




DECEMBER 30, 2019

FLORIDA'S UNIFIED ENDING THE HIV EPIDEMIC DRAFT PLAN

Florida Department of Health
Division of Disease Control and Health Protection
Bureau of Communicable Diseases
HIV/AIDS Section



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EXECUTIVE SUMMARY

In 2016, the Florida Department of Health (FDOH) HIV/AIDS Section developed a 4-Key Component Plan to eliminate HIV transmission and reduce HIV-related deaths: 1) implement routine HIV and sexually transmitted infection (STI) screening in health care settings and priority testing in non-health care settings; 2) provide rapid access to treatment and ensure retention in care (Test and Treat); 3) improve access to antiretroviral pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP); and 4) increase HIV awareness and community response through outreach, engagement, and messaging. Florida's 4-Key Component Plan aligns well with the pillars of the Ending the HIV Epidemic (EHE) initiative—diagnose, treat, prevent, and respond—released by the President in February 2019.

This document serves as Florida's draft unified EHE plan, representing the state and seven counties identified as Phase 1 EHE jurisdictions (Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, and Pinellas). As the process for moving from planning to implementation is expected to be iterative, this plan will be a "living" document as implementation begins. In mid-October through early December 2019, varying degrees of community engagement took place at the state and local levels. Some counties initiated community and provider surveys, while others held listening sessions, town hall meetings, and/or key informant interviews. Additional community engagement will take place throughout the remainder of the accelerated planning process, with the final EHE plan submitted by September 29, 2020.

Florida is a large state, with a total population of approximately 21 million in 2018 (third in the nation). A total of 119,661 persons were living with HIV in Florida through 2018, and an additional estimated 17,700 (12.9%, based on the Centers for Disease Control and Prevention [CDC] methodology for Florida's population) persons were living with HIV but unaware of their status. To reduce new HIV diagnoses in Florida, it is critical to ensure that everyone with HIV is aware of their status, is linked to and retained in HIV medical care, and maintains viral suppression. Collaborative efforts from prevention and patient care programs at the state and local level, including by county health departments (CHDs), Ryan White HIV/AIDS Program partners, community-based organizations (CBOs), and health care providers, are an integral part of accomplishing this agenda.

Care and support services are provided to low-income Floridians living with HIV/AIDS who have inadequate or no health insurance and are ineligible for Medicaid, Medicare, or other public insurance programs. Medical care, pharmaceuticals, dental services, payment of health insurance premiums, medical case management, and housing assistance are some of the funded services. Approximately 90 percent of AIDS Drug Assistance Program (ADAP) clients have undetectable HIV viral loads, indicating their disease is controlled. Medical professionals provide clinical consultation to health care professionals regarding quality care, adherence, antiretroviral resistance, drug regimens, laboratory requirements, and other medically related concerns.

Keeping persons living with HIV/AIDS (PLWH) in care and virally suppressed is key. Holistic management can stop transmission. For this reason, it is important to expand access to care for those with HIV/AIDS by implementing person-centered care models, streamlining protocols, training more health care workers on the Ryan White HIV/AIDS Program, and offering mental health and substance abuse

treatment. Ryan White HIV/AIDS programs provide a comprehensive system of care that includes primary medical care and essential support services for uninsured or underinsured PLWH.

There must also be a focus on the social determinants of health that preclude people from engaging in prevention activities, seeking treatment, and acquiring an adequate level of health literacy. Key social determinants for the state include, but are not limited to, homelessness, poverty, racism, violence, stigma, homophobia, and transphobia. Initiatives such as anti-stigma campaigns, collaborations with faith-based organizations, and those that address social determinants will aid in ending the HIV epidemic. The HIV/AIDS Section will collaborate with the Florida Department of Health, Office of Minority Health and Health Equity (FDOH, OMH) to promote synergistic initiatives between the Closing the Gap grant program and the HIV/AIDS Section.

DRAFT

SECTION I: COMMUNITY ENGAGEMENT

Many definitions of ‘community’ exist. Community may refer to geographically defined areas or groups that share a common history or interest, a sense of collective identity, values and norms, mutual influence among members, common symbols, or some combination of these dimensions.¹ In the events described below, community engagement took place at the state level and in the seven counties identified through the EHE initiative: Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, and Pinellas.

Community members are engaged in all phases of the planning process and will continue with the implementation of strategies and activities to end the HIV epidemic in Florida. Community member insights and perspectives enhance FDOH knowledge and understanding of community dynamics and conditions. These events serve two purposes: they provide an opportunity to hear community concerns from various perspectives and engage individuals in becoming part of ongoing planning.

FLORIDA GAY MEN’S WORKGROUP

A consultation session was held with the Florida Gay Men’s Workgroup on November 8, 2017, in Fort Lauderdale, FL. The purpose of the consultation was to identify activities that address the rising HIV and syphilis rates among gay, bisexual, and other men who have sex with men (MSM). Session participants developed recommendations for an action plan that would prioritize activities around Florida’s 4-Key Component Plan, specifically within the MSM community.

The participants were divided among three groups to address these key topics: intersection of MSM and transgender populations, public sex environments, and media and marketing processes. The group exercise was designed to promote a new framework to develop strategies for addressing HIV and syphilis in the MSM community. Key strategies identified included developing educational tools around acceptance, stigma, communication skills, and service barriers; attempting to use local celebrities in ads and messaging; and working closely with the workgroup to review graphics and language. Additional engagement with the workgroup will occur during the accelerated planning process.

FLORIDA COMPREHENSIVE PLANNING NETWORK

The FDOH HIV/AIDS Section works in partnership with a statewide HIV planning body—the Florida Comprehensive Planning Network (FCPN). Members of FCPN include PLWH and representatives from local planning bodies, CBOs, academic institutions, local and regional clinics, city and county governments, Ryan White HIV/AIDS Program Part A recipients, the transgender community, advocacy groups, substance abuse and social service providers, and behavioral science groups.

On November 19–21, 2019, in Lutz, FL, the full FCPN membership (48 voting members and 60 guests) met to discuss the state of HIV/AIDS at the federal, state, and local level. Participants were divided into working groups tasked with providing input on common strategies for each of the four EHE pillars. These common strategies reflect a unified approach to ending the HIV epidemic in Florida. FDOH and FCPN will continue to refine the strategies and activities through additional community engagement sessions with local prevention and care integrated planning bodies, local community partners, and local service providers. Strategies identified as *county specific* are included in subsequent sections of this plan.

STATEWIDE COMMUNITY HIV ADVISORY GROUP

The primary function of the Community HIV Advisory Group (CHAG) is to provide meaningful input into the development of FDOH procedures and programs that impact PLWH. CHAG is a group of PLWH from around the state of Florida selected through an application process and reflective of the HIV community throughout the state.

During the statewide CHAG meeting May 16–17, 2019, in Lutz, FL, members engaged in discussion with HIV/AIDS Section representatives to discuss the importance of the Prevention Access Campaign’s Undetectable=Untransmittable initiative (U=U). It was relayed that U=U helps reduce stigma, helps motivate individuals to get in and stay in care, and could be used as an adherence tool. Members suggested that the HIV/AIDS Section review messaging from other southern state departments of health that have endorsed U=U. The group emphasized the importance of messaging and the need for continued condom use in order to prevent other STIs.

A follow-up meeting was held on November 18, 2019, to review and discuss strategies and activities included in the recent Ryan White HIV/AIDS Program Part A applications and CHAG member roles in ensuring authentic community engagement occurs at the local level. An annual work plan was developed around the EHE common strategies.

AD-HOC CONSULTATIONS

From 2016 to 2018, the HIV/AIDS Section held sessions with representatives from priority populations in an effort to engage and obtain programmatic feedback on HIV prevention and care activities. Certain recommendations from these sessions became key strategies and activities in FDOH’s statewide plans—the Agency Strategic Plan and State Health Improvement Plan—as well as the state’s Integrated HIV Prevention and Surveillance Cooperative Agreement (CDC PS18-1802), which was funded in January 2018.

In June 2016, a consultation session was held in Orlando, FL, to assist in developing strategies that address the HIV epidemic among Florida’s Latinx population. Participants were divided among three groups to address each of the National HIV/AIDS Strategy goals. A set of questions was used to facilitate the discussion. Many of the same topics surfaced among the groups and were used to identify key recommendations or strategies for inclusion in the statewide plans to address identified needs among the Latinx population. Recommendations included 1) providing a more holistic approach to health and include HIV testing along with other disease screening; 2) providing more testing opportunities in non-traditional settings during non-business hours; 3) examining the disease intervention specialist position to determine ways to stabilize the workforce necessary to address linkage-to-care issues; 4) providing formalized training for ambassadors to assist in spreading the word in the community; 5) reinvigorating the Faith Responds to AIDS (FRTA) initiative as an effective way to reach the Latinx population; 6) reducing stigma by removing the focus on sin related to HIV and other lesbian, gay, bisexual, transgender, and queer (LGBTQ+) issues within the church setting; and 7) providing cultural awareness training to clinic staff, including providers and others who may interact with clients.

In 2017, a group of 15 Black women from across the state of Florida convened in Fort Lauderdale, FL, to participate in a Black women’s consultation. The participants were tasked with summarizing and discussing data presented by FDOH on the HIV epidemic in Florida. The group identified a common agenda, which was to recommend systems, activities, and responsibilities by various entities that would assist in progressing toward zero HIV cases for Black women. Recommendations were provided to FDOH with examples of activities, programs, actions, messaging, and messengers that should be included in a framework designed to address HIV among Black women. Recommendations focused on five areas: individuals, providers/policy, community, social media, and FDOH programming. For individuals, they recommended promoting HIV education with professionals outside of the traditional work force. For providers/policy, they recommended incorporating health equity strategies and reviewing the legislative intent of the Targeted Outreach for Pregnant Women Act to ensure comprehensive services are offered. For the community, the women recommended implementing an ambassador program for Black women. For social media, they suggested using minority media companies to develop minority focused materials and a campaign focused on newly diagnosed individuals to demonstrate that PLWH can live happy, healthy, and productive lives; HIV campaigns should also include healthy relationships between sero-discordant couples. For FDOH, the women suggested reviving and revising Sistas Organizing to Survive, approving the use of social media platforms beyond FDOH sites to promote HIV prevention, and developing a statewide workgroup specifically for Black women.

A statewide Haitian consultation was facilitated by the Black AIDS Institute December 10–11, 2018, in Tallahassee, FL. Specific leaders who are providers and advocates within the Haitian community were invited to participate in the session. Consultation objectives were to develop a shared understanding of demographic data around HIV and other STIs in Florida’s Haitian communities; to understand and discuss the context in which the demographic data exist, including, but not limited to, the effects of xenophobia, racism, language access, and stigma; and to have a deeper understanding of cultural attitudes around HIV, including medical mistrust and other healing systems.

Recommendations were developed and provided to FDOH to assist in continued engagement activities with the Haitian community. Recommendations included using materials that show positive trends in decreasing HIV transmission and/or successes in viral load suppression, using storytelling tactics to convey information about PrEP, translating written materials into both French and Haitian Creole, offering opportunities for community members to review materials, including more frontline staff from the Haitian community, and further incorporating the experiences and knowledge of frontline staff into institutional decisions.

LOCAL COMMUNITY ENGAGEMENT

FDOH collaborates with regional HIV/AIDS Program Coordinators to engage with local communities regarding EHE planning. In mid-October through early December 2019, varying degrees of community engagement took place at the state and local levels. Several counties initiated community and provider surveys, while others held listening sessions, town hall meetings, and/or key informant interviews. Additional community engagement will take place throughout the remainder of the accelerated planning process.

Broward County

Listening sessions and focus groups with priority populations (providers, transgender individuals, MSM, Black heterosexual women, Latinx individuals) took place in Broward County in October and November 2019. These sessions were used to discuss strengths within the county that will aid in successful implementation of EHE activities and barriers that will need to be addressed. Within the context of the strengths and barriers, each engagement session produced relevant strategies and activities that should be implemented.

Forty key informant interviews took place between October 28 and December 2, 2019. Interviews were conducted with partners and community members and included representatives from Federally Qualified Health Centers (FQHCs), the housing and private sectors, physicians' groups, LGBTQ+ centers, law enforcement agencies, the Urban League, the local school board, retail pharmacies, transgender groups, legal aid services, the Children's Services Council, Equality Florida, and community-based HIV service providers.

In addition to listening sessions and focus groups, a needs-based survey tailored to the county/community was designed and administered by the Florida Department of Health in Broward County. The survey was conducted with service providers and the community at large. The survey was delivered to populations across the county, and respondents could complete it either online or on paper. To-date, over 2,100 surveys have been collected, of which nearly 1,700 are from community members and over 400 are from providers and partners. Marketing for the community survey was conducted on multiple platforms and to priority populations. The survey was advertised through newspapers (Sun Sentinel, El Sentinel, South Florida Gay News, Westside Gazette, AcheiUSA-Brazilian news, Gazeta Brazilian News, Caribbean National Weekly), radio (WEDR-FM/WHQT-FM, WHYI-FM [Y100], WZTU-FM, WLQY 1320/WSRF 1580), and digital platforms (Facebook, Grindr, NextDoor).

Duval County

In November 2019, a focus group session with partners in the faith community was held to discuss the faith community's role in ending the HIV epidemic. Faith leaders identified the need for increased involvement in combating the epidemic. Working with these trusted messengers in the community is key to addressing stigma and the social justice aspect of the HIV epidemic. This new line of communication could lead to permanent changes in the interaction between faith-based organizations and the community. Community engagement sessions will continue and increase as we move through the accelerated planning process.

Hillsborough County

The EHE planning process and a summary of the Ryan White Part A application were discussed at Fast-Track Tampa Bay's Community Engagement Committee meeting in October 2019 to make the participants aware of the process to date and more opportunities for community engagement in early 2020. During the National Black Leadership Commission on Health Town Hall meeting, ending the HIV epidemic was discussed and the Tampa Chapter announced the rebranding and expansion of the organization's health focus to include HIV/AIDS and hepatitis, among other health concerns.

Miami-Dade County

Community members in Miami-Dade have been engaged via surveys, listening sessions, town hall meetings, online community forums, and key informant interviews. Community engagement sessions are ongoing through the accelerated planning process. A needs-based survey tailored to the county/community was designed and administered by the Florida Department of Health in Miami-Dade County. The survey was delivered to populations across Miami-Dade County, and respondents could complete it either online or on paper. The survey was live from October 22 to November 15, 2019.

Listening sessions were conducted with a variety of groups, including but not limited to trans focus groups, organizations that primarily serve Black and Latinx communities, and prevention committee members of the Miami-Dade HIV/AIDS Partnership.

Nine key informant interviews took place with individuals involved in various field work related to HIV prevention and care. Each participant came from a different organization. These individuals are senior-level professionals within their organizations. The nine types of organizations represented were Ryan White HIV/AIDS Part A programs, FQHCs, housing authorities, syringe services programs (SEPs), private sector businesses, homelessness councils, hospitals, mental health providers, and correctional institutions. Six interviews were conducted in person and three were conducted over the phone; these interviews ranged from 45 to 60 minutes. Interview questions were related to HIV prevention and care, PrEP, and community engagement.

Four online community forums were coordinated and facilitated by representatives of targeted communities (e.g., LGBTQ+, Black, Latinx, and PLWH). Facebook Live was used as the medium for each online forum, and Instagram Live was used simultaneously for one of the forums. While a tool with questions was prepared as a guide, the session was driven mostly by input provided by members in the online audience. Comments, number of views, and other data were captured through screen recordings of the live sessions. Each online forum lasted for about 60 minutes. This same session was also conducted during a live radio session on Cadena Azul 1550 AM.

Four town hall meetings were organized in Miami-Dade County. Each town hall was in a different geographic area—North, Central, West, and South Miami-Dade—to capture different portions of the population. They were promoted through flyers individualized for each event. The North town hall was facilitated in Creole by a representative from FDOH, and the South town hall was facilitated in Spanish by the regional planning council. Each town hall lasted between one and two hours. Feedback was analyzed to identify common themes for inclusion in the draft EHE plan.

Orange County

Two surveys, one specific to the community and the other specific to providers, were conducted in Orange County November 4–25, 2019. The community survey focused on clients and advocates to gather feedback on strategies that will help decrease HIV transmission rates in the county. The provider survey was distributed to service providers, including but not limited to medical providers and case managers. A comprehensive analysis of survey responses is currently underway.

In collaboration with the Heart of Florida United Way, a listening session was conducted with community partners in December 2019. PLWH were invited to engage in discussion on gaps and barriers

that should be addressed through EHE activities. An open town hall meeting for the public and HIV community took place to discuss and allow feedback on the four EHE pillars.

Two Facebook Live virtual meetings occurred with the transgender community. Findings from these sessions will be included in the final plan.

Palm Beach County

In November 2019, the local Community Prevention Partnership, with support and guidance from FDOH, developed an EHE community survey. At this early stage in the planning and community engagement process, the limited dissemination of the survey affords the opportunity to obtain early feedback from respondents regarding the tool itself to make appropriate adjustments and edits prior to a larger distribution. As the accelerated planning process progresses, Palm Beach County will refine the survey tool to align with the evolving strategies and activities.

The initial community survey is only a small component of the overall EHE engagement strategy, as there are several limitations to this method, including survey fatigue, literacy and linguistic issues, survey bias, reluctance to participate, and a perceived sense of lack of post-survey feedback. No single method of engagement works for all community members. Therefore, the approach is multi-faceted and will include a combination of surveys, community conversations, key informant interviews, and online community forums. Each of these will be a platform for an ongoing feedback loop to ensure that not only are voices heard, but that community members feel validated and are motivated to continue participating. Finally, efforts in this regard will seek to share power with the community to the extent that it is appropriate and feasible. These methods will guide transparent and authentic engagement and dialogue.

