of the Ryan White providers in the EMA and are provided in English and Spanish. Clients are asked to provide feedback for each service category they have utilized through the Ryan White funded provider network. Client satisfaction results and suggestions for calendar year 2015 were reviewed by the Care Council's Community Advisory Committee (CAC) in January 2016 to identify service gaps and suggestions for improvement. Survey results are also reviewed by the Ryan White Quality Management Technical Workgroup along with Part A Recipient and Part B Lead Agency. A total of 1,309 surveys were returned and reviewed.

The 2016 Resource Survey was initiated by the Planning and Evaluation (P&E) committee of the West Central Florida Ryan White Care Council to gather input from providers on needed community services as well as needed human resources. The survey contained 3 questions and was distributed to providers via SurveyMonkey. A total of 11 providers responded. All counties were represented in the sample.

The 2016 Linkage to Care Survey was initiated by the Planning and Evaluation (P&E) committee of the West Central Florida Ryan White Care Council. A community group was convened to create a short survey specifically targeted at collecting information about retention and re-engagement in care and opinions about Pre-exposure Prophylaxis (PrEP) as these issues are highlighted in the National HIV/AIDS Strategy for 2020. The survey, containing three questions about retention/re-engagement in care, one question about taking HIV medications, and two questions about PrEP, was reviewed by P&E committee members, key stakeholders, and consumers prior to implementation on January 4, 2016. The survey was administered via Ryan White providers, key partners, and county health departments throughout the month of January 2016. It was available in both English and Spanish and was completed on paper (through a color-coded system by provider to avoid duplication). A SurveyMonkey link was available for clients to complete the survey online, but this option was not utilized. A total of 1,124 surveys were completed at 12 provider sites throughout the EMA. All counties were represented in the sample.

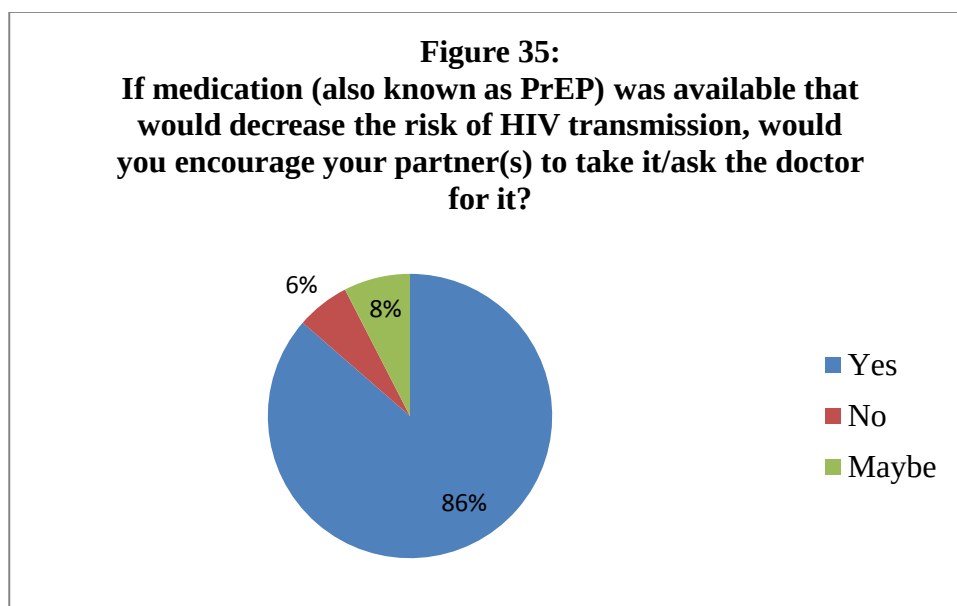
Focus group data was collected from the Care Council's Community Advisory Committee (CAC) and the Women, Infants, Children, Youth, and Families (WICY&F) Committee. Both committees hosted town-hall meetings in January, February, and March 2016 to identify community needs, gaps, and barriers to accessing HIV care. These meetings were advertised on the Care Council's website as well as their Facebook page. The focus groups consisted of PLWHA, HIV care and prevention service providers, community members, as well as Ryan White Part A, Part B, and Part D representatives. These committees will host town-hall meetings bi-annually to assess the continued needs, gaps and barriers to assessing HIV care as the Integrated HIV Prevention and Care Plan is implemented.

Community input was collected from The AIDS Institute, the Florida Consortium of HIV/AIDS Research, and Connect to Protect Tampa Bay's Research and Practicum Symposium on March 3, 2016. Symposium participants were recruited through social media, e-mail notifications, and through announcements at various community events. The event featured a community round table discussion on strategies for HIV testing, community access to Post-exposure prophylaxis (PEP) and PrEP. The round table consisted of PLWHA, HIV care and prevention providers,

community members, and researchers. Information about community needs, gaps, and barriers to accessing HIV prevention services was also collected at The Area 5, 6, and 14 HIV Planning Partnership (HPP)'s March 28, 2016 meeting. The meeting consisted of PLWHA, Community Based Organizations (CBOs), healthcare providers, community members, as well as representatives from the Department of Health and the Department of Education. The HPP will host an annual meeting to assess the continued needs, gaps and barriers to assessing HIV prevention as the Integrated HIV Prevention and Care Plan is implemented.

Service Needs

Access to PrEP and education about the medication were identified as HIV prevention service needs in community forums. The community round table discussion at the Research and Practice Symposium emphasized the need for more community providers who are willing to prescribe PrEP and monitor long-term adherence. Participants also discussed the need for community education about PrEP for both clients and providers. The 2016 Linkage to Care Survey also highlighted the need for PrEP access. Figure 35 shows the percentage of survey respondents who would encourage their partner(s) to take PrEP if the service was available.



Tampa-St. Petersburg EMA Linkage to Care Survey, 2016.

HIV testing service needs were discussed at the Research and Practice Symposium. The group cited community testing and street outreach in high risk areas as an effective strategy. Additional peer to peer programs and continued testing of men who have sex with men (MSM) were also identified as needed services in the local area. The WICY&F focus group identified HIV testing and education targeted to heterosexual women as a community need as well as HIV prevention education in schools. The HPP community forum noted the need for HIV testing in Emergency Rooms, mobile testing units, and routine testing for all populations.

Figure 36 highlights the perceived service needs for PLWHA as identified in the 2013 Anonymous Needs Survey. Respondents were asked to rank the five services they felt were most important. Responses are listed in order of how frequently they were selected. Brief

definitions for each service were provided. “Other” services specified were housing assistance (n=55), emergency financial assistance (n=9), support groups (n=7), and acupuncture/massage (n=7).

Figure 36: Most Important Services to provide for people with HIV/AIDS in the TSA

Which five services do you think are most important for people living with HIV/AIDS to be able to access throughout the state?		
Answer Options	Response Percent	Response Count (#) n= 1076
Outpatient Medical Care	74%	797
Payment for Medications	68%	729
Dental/Oral Health Services	56%	606
Assistance receiving and accessing services	45%	480
Food Bank/Food Voucher	39%	417
Mental Health Services	32%	348
Private Health Insurance co-payment or premium assistance	30%	318
Transportation to and from HIV related care services	24%	256
Linking newly diagnosed HIV patients to care	17%	182
Outreach to HIV patients who have fallen out of care to get them back into care	17%	187
Legal services	16%	175
Nutritional Counseling for healthy eating habits	15%	161
Health education about risk reduction	11%	123
Substance Abuse Treatment	10%	106
Home Health Care	8%	85
Treatment adherence counseling	8%	87
Other (please specify)	7%	80
Rehabilitation services	6%	68
Hospice Services	5%	51
Early Intervention Services	2%	19

Care service needs mentioned in the 2015 Ryan White Client Satisfaction Survey included outpatient medical care, transportation assistance, shorter wait times for dental services, medication payment assistance, support groups, access to a food pantry, medical case management, and substance abuse services. The needs of PLWHA identified in the CAC and WICY&F focus groups included transportation assistance, access to dental providers, outpatient medical care, help navigating services among various agencies, medication payment assistance, medical providers that have flexible office hours and convenient locations, health literacy,

support groups for females, support groups for youth, as well as reliable and affordable health insurance.

Service Gaps

Prevention service gaps identified in the 2016 Resource Survey included funding for PrEP/PEP for uninsured patients and prevention materials in Spanish/Creole. The HPP community forum identified the following HIV prevention service gaps:

- Transportation to/from testing sites
- Lack of PrEP clinics and funding for the labs required to prescribe the medication
- Provider training for PrEP
- Testing in non-clinical settings, specifically in Hernando and Pasco Counties
- Community resource guide for the local area that details services available at each agency
- Health information available in various languages as well as for various reading levels

Figure 37 showcases the care service gaps for PLWH as identified in the 2013 Anonymous Needs Survey. Service gaps combines respondents who selected “needed service, but could not get service” and “needed service, but did not know about service.” The services are ranked in order from highest service gap percentage to lowest service gap percentage.

Figure 37: Service Gaps

Service	Service Gap Percentage (%)
Dental/Oral Health	30%
Food Bank or Food Vouchers	27%
Legal Support	24%
Housing	24%
Health Insurance	22%
Transportation	20%
Nutritional Counseling	15%
Mental Health Services	13%
Peer Mentoring	13%
Rehabilitation	12%
Other: A service not listed	12%
Outreach	10%
Case Management	8%
Home Health Care	7%
Early Intervention Services	6%
Health Education/Risk Reduction	6%
Hospice Services	4%
Treatment Adherence	4%
Outpatient Medical Care	3%
Medications	3%
Substance Abuse Treatment	3%

Additional care service needs that were mentioned in the previous section, but are not currently funded through Ryan White include support groups, acupuncture, and health literacy. Care service gaps identified in the 2016 Resource Survey included food banks, housing for HIV positive men, peer education programs, transportation, funding for Hepatitis C/HIV co-infection, expanded insurance premium/medication co-pay assistance, additional funding for dental services, and youth case management services in Pinellas County.

Barriers

A variety of barriers exist within the EMA that hinder access to prevention services. The HPP community forum discussed the following barriers:

- Need to change policies that hinder data sharing between service providers
- Accessible child care
- Limited testing services available in fast-growing areas in the EMA (i.e., Brandon, Wesley Chapel, New Port Richey)
- Limited collaboration among providers
- Absence of services available at night and on the weekends
- Stigma about HIV among the medical community in rural areas
- Funding is limited to testing specific populations rather than for routine testing of all populations

Barriers can limit or prevent PLWH from receiving available services that are essential to improving or maintaining their health and well-being. Barriers to care were identified by clients in the 2013 Anonymous Needs Survey. Respondents were asked to describe the reasons they did not receive a service they needed. A list of responses is detailed below (listed in order from most responses to least) (N= 1,154).

- I did not know where to get services (n=141).
- I could not pay for services (n=114).
- I could not get transportation (n=111).
- I was depressed (n=95).
- Other (n=85).
- I did not qualify for services (n=67).
- I did not want people to know that I have HIV (n=43).
- I could not get an appointment (n=35).
- I had a bad experience with the staff (n=35).
- I could not get time off work (n=15).
- I could not get childcare (n=4).
- Services were not in my language. (n=2).

“Other” reasons cited included length of time they had been on a waiting list and various complications of getting through the process to receive assistance. Several respondents listed jail or prison as a barrier. Other respondents listed the need for a service that was unavailable to them or lacks funding such as vision care, specialty dentistry, and legal services.

The 2016 Linkage to Care Survey identified reasons clients fell out of care. A total of 1,124 surveys were completed. Respondents were asked what prompted them to stop coming in to care (listed in order from most responses to least).

- Had transportation issues (n=113).
- Change in financial/insurance status (n=97).
- Confidentiality concerns (n=67).
- Other (n=67).
- Did not feel sick (n=66).
- Did not feel ready to engage in care (n=43).
- Provider issue, not comfortable/not respected (n=42).
- Family/child care issues (n=30).
- Relocation (moved) (n=10).
- Substance abuse (n=7).
- Incarceration (n=3).

“Other” reasons cited included: mental health issues (denial/depression/anxiety), medication side effects, missed medical appointments, fear that their family would find out their HIV status, difficulty scheduling an appointment to see a doctor at a time convenient for the client, incarceration, treatment fatigue, fear of losing their job if they had to explain frequent doctor’s visits, client was not comfortable with their healthcare provider.