Pinellas County

FDOH worked within existing local HIV/AIDS planning bodies to recruit partners to actively engage in creating the EHE plan. These partners include but not limited to Zero Pinellas, Metro Inclusive Health, the AIDS Healthcare Foundation, Empath Health, University of South Florida Pediatrics, Simply Healthcare, Humana Health, Walgreens, and others that currently participate in the Pinellas Planning Partnership. Support was also elicited from local organizations and community leaders who do not directly provide HIV prevention/care services but serve those priority populations.

To improve the understanding of community needs, programs, and delivery strategies, community members will provide feedback and vital information that will assist the EHE Advisory Council in determining priority areas for the EHE plan. This council will have the specific task of providing input and advice on the EHE approach for Pinellas County.

SECTION II: EPIDEMIOLOGIC PROFILE

According to the CDC, in 2018, Florida was ranked first for new HIV diagnoses and third for new HIV diagnosis rates per 100,000 population in the U.S. (including District of Columbia).² In 2018, 4,906 persons received an HIV diagnosis in Florida, of whom 81 percent were linked to HIV-related care within

30 days of diagnosis. There were 119,661 confirmed PLWH in Florida through 2018; an additional estimated 12.9 percent of persons were living with HIV but not aware of their HIV status.

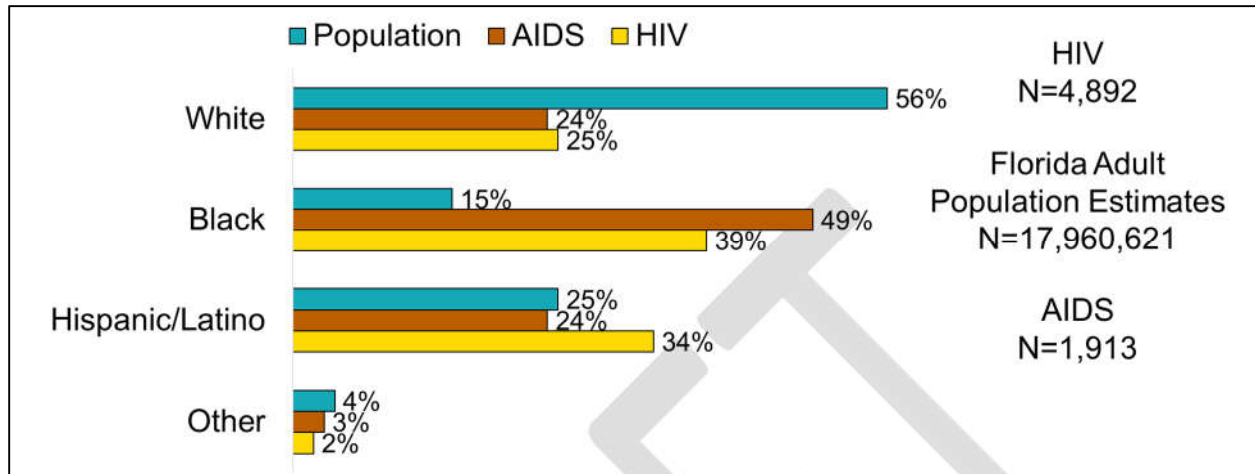
GEOGRAPHICAL REGION AND SOCIO-DEMOGRAPHIC CHARACTERISTICS OF FLORIDA

Florida is a southern state that spans a geographic region of 53,624 square miles, comprises 67 counties and 283 cities, and has a mix of urban, suburban, and rural areas. The 2018 population in Florida was approximately 21 million residents, with over 350 residents per square mile. Approximately 20 percent of the population is under 18 years of age, and 20.5 percent is over the age of 65. According to the U.S. Census Bureau in 2018, 13.6 percent of Floridians were living in poverty, and 16 percent under the age of 65 were without health insurance.³ The population of Florida is very diverse, with approximately 20.2 percent of persons residing in the state being foreign born. Although most new HIV diagnoses in 2018 were among those born in the U.S. (61.4%), 31.9 percent of new HIV diagnoses in Florida were among foreign-born persons.

The racial distribution for Florida in 2018 was 77.4 percent White, 16.9 percent Black, and 5.7 percent other races; the ethnic breakdown is 74.3 percent non-Hispanic and 25.7 percent Hispanic.⁴ There were 4,892 HIV diagnoses among adults (aged 13 and above) in 2018. The greatest burden was among the Black population, which received 39 percent of the new HIV diagnoses and 49 percent of the AIDS diagnoses despite only representing 15 percent of the adult population in Florida. Hispanics/Latinos were also disproportionately represented for new HIV diagnoses compared to those who identified as White, with 34 percent of the new HIV diagnoses among Hispanic/Latinos compared to 25 percent among Whites (Figure 1).

In 2018, Florida continued to see disparities in HIV diagnoses among adults. The HIV diagnosis rate per 100,000 population among Black males (106.5) was over five times higher than for White males (20.5), and the rate for Hispanic/Latino males (66.5) was three times higher than for White males. The HIV rate among Black females (41.1) was 11 times higher than for White females (3.9); the rate for Hispanic/Latina females (9.6) was two times higher than for White females. Blacks had a lower statewide viral suppression (<200 copies/mL) rate of 58 percent compared to 70 percent for Whites and 67 percent for Hispanics/Latinos.

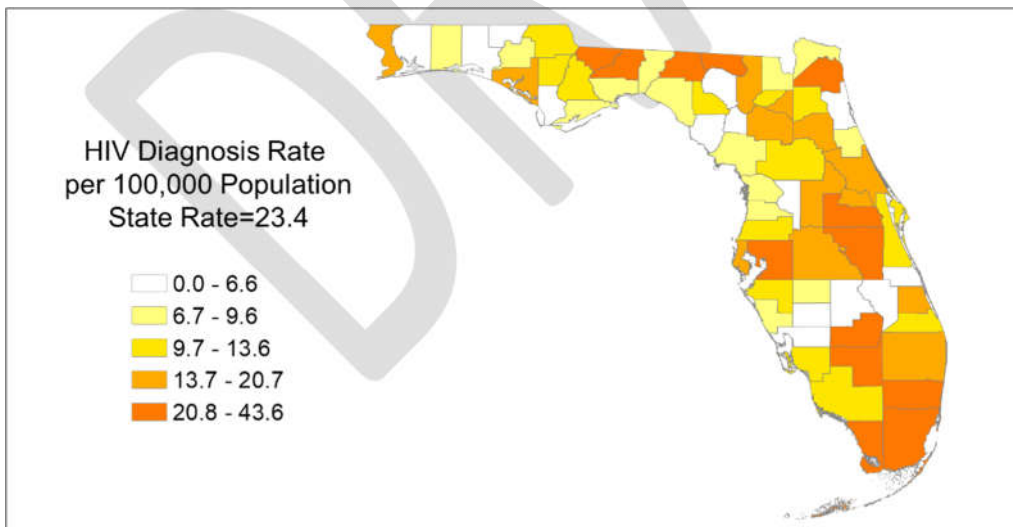
Figure 1: Percentage of Adult (Age 13+) HIV and AIDS Diagnoses and Population by Race/Ethnicity, 2018, Florida



TRENDS IN HIV DIAGNOSES

In 2018, there was at least one HIV diagnosis in all but one county in Florida, and the state HIV diagnosis rate was 23.4 per 100,000 population (Figure 2). The greatest numbers of HIV diagnoses were from the seven EHE counties: Miami-Dade (N=1,124), Broward (N=661), Orange (N=500), Hillsborough (N=323), Palm Beach (N=298), Duval (N=296), and Pinellas (N=182). These seven counties diagnosed a combined total of 3,384 cases in 2018, or 69 percent of the statewide total. Miami-Dade (43.6), Orange (36.5), Broward (34.7), and Duval (31.0) counties had the highest HIV diagnosis rates in 2018.

Figure 2: HIV Diagnosis Rate by County in 2018, Florida

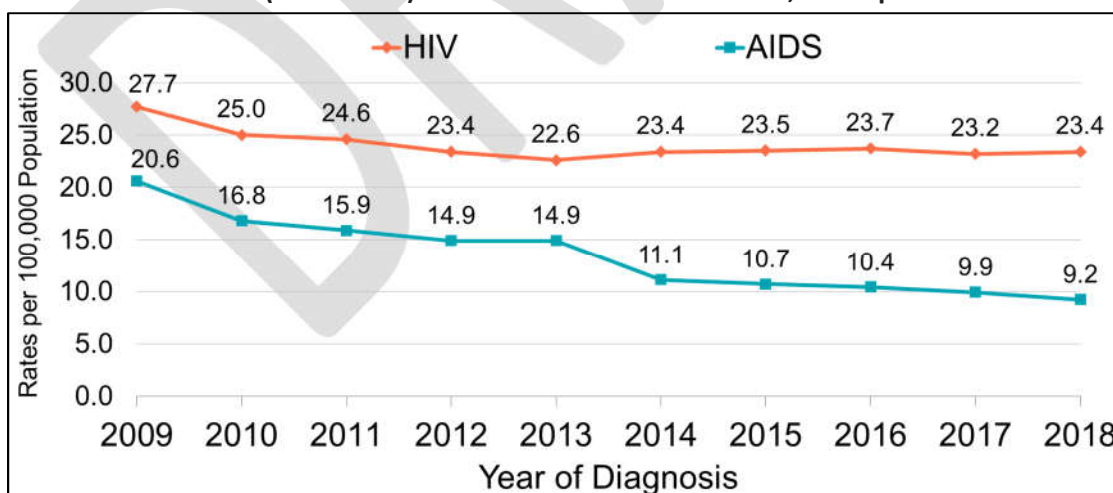


Despite seeing trends decreasing over the past ten years (2009–2018) in the state, where the number of diagnosed HIV and AIDS cases have decreased five and 50 percent respectively, we have observed an

increase in those diagnosed in Florida in the last five years (Figure 3). HIV diagnoses have increased by seven percent from 2014 (N=4,588) through 2018 (N=4,906). The number of new HIV diagnoses increased by eight percent among adult males and by three percent among adult females over that same time. The age group with the highest increase in new HIV diagnoses over the past five years (25%) was aged 25–29. Additionally, the number of new diagnoses increased by 24 percent among the 55–59 age group and by 21 percent among those aged 35–39. Male-to-male contact continues to be the primary mode of exposure, demonstrating a seven percent increase in new HIV diagnoses from 2014 to 2018. Male injection drug use (IDU) was the mode of exposure with the highest increase (31%) over the past five years.

Nearly one-half of the counties in Florida (31 of 67) saw an increase in the number of new HIV diagnoses from 2017 to 2018. An annual decrease in HIV diagnoses from 2017 to 2018 was observed in three of the seven largest reporting counties: Broward (-7%), Duval (-4%), and Palm Beach (-1%). Pinellas County saw no change. The remaining three counties, Orange, Miami-Dade, and Hillsborough had an increase: 6 percent, 5 percent, and 4 percent, respectively. All but one of the seven EHE counties, Miami-Dade (1%), experienced a decrease in new AIDS diagnoses (regardless of the date of HIV diagnosis) from 2017 to 2018. Further, Orange (8%), Pinellas (5%), and Hillsborough (3%) experienced an increase in HIV resident deaths from 2017 to 2018. In 2018, eight perinatally acquired HIV diagnoses were reported in Florida. One-half of these were from two of the seven EHE counties: two from Duval and two from Orange. The seven EHE counties make up approximately 13 percent of the total national HIV burden as outlined in the EHE Plan and represent 72 percent of the total persons living with an HIV diagnosis in Florida. Pinellas (69%), Hillsborough (67%), and Broward (66%) counties had a viral suppression rate greater than the state rate of 64 percent; however, Orange (63%), Miami-Dade (60%), Duval (59%), and Palm Beach (59%) had lower viral suppression rates than the state at the end of 2018.

Figure 3: Ten-Year Trend (2009–2018) of HIV and AIDS Rates Per 100,000 Population in Florida

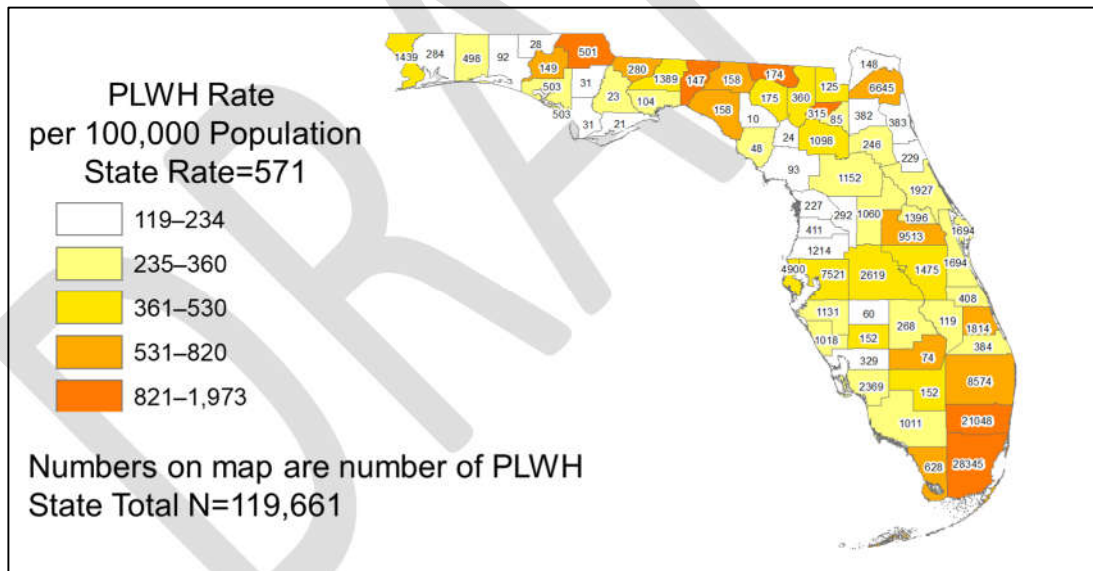


PREVALENCE OF PLWH IN FLORIDA

The rate of PLWH in Florida is 571 per 100,000 population, with the majority of PLWH living in the large metropolitan areas and the seven counties outlined in the EHE plan. However, there is also a high rate of PLWH living in smaller, more rural counties, such as those in Northern Florida (Figure 4).

Of the 119,661 persons living in Florida with a diagnosis of HIV in 2018, 45 percent were Black, 29 percent were White, 24 percent were Hispanic, and 2 percent were multiracial. More than one-half (53%) were over the age of 50. Male-to-male sexual contact was the mode of exposure for 70 percent of males, and heterosexual contact was the mode for 85 percent of females. Florida continues to try to overcome the barriers to obtaining complete identification and HIV surveillance of transgender men and women living with HIV. In 2018, 336 transgender women and 13 transgender men were known to be living with an HIV diagnosis in Florida. Among those persons, sexual transmission was their primary mode of exposure. Florida collects data and information on transgender persons from case report forms and laboratory imports and matches with other HIV databases to increase understanding of the burden of HIV among our transgender population. All data on transgender persons are validated to maintain integrity of the data.

Figure 4: Diagnoses and Rates of PLWH by County of Residence, Year-End 2018, Florida



PERINATAL HIV TRANSMISSION

A strategic long-term goal in Florida is to reduce the annual number of babies born in Florida with perinatally acquired HIV to fewer than five. Over the past five years (2014 to 2018), an average of 507 babies born in Florida were perinatally exposed to HIV each year, of whom a total of 40 (an average of eight per year) perinatally acquired HIV.

LATE HIV DIAGNOSIS AND RESIDENT DEATHS DUE TO HIV/AIDS

HIV/AIDS-related deaths decreased markedly from 1996 to 1998 after the advent of highly active antiretroviral therapy (HAART) in 1996. A leveling of the trend since 1998 may reflect factors such as viral resistance, late diagnosis of HIV, adherence problems, and lack of access to or acceptance of care. Overall, there has been huge decline in the number of Florida resident deaths due to HIV from 1995 (the peak of resident HIV-related deaths) to 2016. AIDS diagnoses in Florida decreased by 12 percent from 2014 (N=2,172) through 2018 (N=1,918). Furthermore, resident deaths in Florida due to HIV have decreased 21 percent from 2014 (N=878) through 2018 (N=692). The Black community has been disproportionately affected by HIV in Florida since the epidemic began in 1981, and despite a great decrease in Black resident deaths due to HIV (75% since 1996), disparities still exist among Florida's Black population. Rates of HIV-related death are nearly 5 times higher for Black men (13.8 per 100,000 population) and nearly 20 times higher for Black women (9.8 per 100,000 population) than for White men (2.8 per 100,000 population) and White women (0.5 per 100,000 population) living with HIV.

HIV CARE CONTINUUM

The HIV Care Continuum is a diagnosis-based model that reflects the series of steps PLWH take from initial diagnosis to being retained in care and achieving viral suppression. The HIV Care Continuum has four main “steps” or stages: HIV diagnosis, linkage to care, retention in care, and viral suppression. It demonstrates the proportion of individuals living with HIV who are engaged at each stage. This model 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 continuum. The Florida model, like the federal and other models, represents data on persons living in Florida (regardless of where they were diagnosed) at the end of the year being measured. In 2018, of the 119,661 PLWH in Florida, 69 percent (N=82,422) were retained in care and 64 percent (N=76,242) achieved a suppressed viral load; 25 percent (N=29,736) did not receive any HIV-related care in 2018.

HIV-RELATED CO-MORBIDITIES

Sexually transmitted infections and hepatitis B (HBV) and C (HCV) have been steadily increasing in Florida over the past five years, including a 26 percent increase in chlamydia, a 58 percent increase in gonorrhea, and a 92 percent increase in early syphilis. Co-infection of PLWH with STIs has also increased, with an increase of 111 percent for HIV/gonorrhea, 88 percent for HIV/chlamydia, and 71 percent for HIV/early syphilis. In 2018, there were 279 PLWH who were also co-infected with HBV, 86 percent of whom were male; 67 percent of the males reported MSM exposure and 18 percent of females reported IDU exposure. There were 479 PLWH who were coinfected with HCV in 2018, the majority of whom were males (77%) with an MSM (50%), IDU (19%), or MSM/IDU (16%) exposure. Fifty percent of female PLWH co-infected with HCV had IDU exposure. Increased need for routine screening of all STIs, HIV, and hepatitis is needed.

HIV TRANSMISSION CLUSTERS AND NETWORKS

One aspect of the EHE plan is to detect and respond to rapidly growing clusters and prevent new HIV transmission using routine molecular HIV surveillance (MHS). MHS uses data from point-of-care HIV-1

genotypic resistance testing to identify molecular links between individuals by linking and comparing those with similar HIV genetic sequences and is used to identify recent and rapid transmission within molecularly linked clusters. The observed HIV transmission rate in molecular clusters identified across the U.S. is on average 11 times higher than the transmission rate within the general HIV population. HIV molecular clusters are considered rapidly growing when there have been five or more new HIV diagnoses within the previous 12 months. As of November 2019, the FDOH HIV/AIDS Section has identified 24 ever rapidly growing molecular clusters at the 0.5 percent genetic distance. The identified molecular clusters contain a total of 541 cluster members as well as 2,277 additional claimed partners within the broader HIV risk networks. Molecular clusters are spread throughout the state; however, 358 (66.2%) individuals identified within these clusters currently reside in the seven high-burden EHE counties; 59.8 percent received their initial diagnosis within an EHE county.

PRIORITY POPULATIONS AT RISK FOR HIV

Priority populations are derived from the average proportion of those diagnosed with HIV in the last three years (2016–2018). This information is used to address those at highest risk of acquiring HIV and having the greatest need for primary prevention services. The top five priority populations are Hispanic/Latino MSM (26 percent of new diagnoses over the past three years), Black heterosexual men and women (22%), Black MSM (18%), White MSM (17%), and Hispanic heterosexual men and women (7%). For those living with HIV, prevention priorities include improving viral suppression among Black men and women and among women of childbearing age (aged 15–44).

SECTION III: SITUATIONAL ANALYSIS

Florida is one of the most diverse states in the nation. With this diversity comes a higher incidence of disease burden from those in the emerging racial/ethnic minority populations from rural, socioeconomically disadvantaged, and medically underserved backgrounds. FDOH recognizes that Florida's racial/ethnic minority populations continue to increase in size, correlating with persistent and often growing health disparities.

Florida is at a critical juncture in determining the best strategies for ending the HIV epidemic among racial/ethnic minorities and other underserved groups. HIV prevention needs exist among PLWH, Black and Hispanic gay and bisexual men, Black heterosexuals including Black women of childbearing age, and transgender persons of all races/ethnicities. For those who are already diagnosed and living with HIV in Florida, activities focusing on access to HIV care, including antiretroviral treatment, retention in HIV care, and viral suppression, should be focused toward Black heterosexuals (specifically Black women of childbearing age), gay and bisexual men of all races/ethnicities, and transgender persons of all races/ethnicities.

PILLAR ONE: DIAGNOSE

Routine HIV, STI, and Hepatitis C Testing in Health Care Settings

In July 2015, the Florida Legislature amended Florida's HIV testing law to remove the need for separate informed consent prior to HIV testing in health care settings. In September 2016, Florida Administrative

Code Rule 64D-2.004 was adopted to implement the amended HIV testing law. The intent of this amendment was to simplify routine HIV testing in health care settings, improve the identification of new or existing HIV infections, and help to normalize HIV testing as a routine component of primary health care. There was no change in the law regarding non-health care settings. These changes align Florida more closely with CDC 2006 Revised Recommendations for HIV Testing in Adults, Adolescents, and Pregnant Women and the U.S. Clinical Preventive Services Task Force 2013 Updated Recommendation for HIV Screening.

The most recent Behavioral Risk Factor Surveillance System survey (2018) data show that 53.6 percent of Florida adults under the age of 65 had ever been tested for HIV, and, of these, 21.1 percent had been tested in the past 12 months.⁵ Also, an estimated 137,400 persons in Florida were living with HIV, of which 12.9 percent unaware of their status.⁶ Individuals who know their status tend to practice safer sex behaviors, and when PLWH achieve and maintain an undetectable viral load, there is effectively no risk of HIV transmission to sexual partners.⁷ Florida maintains over 1,440 registered HIV test sites and annually conducts over 350,000 publicly funded HIV tests, with an average positivity rate of 0.9–1.0 percent; however, there are missed opportunities and gaps with HIV testing in non-public health settings (e.g., private physicians, hospitals, clinics).

In 2015, FDOH established a public/private partnership with Gilead’s On the Frontlines of Communities in the United States (FOCUS) initiative to implement routine HIV and HCV testing in hospital emergency departments (EDs) and community health centers located in high HIV incidence areas. Since that time, the number of participating FOCUS sites has risen to 15 sites with 22 locations, and in 2018, over 102,000 HIV tests and 83,000 HCV tests were conducted (1.6 percent and 4.3 percent seropositivity, respectively).

Gaps still exist in implementation of routine HIV, STI, and HCV testing in hospital EDs and primary health care settings. Accounts of individuals seeking medical care in hospital EDs for symptoms akin to acute HIV infection are frequent and, oftentimes, persons visit the ED several times before being tested for HIV, diagnosed, and linked to care. From June 2018 to April 2019, the University of Miami AIDS Education and Training Center (UM-AETC) performed outreach to health care facilities in the highest HIV incidence areas throughout Miami-Dade and Broward counties to conduct assessments and academic detailing. Facilities included community health centers and primary care and internal medicine clinics. Assessments examined the status of health care facilities in implementing routine HIV testing and PrEP provision in accordance with CDC guidelines and in implementing or extending third-party billing for routine HIV screening. Less than half (42.9%) of the health care provider practices reported offering routine HIV screening services to all patients ages 13 to 64, regardless of symptoms or demographics. Of the remaining clinics, 28.6 percent reported that they test patients based on symptoms and demographics, and 28.5 percent reported testing only those who requested an HIV test.

Rapid HIV Testing through Non-Traditional Settings and Modalities

Considering Florida’s percentage of persons living with HIV but unaware of their status (12.9%), increased access to rapid HIV testing is needed. Feedback received through community engagement

indicated a need for expanded use of mobile testing units, HIV self-test kits, social/sexual network screening, and testing at non-traditional settings and hours. FDOH currently supports over 1,440 testing sites with rapid HIV test kits at no cost to the site. Sites must register with FDOH and submit HIV testing data as criteria to receive rapid HIV test kits. Rapid HIV tests are typically costlier than traditional lab-based tests (when controls are considered), and HIV self-test kits (or in-home test kits) are significantly more expensive than a point-of-care rapid HIV test. In-home rapid HIV test kits average \$28–\$30, whereas point-of-care rapid HIV tests range between \$5 and \$10, depending on the device. FDOH currently makes several rapid HIV testing kits available to registered test sites and, in June 2019, began an in-home testing pilot program to provide self-test kits to individuals at no cost through an online request form. Additional funds will be needed to support and sustain the expansion of in-home and point-of-care HIV testing program. Concerns around linkage to care for persons using HIV self-test kits exist, and mechanisms will need to be developed to ensure appropriate follow-up and timely linkage to care.

Integrated HIV, STI, and HCV Testing

The increasing burden of HIV, STI, and HCV in Florida presents a need to encourage the integration of routine HIV testing in conjunction with STI and HCV testing as well as the integration of routine STI and HCV testing in HIV primary care settings. Testing for STIs and HCV should occur in tandem with HIV testing. Persons with a diagnosed STI are at increased risk for HIV if exposed sexually, and not testing them for HIV, STIs, and HCV is a missed opportunity for diagnosis, education, and treatment.

Partner Notification Services

In section 384.26, Florida Statutes, FDOH is the only entity authorized to perform HIV and STI partner services and notification, and these activities are carried out by trained disease intervention specialists (DIS). While Florida maintains a mature and robust HIV/STI partner services program, opportunities to strengthen the DIS workforce and update partner notification mechanisms exist. Extensive training needs, high caseloads, and low staff retention not only contribute to high DIS turnover rates, averaging 40 percent annually over the past five years, but also impact the effectiveness of partner elicitation. Numbers of claimed partners have decreased as increasing numbers of anonymous partners are reported through mobile dating applications, creating challenges for intervention. In 2017, FDOH piloted the usage of mobile dating applications as an added partner notification tool for persons exposed to HIV/STIs, with marginal success. Additional strategies are being explored to allow for HIV partner notification via text messaging or phone calls.

Third-Party Billing and Reimbursement

Of the perceived barriers to billing and reimbursement gathered through UM-AETC's provider assessments, billing third-party insurance was reported as a barrier by almost one-third of providers and was the most prominent barrier encountered. Most clinics reported staff lack of knowledge regarding billing/coding and corporate decisions to be the greatest barriers to implementing routine HIV screening. Other notable barriers were lack of time/staffing capacity to perform billing, challenges in contracting with third-party payers, and managing multiple contracts with third-party payers.

Stigma

Stigma related to HIV/STI screening can sometimes lead individuals to state they do not possess insurance coverage for the service. Similar confidentiality concerns exist for young people who receive health insurance coverage through their parent or guardian (e.g., Explanation of Benefits). Fear of disclosure of confidential health information can deter youth and adults from seeking out HIV/STI screening and PrEP services.⁸ HIV testing locations that are associated with HIV/AIDS service organizations are also perceived as more stigmatizing, with clients citing additional disclosure concerns. There is a need for HIV testing locations to be integrated with other health care services and screenings to minimize stigma.

PILLAR TWO: TREAT

Access to Comprehensive Care

Florida's Test and Treat program offers newly diagnosed patients with HIV, as well as those who have been lost to care and are returning to care, an opportunity to obtain expedited practitioner office visits, labs, and antiretroviral (ARV) therapy, combined with a support system of retention-in-care specialists, to reduce barriers to care engagement. In this expedited, "red-carpet" scenario, PLWH have immediate access to a medical provider who can start them on ARV medications immediately. Since 2016, over 4,500 clients have been enrolled in the FDOH statewide Test and Treat program. Wider expansion and adoption of this strategy is needed to impact linkage, retention, and viral load suppression rates. Almost all of Florida's 67 counties have a Health Resources and Services Administration (HRSA)-designated Health Professional Shortage Area (areas categorized as rural, partially rural, or non-rural), which represents a need to recruit and train more primary health care and dental service providers. Additionally, needs exist for expanded access points, hours of operation (to include non-traditional hours and locations), and telehealth capabilities to reach persons in rural areas. There is also a need for increased access to treatment for persons diagnosed and living with co-occurring HCV/HIV.

There are also gaps in the level of knowledge of non-Ryan White network health care providers on the Ryan White system of care. More education and training is needed for providers on the services available to clients (including ADAP), eligibility requirements, and access points within their service regions.

It is also important to note the need for more training and resources for health care providers related to trauma-informed care and intersectionality. Past and current traumatic experiences have an impact on whether a person acquires HIV, is diagnosed, is linked to care and retained, and maintains viral suppression.⁹ Because HIV disproportionately impacts marginalized communities, it is important to consider intersectionality in concert with trauma-informed care. Intersectionality is a framework for conceptualizing a person, group of people, or social issue as affected by several discriminations and disadvantages; it considers people's overlapping identities and experiences to better understand the complex prejudices they may face.⁹ Examples of social categorizations that inform identity include race/ethnicity, class, gender, sexual orientation, poverty/homelessness, and substance use.

Housing

Many Floridians experience homelessness or unstable housing, which presents a barrier to wellness for PLWH as well as those at increased risk for HIV acquisition. Stable housing is closely linked with and is often one of the main determinants affecting HIV health outcomes.¹⁰ Florida's Council on Homelessness annual report showed that on one day and one night in January 2018, Florida communities identified 29,717 persons who were living on the streets, in the woods, or in emergency shelters. This included 2,515 homeless veterans, 8,300 persons in homeless families, and 5,230 chronically homeless and disabled persons.¹¹ While the federal Fair Housing Act makes it illegal to discriminate against PLWH in the provision of housing, consumers frequently cite discrimination, fear of disclosure, and stigma as barriers to safe and affordable housing.

Patient Navigation

The need for enhanced training programs for patient navigators and peer navigators is repeatedly expressed by PLWH and providers through community listening sessions. Patient navigation programs for persons newly diagnosed with HIV or those previously diagnosed and returning to care have consistently proven to be efficacious in ensuring individuals get linked to and are retained in treatment.¹² Peer navigators (specifically, PLWH) can share their lived experience with newly diagnosed individuals who may be overwhelmed by the thought of entering a health care system as complex as the HIV system of care. In addition, peer navigators act as a support line for persons newly entering or re-entering the care system, providing non-judgmental guidance. There is also a need for expanded patient or peer navigation among persons diagnosed with HCV. About one in four PLWH is coinfecting with HCV, and the current opioid epidemic is fueling the number of co-infections.¹³ People living with HCV often have difficulty accessing HCV treatment and related health care. In recent years, there have been improved HCV treatments that can cure HCV in as little as 8–12 weeks. There are more opportunities for uninsured HCV patients to be treated at some free clinics, FQHCs, private clinics, and a limited number of CHDs, but many patients are unaware of where to go when they are first diagnosed. Expanded patient navigation is also needed for HIV-negative partners of PLWH seeking PrEP services.

Case Management

Case management plays a critical role in the care coordination of PLWH as it assists patients in accessing services, identifying needs, and addressing gaps in services. Case manager caseloads are high and continue to increase, impacting the ability to effectively manage caseload complexity, such as providing medication adherence counseling, navigating the health care system, and staying informed and educating PLWH on available health care coverage plans. There is a need for additional resources and training to support the case management workforce.

Insurance Coverage and Affordable Health Care

Florida remains a non-Medicaid expansion state, and in 2013–2017, 14.9 percent of people living in Florida did not have health insurance coverage (compared to 10.5 percent for the U.S.).¹⁴ Counties with over 20 percent of the population uninsured were Hendry, Liberty, Glades, DeSoto, and Miami-Dade. The Affordable Care Act (ACA) enabled more individuals to enroll in health insurance, but some,

particularly those who live just above the federal poverty level (i.e., the working poor), are still unable to afford the cost of coverage. Individuals who fall into this category who need health care are often forced to make difficult choices based on competing life priorities.

Additional Unmet Needs of PLWH

The Medical Monitoring Project (MMP), a surveillance system that surveys PLWH, asks questions to understand the met and unmet needs of PLWH. Among those surveyed in Florida in 2017, the most common unmet need was access to dental services (58%), followed by food assistance (25%), shelter and housing services (23%), and case management services (16%). Other unmet needs included access to meal and food services (15%), Social Security Disability Insurance (13%), Supplemental Security Income (11%), transportation assistance (11%), mental health counseling (10%), and patient navigation services (7%).

Stigma

The MMP surveillance system also asks questions to understand stigma PLWH have experienced and its various types, including anticipated, enacted, and internalized stigma. Analysis of the 2015–16 Florida MMP cycle data (N=603) found that overall, 20 percent of those surveyed experienced low levels of stigma, 52 percent experienced moderate levels of stigma, and 24 percent experienced high levels of stigma. It was also found that the proportion of PLWH with a detectable viral load increased based on the level of stigma they experienced. When analyzed by demographic and risk factors, overall stigma was found to be significantly higher among those with a disability and those experiencing high levels of depression. Anticipated stigma, concerns of others knowing one's status and how that would be perceived, was significantly higher for those ages 18 to 29, Whites, those who do not use drugs, and those experiencing depression. Internalized stigma, negative self-image due to HIV, did not show significant differences between groups.

PILLAR THREE: PREVENT

Access to PrEP and nPEP

The use of antiretroviral medications to prevent HIV infection in persons at risk for acquiring HIV is an effective tool in HIV prevention. Part of CDC's high-impact prevention approach included PrEP, and in 2014, CDC issued clinical PrEP guidelines for health care providers. CDC recommends PrEP as a prevention tool for persons at increased risk for HIV: persons in serodiscordant relationships, gay and bisexual men who have sexual partners of unknown HIV status, and persons who inject drugs (PWID). As of December 2018, all 67 FDOH CHDs are providing PrEP services (counseling, medications, follow-up testing) with support from state funding. CHDs provide PrEP primarily through the STI and family planning clinics, and medication is provided at no cost to the client (repeatedly) through the state's supply of medication. As of November 2019, over 15,000 FDOH CHD clients have received PrEP counseling and nearly 5,000 have received PrEP medications. Disparities in the uptake of PrEP and nPEP still exist among key priority populations (i.e., Black and Hispanic men and women, including transgender women). Taking a sexual history and discussing sexual health with patients should be a routine practice for primary health care providers; however, limited time for office visits and a reluctance of some providers to discuss sex with their patients presents barriers to routinization. There

is a need for increased access to PrEP services in non-traditional settings and through innovative practices. PrEP delivery via telehealth (or TelePrEP) was recommended by community groups, clients, and providers as a mechanism by which people facing transportation and employment barriers could access PrEP and increase adherence to follow-up testing. Partnerships with retail pharmacies and clinics and through mobile applications may assist in bridging gaps in PrEP access.