WICY&F facilitated a specific focus group to identify barriers to accessing care for youth. HIV-positive youth (18-24) identified the following barriers: insurance does not cover all needed medications, the location of services is not convenient, difficulty understanding the directions being given by their healthcare providers and/or case managers, difficulty communicating with service providers, fear their HIV status will be disclosed to others, dependence on parents/not wanting to disclose their status to their parents, and difficulty balancing the stress of school/work/health appointments. One member of the group noted that she was not adherent to her medications until she was hospitalized. Another member mentioned treatment fatigue as a barrier to accessing care. Obstacles to accessing care identified at the general WICY&F and CAC focus groups are: strict provider policies that don’t allow for missed appointments, feeling stigmatized because there is a separate waiting area for PLWH at one of the Health Departments, inconvenient provider hours for lab work, stigma, and difficulty navigating the system of care.

Barriers to care that were identified by community service providers included lack of data sharing among healthcare providers and difficulty sharing data among HIV prevention and care service providers. Service providers also identified the lack of resources for general HIV prevention programs for all communities as a barrier. Current funding is specified for target populations (i.e., men who have sex with men (MSM), Hispanic outreach). There is also a lack of funding for non-core HIV care services as all Ryan White funding is allocated to core services such as outpatient ambulatory medical care (OAMC), medication assistance, oral health, and medical case management.

E. Data: Access, Sources and Systems

Primary Data Sources: Data for the needs assessment and developing the HIV continuum of care is obtained from multiple sources, managed predominately by the Florida Department of Health, (surveillance and epidemiological data), as well as all Part B patient care data which includes the AIDS Drug Assistance Program (ADAP). Surveillance data is derived by the Florida Department of Health from eHARS (enhanced HIV/AIDS Reporting System), a browser-based, CDC-developed application that assists the Department with reporting, data management, analysis and transfer of non-confidential data. The care continuum is developed based on data collected by CAREWare, as well as the other sources, all managed currently by the Department of Health.

Multiple systems are used for prevention and patient care programs locally, which are not linked for data sharing purposes. These include CAREWare for Parts A, B and D; a separate ADAP database; the Counseling, Testing, and Linkage (CTL) database; the AIDS Information Management System (AIMS) for patient care services and financials; the Medical Monitoring Project (MMP) database, a surveillance special project used to collect comprehensive clinical and behavioral information about PLWHA; Evaluation Web, used by contracted HIP (High Impact Prevention) providers; and PRISM (Patient Reporting Investigating Surveillance Manager), used by linkage to care coordinators. Effective 2016, a new system is being implemented by Part A named e2Hillsborough for patient care data, program reporting, and claims reimbursement.

Data Policies: The Florida Department of Health's data which is provided routinely for planning and analysis purposes is dependent on the accuracy and complete reporting in eHARS, maintaining timely reporting of deaths, maintaining accurate addresses, and accommodating for in and out migration, which is a significant issue in Florida due to the transient nature of the population. Adjustments also are made to the data profiles to account for the populations within the Department of Corrections (DOC). The most significant challenge to the HIV Care Continuum for the EMA in the coming year will be maintaining and expanding quality data collection. Due to the transition in 2016 from CAREWare to the new e2Hillsborough database, it will be difficult to analyze any trends in utilization and potential unmet need in the initial stages of implementation as there will not be enough consistent mature data collected to be analyzed for trends such as service gaps, utilization, and outcomes.

Unavailable Data: There are pieces of HIV prevention data that are not available at the local level. For example, there is not a centralized database tracking the number and type of educational and outreach activities conducted. Counseling and testing data are available at the local level through DOH's database. Other prevention information is entered into the CDC's Evaluation Web but that information is not easily accessible for community planning purposes.

In addition, data on co-morbidities for PLWHA such as cancers, heart disease, diabetes, and other chronic health conditions is not currently tracked or available but would be useful for planning especially as the population ages.

Due to the Quality Management program being reliant upon multiple data systems, some of the HRSA indicators (viral load, prescription of HAART, HIV test results, linkage to care, CD4 counts, etc.) that would be available for planning purposes are currently difficult to obtain since

Part A moved from a previously utilized data system in 2014 to CAREWare, and now another data migration/transfer will occur in 2016. Optimally, the EMA wants to have the ability to analyze the local Part A and B data in these categories with a uniform baseline, but this has not been achieved yet. The current data is limited because it is all sourced from the Department of Health and includes the entire area profiles, with no specific data limited strictly to Ryan White clients.

SECTION II: HIV PREVENTION AND CARE PLAN

A. Integrated HIV Prevention and Care Plan

The Tampa-St. Petersburg EMA collaboratively established its prevention and care plan for 2017-2021 to achieve a more coordinated response to addressing HIV in the local area. The plan aligns with the National HIV/AIDS Strategy (NHAS)'s primary goals of reducing new infections, increasing access to care, and reducing HIV-related disparities. The plan was developed as a response to the needs detailed in the preceding section.

Tampa-St. Petersburg EMA Objectives, Strategies, and Activities

I. NHAS Goal 1: Reducing New Infections

- A. Tampa-St. Petersburg EMA Objective 1: By January 2019, increase the number of providers offering PrEP in the EMA by 50%.

Strategy 1: Increase PrEP awareness and support within the Tampa/St. Petersburg EMA.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Community-Based Organizations (CBOs), Department of Health, Healthcare Providers	Educate high-risk populations and communities about PrEP	Communities where HIV is most heavily concentrated	Number of PrEP education sessions
Ongoing	AIDS Education and Training Center	Educate healthcare providers about PrEP	Healthcare providers	Number of PrEP education sessions
Ongoing	CBOs, Department of Health, Healthcare Providers	Facilitate community PrEP education seminars	Communities where HIV is most heavily concentrated	Number of education seminars
By December 2017, updated by December 2019	CBOs, Department of Health	Develop a community PrEP resource guide	Persons at risk for HIV infection	Creation of the resource guide

Strategy 2: Develop a system for PrEP delivery within the Tampa/St. Petersburg EMA.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2016	Department of Health	Identify potential PrEP providers	Healthcare providers	Number of identified providers
Ongoing	AIDS Education and Training Center	Identify resources available for clinical consultation and education	Healthcare providers	• Number of trainings offered/consultations in the EMA • Number of healthcare providers attending each training
Ongoing	Department of Health, Healthcare Providers	Identify best practices to finance PrEP	Persons at risk for HIV infection	Discussion of best practices with the HIV Planning Partnership

Strategy 3: Increase PrEP marketing within the Tampa/ St. Petersburg EMA.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	CBOs, Department of Health	Advertise PrEP through direct marketing (face-to-face and mail)	Persons at risk for HIV infection	Creation and distribution of the direct marketing messages
Ongoing	CBOs, Department of Health	Advertise PrEP through social media	Persons at risk for HIV infection	Creation and distribution of the advertisement
Ongoing	CBOs, Department of Health	Advertise PrEP at community events	Persons at risk for HIV infection	Creation and distribution of the advertisement

B. Tampa-St. Petersburg EMA Objective #2: By December 2021, increase to 90% the number of persons living with HIV in the EMA who know their status.

Strategy 1: Test high risk communities in non-conventional venues.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health	Increase testing and education in correctional facilities	Incarcerated persons	Number of persons tested
Ongoing	Department of	Increase testing,	Persons	Number of

	Health, CBOs	education, and follow-up with persons experiencing homelessness	experiencing homelessness in rural communities	persons tested
Ongoing	Emergency Room Staff	Increase testing, education, and linkage to care at Emergency Rooms in the EMA	Patients who visit the Emergency Room	Number of persons tested

Strategy 2: Use peers and partners to help identify persons at high risk for HIV in their social network.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health, CBOs	Use of Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies)	Persons at risk for HIV	Number of persons training in Community PROMISE
Ongoing	Department of Health, CBOs	Train peer educators to disseminate accurate and relevant HIV information in their communities	Persons living with HIV	Number of persons trained
Ongoing	Department of Health	Continue HIV partner counseling and referral services	Partners of persons diagnosed with HIV	Number of partners who are tested and referred to services
Ongoing	Department of Health, CBOs	Testing for persons at risk for HIV as identified by persons living with HIV in their social network	Persons at risk for HIV	Number of persons trained

Strategy 3: Encourage routine HIV testing.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health, CBOs	Utilize social media to advertise information about HIV testing	Persons at risk for HIV	Number of posts on the Department of Health's social media pages about HIV testing
Ongoing	AIDS Education and Training Center	Inform healthcare providers about routine testing	Healthcare providers	Number of healthcare providers trained

		strategies		
Ongoing	Department of Health, CBOs	Incentivize testing	Persons at risk for HIV	Number of persons tested

C. Tampa-St. Petersburg EMA Objective #3: By December 2021, reduce the number of new HIV diagnoses in the EMA by 10%.

Strategy 1: Intensify HIV prevention efforts funded through the Department of Health in communities where HIV is most heavily concentrated.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health, Department of Health funded CBOs	Increase HIV education in local schools using age-appropriate HIV prevention materials	Youth	Number of outreach activities conducted
Ongoing	Department of Health funded CBOs	Collaborate with faith-based organizations to provide HIV education	Persons at risk for HIV	Number of outreach activities conducted
Ongoing	Department of Health, Department of Health funded CBOs	Continue distributing condoms in the community through outreach	Persons at risk for HIV	Number of condoms distributed
Ongoing	Department of Health, Department of Health funded CBOs	Continue safer sex kit distributions in the community through outreach	Persons at risk for HIV	Number of safer sex kit distributed

Strategy 2: Provide clear, specific, consistent, and scientifically up-to-date messages about HIV risks and prevention strategies.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health, Department of Health funded CBOs	Use YouTube videos approved by the Department of Health to disseminate prevention strategies to youth	Youth	Number of times YouTube videos are shared or viewed
Ongoing	Department of Health, Department of Health funded CBOs	Disseminate education materials approved by the Department of Health	Persons at risk for HIV	Number of education materials handed out

Strategy 3: Disseminate HIV prevention messages through social media.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health funded CBOs	Use Facebook, Twitter, and Instagram to disseminate HIV prevention education	Youth	Number of posts about HIV prevention education
Ongoing	Department of Health funded CBOs	Use pop-ups on dating websites to disseminate HIV prevention education	Persons at risk for HIV	Number of HIV prevention education pop-ups

II. NHAS Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV

The following objectives, strategies, and activities are all aimed at addressing gaps along the HIV Care Continuum.

- A. Tampa-St. Petersburg EMA Objective 1: By December 2021, increase the percentage of difficult to reach persons newly diagnosed with HIV* who are linked to Ryan White-funded medical care.

*Difficult to reach persons newly diagnosed with HIV is defined as individuals who have tested positive for HIV, but do not have any evidence of engagement in care (CD4 count, Viral Load or HIV medical visit).

Strategy 1: Identify the process for tracking difficult to reach persons newly diagnosed with HIV who are Ryan White eligible and linked to medical care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of January 2017	Department of Health Surveillance, Disease Intervention Specialists (DIS), and Linkage Coordinators	Identify the process of how newly diagnosed individuals are linked to care in the EMA	Difficult to reach persons newly diagnosed with HIV	Establishment of a written process
Annually, by the end of January for the previous calendar year	DOH-funded Linkage Coordinators	Track the number of individuals who are referred to Ryan White care	Difficult to reach persons newly diagnosed with HIV	Number of persons referred to care
Annually, by the end of	Re-entry providers, DOH-funded	Track the number of individuals	Difficult to reach persons	Number of persons

January for the previous calendar year	Linkage Coordinators	who are referred to Ryan White care	newly diagnosed with HIV	referred to care

Strategy 2: Establish a baseline of persons eligible for Ryan White funding in the EMA who are linked to Part A, Part B, and Part D-funded medical care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Annually, by the end of January for the previous calendar year	Part A, Part B, and Part D	Compare the names of newly diagnosed individuals referred to care with those in the Ryan White care database	Difficult to reach persons newly diagnosed with HIV	Number of persons referred to care vs. number of persons in care
Annually, by the end of January for the previous calendar year	Linkage Coordinators, Part A, Part B, and Part D.	Meet to review baseline data and discuss strategies to enhance linkage and engagement in care	Difficult to reach persons newly diagnosed with HIV	Meeting attendance

Strategy 3: Strengthen relationships and referral systems among providers in the EMA to ensure persons newly diagnosed with HIV are engaged in care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	ARTAS funded providers	Continue the use of Anti-Retroviral Treatment and Access to Services (ARTAS)	Persons newly diagnosed with HIV	Number of persons receiving ARTAS services
By December 2021	CBOs	Create a community resource guide detailing available services at community providers utilizing the What's Next resource guide as a baseline	Persons living with HIV Case managers	Creation of a community resource guide

- B. Tampa-St. Petersburg EMA Objective 2: By December 2021, increase the percentage of persons with diagnosed HIV infection, who are accessing Ryan White outpatient ambulatory medical care (OAMC), and who are retained in care, from 81% to 86%.