Currently, federal funding requires the implementation of PrEP and nPEP services but does not allow states to allocate funding for medications and associated clinical costs. While there are patient assistance programs available to offset the cost of medications, medical visit and lab testing costs still pose a significant barrier to already disproportionately impacted populations.

Clients receiving PrEP have reported that returning every three months for follow-up testing is a barrier to remaining adherent, and in rural and semi-rural areas of the state, transportation to follow-up medical appointments can present further challenges. Clients also cited the cost of medical visits and lab tests, and not being able to get time off from work for appointments, as barriers to PrEP initiation and maintenance.

Increased public/private partnerships are needed to fill gaps in access to nPEP services. Many CHD clinics have traditional hours, making them ill-suited as nPEP delivery points. Access to nPEP is needed quickly after exposure to HIV (within 72 hours) to prevent seroconversion. Clients requesting nPEP tend to do so more often during evening hours and weekends. Partnerships with retail pharmacies, rape crisis centers, and sexual assault nursing teams in hospital EDs are needed to expand access points to nPEP.

Syringe Exchange Programs (SEP) and Substance Abuse Treatment

Florida's first approved SEP, the University of Miami IDEA Exchange, opened in Miami-Dade County on December 1, 2016. The program provides compassionate and nonjudgmental services and empowers people who use drugs to make healthier and safer choices, regardless of whether they are ready to stop using drugs. Effective July 1, 2019, section 381.0038, Florida Statutes was revised to allow county commissions to authorize the establishment of additional SEPs through county ordinances. These programs cannot be funded with state, county, or municipal funds and must provide for one-to-one sterile needle and syringe exchange. The law requires county commissioners to take several steps, including enlisting the help of CHDs to provide ongoing advice and recommendations regarding program operation. The Florida Department of Children and Families (FDCF) is assisting FDOH by ensuring that new programs are equipped with overdose reversal kits and establishing the processes and relationships needed to effectively link individuals to addiction treatment services. Florida's amended legislation is the first step in increasing the state's ability to expand SEPs and reduce HIV and HCV transmissions among persons who inject drugs (PWID). As of December 15, 2019, Broward, Leon, Manatee, Miami-Dade, and Palm Beach counties have passed ordinances approving SEPs.

Comprehensive Sexual Health Education and Interventions for Youth

In 2018, more than 32,000 persons between 15 and 19 years of age in Florida were diagnosed with a bacterial STI (syphilis, chlamydia, gonorrhea), for a rate of 2,670 per 100,000 population.¹⁵ The presence of an STI increases a person's risk of acquiring HIV. Over the past five years (2014–2018), 871 persons aged between 15 and 19 were diagnosed with HIV, with 60 individuals being diagnosed late with AIDS over the same period. To see reductions in the rates of STIs and HIV among this age group, progress is

needed to expand the use of comprehensive sexual health education in Florida's schools. Section 1003.42 (2)(n), Florida Statutes, requires comprehensive health education that incorporates both sex education and disease prevention and includes language on the benefits of sexual abstinence and the consequences of teenage pregnancy. Specific content in any subject matter is determined by local school district policy, which gives districts the latitude to determine the type of education program that is implemented. The different types of programs school districts can choose to implement are Abstinence-Based (Plus), Abstinence-Only, Abstinence-Only Until Marriage, and Comprehensive Sexuality Education. Florida's current policies around sexual health/reproductive education present barriers to implementing comprehensive curricula statewide, as some counties choose to adopt abstinence-only programs.

PILLAR FOUR: RESPOND

Community-Level HIV Cluster Response

Current intervention responses to disease transmission include partner services for those newly diagnosed with HIV. As a largely individual-level intervention, this work is inherently difficult, which is exacerbated by the number of anonymous and unknown sex and needle-sharing partners. Provided the difficulty in locating all those in need of testing and health services and the large proportion of those at risk for exposure to HIV, it is crucial that public health interventions be designed around broader strategies to enhance positive health outcomes at the community level. Response to HIV transmission clusters at the community level will require the incorporation of novel data analysis along with the building of partnerships with community advocates, local organizations, and care providers to successfully respond to rapidly growing HIV transmission networks.

Data Systems Infrastructure

Although FDOH follows Florida Statutes and CDC guidelines related to the security and confidentiality of HIV surveillance data, there is increased need to improve the state's capacity and infrastructure to be able to share data appropriately. Simultaneously, community concerns about confidentiality should be considered. FDOH continues to streamline and enhance standards of operation for establishing and maintaining data use agreements for improved and ongoing program planning and evaluation.

Provider Ordering and Laboratory Reporting of Genotype Tests

Efforts are needed to educate and inform providers of HRSA recommendations and the necessary function that genetic sequence testing plays in the accurate conducting of molecular HIV surveillance (MHS) and the improvement of MHS programs. Further engagement of health care providers is needed to better understand and assess barriers for the ordering of genetic sequence tests and to strategize to reduce deficits and fill gaps in treatment best practices. A recent publication investigating the cost effectiveness of genotype testing at diagnosis and its clinical impact indicated that baseline genotyping did not provide significant clinical benefit and was not cost effective to the patient when integrase inhibitors are used as first-line regimens. This may have a potential impact on provider attitudes and perceptions.

To promptly identify and assess molecular HIV transmission clusters, complete, accurate, and timely reporting of genetic sequence data must be improved through collaboration with all reporting laboratories in Florida.

HIV Criminalization Laws

While MHS cannot determine the directionality of disease transmission, it remains a great public and community concern that these data could be used in criminal transmission prosecutions.¹⁶ An often-required aspect of criminal prosecutions is the “intent to transmit” disease, which cannot be presumed through molecular surveillance or epidemiologic data. However, the ability to use these data in a criminal prosecution poses a threat to community buy-in of public health surveillance practices and the use of these data for improving HIV prevention efforts.¹⁶ Education to the community at-large is needed on the recent advancements in biomedical interventions since HIV-positive patients on medication are unlikely to transmit the virus to others.

ADDITIONAL GAPS, NEEDS, AND BARRIERS SPANNING ACROSS ALL PILLARS

Meaningful Community Engagement with Priority Populations

The Department received feedback from community partners on their impressions of the effectiveness of the current public health initiatives. Partners identified across all EHE pillars determined there is a need for increased and meaningful community engagement with all of Florida’s populations that are disproportionately affected by and/or living with HIV. Trans persons and gay and bisexual men continue to be disproportionately impacted by HIV, and increased engagement with these populations is needed along with more sensitivity training for public health staff and health care providers.

FDOH recognizes that Florida’s racial/ethnic minority populations continue to increase in size, correlating with persistent and often growing health disparities. Despite improvements in HIV outcomes over the last decade, substantial gaps continue to exist for Blacks, Hispanics, Native Americans, and Asian/Pacific Islanders compared to the state’s majority population. For Florida’s racial/ethnic minority populations, HIV outcomes have not improved for everyone at the same rate due to health disparities and inequities related to many social determinants of health.

While Florida has maintained the Business Responds to AIDS (BRTA) and Faith Responds to AIDS (FRTA) initiatives for over a decade, additional efforts are needed to involve faith-based and business leaders. Faith-based leaders, as trusted members of their communities, are well-poised to educate and mobilize Black and Hispanic populations around HIV/AIDS. Feedback received from Black gay men indicates that churches sometimes perpetuate stigma associated with HIV (e.g., homophobia, transphobia).¹⁷ There is a need for business leaders and leaders of faith-based institutions to help raise awareness and educate their congregants, employees, and customers in communities highly impacted by HIV.

Geography and Transportation

While there are major metropolitan areas in the state, 30 of Florida’s 67 counties (45%) are designated as rural per the 2010 U.S. Census. Many Floridians live in areas that have both rural and urban characteristics, which makes addressing the needs of these communities challenging. Transportation is

often a barrier for clients attempting to access HIV care services and can lead to missed appointments, decreased medication adherence, and disengagement from care.¹⁸

Poverty and Education

In 2013–2017, 15.5 percent of people living in Florida reported living below the federal poverty level.¹⁹ Counties with over a quarter of the population experiencing poverty during those same years included DeSoto, Hamilton, Hendry, Holmes, Madison, and Putnam. In 2013–2017, 87.6 percent of people age 25 and older living in Florida had at least graduated from high school (compared to 87.3 percent for the U.S.).¹⁹ Counties with less than three quarters of the population with at least a high school diploma were DeSoto, Glades, Hardee, Hendry, Lafayette, and Okeechobee. Counties with the lowest education levels were found in central and northeast Florida.

Mental Health and Substance Use Disorders

Persons experiencing mental health and/or substance use disorders are at increased risk for HIV and frequently lack access to HIV/STI education, prevention, and care services.²⁰ Florida has observed a 118 percent increase in the number of opioid-caused deaths²¹ and an approximate 28 percent increase in the number of persons treated for addiction with self-reported IDU between 2014 and 2017.²² Over the past five years (2014–2018), acute HCV infection and HIV with IDU-associated risk have also increased 165 percent and 10 percent, respectively.⁶ Efforts are needed to ensure organizations providing behavioral health and substance abuse treatment services are providing education around HIV, STI, and HCV and are knowledgeable about local testing and treatment resources.

Multicultural and Multilingual Issues

Florida population estimates for 2018 show racial/ethnic distributions as follows: 77.4 percent White (53.3 percent non-Hispanic White), 16.9 percent Black or African American (includes Afro-Caribbean), 2.8 percent Asian American, and 0.3 percent Native American. Hispanics make up over a quarter (25.7%) of the population.⁴ Florida ranks within the top five states with the highest Hispanic populations in the U.S. and maintains one of the largest Black/African-American populations in the country. Florida has also experienced a growth in Asian populations settling in Gulf Coast locations. The state is home to two federally recognized American Indian tribes (the Seminole and Miccosukee in South Florida) and many more non-federally recognized tribes, bands, and clans. The Miami metropolitan area (along with New York City) maintains one of the highest populations of Caribbean immigrants, with approximately 63 percent of Caribbean immigrants in the U.S. living in these two metro areas. Just over 20 percent of Florida's population is foreign-born, and nearly 30 percent of households in Florida speak a language other than English.⁴ There is a lack of bilingual and multilingual health care providers and media/marketing messages in certain regions of the state.²³

Racism, Discrimination, and Medical Mistrust

Persons experiencing racism and discrimination are less likely to remain adherent to care and more likely to have poorer health outcomes.²⁴ Medical mistrust also tends to be higher among Black/African American and American Indian populations in Florida. The Tuskegee Study conducted by the U.S. Public Health Service left lasting impacts on the way Blacks/African Americans view health care, particularly

public health.²⁵ Similarly, studies have shown the sterilization of American Indian women by the Indian Health Service in the 1960s and 70s created a culture of distrust of government-funded health care services.²⁶

In-Migration, Transient, and Mobile Populations

Florida draws more than 100 million tourists each year, many of whom are drawn to popular beach towns and cities like Miami, Fort Lauderdale, and Key West.²⁷ The many theme park attractions and over 8,400 miles of coastline make Florida a destination for tourists from around the world. The state also maintains a large population of seasonal residents—students, seasonal workers (in industries such as hospitality, agriculture, and tourism), and those who reside here part time to avoid harsh winters. In addition, Florida is home to several state and private higher learning institutions, including Historically Black Colleges/Universities. These colleges and universities are often located in major metropolitan areas, which have higher than average HIV incidence.

Immigration

Over the past few years, foreign-born individuals and individuals born in U.S. dependent areas have immigrated to Florida and have accounted for roughly half of the population's growth.²⁸ Individuals born outside the continental U.S. comprise roughly 20 percent of the state's population, and in Miami-Dade County, more than 60 percent of the population is foreign-born. Florida residents born in Haiti, Cuba, Venezuela, and Puerto Rico experienced the highest numbers of HIV diagnoses in 2018.²⁹ This presents a need for increased cultural competency training to ensure health education, prevention, and care services are delivered in a culturally and linguistically appropriate manner.

Criminal Justice

Florida's incarceration rate is slightly over 800 per 100,000 population, which is higher than the U.S. average incarceration rate of 698 per 100,000 population.³⁰ In 2017, the U.S. Bureau of Justice Statistics ranked Florida 14th among states in terms of incarceration rates.³⁰ Most incarcerated PLWH were diagnosed prior to entering the correctional system; however, HIV testing within a correctional setting may be the first time persons who are incarcerated take advantage of testing and prevention education. Section 945.355, Florida Statutes requires inmates of Florida's Department of Corrections (FDOC) to be offered HIV testing prior to release, while jails (which are governed by each county) do not have statewide HIV testing policies. Over time, FDOH has built relationships with county jails to establish HIV testing and linkage programs. Increased partnerships with county jails are needed to expand HIV, STI, and HCV testing.

Environmental Impact

Severe weather events can disrupt and interrupt HIV prevention and care delivery systems. Florida is a state particularly vulnerable to frequent hurricanes. When Hurricane Michael hit the Florida panhandle in October 2018 as a category 5 storm, it caused mass destruction. Thousands of homes were destroyed, and residents were displaced. PLWH in the area had trouble accessing services and medications due to widespread devastation. Displacement was also an issue, with many people being forced to find housing elsewhere in Florida or even in other states. Emergency medication fills were available through the

ADAP program, however increased efforts are needed to identify PLWH in need of re-engagement in care and ancillary services following a natural disaster.

SECTION IV: UNIFIED GETTING TO ZERO BY 2030

The overall goal of Florida’s EHE Plan is to decrease the number of HIV transmissions diagnosed annually. The key strategies and activities provided represent unified approaches for the state health department and seven counties listed in phase one of the EHE initiative. These strategies and activities will be refined after additional community engagement with key stakeholders.

PILLAR ONE: DIAGNOSE

GOAL: Identify PLWH as soon as possible after transmission

KEY STRATEGIES AND ACTIVITIES:

1. Expand routine HIV, HCV, and STI screening to all health care settings, particularly in emergency departments, primary health care providers, rural health centers, and urgent care centers and jails as a standard protocol
 - a. Collaborate with FQHCs to improve the delivery of HIV, HCV, and STI screening
 - b. Increase provider detailing and knowledge on HIV, HCV, and STI screening
 - c. Ensure health care providers have access to adequate protocols for integrating routine testing into practice
2. Strengthen field workforce conducting partner services, linkage, and re-engagement activities to identify at-risk persons in need of intervention
 - a. Improve and increase comprehensive training for a strong and competent DIS workforce
 - b. Incorporate the use of dating apps to increase awareness and/or for partner notification
 - c. Support a linkage-first model of care at time of intervention
 - d. Explore ways to increase the field workforce
3. Expand use of peers to offer and/or provide in-home test kits to those in their social network
 - a. Identify best practices for integrating peer navigators into the HIV model of care
 - b. Develop a peer training program and establish protocols and procedures
 - c. Increase training around peer recruitment
4. Reduce stigma in communities and among providers around HIV testing by helping them recognize stigmatizing situations
 - a. Train medical providers to create environments that are welcoming and culturally aware in collaboration with members of key populations
 - b. Encourage medical providers to collaborate with leaders in key populations (e.g., transgender, minority) to develop resources on accessing care and HIV prevention
 - c. Partner with academic institutions to assess current stigma and associated factors in Florida to help identify possible solutions and interventions

KEY PARTNERS: Academic institutions (University of Miami, University of South Florida, University of Florida, Nova Southeastern University, Florida State University, Florida A & M University), Agency for Health Care Administration (AHCA), community colleges, CHDs, CBOs, FDOC, emergency room physician groups, FQHCs, Florida Hospital Association, Florida Association of Health Plans, Florida Insurance Commission, hospital systems, private providers, social media platforms, corporate entities, local planning bodies, local coalitions, other southern states addressing stigma

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, private funding, pharmaceutical grants

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Increased number of individuals who know their status, increased number of health care settings implementing a routine screening protocol, number of DIS workforce trained to perform comprehensive functions, increased number of persons receiving care, number of peer programs, minimize stigma as a barrier to obtaining care for PLWH

MONITORING DATA SOURCE: State surveillance data, local testing data, peer program data

PILLAR TWO: TREAT

GOAL: Ensure PLWH receive ongoing care and treatment

KEY STRATEGIES AND ACTIVITIES:

1. Enhance the patient care system to better respond to the HIV/AIDS epidemic
 - a. Evaluate the current capacity to address Florida's large out of care population (approximately 30,000 as of December 31, 2018)
 - b. Develop a more streamlined, coordinated, high-standard level of HIV prevention and care services
 - c. Educate private medical providers on the availability of Ryan White services
 - d. Train providers and staff on trauma-informed care and intersectionality with HIV
 - e. Collaborate with partners to address the limited availability of mental health and substance abuse treatment services
2. Expand the rapid access to treatment model
 - a. Educate and mobilize hospitals and primary care providers to begin treatment at initial diagnosis
 - b. Use telehealth to establish initial visits, re-engage patients, and monitor medication adherence
 - c. Expand access points to care and hours services are available
 - d. Use mobile units to provide access to care to address transportation issues for clients
 - e. Provide cultural humility and responsiveness training for medical providers and staff
3. Expand available housing services throughout the state
 - a. Educate PLWH on available housing services
 - b. Identify eligible PLWH in need of stable housing
 - c. Examine public-private partnerships to secure affordable housing for PLWH
4. Evaluate the unmet ancillary needs such as dental and transportation services of PLWH in Florida
 - a. Identify barriers and solutions to provision of these services
 - b. Conduct community and provider focus groups
 - c. Conduct an analysis of available dentists who will serve Ryan White clients

KEY PARTNERS: AHCA, CBOs, CHDs, FDCF, FQHCs, Florida Association of Health Plans, Florida Hospital Association, Florida Medical Association, pharmaceutical partners, private providers, hospital systems, Ryan White partners, state and city Housing Opportunities for Persons with AIDS (HOPWA) programs

POTENTIAL FUNDING RESOURCES: Ryan White HIV/AIDS Program funding, HOPWA funding, federal, state and local funding, private funding sources

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Improved access to the system of care for PLWH, increased number of PLWH retained in care, decreased number of persons out of care, increased number of persons linked to care in 30 days, increased number of PLWH virally suppressed and adherent to medication regimen, increased number of PLWH in stable housing

MONITORING DATA SOURCE: State surveillance data, local testing data

PILLAR THREE: PREVENT

GOAL: Lower the rate of HIV transmissions diagnosed annually in Florida

KEY STRATEGIES AND ACTIVITIES:

1. Engage key partners to increase available services
 - a. Provide education and academic detailing sessions to health care providers (sexual history taking, PrEP provision, risk assessment)
 - b. Strengthen work with academic institutions to include in future curricula for upcoming health care professionals
 - c. Use peer educators or community health workers to provide education on PrEP and HIV prevention
2. Expand PrEP access points
 - a. Increase the number of non-traditional settings providing PrEP services (e.g., Minute Clinics, retail, mobile units)
 - b. Increase the use of telehealth to provide PrEP services
 - c. Explore the use of HIV self-test kits for follow up PrEP screening
 - d. Develop corporate partnerships to provide PrEP services in their settings
 - e. Work with AHCA to address Medicaid preauthorization process for PrEP
 - f. Work with state's insurance commissioner to explore ways to mask information contained in insurance benefit statements
 - g. Work with academic institutions to determine ways to increase PrEP and HIV/STI testing in student health centers
3. Implement media and social marketing of PrEP to Black and Hispanic MSM, heterosexual women, and transgender persons
 - a. Market availability and benefit of PrEP to priority populations (e.g., transgender, Black and Hispanic MSM, Black heterosexual women)
 - b. Market availability of telehealth services for PrEP
4. Support implementation of SEPs in the state
 - a. Educate communities on the purpose and intent of SEPs and importance of harm reduction
 - b. Provide counseling/referrals for drug abuse treatment
 - c. Offer and refer for HIV and viral hepatitis testing
 - d. Coordinate with FDCF to ensure distribution of Naloxone
 - e. Support SEP wrap-around services such as condoms, test kits, and family planning services
5. Establish nPEP delivery system
 - a. Build collaborations with private pharmacies, sexual assault teams, nurses, and rape crisis centers

6. Address stigma and discrimination

- a. Develop public health approaches and solutions that address stigma, homophobia, transphobia, and other social determinants of health
- b. Implement stigma reduction curricula for all personnel in health care settings providing prevention and care services to PLWH
- c. Enhance and implement comprehensive sexual health education
- d. Develop marketing campaigns to combat stigma directly and change attitudes towards PLWH

KEY PARTNERS: AHCA, academic institutions (University of Miami, University of South Florida), community colleges, CBOs, corporate entities, CHDs, FDOC, FDCF, FQHCs, HIV/AIDS service organizations, insurance commission, private providers, social media platforms, hospital systems, medical schools, public health and schools of allied health, health care clinics, licensed addictions receiving facilities, FDOH Office of Minority Health and Health Equity, FDOH Office of Rural Health, FDOH Bureau of Chronic Disease, FDOH Division of Children’s Medical Services

POTENTIAL FUNDING RESOURCES: Minority AIDS funding; federal, state and local funding; private funding; pharmaceutical grants; CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of providers trained/educated, increase in PrEP uptake among priority populations, number of PrEP prescriptions provided, number of non-traditional settings offering PrEP services, number of PrEP telehealth services, increased adherence to PrEP regimen, increased PrEP availability and HIV/STI testing in student health centers, number of marketing views, website analytics

MONITORING DATA SOURCE: State and local databases, medical records, pharmacy records

PILLAR FOUR: RESPOND

GOAL: Enhance the state’s infrastructure to rapidly detect and respond to regions and networks of rapidly growing HIV transmission

KEY STRATEGIES AND ACTIVITIES:

1. Educate the community at-large on the recent advancements in biomedical interventions
 - a. Increase community engagement around biomedical interventions for HIV medical care and prevention
2. Enhance physician capacity to order genotype testing for those newly diagnosed or those not on antiretroviral therapy returning to care
 - a. Increase linkage to HIV care for those newly diagnosed or returning to HIV care
 - b. Engage and educate providers on current HRSA recommendations to order baseline genotypes for newly diagnosed
 - c. Educate providers and laboratories on reporting requirements for HIV
 - d. Engage laboratories to improve the timeliness of electronic reporting of genotype consensus sequences used in transmission network analysis
 - e. Investigate other funding mechanisms to pay for genotype tests
 - f. Create a health care provider letter demonstrating the importance of genotype testing
3. Engage community in developing community-level response framework
 - a. Identify community partners to engage in development of response framework

- b. Hold community engagement events to develop and refine a HIV transmission response plan that addresses stigma, fear, and security of personal identifiable information
- 4. Improve community awareness of rapidly growing transmission network response
 - a. Create a campaign to educate community and improve community awareness surrounding rapidly growing transmission networks and data security and confidentiality
 - b. Partner with academic institutions and entities to improve communication around transmission network response
 - c. Create education materials to improve awareness and reduce anxiety surrounding HIV transmission network response
- 5. Improve use of aggregated routinely collected HIV laboratory data to improve precision prevention
 - a. Implement social networking strategies at the community level using routinely collected laboratory data to identify regions of increasing HIV transmission and initiate response
 - b. Use CBOs and other providers to implement a community-level response to transmission networks in areas of high burden

KEY PARTNERS: Academic institutions (University of Miami, University of Florida, Florida State University, University of South Florida, Florida International University), community colleges, CHDs, FQHCs, Florida AIDS Institute, private providers, CBOs, social media platforms

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, private funding, CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of community-level response actions using developed protocol, number of people tested from community-level response, number of persons diagnosed with HIV linked to care through use of response protocol, number of people offered PrEP as part of community-level response, number of community engagement sessions conducted around development of response protocol, number of awareness campaigns and messaging materials produced around HIV transmission network response, number of community engagement sessions number of genotypes received

MONITORING DATA SOURCES: Florida enhanced HIV/AIDS reporting system (eHARS), Health Management System (HMS), Florida Partner Services Database: Surveillance Tools and Reporting System (STARS), community partner databases

While this is a unified plan for the state of Florida, seven counties are specifically named as Phase 1 areas in the national EHE: A Plan for America initiative. The following sections are dedicated to those counties and highlight focused strategies and activities based on their local epidemic.

SECTION V: BROWARD COUNTY

In 2018, 661 persons received an HIV diagnosis in Broward County, of whom 84 percent were linked to HIV-related care within 30 days of diagnosis. There were 21,048 PLWH in Broward County through 2018, of which 71 percent (N=14,919) were retained in care, and 66 percent (N=13,902) achieved a suppressed viral load. This compares to 69 percent and 64 percent respectively for the state. A total of 4,905 (23%) did not receive any HIV-related care in 2018. In 2018, Broward County continued to see the disparities in HIV diagnoses among adults (age 13 and above). Among Whites, Blacks and

Hispanic/Latinos, the HIV diagnosis rate per 100,000 population among Black males (100.6) was 2.5 times higher than for White males (40.3), whereas the rate among Hispanic/Latino males (84.0) was two times higher than for White males. The HIV rate among Black females (43.0) was eight times higher compared to White females (5.2) whereas the rate among Hispanic/Latina females (5.8). Blacks had a lower viral suppression rate of 60 percent compared to 72 percent for Whites and 71 percent for Hispanic/Latinos. Over the past five years, HIV diagnoses have decreased by 5 percent from 2014 (N=693) through 2018 (N=661). The number of new HIV diagnoses among males decreased by 4 percent and among females by 11 percent over that same time. The age group with the highest increase in new HIV diagnoses over the past five years (24%) was among those aged 25–29. Additionally, the number of new diagnoses increased by 22 percent among those aged 60 and older, and by 16 percent among those aged 30–34. Male-to-male sexual contact continues to be the primary mode of exposure, however, demonstrating a 1 percent decrease in new HIV diagnoses from 2014–2018. Males with male-to-male sexual contact and IDU was the primary mode of exposure with the highest increase (17%) over the past five years.

PILLAR ONE: DIAGNOSE

GOAL: Identify PLWH as soon as possible after transmission

KEY STRATEGIES AND ACTIVITIES:

1. Expand routine HIV testing in targeted health care settings
 - a. Expand detailing to primary care physicians regarding routine HIV testing
 - b. Reframe the care continuum to promote sexual wellness regardless of HIV status
 - c. Increase the cultural competence of health care providers and their staff to serve the LGBTQ+ community
 - d. Explore the provision of routine HIV testing in dental practices starting with a pilot at a university, college, or CHD
 - e. Partner with substance abuse treatment providers to provide routine HIV testing on admission
 - f. Partner with academic institutions to provide routine HIV and STI testing in student health clinics
2. Expand targeted HIV testing of priority populations in the non-health care setting
 - a. Use the social network strategy to identify and test persons at risk for HIV through peers and partners
 - b. Expand access to HIV testing through the provision of in-home test kits at community sites including a pilot for free mail order test kits
 - c. Explore a partnership with high schools to conduct HIV and STI screening
 - d. Ensure HIV testing and other HIV prevention activities are appropriately directed to engage priority populations
 - e. Explore the provision of incentives to increase HIV testing in priority populations
3. Develop and implement a social marketing campaign
 - a. Develop and implement a community-driven campaign to decrease stigma and fear around HIV testing
 - b. Develop and implement a community-driven campaign to educate the community on the importance of knowing your HIV status and where to obtain an HIV test

KEY PARTNERS: Academic institutions (Nova Southeastern University, Florida International University), community colleges, CBOs, community members, corporate entities, CHD, school districts, FQHCs, hospital systems, local coalitions, local planning bodies, private providers, social media platforms

POTENTIAL FUNDING RESOURCES: Federal, state and local funding, private funding, pharmaceutical grants, CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Increased number of individuals who know their status, increased number of health care settings implementing a routine screening protocol, increased number of persons receiving care, number of peer programs, minimize stigma as a barrier to obtaining care for PLWH

MONITORING DATA SOURCE: State surveillance data, local testing data

PILLAR TWO: TREAT

GOAL: Ensure PLWH receive ongoing care and treatment

KEY STRATEGIES AND ACTIVITIES:

1. Expand access to Test and Treat services in HIV primary care
 - a. Expand hours of operation at public HIV primary care providers including evenings and weekends
 - b. Expand the network of Test and Treat providers in the private sector
 - c. Expand detailing to primary care physicians regarding Test and Treat
 - d. Partner with hospitals for rapid initiation of treatment during the hospital stay and appropriate discharge planning
 - e. Explore the provision of rapid initiation of treatment and HIV primary care in a mobile health care clinic
 - f. Research provision of private and confidential medical transportation
2. Improve health equity among health care providers
 - a. Increase the cultural competence of health care providers and their staff to serve the LGBTQ+ community
 - b. Increase health equity through the implementation of evidence-based curricula
 - c. Provide trauma informed care training for all Ryan White-funded entities and contracted providers
3. Expand access to safe/affordable housing opportunities for PLWH
 - a. Increase communication and coordination across agencies that provide affordable housing opportunities
 - b. Identify and provide additional affordable housing opportunities in Broward County
4. Increase retention in care and treatment and viral suppression
 - a. Improve the provision of care coordination using multi-disciplinary teams including peers, coaches and navigators, to provide varying intensity services over the course of a lifetime to meet patients' needs
 - b. Explore the implementation of a pilot project to provide incentives for attaining and maintaining viral load suppression
 - c. Implement a social marketing campaign promoting the Undetectable=Untransmittable (U=U) strategy
 - d. Explore the expansion of the county's local resource and referral line to serve PLWH

KEY PARTNERS: Academic institutions (Nova Southeastern University, Florida International University), community colleges, CBOs, community members, corporate entities, FQHCs, CHD, hospital systems, local coalitions, local planning bodies, private providers, Ryan White HIV/AIDS Program Part A recipient, social media platforms

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, private funding, pharmaceutical grants, CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Improved access to the system of care for PLWH, increased number of PLWH retained in care, decreased number of persons out of care, increased number of persons linked to care within 30 days, increased number of PLWH virally suppressed and adherent to medication regimen, increased number of PLWH in stable housing

MONITORING DATA SOURCE: Electronic health records, local testing data, state surveillance data

PILLAR THREE: PREVENT

GOAL: Lower the rate of HIV transmissions diagnosed annually in Broward County

KEY STRATEGIES AND ACTIVITIES:

1. Expand access to PrEP
 - a. Expand hours of operation at public HIV primary care providers including evenings and weekends
 - b. Use telemedicine to provide PrEP
 - c. Explore the provision of PrEP in a mobile health care clinic
 - d. Work with partners to provide PrEP in conjunction with an SEP (if implemented)
 - e. Partner with big box stores and retail pharmacies to offer PrEP in onsite clinics
 - f. Expand detailing to primary care physicians to recruit additional PrEP prescribers
 - g. Address the financial barriers to PrEP initiation and retention
2. Raise community awareness of PrEP through outreach and social marketing
 - a. Expand street outreach regarding PrEP
 - b. Develop a community-driven campaign to educate the community on PrEP, available resources to access PrEP, and decrease stigma

KEY PARTNERS: Academic institutions (Nova Southeastern University, Florida International University), community college, CBOs, community members, corporate entities, FQHCs, CHD, hospital systems, local coalitions, local planning bodies, private providers, Ryan White HIV/AIDS Program Part A recipient, social media platforms

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, private funding, CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of providers trained/educated, number of PrEP prescriptions provided, number of non-traditional settings offering PrEP services, number of PrEP telehealth services, number of academic institutions educating on PrEP

MONITORING DATA SOURCE: State surveillance data, local testing data

PILLAR FOUR: RESPOND

GOAL: Enhance the state’s infrastructure to rapidly detect and respond to regions and networks of rapidly growing HIV transmission

KEY STRATEGIES AND ACTIVITIES:

1. Enhance the ability to conduct molecular cluster response by increasing the number of genotypes performed
2. Strengthen grassroots organizations that are by/for the communities served including PLWH, transgender community, and other priority populations
3. Increase health equity through the implementation of evidence-based curricula

KEY PARTNERS: Academic institutions (Nova Southeastern University, Florida International University), community colleges, CBOs, community members, corporate entities, CHD, hospital systems, FQHCs, FDOH OMH, local coalitions, local planning bodies, private providers, Ryan White HIV/AIDS Program Part A recipient, social media platforms

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, private funding, CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Increased number of genotypes performed, increased capacity of grassroots organization to address molecular clusters in priority population, decreased health inequities among local providers

MONITORING DATA SOURCE: State surveillance data, local testing data

SECTION VI: DUVAL COUNTY

In 2018, 296 persons received an HIV diagnosis in Duval County, of whom 71 percent were linked to HIV-related care within 30 days of diagnosis. There were 6,645 PLWH in Duval County through 2018, of which 70 percent (N=4,645) were retained in care, and 59 percent (N=3,902) achieved a suppressed viral load. This compares to 69 percent and 64 percent respectively for the state. A total of 1,449 (22%) did not receive any HIV-related care in 2018. In 2018, Duval County continued to see the disparities in HIV diagnoses among adults (age 13 and above). Among Whites, Blacks and Hispanic/Latinos, the HIV diagnosis rate per 100,000 population among Black males (143.4) was six times higher than for White males (22.9), whereas the rate among Hispanic/Latino males (62.9) was nearly three times higher than for White males. The HIV rate among Black females (40.0) was four times higher compared to White females (9.8) whereas the rate among Hispanic/Latina females (8.4) was slightly less than that for White females. Blacks had a lower viral suppression rate of 57 percent compared to 64 percent for Whites and 61 percent for Hispanic/Latinos. Over the past five years, HIV diagnoses have increased by 8 percent from 2014 (N=273) through 2018 (N=296). The number of new HIV diagnoses increased by 5 percent among males and by 18 percent among females over that same time. The age group with the highest increase in new HIV diagnoses over the past five years (40%) was among those aged 25–29. Additionally, the number of new diagnoses increased by 33 percent among the 30–34 and by 24 percent among 35–39 age groups. Male-to-male sexual contact continued to be the primary mode of exposure, demonstrating a 10 percent increase in new HIV diagnoses from 2014–2018. Males whose mode of exposure was IDU had the highest increase (250%) over the past five years followed by women with heterosexual contact (17%).