Strategy 1: Offer ongoing support services and health education for persons living with HIV.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	CBOs	Increase support groups offered in the EMA	Women Youth Heterosexual men Persons who have fallen out of care	Number of support groups offered in the EMA as reported to the Care Council and HIV Planning Partnership
Ongoing	CBOs, Healthcare Providers	Provide supportive education materials and resources for individuals through each step of the HIV Care Continuum	Persons living with HIV	Number of providers offering education and resources in the EMA as reported to the Care Council and HIV Planning Partnership

Strategy 2: Increase the availability of medical case management services.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Annually, beginning in 2017	Ryan White grant administrators	Facilitate a capacity-building training for case managers	Ryan White funded case managers	Number of trainings offered
Bi-annually in June and December	Quality Management Technical Workgroup	Monitor case management utilization	Persons living with HIV who are accessing Ryan White services	Number of persons who have a Medical Case Management Plan

Strategy 3: Increase the capacity of peer intervention programs.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	CBOs	Identify funding sources available for peer intervention programs	Persons living with HIV	Number of peer programs available in the EMA
Ongoing	CBOs	Replicate successful evidenced-based program	Persons living with HIV	Number of peer programs available

		from other communities		in the EMA

C. Tampa-St. Petersburg EMA Objective 3: By December 2021, increase the percentage of persons with diagnosed HIV infection, who are accessing Ryan White outpatient ambulatory medical care (OAMC), who are virally suppressed from 78% to at least 83%.

Strategy 1: Increase the number of people who are prescribed and adherent to Anti-Retroviral Therapy (ART).

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Ryan White grant recipients	Continue funding for OAMC	Persons living with HIV	Number of OAMC providers funded by Ryan White in the EMA
Annually in December	Quality Management Technical Workgroup	Monitor prescription of ART among persons living with HIV who are accessing Ryan White funded OAMC services	Persons living with HIV who are accessing Ryan White funded OAMC services	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.

Strategy 2: Support screening for and referral to substance use and mental health services for people living with HIV.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Healthcare Providers, Department of Health, CBOs	Increase community collaboration to ensure identification of and treatment for substance abuse and mental health problems	Persons living with HIV experiencing substance abuse and/or mental health problems	Number of providers offering substance abuse and mental health services in the EMA as reported to the Care Council and HIV Planning Partnership
Ongoing	Healthcare Providers, Department of Health	Increase the use of brief screening tools for substance abuse and mental health problems	Persons living with HIV experiencing substance abuse and/or mental health problems	Number of providers using the brief screening tool in the EMA as reported to the Care Council and HIV Planning Partnership

Strategy 3: Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-infections.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Healthcare Providers, Department of Health	Increase the number of providers offering HIV/Hepatitis C (HCV) treatment	Persons living with HIV who are co-infected with HCV	Number of providers offering HIV/HCV treatment in the EMA as reported to the Care Council and HIV Planning Partnership
Ongoing	Healthcare Providers, CBOs, Department of Health	Encourage providers to refer persons living with HIV to other community services (i.e., housing, child care, etc.)	Persons living with HIV	Creation of a community resource guide

III. NHAS Goal 3: Reducing HIV-Related Disparities and Health Inequities

- A. Tampa-St. Petersburg EMA Objective 1: By December 2021, increase culturally and linguistically competent outreach efforts, funded through the Department of Health and Ryan White, targeting Hispanic persons in the EMA by 25% in order to engage the community in the continuum of care.

Strategy 1: Establish a baseline of the number of outreach activities conducted by CDC-funded organizations and Ryan White Part A Minority AIDS Initiative (MAI)-funded organizations targeting Hispanic persons. Outreach is defined as face-to-face health information and education, linkage to care, testing, health system navigation, social marketing, and adherence support.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of CY 2017	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC, Ryan White Part A Recipient	Compile the number of outreach activities that were conducted targeting Hispanic persons and Hispanic clients served in CY 2017	Hispanic persons in the EMA	Number of clients served Number of outreach activities conducted
January 2018	Care Council Planning Staff	Compile the number of outreach activities that were conducted targeting	Hispanic persons in the EMA	Number of clients served

		Hispanic persons and Hispanic clients served in CY 2017 based on information provided by the previously referenced responsible parties		Number of outreach activities conducted

Strategy 2: Monitor and track progress on the number of outreach activities conducted and Hispanic clients served.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
February 2018 – March 2018	Care Council Planning Staff	Present results of the collected baseline data to community stakeholders	Community groups Care Council HIV Planning Partnership	Number of clients served Number of outreach activities conducted
Annually	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC, Ryan White Part A Recipient	Compile the number of outreach activities conducted and clients served in CY 2018, CY 2019, CY 2020, and CY 2021	Hispanic persons in the EMA	Number of clients served Number of outreach activities conducted
Annually	Care Council Planning Staff	Update community stakeholders on the area's progress towards increasing outreach efforts by 25%	Community groups Care Council HIV Planning Partnership	Number of clients served Number of outreach activities conducted

Strategy 3: Identify and prioritize effective outreach strategies targeting Hispanic persons based on feedback from PLWH and community providers.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2018, updated December 2020	HIV Planning Partnership	Host a focus group to assess strategies for engaging Hispanic persons in HIV prevention and care activities	Hispanic persons at high risk of HIV Hispanic persons living with HIV/AIDS Community providers	Meeting minutes
By December 2018, updated December 2020	Care Council	Host a focus group to assess strategies for engaging Hispanic persons in HIV prevention and care activities	Hispanic persons at high risk of HIV Hispanic persons living with HIV/AIDS Community providers	Meeting minutes

B. Tampa-St. Petersburg EMA Objective 2: By December 2021, increase culturally and linguistically competent outreach efforts, funded through the Department of Health and Ryan White, targeting Black persons in the EMA by 25% in order to engage the community in the continuum of care.

Strategy 1: Establish a baseline of the number of outreach activities conducted by CDC-funded organizations and Ryan White Part A Minority AIDS Initiative (MAI)-funded organizations targeting Black persons. Outreach is defined as face-to-face health information and education, linkage to care, testing, health system navigation, social marketing, and adherence support.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of CY 2017	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC,	Compile the number of outreach activities that were conducted targeting Black persons and Black clients served in CY 2017	Black persons in the EMA	Number of clients served Number of outreach activities conducted

	Ryan White Part A Recipient			
January 2018	Care Council Planning Staff	Compile the number of outreach activities that were conducted targeting Black persons and Black clients served in CY 2017 based on information provided by the previously referenced responsible parties	Black persons in the EMA	Number of clients served Number of outreach activities conducted

Strategy 2: Monitor and track progress on the number of outreach activities conducted and Black clients served.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
February 2018 – March 2018	Care Council Planning Staff	Present results of the collected baseline data to community stakeholders	Community groups Care Council HIV Planning Partnership	Number of clients served Number of outreach activities conducted
Annually	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC, Ryan White Part A Recipient	Compile the number of outreach activities conducted and clients served in CY 2018, CY 2019, CY 2020, and CY 2021	Black persons in the EMA	Number of clients served Number of outreach activities conducted
Annually	Care Council Planning Staff	Update community stakeholders on the area's progress towards increasing outreach efforts by 25%	Community groups Care Council HIV Planning Partnership	Number of clients served Number of outreach activities conducted

Strategy 3: Identify and prioritize effective outreach strategies targeting Black persons based on feedback from PLWH and community providers.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2018, updated December 2020	HIV Planning Partnership	Host a focus group to assess strategies for engaging Black persons in HIV prevention and care activities	Black persons at high risk of HIV Black persons living with HIV/AIDS Community providers	Meeting minutes
By December 2018, updated December 2020	Care Council	Host a focus group to assess strategies for engaging Black persons in HIV prevention and care activities	Black persons at high risk of HIV Black persons living with HIV/AIDS Community providers	Meeting minutes

C. Tampa-St. Petersburg EMA Objective 3: By December 2021, increase culturally and linguistically competent outreach efforts, funded through the Department of Health and Ryan White, targeting youth in the EMA by 25% in order to engage the community in the continuum of care.

Strategy 1: Establish a baseline of the number of outreach activities conducted by CDC-funded organizations and Ryan White funded organizations targeting youth. Outreach is defined as face-to-face health information and education, linkage to care, testing, health system navigation, social marketing, and adherence support.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of CY 2017	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC,	Compile the number of outreach activities conducted and clients served in CY 2017	Youth (age 13-24) in the EMA	Number of youth served Number of outreach activities conducted targeting youth

	Ryan White funded grant recipients			
January 2018	Care Council Planning Staff	Compile the number of outreach activities conducted and clients served in CY 2017 based on information provided by the previously referenced responsible parties	Youth (age 13-24) in the EMA	Number of youth served Number of outreach activities conducted targeting youth

Strategy 2: Monitor and track progress on the number of outreach activities conducted and youth served.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
February 2018 – March 2018	Care Council Planning Staff	Present results of the collected baseline data to community stakeholders	Community groups Care Council HIV Planning Partnership	Number of youth served Number of outreach activities conducted targeting youth
Annually	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC, Ryan White funded grant recipients	Compile the number of outreach activities conducted and clients served in CY 2018, CY 2019, CY 2020, and CY 2021	Youth (age 13-24) in the EMA	Number of youth served Number of outreach activities conducted targeting youth
Annually	Care Council Planning Staff	Update community stakeholders on the area's progress towards increasing outreach efforts by 25%	Community groups Care Council HIV Planning Partnership	Number of youth served Number of outreach activities conducted targeting youth

Strategy 3: Identify and prioritize effective outreach strategies targeting youth based on feedback from PLWH and community providers.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2018, updated December 2020	HIV Planning Partnership	Host a focus group to assess strategies for engaging youth in HIV prevention and care activities	Youth at high risk for HIV Youth living with HIV/AIDS Community providers	Meeting minutes
By December 2018, updated December 2020	Care Council	Host a focus group to assess strategies for engaging youth in HIV prevention and care activities	Youth at high risk of HIV Youth living with HIV/AIDS Community providers	Meeting minutes

Challenges and Barriers

The Integrated HIV Prevention and Care Plan encourages a streamlined approach to HIV planning. Unfortunately, data and funding limitations can impede the ability to achieve all identified objectives. Some of the anticipated barriers to plan implementation include difficulty sharing data between the various databases utilized for prevention and care services in the EMA, additional capacity needed to accommodate new positives, limited funding available for HIV support services (i.e., peer programs, support groups), and additional staff support needed to monitor plan progress.

B. Collaborations, Partnerships, and Stakeholder Involvement

Collaboration among stakeholders is critical to maximizing resources and efficiencies in serving people at-risk for HIV-infection and PLWHA. As the Tampa-St. Petersburg EMA strives to coordinate prevention, care, and treatment, collaboration becomes paramount to providing services that fully address each component of the HIV care continuum. This section describes the contributions of stakeholders and key partners to the development of the plan; describes stakeholders and partners not involved in the planning process, but who are needed to improve outcomes along the HIV care continuum; and includes letters of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the Area 5, 6, and 14 HIV Planning Partnership and the West Central Florida Ryan White Care Council.

Contributions of Stakeholders and Key Partners

Collaborative partnerships exist with local AIDS service organizations, community-based organizations, faith-based organizations, mental health providers, substance abuse agencies, housing providers, community health centers, hospitals, clinics, research institutions, the University of South Florida, and other representatives from state and local governments and agencies. All of these individuals/groups were actively involved in the drafting, reviewing, revising, disseminating, and soliciting input processes that went into the Integrated Plan, with the local HIV prevention and care planning bodies completing and providing concurrence on the Tampa-St. Petersburg Integrated HIV Plan. The Part A Recipient submitted the Tampa-St. Petersburg Plan to the HIV/AIDS Section of the Florida Department of Health, to be included as a chapter in Florida's Integrated HIV Plan. The Part A Recipient plans to submit the entire Plan to the Part A project officer. The HIV/AIDS Section will submit the entire Integrated Plan to both the CDC and Part B project officers.

The local HIV prevention planning body is the Area 5, 6, and 14 HIV Planning Partnership (HPP) covering the EMA and four additional counties. The HPP is co-chaired by a community representative and someone from the Florida Department of Health. The HPP is also responsible for electing a community representative and alternate to serve on the Florida HIV/AIDS Prevention Planning Group (PPG). The PPG assists with the development and has concurrence responsibilities for Florida's Statewide Integrated Plan. The current DOH co-chair of the HPP is also the DOH co-chair of the PPG.

The overall goal of the HPP is, "to improve local HIV prevention programs by strengthening the 1) scientific basis, 2) community relevance, 3) key stakeholder involvement, 4) risk-based focus of HIV prevention interventions, and 5) communication and coordination of services across the continuum of HIV prevention, care, and treatment, including social determinants of health associated with HIV/AIDS, STDs, infectious diseases, substance abuse, and mental health." With regard to stakeholders, the HPP defines a stakeholder as, "a person or representative who has personal or professional experience, skills, resources, or expertise in HIV." The HPP continually works on strategies to recruit and retain members, targeting participants who represent the diversity of HIV-infected populations, HIV service providers, and other individuals who are able to assist with the coordination and collaboration of prevention, care, and treatment services. The HPP also works to ensure the planning process aligns with the National HIV/AIDS Strategy and High Impact Prevention. The HPP identifies the top six priority populations for primary and secondary prevention based on persons living with HIV disease. The priority populations include 1) White MSM, 2) Black Heterosexuals, 3) Black MSM, 4) Hispanic MSM, 5) White Heterosexuals, and 6) Hispanic Heterosexuals.

The local HIV patient care planning body is the West Central Florida Ryan White Care Council. The Care Council carefully determines the needs of the HIV community in eight counties, including the Tampa-St. Petersburg EMA, by conducting a needs assessment. With this information and the input of community members who participate in committee meetings, town halls, and other community events, the Care Council decides how much Ryan White funding is allocated to each service category. The Care Council does not provide direct services, rather planning for and evaluating them. The Care Council is also responsible for electing a community representative and alternate to serve on the Florida HIV/AIDS Patient Care Planning Group

(PCPG). The PCPG assists with the development and has concurrence responsibilities for Florida's Integrated Plan, particularly the Statewide Coordinated Statement of Need.

Per the bylaws, the Care Council shall include representatives of health care providers, including Federally Qualified Health Centers; community based organizations serving affected populations and AIDS service organizations; social service providers, including housing and homeless services; mental health providers; substance abuse providers; local public health agencies; hospital planning agencies or health care planning agencies; affected communities, including PLWHA and historically underserved groups and sub-populations; non-elected community leaders; Medicaid representatives; Ryan White Parts B, C, and D; recipients under federal HIV programs; and formerly incarcerated individuals.

The Tampa-St. Petersburg EMA holds community input as the core component of providing HIV services and programs. The main sources of community input are the prevention and Ryan White needs assessments, the HPP and its committees, and the Care Council and its committees. The HPP has three committees, broken down by the Florida Department of Health's HIV/AIDS Program geographical areas. Areas 5 and 6 cover the Tampa-St. Petersburg EMA plus Manatee County. The Care Council Committees include the following: Planning and Evaluation; Membership; Standards, Issues, and Operations; Resource Prioritization and Allocation Recommendations; Health Services Advisory; Women, Infants, Children, Youth, and Families; and Consumer Advisory. Planning activities are guided by the Updated National HIV/AIDS Strategy and the HIV care continuum.

The community assessment serves as the basis for identifying populations at risk for HIV infection in Florida, the prevention needs of those populations, activities/interventions being implemented to address those needs and service gaps. The Ryan White needs assessment includes the process of establishing priorities and allocating resources based upon community input. The Care Council Planning and Evaluation Committee was responsible for overseeing the completion of the needs assessment elements. The needs assessment utilizes client surveys, focus groups, town hall meetings, epidemiological data, service utilization and expenditure data, analysis of public funding streams, and estimates of unmet need. The needs assessment components were presented to the Care Council by the Planning and Evaluation Committee for adoption. All Care Council meetings are open to the public and include an agenda item for community input.

This section highlights the collaborative spirit in the Tampa-St. Petersburg EMA for HIV programming and services. Key partners and stakeholders are actively involved in the HIV planning processes and were intimately involved in the development of the Integrated Plan, from stakeholder identification, to community engagement, to drafting pieces of the Plan (with so many pieces relying on community input for their development) including the goals and objectives, to commenting on said pieces, suggesting revisions, reviewing the revisions, and finally to accepting the Plan through formal voting at the HPP and at the Care Council. The Integrated Plan is designed to be a living document, meaning that future changes, revisions, evaluation, etc. will all rely heavily on collaborations, continued partnerships, and community involvement.

Stakeholders and Partners Not Involved in the Planning Process

As stated above, local planning activities are guided by the Updated National HIV/AIDS Strategy and the HIV care continuum. The Updated National HIV/AIDS Strategy states the following: “HIV does not impact all Americans equally.” Looking at this statement from the local level, it still holds true. While anyone can become infected with HIV, the epidemic is concentrated in key populations. Of the groups where HIV is most concentrated, there are three who are not currently actively involved in HIV planning in the Tampa-St. Petersburg EMA. These stakeholders include youth aged 13 to 24 years, with a special emphasis on young gay and bisexual men of color; transgender women, with a special emphasis on Black transgender women; and people who inject drugs.

Unique challenges for these three populations include social, economic, and cultural barriers that limit access to prevention and care. Stigma, misinformation about HIV and AIDS, low rates of condom usage, survival sex, and low rates of PrEP utilization are also contributing factors for their disproportionately higher rates of HIV infection. Additionally, state-prohibited syringe access programs continue to place injection drug users at increased risk of transmission. In recent years, there has been a drop-off of healthcare providers serving as members of the HPP, the Care Council, and their respective committees. As mentioned earlier, healthcare providers are still surveyed on a regular basis for emerging needs and identification of gaps and barriers.

The Area 5, 6, and 14 HIV Planning Partnership and the West Central Florida Ryan White Care Council will develop strategies to recruit and maintain members from all of these populations in order to develop strategies and interventions that will help improve the outcomes along the HIV care continuum.

C. People Living with HIV (PLWH) and Community Engagement

The Tampa-St. Petersburg Integrated Plan follows the strategies supported by CDC and HRSA for development by including at-risk groups and representation of people living with HIV/AIDS (PLWHA). This section describes how the people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the Tampa-St. Petersburg epidemic. It includes a description of how PLWHA contributed to the Plan’s development. The section describes the methods used to engage communities, PLWHA, and those at substantial risk of acquiring HIV, as well as other impacted populations. Lastly, this section details how impacted communities are engaged in the planning process.

How Plan Developers are Reflective of the Epidemic

The people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction since the Plan is developed jointly between the West Central Florida Ryan White Care Council and the Area 5, 6, and 14 HIV Planning Partnership (HPP).

The Tampa-St. Petersburg Eligible Metropolitan Area (EMA) engages the local communities through the West Central Florida Ryan White Care Council. As of February 2016, the Council is comprised of 24 members and is reflective of the epidemic in the EMA in most demographic areas. Overall, 39% of the Council are Persons Living with HIV/AIDS (PLWHA); 26% of the total Care Council members are Black, 22% Hispanic, 43% White and 9% are other races. The

Council is actively recruiting more Black members so the Council is more reflective of the epidemic. Overall, 48% of the Council members are 50-59 years of age, 13% are 40-49 years of age, 26% are 30-39 years of age and 13% are 20-29 years of age. The Council is currently recruiting members in the 20-29 year old age group and the 40-49 years of age group.

Of the nine self-identified PLWHA members, seven are men, and two are women. Three of the PLWHA members are Black, one is Hispanic and five are White. Seven of the PLWHA members are ages 50-59, one is 40-49 and one is 30-39 years of age.

The members of the Ryan White Care Council come from very diverse backgrounds--some are People Living with HIV/AIDS, some are community service providers (such as healthcare providers, case managers, mental health providers and housing providers), while others are family or friends of PLWHA.

The Care Council and its seven associated committees, comprised of Care Council members and additional committee members meet regularly and bring action items to the Council on a monthly basis. Members are responsible for disseminating information from the Council back to their respective areas of representation, as well as bringing concerns from those same areas to such meetings, thus ensuring that the voice of PLWHA in the EMA are included in the process.

As of December 2015, there were 68 members of the HPP. The top priority populations are represented on the HPP, whose members self-identify by race/ethnicity as 45.6% Black, 33.8% White, 19.1% Hispanic, and 1.5% Asian Pacific Islander. With respect to gender, the membership is 61.8% female and 38.2% male. Overall, 83.8% of the members self-identify as heterosexual and 16.2% as LGBTQ. Of the males, 38.5% self-identify as gay. Overall, 20.6% of HPP members self-identify as clients.

Inclusion of Persons Living With HIV/AIDS to the Plan Development

PLWHA are well represented in the development of this Integrated HIV Prevention and Care Plan, as 20.6% of the HPP members and 39% of the Care Council members self-identify as PLWHA, with Care Council committees having additional self-identified PLWHA representatives. The clients on the local HIV planning bodies were crucial in the review process of the plan. The Planning and Evaluation Committee of the Care Council was responsible for overseeing the completion of the Integrated Plan elements. Each element was reviewed, in conjunction with the comprehensive plan, unmet need estimates, and emerging issues in the EMA. The limitations and strengths of each element were discussed. The HPP, including client members, were surveyed about the goals, objectives, and strategies, as well as how to monitor and evaluate these. The Integrated Plan is designed to be a living document, meaning that future changes, revisions, evaluation, etc. will all rely heavily on at-risk groups, PLWHA, and those affected by HIV/AIDS through various community engagement processes.

Methods of Engaging Communities

The Tampa-St. Petersburg EMA regularly engages the community for input into the local HIV system. Methods for engaging the general community include HIV/AIDS awareness and testing day events; health fairs and community-events; targeted interventions and HIV testing; presentations on HIV such as National Public Radio's *HIV in the Community* held at the

University of South Florida (USF); the annual research symposium held at USF; and the *Faces of HIV* mobile art exhibit. For clients, they are regularly surveyed for customer satisfaction. The Florida Department of Health conducts an HIV testing customer satisfaction survey every two years, with the latest version being held in March 2016.

The Planning and Evaluation Committee regularly reviews and establishes service priority ranks for needed services in the EMA and reviews the HIV care continuum of the United States, Florida, the EMA and special populations. PLWHA are involved in the priority setting process in several key ways. First, a total of 1,154 clients completed an anonymous needs assessment survey designed to assess needs and identify service gaps. This resulted in 1,127 viable surveys for analysis. Second, there is PLWHA representation on the Planning and Evaluation Committee. The committee oversaw the design of instruments and developed the final priority rankings for Care Council adoption. Third, PLWHA were also represented on the RPARC, as well as the full council, the group ultimately responsible for adopting priorities and allocations. Fourth, all committee and council meetings were open to the public and included an agenda item for community input.

Unmet need estimates are used to concentrate efforts to areas and target populations and continue to build capacity in our care system. According to the Florida Department of Health in 2014, 3,708 PLWHA (30%) were aware of their status yet were not retained in care.

These estimates are used to focus efforts and activities of the local Early Identification of Individuals Living with HIV/AIDS (EIIHA) plan. EIIHA efforts focus on pre/post-test counseling, referrals and linkage into appropriate services. The overall goal is to identify people who are HIV+ and bring them into and/or retain them in care. The EMA's community based AIDS service organizations work to identify and engage HIV positive clients and get them into care. Major testing efforts continue in the area.

How Impacted Communities are Involved in the Planning Process

The Community Advisory and WICY&F Committees completed focus group style meetings within their committee meetings to ensure the voices of the community were heard and part of this Integrated HIV Prevention and Care Plan. Through these meetings, the committees were able to identify what is working well, what could be improved, barriers to accessing prevention and care services, and emerging and other unmet needs in the EMA. In addition, the Community Advisory Committee reviews the Client Satisfaction Survey to identify areas that have room for improvement, service needs and the areas that the EMA is reaching successfully.