PILLAR ONE: DIAGNOSE

GOAL: Identify PLWH as soon as possible after transmission

KEY STRATEGIES AND ACTIVITIES:

1. Expand routine HIV, HCV, and STI screening in targeted health care settings (EDs, provider offices, urgent care centers) and jails as a standard protocol
 - a. Provide capacity building to organizational staff
 - b. Expand HIV jail linkage program to outlying counties (Baker, Clay, Nassau, St. Johns)
 - c. Ensure health care providers have access to adequate protocols for integrating route testing into practice
2. Expand use of peer programs
 - a. Increase training around effective use of peers
 - b. Create a “Sexual Health Ambassador” team to increase field testing, education, linkage to care and assist with transportation for medical needs in high incidence/prevalence areas
 - c. Expand services at the Teen Health Center
3. Reduce stigma in communities and among providers around HIV testing
 - a. Promote anti-stigma campaigns in multiple media platforms
 - b. Deliver HIV messaging in different languages to reach more communities and ensure messaging is consistent among all partners
 - c. Increase engagement of community leaders

KEY PARTNERS: Academic institutions (University of North Florida, University of Florida), community colleges, CBOs, corporate entities, CHD, FQHCs, hospital systems, jails, local coalition, local planning bodies, private providers, social media platforms

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, private funding, pharmaceutical grants, CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of newly identified persons with HIV, number of health care settings implementing routine screening, number of peer programs

MONITORING DATA SOURCE: State surveillance data

PILLAR TWO: TREAT

GOAL: Ensure PLWH receive ongoing care and treatment

KEY STRATEGIES AND ACTIVITIES:

1. Enhance the local patient care system to better respond to the HIV/AIDS epidemic
 - a. Increase access to care for people who test positive for HIV and/or living with HIV by providing extended and weekend hours in clinics
 - b. Review and enhance local case management services to meet the changing needs of the community
 - c. Provide capacity building training for CBOs and CHD staff on health literacy
 - d. Increase use of outreach peer navigation services
2. Increase the number of sites providing rapid access to treatment

- a. Expand HIV medical services to the community by introducing two mobile medical units into the community
 - b. Address transportation issues and implement accessible resolution to ensure medical adherence
 - c. Ensure rapid access to care through the Test and Treat program by engaging all CBOs in the process
3. Increase the number of PLWH in stable housing
- a. Expand housing services to eligible PLWH
 - b. Incorporate evidence-based programs to assist with job training and skills development

KEY PARTNERS: CBOs, community housing providers, CHD, FQHCs, Gateway Community Services, HOPWA providers, hospital systems, Operation New Hope, private provider networks, River Region Human Services, Ryan White HIV/AIDS Program Part A recipients, Work Source

POTENTIAL FUNDING RESOURCES: HOPWA funding, private funding, Ryan White HIV/AIDS Program funding, state and local funding, other federal funding sources

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of PLWH in stable housing, number of new access points, access points with expanded hours

MONITORING DATA SOURCE: Local database, CAREWare, ADAP Provide

PILLAR THREE: PREVENT

GOAL: Lower the rate of HIV transmission diagnosed annually in Duval County

KEY STRATEGIES AND ACTIVITIES:

1. Ongoing community engagement
 - a. Strategize priority condom distribution with focus group input and surveillance data
 - b. Improve knowledge of condom negotiation techniques
 - c. Use peer educators or community health workers to provide education on PrEP and HIV prevention
2. Increase PrEP access points
 - a. Increase access to same-day PrEP
 - b. Initiate PrEP navigation and support groups
3. Collaborate with community groups and county commission to discuss a county syringe exchange program

KEY PARTNERS: CBOs, CHD, Jacksonville City Council, family planning clinics, hospital systems, private providers

POTENTIAL FUNDING RESOURCES: Federal, state and local funding, pharmaceutical grant, private funding, CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Increased PrEP uptake among priority populations, increased adherence to PrEP regimen, increased access to PrEP, adoption of SEP

MONITORING DATA SOURCE: State surveillance data, local database

PILLAR FOUR: RESPOND

GOAL: Increase use of combined FDOH and community resources to rapidly respond to the HIV epidemic

KEY STRATEGIES AND ACTIVITIES:

1. Increase engagement of community leaders
2. Ensure genotypes are ordered on newly identified HIV cases
3. Use statistics and Data-to-Care (D2C) information to minimize potential outbreaks
4. Provide capacity building training on molecular response protocol to CHD staff and CBOs
5. Promote anti-stigma campaigns in multiple media platforms

KEY PARTNERS: CBOs, CHD, Jacksonville City Council, family planning clinics, hospital systems, private providers

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, pharmaceutical funding, private funding, CDC HIV Prevention and Surveillance funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Increased number of genotypes performed, increased capacity of grassroots organization to address molecular clusters in priority population, decreased health inequities among local providers

MONITORING DATA SOURCE: Local database, medical records, pharmacy records

SECTION VII: HILLSBOROUGH COUNTY

In 2018, 323 persons received an HIV diagnosis in Hillsborough County, of whom 82 percent were linked to HIV-related care within 30 days of diagnosis. There were 7,521 PLWH in Hillsborough County through 2018, of which 72 percent (N=5,376) were retained in care, and 67 percent (N=5,014) achieved a suppressed viral load. This compares to 69 percent and 64 percent respectively for the state. A total of 1,602 (21%) did not receive any HIV-related care in 2018. In 2018, Hillsborough County continued to see the disparities in HIV diagnoses among adults (age 13 and above). Among Whites, Blacks and Hispanic/Latinos, the HIV diagnosis rate per 100,000 population among Black males (130.1) was nearly six times higher than for White males (23.2), whereas the rate among Hispanic/Latino males (55.2) was more than two times higher than for White males. The HIV rate among Black females (27.5) was almost nine times higher compared to White females (3.2) whereas the rate among Hispanic/Latina females (9.1) was nearly three times that for White females. Blacks had a lower viral suppression rate of 62 percent compared to 71 percent for Whites and 69 percent for Hispanic/Latinos. Over the past five years, HIV diagnoses have decreased by 6 percent from 2014 (N=343) through 2018 (N=323). The number of new HIV diagnoses among males increased by 2 percent, whereas females decreased by 30 percent over that same time. The only age group with an increase in new HIV diagnoses over the past five years (44%) was among those aged 25–29. Male-to-male sexual contact continued to be the primary mode of exposure, demonstrating a 7 percent increase in new HIV diagnoses from 2014–2018. Males with and IDU mode of exposure had the highest increase (36%) over the past five years.

PILLAR ONE: DIAGNOSE

GOAL: Identify PLWH as soon as possible after transmission

KEY ACTIVITIES AND STRATEGIES:

1. Test priority populations in non-conventional venues
 - a. Increase testing and education in correctional facilities

- b. Increase testing, education, and follow-up with persons experiencing homelessness
 - c. Increase testing, education, and linkage to care at emergency departments
- 2. Use peers and partners to help identify persons at risk for HIV in their social network
 - a. Work with the community to identify evidence-based interventions to implement
 - b. Train peer educators to disseminate accurate and relevant HIV information in their communities
 - c. Continue HIV partner and referral services
 - d. Offer testing to persons at risk as identified by PLWH in their social network
- 3. Encourage routine HIV testing
 - a. Collaborate with FQHCs, CHD, and the Association of Free Clinics to encourage routine HIV testing
 - b. Work with partners to develop social media messaging to advertise information about HIV testing
 - c. Inform health care providers about routine HIV testing
 - d. Identify ways to incentivize testing at the provider and individual level
- 4. Sexual Health Education
 - a. Activities will be identified after additional community engagement session
- 5. Implement universal HIV testing in emergency departments and primary health care settings
- 6. Explore the use of dating apps to improve awareness of HIV testing and treatment options, and/or a partner notification strategy

KEY PARTNERS: Correctional facilities, CHD, FQHCs, hospitals, local providers, PLWH, Ryan White HIV/AIDS Program Part A recipient, Center for Systems Integration and Coordination

POTENTIAL FUNDING SOURCES: CDC HIV Prevention and Surveillance funding, federal, state and local funding, private funding, Ryan White HIV/AIDS Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Increased HIV testing numbers; increased linkage to care rates, increased testing in emergency rooms and/or primary care setting

MONITORING DATA SOURCE: Electronic health records, state surveillance data

PILLAR TWO: TREAT

GOAL: Ensure PLWH receive ongoing care and treatment

KEY ACTIVITIES AND STRATEGIES:

1. Increase linkage rate for newly diagnosed individuals through use of innovative evidence-informed models.
 - a. Link all newly diagnosed individuals to care within 30 days, using Florida’s Test and Treat protocol (rapid access to treatment)
 - b. Educate hospitals on the importance of beginning treatment after diagnosis
 - c. Review available data sources to identify difficult to reach persons who have previously had a reactive test but have not been linked to care

- d. Identify and implement innovative models to increase linkage to care rates
- e. Use telehealth as a method to establish initial visits, re-engage patients and ensure medication adherence
- f. Improve transportation options through innovative channels
- 2. Increase the reengagement rate of PLWH by mobilizing interventionists
 - a. Discuss role of interventionist with community partners to obtain buy-in
 - b. Identify, hire, and train interventionists
 - c. Review medical records for individuals who have missed one or more medical appointments within the previous six months
 - d. Determine those individuals who failed to reengage in care using traditional engagement strategies
 - e. Provide personalized assessment and assistance designed to reengage clients
- 3. Increase the number of individuals who are virally suppressed
 - a. Discuss role of interventionist with community partners to obtain buy-in
 - b. Identify, hire, and train interventionists
 - c. Review medical records for individuals who are not virally suppressed
 - d. Determine those who have not reached viral suppression using traditional strategies
 - e. Provide personalized interventions designed to assist clients achieve viral suppression through use of adherence assessment and other strategies
- 4. Establish data sharing agreements between surveillance and other programs that include or provide services to PLWH to ensure clarity about the process and purpose of the data sharing and utilization
 - a. Review existing data sharing agreements between surveillance and other programs
 - b. Identify gaps and create new agreements as necessary
 - c. Examine needed data points to improve HIV care and treatment delivery system
 - d. Facilitate execution of new/revised data sharing agreements

KEY PARTNERS: Area providers, Center for Systems Integration and Coordination, clinical interventionists, clinic sites, CHDs, PLWH, Ryan White HIV/AIDS Program Part A recipient

POTENTIAL FUNDING SOURCES: CDC HIV Prevention and Surveillance Program funding, federal, state and local funding, Ryan White HIV/AIDS Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Linkage to care within 30 days rates for newly diagnosed individuals; reengagement rates for PLWH; viral suppression rates; new/revised data sharing agreements

MONITORING DATA SOURCE: Electronic health records, surveillance data

PILLAR THREE: PREVENT

GOAL: Lower the rate of HIV transmission diagnosed annually in Hillsborough County

KEY ACTIVITIES AND STRATEGIES:

- 1. Increase PrEP awareness and support within the Eligible Metropolitan Area (EMA)
 - a. Educate priority populations about PrEP
 - b. Educate health care providers about PrEP

- c. Facilitate community PrEP education seminars
 - d. Identify best practices to finance PrEP
- 2. Increase the number of providers trained to prescribe PrEP
 - a. Identify potential PrEP providers
 - b. Educate students in health care professions and existing providers to collect sexual health history and prescribe PrEP, where necessary
 - c. Identify resources for clinical consultation and education
- 3. Increase PrEP prescriptions among priority populations
 - a. Increase the use of Tele-PrEP to connect individuals to PrEP
 - b. Explore opportunities for individuals to access PrEP without a prescription
- 4. Increase PrEP marketing within the EMA
 - a. Advertise PrEP through direct marketing, face-to-face and ads
 - b. Advertise PrEP through social media
 - c. Advertise PrEP at community events

KEY PARTNERS: Area providers, Center for Systems Integration and Coordination, CBOs, CHD, FQHCs, Getting to Zero Tampa Bay Collaborative, Hillsborough County Opioid Behavioral Task Force, Ryan White HIV/AIDS Program Part A recipient, social media platforms, Tampa General Hospital, University of South Florida Homeless and Street Outreach Medicine

POTENTIAL FUNDING SOURCES: CDC HIV Prevention and Surveillance Program funding, federal, state, and local funding, Getting to Zero funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of providers trained, number of prescriptions for PrEP, number of community education forums, number of PrEP advertisements

MONITORING DATA SOURCE: Documentation of community forums, electronic medical records, local databases, media advertisement reports, pharmacy records

PILLAR FOUR: RESPOND

GOAL 1: Respond quickly to HIV cluster detection efforts for PLWH needing HIV care and treatment

KEY ACTIVITIES AND STRATEGIES:

- 1. Use e2Hillsborough to identify and respond quickly to HIV clusters
 - a. Use the e2Hillsborough data system to gather information on clusters of new cases in Hillsborough County
 - b. Deploy Early Intervention Specialists (EIS) to locate those who were recently diagnosed to gather additional data
 - c. Work with community partners to develop and implement new strategies to address new HIV clusters

KEY PARTNERS: Area providers, Center for Systems Integration and Coordination, CHD, Hillsborough County Opioid Task Force, Ryan White HIV/AIDS Program Part A recipient

POTENTIAL FUNDING SOURCES: CDC HIV Prevention and Surveillance Program funding, federal, state, and local funding, Ryan White HIV/AIDS Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Clusters identified and explored; EIS hired; new strategies developed for clusters

MONITORING DATA SOURCE: e2Hillsborough database; surveillance data; EIS interview summaries, strategies developed

GOAL 2: Increase community capacity to implement effective and innovative strategies, interventions, approaches, and services to reduce new incidences of HIV in Hillsborough County

KEY ACTIVITIES AND STRATEGIES:

1. Provide individualized consultation and technical assistance to collaborative partners on the replication/integration of innovative and evidence-informed models of care to address local unmet needs and gaps in treatment and care
 - a. Develop local implementation plan based upon summary reports and recommendations
 - b. Access subject matter experts to address topics identified as training, technical assistance, and capacity building needs through the Southeast AIDS Education and Training Center (SEAETC)
 - c. Collaborate with the SEAETC to create a training schedule
 - d. Coordinate delivery of education/technical assistance (TA)
2. Evaluate processes undertaken to implement the objectives under HRSA's EHE funding opportunity
 - a. Facilitate monthly meetings to review progress toward local implementation plans
 - b. Work collaboratively with each organization participating to identify successes, challenges, and barriers
 - c. Modify local implementation plans, as appropriate
 - d. Conduct an outcome evaluation that examines reduction in gaps along the HIV Care Continuum, diminished disparities in health outcomes along the HIV Care Continuum related to certain socio-demographic and co-morbid health conditions and changed capacity of Hillsborough County
3. Evaluate the HIV Care Continuum data for Hillsborough County
 - a. Increase the number of genotypes ordered and receive for new diagnosis
 - b. Educate providers on the importance of genotype testing
 - c. Conduct quarterly review of data indicators such as rates of HIV testing, linkage to care, retention in care, individuals on ARV, and viral suppression
 - d. Track indicators to assess the project's impact on disparities in health outcomes related to certain socio-demographic and co-morbid health conditions

KEY PARTNERS: Area providers, Center for Systems Integration and Coordination, CHD, PLWH, Ryan White HIV/AIDS Program Part A recipient, SEAETC

POTENTIAL FUNDING SOURCES: CDC HIV Prevention and Surveillance Program funding, federal, state and Local funding, Ryan White HIV/AIDS Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Implementation plans, resource inventory, training schedule, HIV testing numbers, improved linkage to care rates, improved retention in care rates, increased adherence to medication, improved viral suppression rates

MONITORING DATA SOURCE: Electronic health record data, surveillance data, HIV Continuum of Care data

SECTION VIII: MIAMI-DADE COUNTY

In 2018, 1,224 persons received an HIV diagnosis in Miami-Dade County, of whom 84 percent were linked to HIV-related care within 30 days of diagnosis. There were 28,345 persons living with an HIV diagnosis in Miami-Dade County through 2018, of which 64 percent (N=18,173) were retained in care, and 60 percent (N=16,967) achieved a suppressed viral load. This compares to 69 percent and 64 percent respectively for the state. A total of 8,755 (31%) did not receive any HIV-related care in 2018. In 2018, Miami-Dade County continued to see the disparities in HIV diagnoses among adults (age 13 and above). Among Whites, Blacks and Hispanic/Latinos, the HIV diagnosis rate per 100,000 population among Black males (137.7) was almost two times higher than for White males (78.6), whereas the rate among Hispanic/Latino males (83.1) was slightly higher than for White males. The HIV rate among Black females (61.0) was nearly eight times higher compared to White females (7.9) whereas the rate among Hispanic/Latina females (8.7) was slightly higher than for White females. Blacks had a lower viral suppression rate of 53 percent compared to 59 percent for Whites and 67 percent for Hispanic/Latinos. Over the past five years, HIV diagnoses have increased by 3 percent from 2014 (N=1,189) through 2018 (N=1,224). The number of new HIV diagnoses among males increased by 2 percent and among females by 5 percent over that same time. The age group with the highest increase in new HIV diagnoses over the past five years (81%) was among those aged 55–59. Additionally, the number of new diagnoses increased by 28 percent among the 13–19 age group and by 17 percent among those aged 60 and older. Male-to-male sexual contact continued to be the primary mode of exposure, demonstrating a 3 percent increase in new HIV diagnoses from 2014–2018. Males with an IDU mode of exposure had the highest increase (25%) over the past five years.