To help assess current needs for HIV prevention services in Florida, the PPG in collaboration with the Florida Department of Health's Prevention Program conducted a HIV Provider Survey in July 2014. The Area 5, 6, and 14 HPP was charged with getting the word out locally about the Survey. The HIV Provider Survey was conducted as part of an ongoing needs assessment process to identify needs and service gaps related to the delivery of HIV services in Florida. The results of the survey, from just under 400 individuals, were used to help the FDOH Prevention Program better understand the prevention need for persons living with HIV/AIDS and those at-risk for HIV. They were also used in determining both Florida's and the EMA's Integrated Goals and Objectives.

To integrate prevention and care planning the EMA has done several things. The Care Council has multiple representatives from prevention who serve as members, in addition the Council elected members to participate on the statewide Patient Care Planning Group (PCPG). Members and Planning Council staff attend the Prevention Planning Group (PPG) and PCPG meetings and report back. The local HIV/AIDS Program Coordinators (HAPCs) attend Care Council meetings on a regular basis and work closely with the Part A Recipient. The Care Council agenda also includes a monthly prevention update.

III. MONITORING AND IMPROVEMENT

Monitoring the Integrated HIV Prevention and Care Plan will assist the EMA in providing high quality HIV prevention and care services. The local area has developed the following strategies to measure progress toward the goals, objectives, and strategies established in Section II.

Plan Updates

Stakeholders and planning bodies will be updated on the progress of plan implementation on an annual basis. A report on plan progress will be presented to the West Central Florida Ryan White Care Council and the HIV Planning Partnership in the first quarter of each calendar year. The planning bodies will utilize regularly collected surveillance and survey data, focus group, and community forum feedback to update the Epidemiologic Overview, Care Continuum, and Financial and Human Resources Inventory pieces of the plan on an as needed basis. These pieces will be utilized when ranking service priorities and allocating funding to care services and prioritizing prevention activities in the local area.

Plan improvements are contingent on a number of factors that must be considered over time including changing regulations and requirements, data limitations, and shifts in funding. As such, goals, objectives and strategies should be seen as fluid. They may adjust as needed to respond to funding and policy changes.

Monitoring and Evaluating Goals and Objectives

Ongoing monitoring of the Integrated Plan is undertaken by the Planning and Evaluation Committee of the Care Council, the Ryan White Quality Management Technical Workgroup, as well as the HIV Planning Partnership. Continual monitoring of plan implementation will assist planning groups in making decisions that are data driven. Monitoring and evaluation of the goals, objectives, and strategies will be executed through a collaborative partnership between HIV prevention and care-funded grantees and providers.

The first goal of the plan, reducing new infections, will be tracked by the Department of Health HIV/AIDS Program Coordinators (HAPCs) and monitored by the HIV Planning Partnership. The second goal, increasing access to care and improving health outcomes will be tracked by the Department of Health as well as Ryan White grant administrators and monitored by the Ryan White Quality Management Technical Workgroup. The third goal, reducing HIV-related disparities and health inequities, will be tracked by the Department of Health HAPCs as well as Ryan White grant recipients and monitored by the Planning and Evaluation Committee.

Community planning groups will monitor each goal as needed to enhance access to HIV prevention, care, and treatment services in the EMA.

Surveillance and Program Data

The EMA monitors surveillance data provided by the Florida Department of Health and analyzes local program data to assess and improve health outcomes along the HIV Care Continuum. Client level data for Ryan White-funded services in the EMA is reported in CAREWare and tracked by the Clinical Quality Management (CQM) program. The CQM program is a collaborative initiative between the Ryan White Part A Recipient, the local Ryan White Part B Lead Agency, providers within the service area and the subcontracted CQM provider. The primary purpose of the program is to improve the quality of care and services and improve health outcomes and quality of life for people living with HIV and AIDS. The CQM program reports their findings to community planning bodies to use as a reference tool when setting service priorities and allocating resources.

West Palm Beach (Palm Beach County)

Palm Beach County Integrated Prevention and Patient Care Plan

Introduction

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

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

Patient Care Programs

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

HIV Prevention Programs

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

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

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

The Community Planning Partnership:

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

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

Development of the Integrated Plan

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

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

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

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

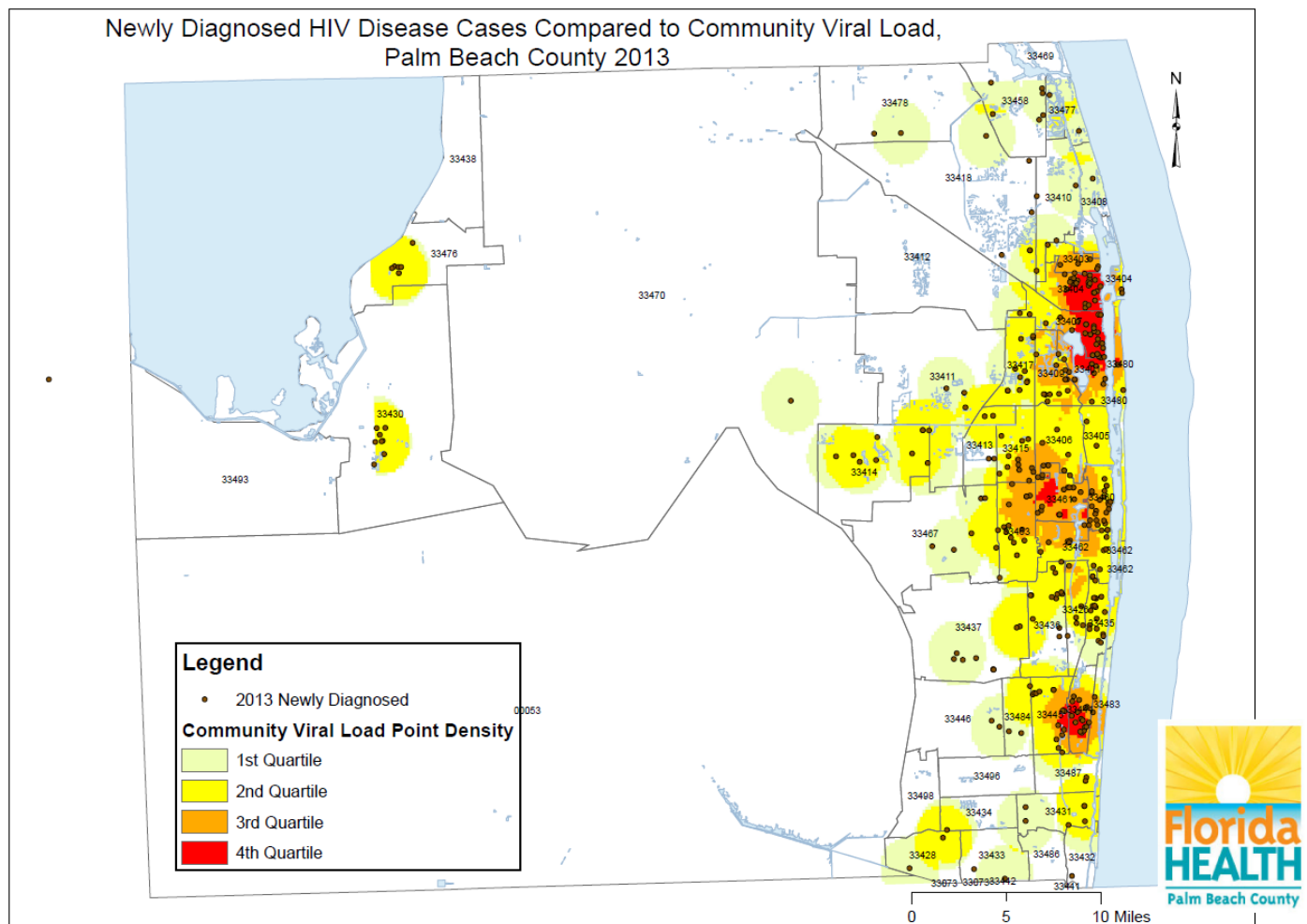
recommendations are discussed below). The RARE 2015 report was presented at the CARE Council annual retreat, and the recommendations were incorporated into this document.

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

Jurisdictional Description of HIV Infection by Geographical Region

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

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



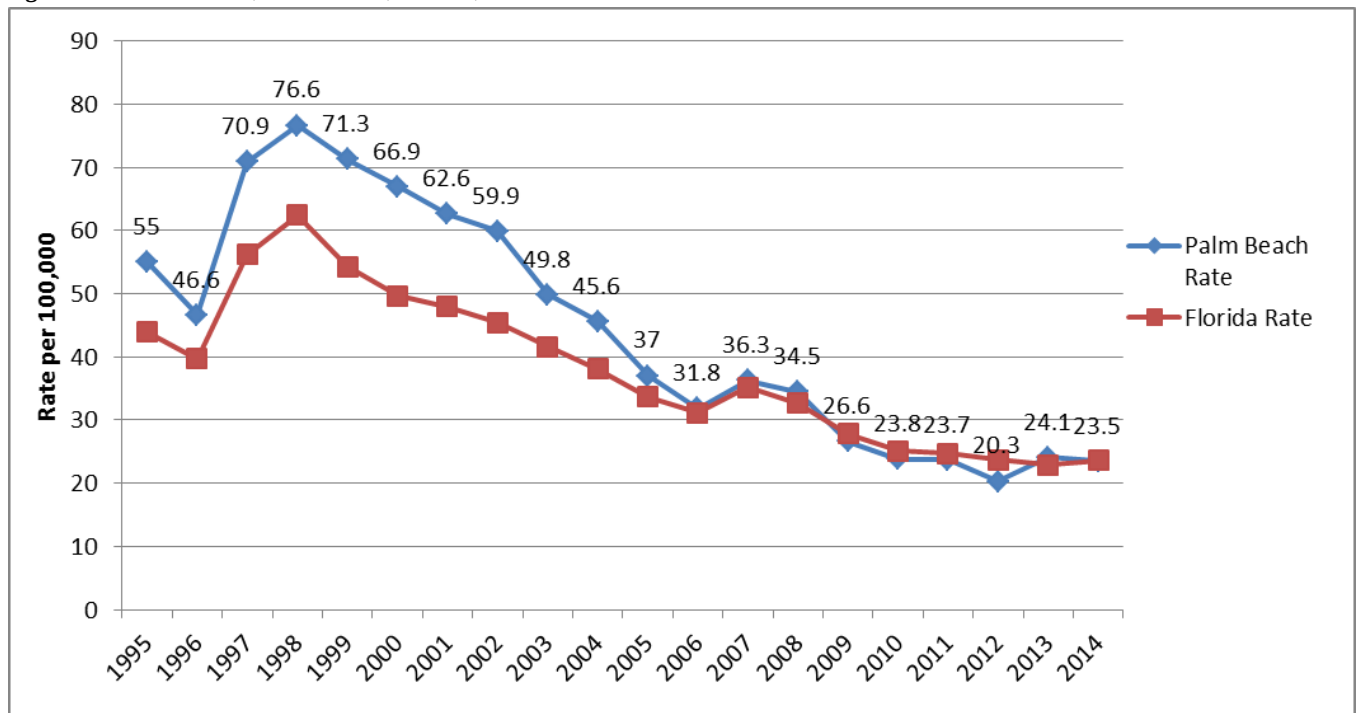
northern and southern coastal area of the county, with surrounding areas demonstrating lower areas of HIV infection. The western side of the county demonstrates areas with a moderate concentration of HIV infection and includes the rural cities of Belle Glade, Pahokee, South Bay and Canal Point.

HIV Incidence

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

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

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



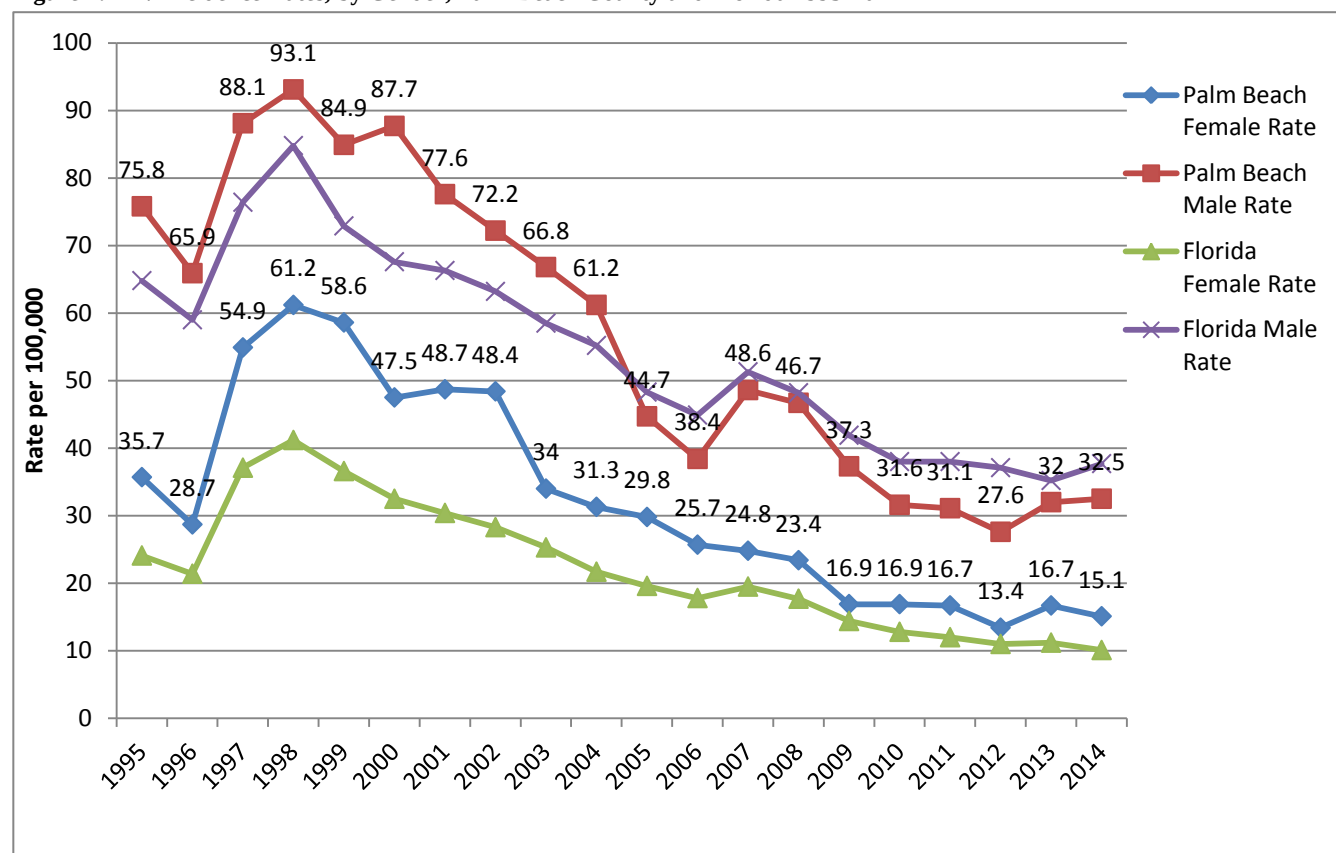
Data Source: FloridaCHARTS, Florida Department of Health, HIV/AIDS Section

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

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

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

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



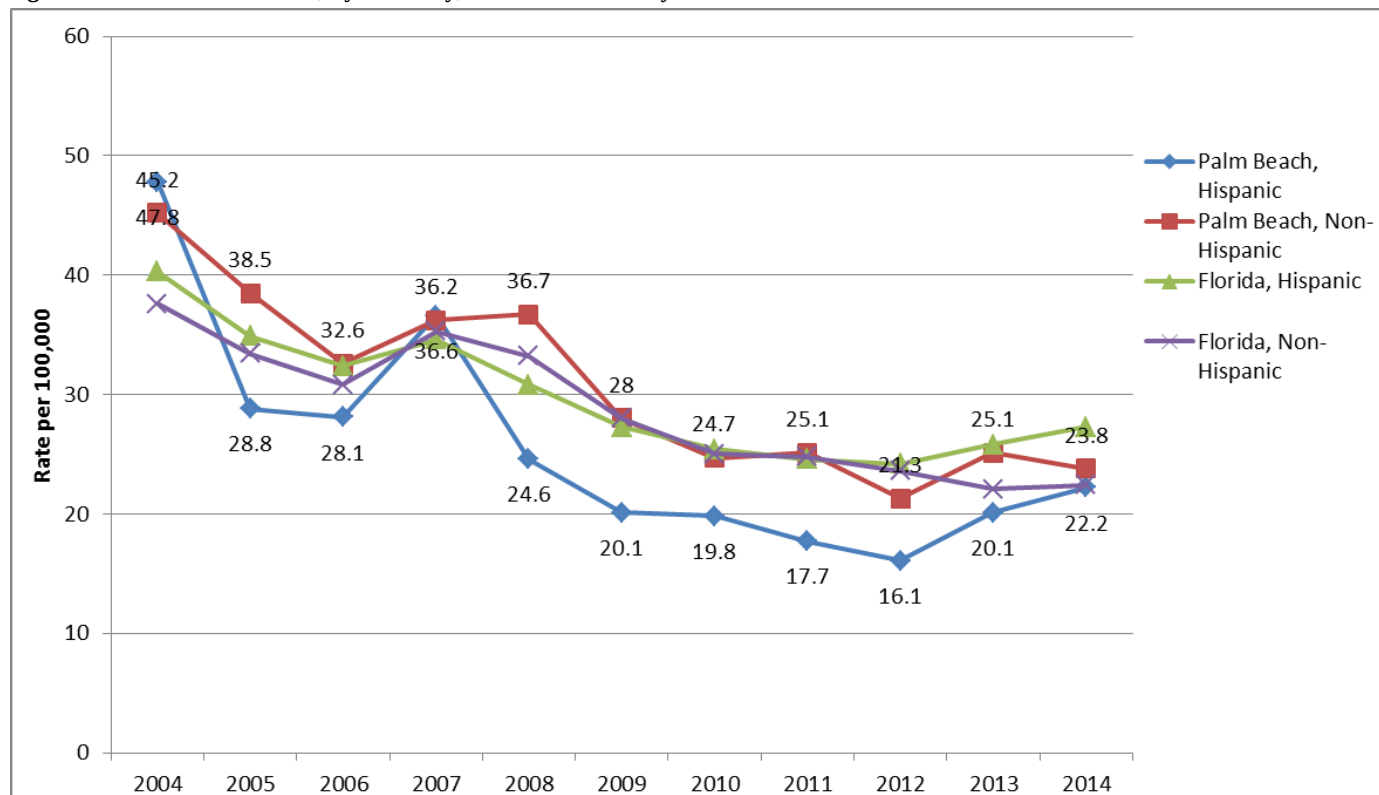
Data Source: FloridaCHARTS, Florida Department of Health, HIV/AIDS Section

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

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

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

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



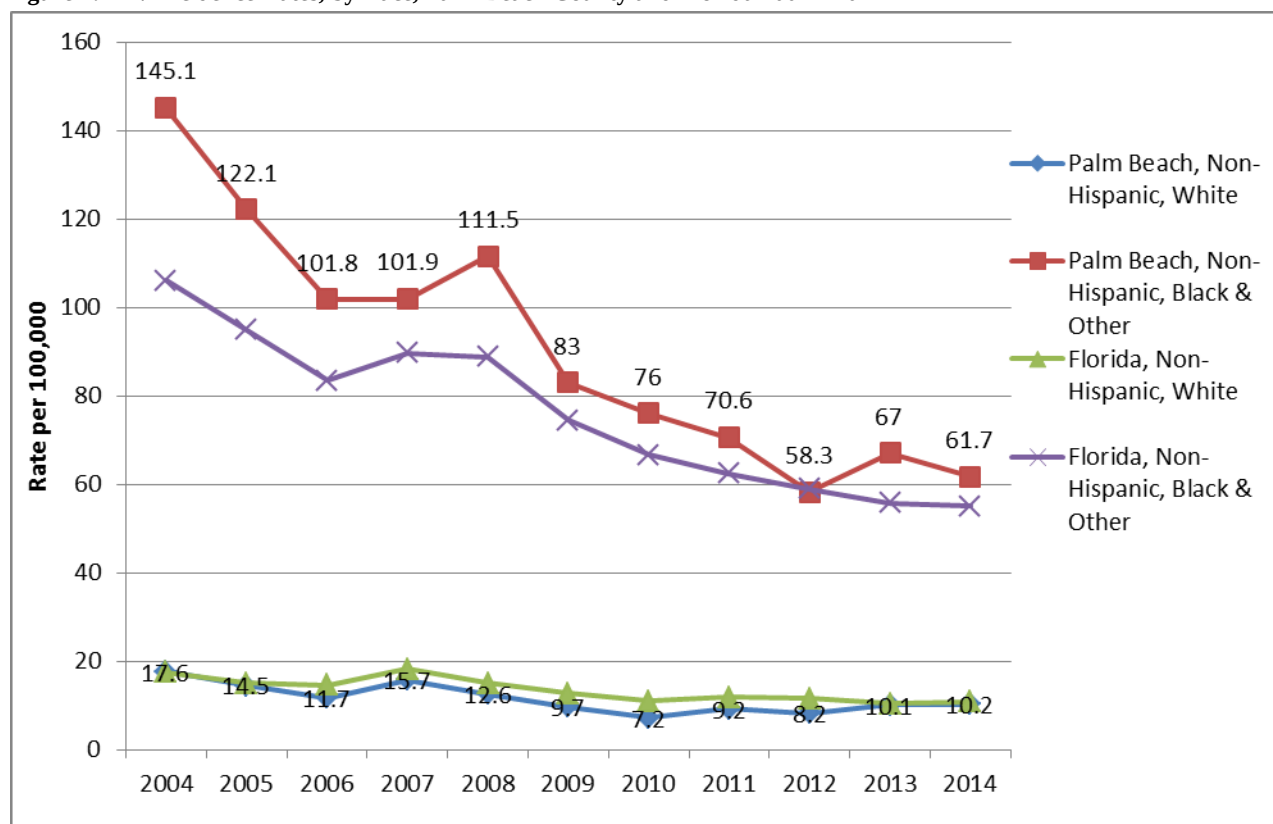
Data Source: FloridaCHARTS, Florida Department of Health, HIV/AIDS Section

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

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

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

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



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

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

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

HIV Prevalence

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AIDS Incidence

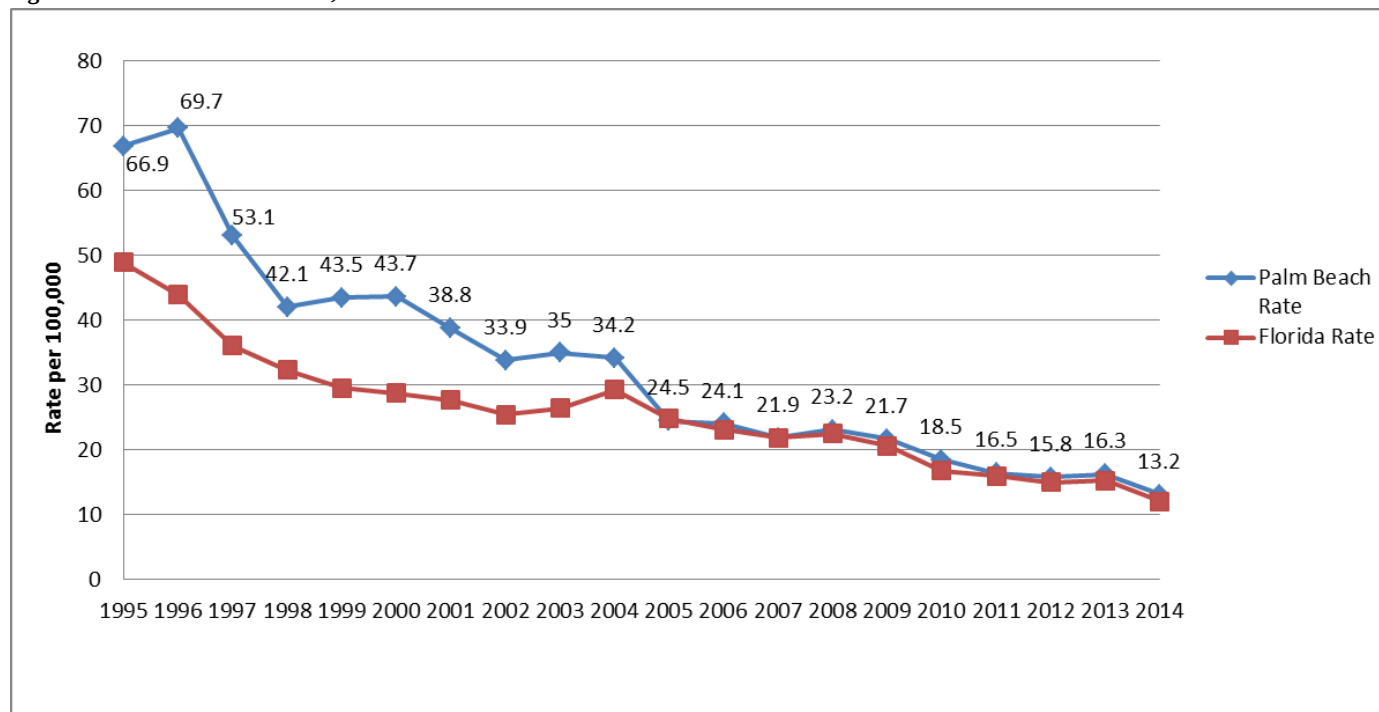
AIDS incidence is the number of newly diagnosed AIDS cases during a period of time. Table 15 and Figure 5 show the AIDS incidence in Palm Beach County and Florida from 1995 to 2014. Data labels are shown for Palm Beach County rates. The rate in both areas decreased considerably during the time period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