PILLAR ONE: DIAGNOSE

GOAL: Identify PLWH as soon as possible after HIV transmission

KEY STRATEGIES AND ACTIVITIES:

1. Routinized opt-out testing
 - a. Quantify the cost barriers for routinized opt-out testing in specific health systems and design ways to reduce the systemic cost of testing
 - b. Educate medical providers, FQHCs, EDs, and other clinical organizations throughout the county (i.e., not just those funded by FDOH and/or Ryan White HIV/AIDS Program funds) on the importance of HIV testing and the benefits that come with opt-out testing
 - c. Provide incentives and/or encouragement for provider groups and hospitals to advise patients
 - d. Recruit hospitals/urgent care centers to routinize HIV testing in the ED
2. Community Engagement
 - a. Use social marketing strategies to encourage people to get tested
 - b. Promote the use of home testing kits as an alternative option especially for hard to reach populations including youth, transgender individuals, sex workers, and MSM
 - c. Partner with Miami-Dade County public schools to increase access to HIV/STI testing among youth
 - d. Increase the number of HIV/STI testing sites in the community
 - e. Increase the number of mobile units offering HIV/STI testing in the community
 - f. Increase capacity building and education among HIV counselors and/or case managers

- g. Develop messaging to address stigma and promote HIV testing and linkage to care in the community

KEY PARTNERS: AIDS service organizations, AETC, Association of Free Clinics, CBOs, community health centers, correctional facilities, FDCF, faith-based organizations, FQHCs, Gilead FOCUS, hospitals, local county government, medical associations, CHD, urgent care centers, academic institutions (University of Miami)

POTENTIAL FUNDING RESOURCES: CDC HIV Prevention and Surveillance Program funding, federal state and local funding, Gilead FOCUS, Medicaid, private insurance

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of providers trained, number of new registered testing sites, number of hospitals/urgent care centers that routinize HIV testing, percentage of newly diagnosed HIV cases in the jurisdiction, number of messages created, number of marketing messages developed

MONITORING DATA SOURCE: Surveillance data, CDC testing linkage data, FOCUS partners

PILLAR TWO: TREAT

GOAL: Ensure PLWH receive ongoing care and treatment

KEY STRATEGIES AND ACTIVITIES:

1. Increase capacity and access to local Test and Treat Rapid Access (TTRA)
 - a. Identify additional TTRA partners, including non-traditional partners
 - b. Promote and educate private sector, insurance companies, hospitals, and private providers on the benefits of TTRA
 - c. Work with FOCUS partners and local EDs to ensure a streamlined path to TTRA for patients in emergency room settings
 - d. Design a comprehensive database of resources or information for TTRA partners to facilitate linking clients to appropriate care programs and services based on income and eligibility for insurance and other benefits programs
 - e. Review and redesign the criteria as necessary for a person to qualify for TTRA to reduce possible barriers
 - f. Streamline the process so that more recently diagnosed TTRA patients receive ART on the same day
 - g. Determine barriers to expansion of TTRA through qualitative methods (e.g., surveys, focus groups)
 - h. Investigate the use of technology such as utilizing telehealth to reduce barriers for TTRA-eligible patients
2. Address the social needs of PLWH through interventions that target specific social determinants of health
 - a. Develop a housing resources database for PLWH who are homeless or have unstable housing, with referrals to housing support programs that provide rental assistance, utilities assistance, etc.
 - b. Determine feasibility and potential of having public-private partnerships to secure subsidized and affordable housing for PLWH
 - c. Provide transportation for PLWH from their home or job to services including case management visits, ADAP, etc.

- d. Discuss changes in ADAP which allow for more than one ADAP pharmacy, extended hours, or for medications to be made accessible at other pharmacies
- e. Increase the number of agencies that offer telehealth services for medical care, medical case management and mental health services
- f. Partner with agencies that serve recently arrived immigrants, uninsured, or underinsured populations to provide these individuals with more information on available resources
- g. Participate in cost-sharing mechanisms that can help reduce the cost burden on PLWH who are uninsured or underinsured

KEY PARTNERS: Association of Free Clinics, community health centers, CHD, FQHCs, Health Choice Network, HOPWA provider, hospitals, insurance plans, Medicaid, pharmaceutical grants, private doctors, Ryan White HIV/AIDS Program recipients

POTENTIAL FUNDING RESOURCES: Federal, state local funding, Medicaid, Ryan White HIV/AIDS Program funding, other public and private funding sources

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of TTRA providers, number of patients enrolled in TTRA, number of trainings offered to providers, number of agencies offering extended hours, number of public/private partnerships created to support housing and transportation

MONITORING DATA SOURCE: Surveillance, Ryan White HIV/AIDS Program data, linkage dashboard

PILLAR THREE: PREVENT

GOAL: Lower the rate of HIV transmission diagnosed annually in Miami-Dade County

KEY STRATEGIES AND ACTIVITIES:

1. Social marketing & media
 - a. Customize messages on PrEP to minority populations, with an inclusive message that promotes diversity
 - b. Increase social media efforts to engage the population on PrEP and educate the online community about the benefits of PrEP
 - c. Use social media messages to educate the population on HIV prevention and further destigmatize HIV
2. Community engagement
 - a. Use mobile units to increase PrEP uptake
 - b. Use peer educators/community health workers to better reach communities where they are and provide education on PrEP and HIV prevention
 - c. Continue providing free condoms and education on condoms through outreach efforts
 - d. Use academic detailing to educate providers on PrEP
3. Increase access to PrEP
 - a. Support pharmacy-driven PrEP protocols
 - b. Improve process for same-day PrEP
 - c. Increase the number of providers offering TelePrEP services
 - d. Increase the number of clients accessing TelePrEP services
 - e. Engage and educate medical providers to further increase potential access points for PrEP

- f. Explore opportunities for individuals to access PrEP without a prescription

KEY PARTNERS: Academic institutions (University of Miami, Florida International University), community colleges, community health centers, CHD, FQHCs, Gilead, hospitals, local county governments, pharmacies, private doctors, social media platforms, urgent care centers

POTENTIAL FUNDING RESOURCES: CDC HIV Prevention and Surveillance Program funding, Bureau of Primary Health Care funding, state and/or local funding, Gilead grants, public and private funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of providers prescribing PrEP, number of clients on PrEP, number of PrEP messages, number of mobile units providing PrEP, number of academic detailing visits, number of clients accessing TelePrEP

MONITORING DATA SOURCE: Local databases, EHE dashboard, PrEP Locator

PILLAR FOUR: RESPOND

GOAL: Create a mobile response team for potential outbreak situations

KEY STRATEGIES AND ACTIVITIES:

1. Deploy a mobile response team
 - a. Improve linkage to care in response to HIV clusters, including mobile response unit or team to engage clients and link them to appropriate resources (medical home, HIV medical care and ART) in the community
 - b. Identify HIV/STI testing partners/agencies to support the mobile response team
 - c. Incorporate information on resources for delivery to at-risk communities
2. Identify key community partners that can educate the community and assist in disseminating information on cluster related activities
3. Develop a communication plan to be shared with partners
4. Develop a protocol for cluster investigations
5. Increase HIV genotyping testing to better determine clusters of HIV cases

KEY PARTNERS: CHD, Ryan White HIV/AIDS Program, state health office, SAMHSA, FDCF, CBOs, FQHCs, public health professionals, medical providers

POTENTIAL FUNDING RESOURCES: CDC HIV Prevention and Surveillance funding, Ryan White HIV/AIDS Program funding, STD funding, state and/or local funding, other public and private funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Establishment of protocol, number of partners, establishment of communication plan, etc.

MONITORING DATA SOURCE: STARS, local protocols, eHARS

SECTION IX: ORANGE COUNTY

Five hundred persons received an HIV diagnosis in 2018 in Orange County, of whom 76 percent were linked to HIV-related care within 30 days of diagnosis. There were 9,513 persons living with an HIV diagnosis in Orange County through 2018, of which 66 percent (N=6,316) were retained in care, and 63 percent (N=6,002) achieved a suppressed viral load. This compares to 69 percent and 64 percent respectively for the state. A total of 2,425 (26%) did not receive any HIV-related care in 2018. In 2018, Orange County continued to see the disparities in HIV diagnoses among adults (age 13 and above).

Among Whites, Blacks and Hispanic/Latinos, the HIV diagnosis rate per 100,000 population among Black males (126.2) was three times higher than for White males (42.1), whereas the rate among Hispanic/Latino males (91.8) was two times higher than for White males. The HIV rate among Black females (48.8) was seventeen times higher compared to White females (2.9) whereas the rate among Hispanic/Latina females (17.8) was six times that for White females. Blacks had a lower viral suppression rate of 57 percent compared to 70 percent for Whites and 66 percent for Hispanic/Latinos. Over the past five years, HIV diagnoses have increased by 32 percent from 2014 (N=380) through 2018 (N=500). The number of new HIV diagnoses among males increased by 36 percent and among females by 18 percent over that same time. The age group with the highest increase in new HIV diagnoses over the past five years (175%) was among those aged 55–59 and older. Additionally, the number of new diagnoses increased by 100 percent among the 60 and older age group and by 58 percent among those aged 50–54 years. Male-to-male sexual contact continued to be the primary mode of exposure, demonstrating a 21 percent increase in new HIV diagnoses from 2014–2018. Males with a heterosexual mode of exposure had highest increase (146%) over the past five years, followed by males who inject drugs (129%).

PILLAR ONE: DIAGNOSE

GOAL: Identify PLWH as soon as possible after HIV transmission

KEY STRATEGIES AND ACTIVITIES:

1. Expand access points that conduct routine screening
 - a. Create routine screening in correctional facilities
 - b. Provide access outside of normal work hours—i.e., after 5:00 p.m. and on weekends
2. Redefine and expand community outreach programs
 - a. Conduct testing in non-conventional settings
 - b. Increase partnerships among communities that may not have local testing facilities
 - c. Increase corporate partnerships—i.e., Walmart, CVS, Target, Walgreens
3. Collaborate with the public-school system
 - a. Expand comprehensive sexual health education and assessments
 - b. Explore opportunities to implement sexual health assessments as a part of school physicals
 - c. Provide access during school activities (sporting activities, etc.)
 - d. Educate at charter schools
 - e. Educate at community centers (Boys and Girls Club, etc.)
4. Collaborate with the medical community
 - a. Explore funding opportunities to incentivize private providers for routine testing
 - b. Review the content for medical provider licensure regarding HIV
5. Expand testing in priority populations
 - a. Improve collaboration with the young MSM community (Black and Hispanic)
 - b. Improve collaboration with the Haitian-Creole community (more information in creole translation, advertising, etc.)
 - c. Increase testing locations that young MSM will access
 - d. Testing driven by PLWH and STI ZIP code data

6. Increased advertising

- a. Increase the use of social media (utilizing Google analytics) to target youth and young adults
- b. Increase education on dating apps, through ads, and banners, that provide access to testing sites and provide home tests to interested clients

KEY PARTNERS: CHD, Orange County Government, local AIDS service organizations, CBOs, Central Florida HIV Planning Council, Orange County Public Schools, University of Central Florida and Valencia Community College (School of Nursing and Medical School), community colleges, hospital systems (Advent Health System and Orlando Health), Orange County Jail, Central Florida Boys and Girls Club, iHeart Media, Health Care Center for Homeless, Hispanic Federation, Walgreens community-based specialty pharmacy, Walmart Center of Excellence Project specialty pharmacy, FQHCs, local private health care providers, medical groups (internal medicine, primary care, OBGYNs)

POTENTIAL FUNDING RESOURCES: CDC HIV Prevention and Surveillance Program funding; federal, state, and local funding; pharmaceutical grants (e.g., Gilead Compass Initiative)

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of newly identified persons with HIV, number of new partnerships, number of outreach activities, increased number of individuals who know their status, improved capacity of correctional facilities to conduct routine screening

MONITORING DATA SOURCE: State surveillance data, local testing data

PILLAR TWO: TREAT

GOAL: Ensure PLWH receive ongoing care and treatment

KEY STRATEGIES AND ACTIVITIES:

1. Increase education to providers
 - a. Educate providers (primary care and internal medicine providers) on patient assistance programs to address the need to start rapid access to medication
 - b. Engage community pharmacists implementing Medication Therapy Management services to ensure best therapeutic outcomes for clients with multiple conditions, complex therapies, multiple prescribers
 - c. Explore mechanisms to reimburse providers conducting routine screening at a higher Medicaid rate as an incentive to increase screening
 - d. Educate private providers on Ryan White care system and eligibility requirements
2. Increase the number of persons retained in care
 - a. Use retention specialist to focus on newly diagnosed clients for up to a year of initially being diagnosed as well as clients who have dropped out of care for over a year
 - b. Use technology to remind of appointments (text messages, emails, etc.)
 - c. Pharmacy synchronization (coordinating the refill of medications so clients can pick them up on a single day each month, which can reduce missed doses of their regular medications)
 - d. Use telehealth medicine for clients to assist with medication compliance and adherence to reduce the amount of clinic visits
 - e. Create an alert system within medical records for clients who have missed a provider visit

- f. Identify and implement initiatives focused on the aging PLWH population (age 50 and older)
- 3. Streamline medical services
 - a. Ensure non-medical support resources are readily available (housing assistance, transportation, case management, mental health, dental, substance abuse, nutrition) within the same facility
 - b. Discuss the feasibility of one eligibility certification that covers Ryan White and ADAP that can be done virtually or in multiple locations at flexible hours
- 4. Implement additional local advertising/treatment campaigns
 - a. Focus on Treatment as Prevention or U=U messaging

KEY PARTNERS: CHD, Orange County Government, local AIDS service organizations, CBOs, Central Florida HIV Planning Council, hospital systems (Advent Health System and Orlando Health), Orange County Jail, Health Care Center for Homeless, Hispanic Federation, Walgreens community-based specialty pharmacy, Walmart Center of Excellence Project specialty pharmacy, FQHCs, local private health care providers, medical groups (internal medicine, primary care, OBGYNs), local medical associations

POTENTIAL FUNDING RESOURCES: Ryan White HIV/AIDS Program funding, federal, state, and local funding, pharmaceutical grants (e.g., Gilead Compass Initiative), HOPWA funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of PLWH linked to care (newly diagnosed and individuals out of care over a year), number of PLWH retained in care, decreased number of persons out of care, increased number of persons linked to care within 30 days, increased number of PLWH virally suppressed and adherent to medication regimen

MONITORING DATA SOURCE: State surveillance data, ADAP data, Ryan White Program data

PILLAR THREE: PREVENT

GOAL: Lower the rate of new HIV infections diagnosed annually in Orange County

KEY STRATEGIES AND ACTIVITIES:

1. Increase PrEP and PEP education
 - a. Use social media, dating apps to target youth and young adults
 - b. Educate primary care providers, internal medicine, hospitals, urgent care centers, pharmacies
 - c. Develop a PrEP provider network to provide rapid access to care
2. Increase and improve PrEP and nPEP access
 - a. Implement an education campaign among key populations (bars, clubs, events, schools, provider offices, hospitals, etc.)
 - b. Provide PrEP in jails
 - c. Provide rapid access to PrEP and nPEP services during outreach activities through use of telehealth
 - d. Implement mobile PrEP and nPEP units
 - e. Use PrEP and nPEP navigators in EDs and urgent care centers
3. Implement a comprehensive syringe exchange program

KEY PARTNERS: CHD, Orange County Government, local AIDS service organizations, CBOs, Central Florida HIV Planning Council, Orange County Public Schools, University of Central Florida and Valencia

Community College (School of Nursing and Medical School), community colleges, hospital systems (Advent Health System and Orlando Health), Orange County Jail, Central Florida Boys and Girls Club, iHeart Media, Health Care Center for Homeless, Hispanic Federation, Walgreens community-based specialty pharmacy, Walmart Center of Excellence Project specialty pharmacy, FQHCs, local private health care providers, medical groups (internal medicine, primary care, OBGYNs), and local medical associations

POTENTIAL FUNDING RESOURCES: CDC HIV Prevention and Surveillance Program funding, state, and/or local county funding, pharmaceutical grants (Gilead Compass Initiative), private funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of providers educated on PrEP and nPEP on an annual basis, number of persons linked to PEP and PrEP services, number of PrEP and nPEP Prescriptions, number of individuals receiving syringe services

MONITORING DATA SOURCE: State surveillance data, local PrEP provider database, medical records

PILLAR FOUR: RESPOND

GOAL: Achieving a more coordinated response to the HIV epidemic in Orange County

KEY STRATEGIES AND ACTIVITIES:

1. Leverage state and local city/county government support
 - a. Establish local HIV taskforce to address HIV stigma, testing, treatment, and prevention
 - b. Address the decriminalization of HIV
2. Send educational, HIV testing, and awareness mailers to neighborhoods with higher rates of HIV/STI diagnoses
3. Create linkage to care/HIV peer teams to address and engage transgender, young Black and Hispanic MSM individuals and their social networks
4. Create harm reduction programs that target central Florida transgender, Black, and Latinx populations
5. Coordinate outreach activities with the public and private providers
6. Use existing and grassroots organizations, faith community, and local businesses to address priority populations

KEY PARTNERS: CHD, Orange County Government, local AIDS service organizations, CBOs, Central Florida HIV Planning Council, Orange County Public Schools, University of Central Florida and Valencia Community College (School of Nursing and Medical School), hospital systems (Advent Health System and Orlando Health), Orange County Jail, Central Florida Boys and Girls Club, iHeart Media, Health Care Center for Homeless, Hispanic Federation, Walgreens community-based specialty pharmacy, Walmart Center of Excellence Project specialty pharmacy, FQHCs, local private health care providers, medical groups (internal medicine, primary care, OBGYNs), and local medical associations

POTENTIAL FUNDING RESOURCES: CDC HIV Prevention and Surveillance Program funding, state and/or local county funding, pharmaceutical grants (Gilead Compass Initiative), private funding, Ryan White HIV/AIDS Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Local protocols, increased number of BRTA/FRTA partners, increased number of peer programs, improved engagement with priority populations

MONITORING DATA SOURCE: Local reports

SECTION X: PALM BEACH COUNTY

In 2018, 298 persons received an HIV diagnosis in Palm Beach County, of whom 79 percent were linked to HIV-related care within 30 days of diagnosis. There were 8,574 PLWH in Palm Beach County through 2018, of which 63 percent (N=5,384) were retained in care, and 59 percent (N=5,040) achieved a suppressed viral load. This compares to 69 percent and 64 percent respectively for the state. A total of 2,594 (30%) did not receive any HIV-related care in 2018. In 2018, Palm Beach County continued to see the disparities in HIV diagnoses among adults (age 13 and above). Among Whites, Blacks and Hispanic/Latinos, the HIV diagnosis rate per 100,000 population among Black males (89.5) was five times higher than for White males (17.6), whereas the rate among Hispanic/Latino males (38.7) was two times higher than for White males. The HIV rate among Black females (59.2) was thirteen times higher compared to White females (4.5) whereas the rate among Hispanic/Latina females (7.7) was nearly twice that for White females. Blacks had a lower viral suppression rate of 55 percent compared to 66 percent for Whites and 61 percent for Hispanic/Latinos. Over the past five years, HIV diagnoses have decreased by 6 percent from 2014 (N=316) through 2018 (N=298). The number of new HIV diagnoses among both males and females decreased by 6 percent over that same time. The age group with the highest increase in new HIV diagnoses over the past five years (113%) was among those aged 13–19. Additionally, the number of new diagnoses increased by 64 percent among the 35–39 age group and by 18 percent among those aged 25–29. Male-to-male sexual contact continued to be the primary mode of exposure, demonstrating a 5 percent increase in new HIV diagnoses from 2014–2018. Females who had an IDU mode of exposure had the highest increase (67%) over the past five years, followed also by males who in injected drugs (60%).

PILLAR ONE: DIAGNOSE

GOAL: Identify PLWH as soon as possible after transmission

KEY STRATEGIES AND ACTIVITIES:

1. Deploy Community Outreach, Response, and Engagement (CORE) teams using a D2C model
2. Test high-risk communities in non-conventional venues
3. Implement universal HIV testing in EDs and primary health care settings
4. Encourage routine opt-out HIV testing in health care settings

KEY PARTNERS: Communities and residents, HIV service providers, private medical providers, community partners, CHD, Health Planning Council, Department of Community Services, behavioral health providers, HIV planning bodies

POTENTIAL FUNDING RESOURCES: CDC and HRSA EHE funding, Ryan White HIV/AIDS Program Part A and B funding, SAMHSA, HOPWA provider, Federal Office of Rural Health Policy, Indian Health Service, Office on Women's Health, Office of Minority Health, Office of Population Affairs, other state and local funding, and other public and private funding sources

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of individuals tested, number of reactive and/or positive results, number of hospitals conducting routine screening

MONITORING DATA SOURCE: Electronic medical records, Provide, surveillance and testing data

PILLAR TWO: TREAT

GOAL: Ensure PLWH receive ongoing care and treatment

KEY STRATEGIES AND ACTIVITIES:

1. Telehealth Adherence Counselors (TAC)
 - a. To address the substantial number of PLWH engaged in care and not virally suppressed, TAC will use telehealth capabilities, including a mobile app called Positive Links to remind clients to take their medications through text or phone calls, and to provide support through video conference with clients regarding adherence
 - b. Engage with new PLWH weekly who are in care but not virally suppressed and mitigate challenges for viral suppression, including utilizing CORE teams to coordinate ARV medication access if mail order or pick-up at pharmacies pose a barrier to adherence
2. Rapid Entry to Care (REC)
 - a. REC sites will be established to provide services to clients within 72 hours of identification by the CORE Team, setting aside appointment time, space, and staff specifically for individuals entering care. Medical assessment, CD4 and viral load testing and ART may be initiated at the same encounter, with a 30-day ARV prescription provided by EHE funding, if no other payer source can reasonably be identified.
 - b. Educate on the importance of starting treatment in hospital settings

KEY PARTNERS: Communities and residents, HIV service providers, private medical providers, community partners, CHD, Health Planning Council, Department of Community Services, behavioral health providers and planning bodies, HIV planning bodies, academic institutions (Florida Atlantic University)

POTENTIAL FUNDING RESOURCES: CDC and HRSA EHE funding, Ryan White HIV/AIDS Program Part A and B funding, SAMHSA, HOPWA funding, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, other state and local funding, and other public and private funding sources

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: number of individuals linked to and engaged in care, number of virally suppressed

MONITORING DATA SOURCE: Electronic health records, Provide, surveillance and testing data

PILLAR THREE: PREVENT

GOAL: Lower the rate of HIV transmission diagnosed annually in Palm Beach County

KEY STRATEGIES AND ACTIVITIES:

1. Increase access to PrEP throughout the county
 - a. Expand the number of PrEP providers
 - b. Initiate telePrEP services and telehealth for prevention
 - c. Increase access to PrEP in non-traditional settings
 - d. Explore ways to implement HIV prevention among youth
2. Increase awareness and acceptance of PrEP
 - a. Educate providers about the benefits and effectiveness of PrEP
 - b. Conduct community education and social marketing, including through social media, to combat stigma and dispel myths related to PrEP and HIV

KEY PARTNERS: Communities and residents, HIV service providers, private medical providers, community partners, CHD, Health Planning Council, Department of Community Services, behavioral health providers and planning bodies, HIV planning bodies, academic institutions (Florida Atlantic University), community colleges

POTENTIAL FUNDING RESOURCES: CDC and HRSA EHE funding, Ryan White HIV/AIDS Program Part A and B funding, SAMHSA, HOPWA funding, Federal Office of Rural Health Policy, Indian Health Service; Office on Women's Health, Office of Minority Health, Office of Population Affairs, other state and local funding, and other public and private funding sources

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of providers trained, number of prescriptions for PrEP, community feedback regarding perception of PrEP

MONITORING DATA SOURCE: Provide, electronic health records, Local databases, medical records data, pharmacy records

PILLAR FOUR: RESPOND

GOAL: Increase the county's capacity to identify, investigate and respond to active HIV transmission clusters and outbreaks

KEY STRATEGIES AND ACTIVITIES:

1. Responding to cluster detection efforts through CORE teams and engaging newly diagnosed individuals into care
2. Enhancing MHS and cluster response
 - a. Increase the number of genotypes ordered and received for new diagnoses
 - b. Engage the community in developing a response framework
 - c. Conduct community awareness and social marketing related to molecular surveillance to mitigate misconceptions and fear
3. Implement D2C framework to rapidly identify PLWH and link them to medical and nonmedical services

KEY PARTNERS: Communities and residents, HIV service providers, private medical providers, community partners, CHD, Health Planning Council, Department of Community Services, behavioral health providers and planning bodies, HIV planning bodies

POTENTIAL FUNDING RESOURCES: CDC and HRSA EHE funding, Ryan White HIV/AIDS Program Part A and B funding, SAMHSA, HOPWA funding, Federal Office of Rural Health Policy, Indian Health Service, Office on Women's Health, Office of Minority Health, Office of Population Affairs, other state and local funding, other public and private funding sources

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Establishment of local protocols for cluster detection and response procedures

MONITORING DATA SOURCE: Local protocols and surveillance reports

SECTION XI: PINELLAS COUNTY

In 2018, 182 persons received an HIV diagnosis in Pinellas County, of whom 85 percent were linked to HIV-related care within 30 days of diagnosis. There were 4,900 PLWH in Pinellas County through 2018,

of which 76 percent (N=3,726) were retained in care, and 69 percent (N=3,381) achieved a suppressed viral load. This compares to 69 percent and 64 percent respectively for the state. A total of 853 (17%) did not receive any HIV-related care in 2018. In 2018, Pinellas County continued to see the disparities in HIV diagnoses among adults (age 13 and above). Among Whites, Blacks and Hispanic/Latinos, the HIV diagnosis rate per 100,000 population among Black males (159.1) was almost seven times higher than for White males (23.2), whereas the rate among Hispanic/Latino males (58.0) was nearly three times higher than for White males. The HIV rate among Black females (36.2) was nearly twenty-one times higher compared to White females (1.8) whereas the rate among Hispanic/Latina females (5.2) was three times that for White females. Blacks had a lower viral suppression rate of 63 percent compared to 72 percent for Whites and 70 percent for Hispanic/Latinos. Over the past five years, HIV diagnoses have increased by 8 percent from 2014 (N=168) through 2018 (N=182). The number of new HIV diagnoses among males increased by 25 percent and decreased among females by 40 percent over that same time. The age group with the highest increase in new HIV diagnoses over the past five years (108%) was among those aged 45–49. Additionally, the number of new diagnoses increased by 43 percent among the 20–24 and 35–39 age groups. Male-to-male sexual contact continued to be the primary mode of exposure, demonstrating an 18 percent increase in new HIV diagnoses from 2014–2018. Males who had an IDU mode of exposure had the highest increase (250%) over the past five years followed by men with male-to-male sexual contact who also injected drugs (83%).

PILLAR ONE: DIAGNOSE

GOAL: Identify PLWH as soon as possible after HIV transmission

KEY STRATEGIES AND ACTIVITIES:

1. Create and share HIV data and info regarding specific high-risk populations in Pinellas (e.g., ZIP-code data, race, gender, age, etc.) with community partners and High Impact Prevention (HIP) contract holders to ensure these groups are targeted for increase testing and information
2. Conduct an analysis of high-risk ZIP-codes to determine specific factors that contribute to increased risk of HIV/STIs
3. Research, share and implement HIV prevention models that target Black and Latinx populations
4. Create campaigns to promote testing, safe sex behaviors and prevention that can be used through TV, radio, and other media outlets
5. Test high-risk communities in non-conventional venues to include non-CHD sites and varying times outside of normal business hours
 - a. Initiate community-coordinated night clinics hosted at non-CHD location
6. Research mechanisms to incentivize and normalize testing in all health care settings through educations, marketing, and advertising
7. Conduct listening sessions to increase awareness and normalization of HIV testing; hosted in various locations throughout Pinellas County focused on high-priority ZIP codes and populations
8. Encourage community health care providers to practice routine testing in their health care settings
9. Use social media and other common Internet apps to advertise free testing services, educate high-risk communities, and create continuous on-line conversation about HIV and STI risks specific to Pinellas County

10. Work with the Gilead FOCUS project to explore the public and private partnership with hospital systems to increase HIV testing

KEY PARTNERS: CHD, FQHCs, private providers, CBOs, academic institutions (University of South Florida), community colleges, social media platforms, corporate entities, hospital systems, local planning bodies, local coalitions

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding; private funding; pharmaceutical grants; CDC HIV Prevention and Surveillance Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of newly identified persons with HIV, number of health care settings implementing routine screening

MONITORING DATA SOURCE: Surveillance data, local testing data

PILLAR TWO: TREAT

GOAL: Ensure PLWH receive ongoing care and treatment

KEY STRATEGIES AND ACTIVITIES:

1. Design and distribute among all providers that serve HIV clients, viral suppression cards and posters to educate clients on the benefits of viral load suppression
2. Provide feedback to HIV providers on the number/percentage of their ADAP clients who are virally suppressed
3. Develop community campaign to market and advertise to PLWH on the benefits of maintaining low viral loads and protecting against STI, vaccine preventable disease (e.g., hepatitis A) and other opportunistic infections
4. Work with community partners to challenge and incentivize PLWH to maintain low/suppressed viral loads
5. Continue to work through Zero Pinellas model to ensure Test to Treat within 72 hours
6. Address social determinants that create barriers to care, compliance and viral load suppression for PLWH to include: housing, transportation, access to specialty care, access to educational and economic opportunities
7. Educate and train HIV providers to provide culturally appropriate health care experiences for PLWH, specifically for those in the Black and Latinx communities that have higher rates of disease

KEY PARTNERS: CHDs, FQHCs, private providers, CBOs, hospital systems, Florida Medical Association, AHCA, FDCF, State and City HOPWA programs, academic partners (University of South Florida)

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, private funding, pharmaceutical grants, CDC HIV Prevention and Surveillance Program funding, Ryan White HIV/AIDS Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Increased number of PLWH retained in care, decreased number of persons out of care, increased number of persons linked to care in 30 days, increased number of PLWH virally suppressed and adherent to medication regimen

MONITORING DATA SOURCE: Local database, CAREWare, ADAP Provide, CDC testing and linkage data

PILLAR THREE: PREVENT

GOAL: Lower the rate of HIV transmission diagnosed annually in Pinellas County

KEY STRATEGIES AND ACTIVITIES:

1. Create campaign to promote and incentivize testing, safe sex behaviors and prevention
2. Conduct listening sessions to increase awareness of PrEP; hosted in various locations throughout Pinellas County, focused on high-priority ZIP codes and populations
3. Review educational and promotional tool kits developed for after-school programs, youth organizations, and other adolescent programs within the community
4. Coordinate with the City of Saint Petersburg, which has the highest burden of disease among the 24 municipalities in Pinellas County, to implement free condom dispensing program in high-risk ZIP codes; these would be in venues that are easily accessible after hours
5. Develop local teen councils in high-risk neighborhoods to train teens to provide peer-to-peer education through local recreation centers.
6. Expand PrEP services at the CHD to include:
 - a. Reducing wait times to start medication
 - b. Increasing access points throughout STI/ family planning clinics
 - c. Increasing marketing and advertising of availability of PrEP to high-risk community
7. SEP implementation
 - a. County Commission ordinance and approval
 - b. Naloxone access (harm reduction strategy)
8. Include HIV education and awareness components to non-health related community events

KEY PARTNERS: FQHCs, private providers, CBOs, social media platforms, corporate entities, hospital systems, academic partners (University of South Florida), community colleges

POTENTIAL FUNDING RESOURCES: Federal, state, and local funding, private funding, pharmaceutical grants, CDC HIV Prevention and Surveillance Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of providers trained/educated, number of PrEP prescriptions provided, number of non-traditional settings offering PrEP services, number of PrEP telehealth services, number of academic institutions educating on PrEP

MONITORING DATA SOURCE: Local databases, medical records, pharmacy records

PILLAR FOUR: RESPOND

GOAL: Enhance the county's capacity to rapidly detect and respond to regions and networks of rapidly growing HIV transmission

KEY STRATEGIES AND ACTIVITIES:

1. Coordinate with FDOH headquarters to develop plan for monitoring and follow-up on molecular HIV clusters:
 - a. Establish goals and objectives for cluster monitoring
 - b. Routine reporting from FDOH headquarters
 - c. Establish protocols for local follow-up
 - d. Identify workforce and time needed for appropriate follow-up
2. Expand linkage to care services for both newly diagnosed cases, and those lost to care

3. Create plan to disseminate information to community on molecular clusters (this term can be perceived negatively by some. The question has been how this information will be used to impact criminalization for individuals who are living with HIV and don't disclose to their sexual partners)

KEY PARTNERS: FQHCs, private providers, CBOs, social media platforms

POTENTIAL FUNDING RESOURCES: State and local county funding, private funding, CDC HIV Prevention and Surveillance Program funding

ESTIMATED FUNDING ALLOCATION: TBD

OUTCOMES: Number of community-level response actions using developed protocol, number of people tested from community-level response, number of persons diagnosed with HIV linked to care through use of response protocol, number of people offered PrEP as part of community-level response, number of community engagement sessions conducted around development of response protocol, number of awareness campaigns and messaging materials produced around HIV transmission network response

MONITORING DATA SOURCES: eHARS, HMS, STARS, community partner local databases

SECTION XII: MONITORING AND EVALUATION

The goal of the monitoring and evaluation plan is to assess successful implementation of the unified EHE plan as measured by:

1. Completion of stated strategies and activities.
2. Annual progress toward the target measurements of stated goals, objectives and benchmarks.

Data are used to direct efforts to ensure the program achieves the intended results and to help identify additional operational and process improvement opportunities.

Through bi-annual meetings and monthly committee calls coordinated by the HIV/AIDS Section, FCPN will actively participate in regular monitoring of strategies and activities set forth in the unified EHE plan. The FCPN Coordination of Efforts Committee will determine the most appropriate mechanism to monitor, evaluate, and update the plan as necessary. This committee takes the lead in ensuring that data indicators for plan activities are being tracked and that progress is communicated with the right programs and partners to meet plan objectives. Data on performance indicators will be collected and disseminated through a status report to statewide partners. Regular FCPN meetings are the principle mechanism for updating planning bodies and stakeholders on the progress of plan implementation as well as soliciting and using feedback from stakeholders for ongoing plan improvements.

The plan will receive a detailed annual review by HIV/AIDS Section leadership. As part of the annual review, the section will use surveillance and program data to assess health outcomes along the HIV Care Continuum that impact the quality of the HIV service delivery system. This will allow for adjustments to be made in response to changing conditions, and information from the review will be provided to FCPN for feedback.

The HIV/AIDS Section, with the engagement of stakeholders, will review the strategic plan using identified measures and indicators to analyze, assess, and evaluate outcomes and determine whether modifications to the plan are necessary. The diverse range of perspectives—knowledge, values, needs

and abilities—of stakeholders will be applied through a participatory planning and evaluation process. The collaborative approach, structured and arranged to interweave state and local community partnerships with shared discretion and responsibilities, will help to achieve the plan objectives more effectively than each program could on its own. This approach will align with, support, and advance the goals of the EHE initiative, the National HIV/AIDS Strategy, and FDOH as well as meet CDC and HRSA requirements. As the state of Florida moves forward in ending the epidemic, regularly scheduled events to inform all stakeholders and researchers of relevant data and evidence for improving or more precisely monitoring and evaluating the implementation and impact of the plan is essential. These opportunities will ensure that plan implementers are working with the best available evidence to work toward ending the epidemic.

DRAFT

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