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

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

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

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



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

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

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

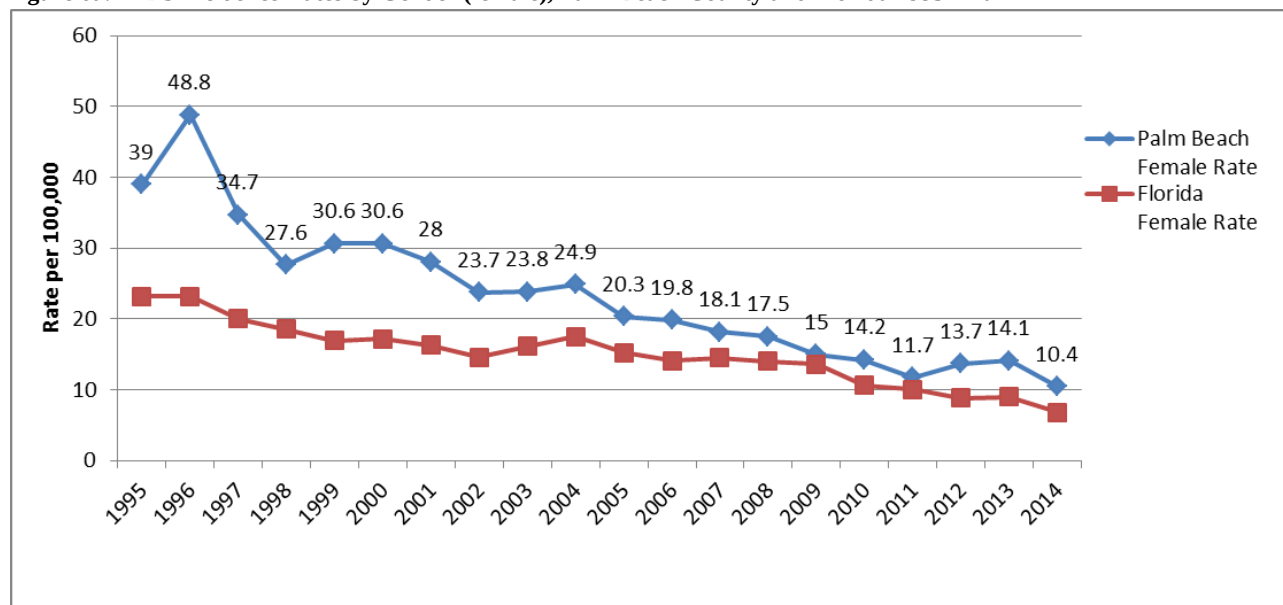
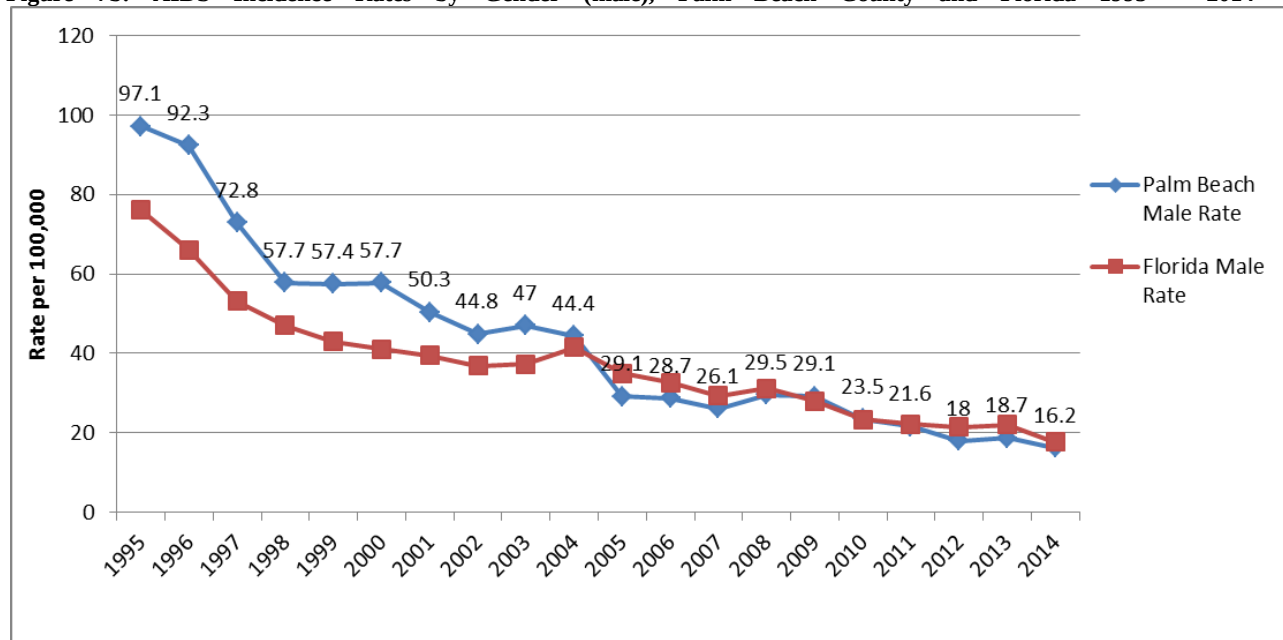


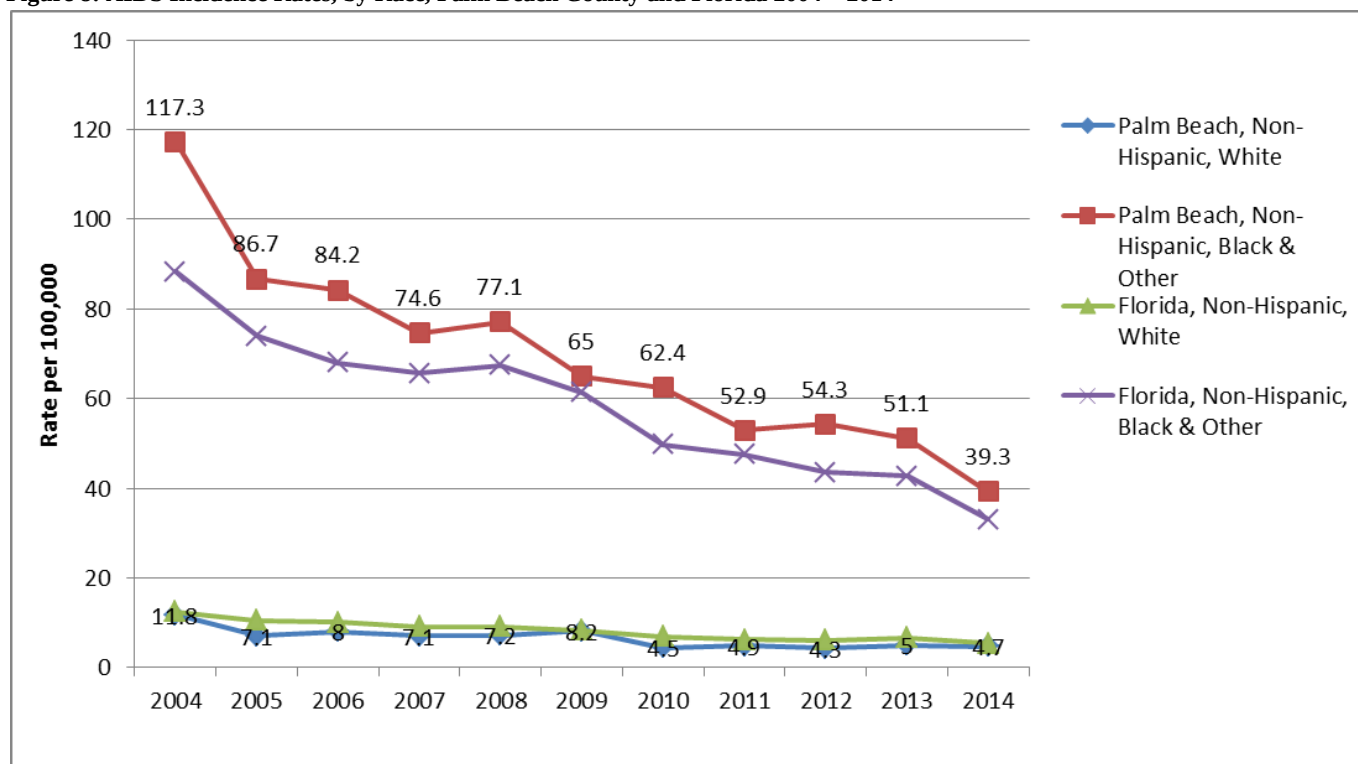
Figure 7b: AIDS Incidence Rates by Gender (male), Palm Beach County and Florida 1995 – 2014



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

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

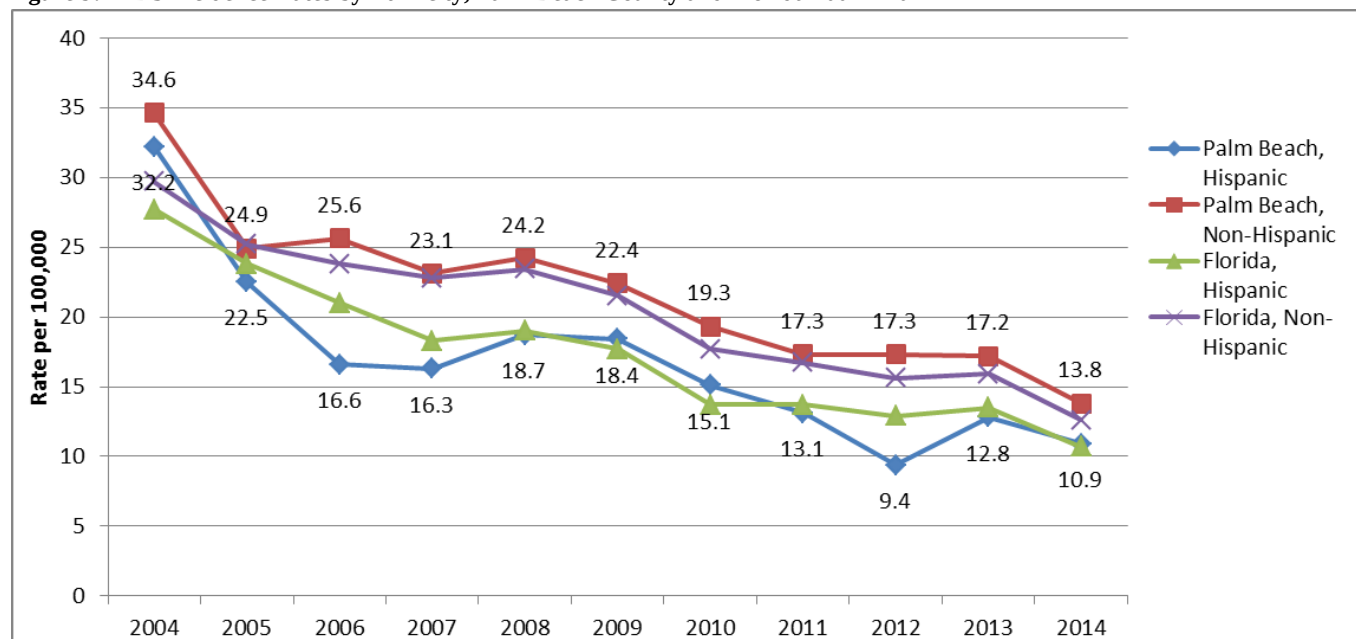
Figure 8: AIDS Incidence Rates, by Race, Palm Beach County and Florida 2004 – 2014



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

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

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



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

AIDS Prevalence

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

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

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

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

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

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

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

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

Comorbidities and Other Infections

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

Infectious Syphilis

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

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

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

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

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

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

⁵ FloridaCHARTS, Accessed 3/12/14

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

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

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

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

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

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

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

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

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

Gonorrhea

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

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

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

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

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

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

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

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

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

⁷ FloridaCHARTS, Accessed 3/12/14

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

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

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

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

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

Tuberculosis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HIV Counseling and Testing

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

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

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

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

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

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

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

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

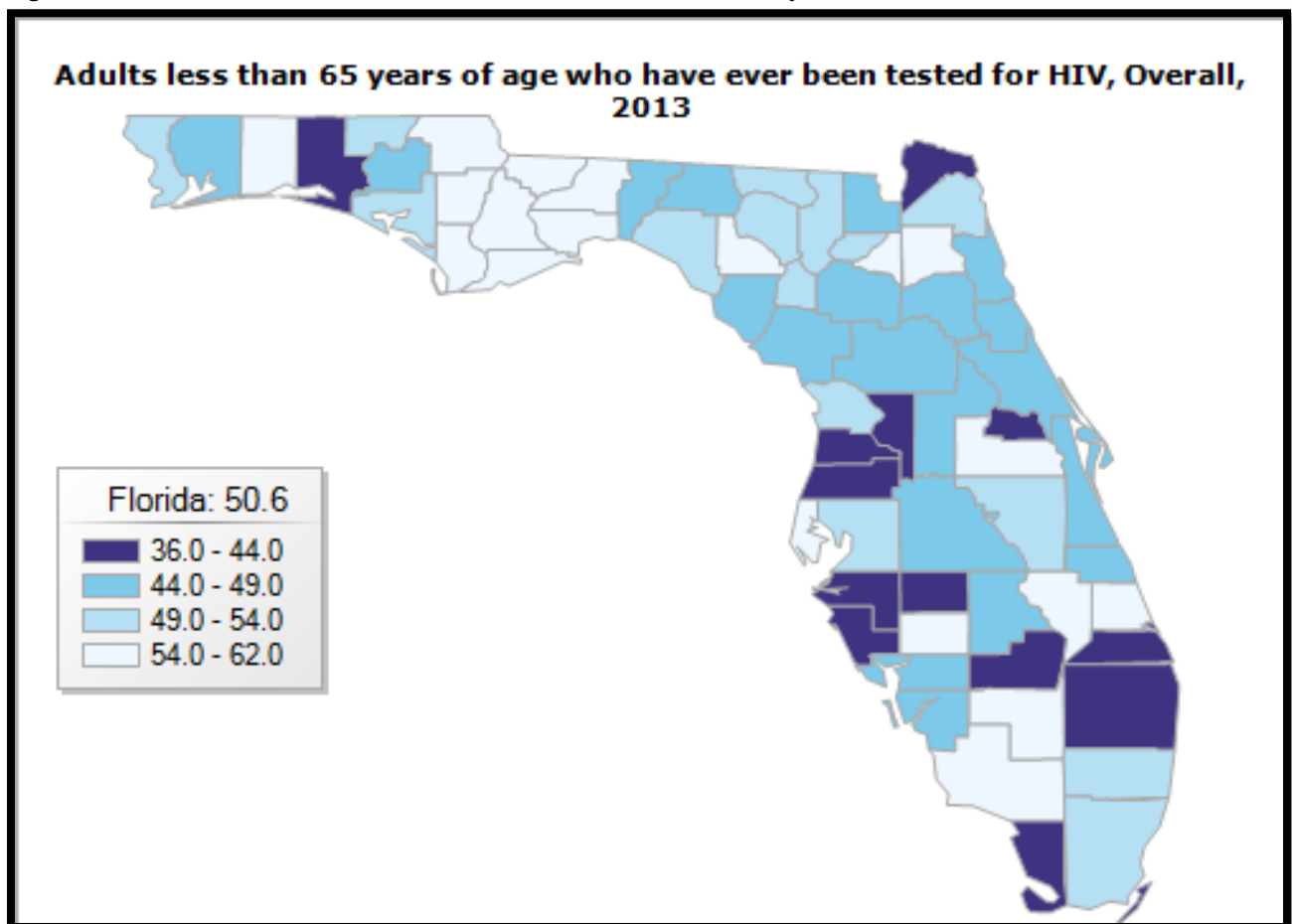
Table 28 and Figure 9 show adults under age 65 in Palm Beach County and in Florida who reported ever having been tested for HIV. In 2013, the percentage in Palm Beach County 42.8% was slightly lower than Florida, 50.6%.

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

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

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

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



HIV Death Rates and Counts

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

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

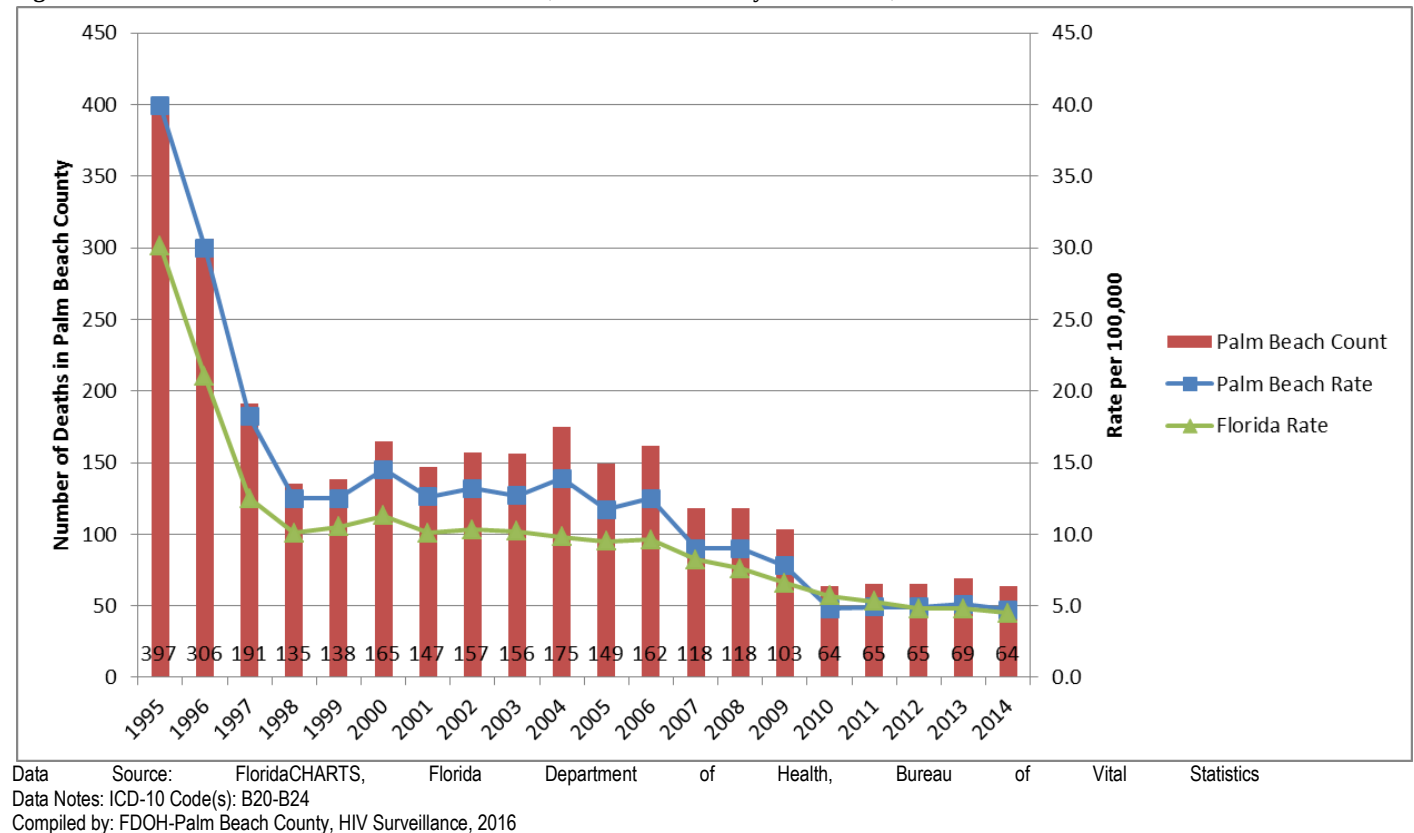


Table 29 shows deaths from HIV and AIDS in Palm Beach County and in Florida in 2012, 2013 and 2014 by gender. In 2014, the Palm Beach County rate of death in males was higher in both the county (6.4 vs. 3.1 per 100,000) and the state (6.2 vs. 2.8 per 100,000) than in females.

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

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

Data Source: FloridaCHARTS, Florida Department of Health, Bureau of Vital Statistics

Data Note: Rates per 100,000

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

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

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

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

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

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

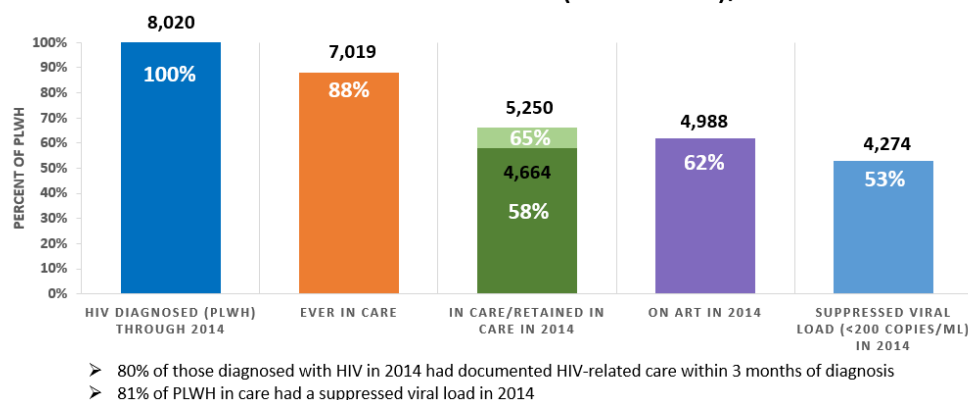
Table 23: Deaths from HIV/AIDS, Palm Beach County and Florida, by Ethnicity 2010, 2011, 2012

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

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

HIV CARE Continuum

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



(1) **HIV Diagnosed:** Persons diagnosed and living with HIV (PLWH) in Florida through the end of 2014.

(2) **Ever in Care:** PLWH with at least 1 documented viral load (VL) or CD4 lab, medical visit or prescription since HIV diagnosis.

(3) **In Care:** PLWH with at least 1 documented VL or CD4 lab, medical visit or prescription in 2014.

Retained in Care: PLWH with 2 or more documented VL or CD4 labs, medical visits or prescriptions (at least 3 months apart) in 2014.

(4) **On ART:** Estimated PLWH on antiretroviral therapy (ART) in 2014 (estimated from 2013 FL MMP data).

(5) **Suppressed Viral Load:** PLWH with a suppressed VL (<200 copies/mL) on last VL in 2014.



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

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

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

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

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

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

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

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

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

Financial and Human Resources Inventory

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

Palm Beach County, Patient Care 2015

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

Community Resources

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

Notes:

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

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

Community Resources

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

Notes:

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

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

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

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

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

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

Needed Resources

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

Assessing Needs, Gaps, and Barriers

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

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

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

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

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

Key Findings

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

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

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

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

Homelessness

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

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

Recently Released Former Prisoners

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

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

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

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

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

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

¹² Ibid.

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

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

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

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

Mental Illness

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

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

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

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

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

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

Substance Use

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

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

Hepatitis C

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

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

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

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

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

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

Data: Access, Sources, and Systems

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

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

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

Section II: Integrated HIV Prevention and Care Plan

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

GOAL 1: REDUCE NEW HIV INFECTIONS

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

Strategies:

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

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

Strategies:

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

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

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

Strategies:

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

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

Strategies:

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

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

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

Strategies:

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

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

Strategies:

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

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

Strategies:

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

GOAL 4: MONITORING AND EVALUATION

Objective 1: Develop an integrated planning and evaluation process

Strategies:

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

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

Strategies:

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

Collaborations, Partnerships and Stakeholder Involvement

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

PLWHA and Community Engagement

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

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

Section III: Monitoring and Improvement

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

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