STATE OF FLORIDA

Integrated HIV Prevention and Care Plan

2022–2026

Prepared for

Division of HIV/AIDS Prevention

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Centers for Disease Control and Prevention

HIV/AIDS Bureau
Health Resources and Services Administration

Submitted by

Florida Department of Health
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Revision History

Version	Date	Author(s)	Revision Notes
1.0	9/30/2022	ISF	Draft to walkthrough with Department
2.0	10/10/2022	Department/ISF	Additional content added, edits made
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7.0	1/19/2023	Department	Final revisions incorporated

Acronyms

Acronym	Definition
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AHCA	Agency for Health Care Administration
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy/Treatment
ARTAS	Antiretroviral Treatment and Access to Services
ARV	Antiretrovirals (medication)
AZT	Azidothymidine
BRTA	Business Responds to AIDS
CBI-HIV	Capacity Building Initiative
CBO	Community-based Organization
CDC	Centers for Disease Control and Prevention
CHARTS	Florida Community Health Assessment and Resource Tool Set
CHD	County Health Department
CHW	Community Health Worker
CLAS	National Culturally and Linguistically Appropriate Services Standards
Department	Florida Department of Health
D2C	Data to Care
DIS	Disease Intervention Specialist
DUA	Data Use Agreement
EBI	Evidence-based Interventions
ED	Emergency Department
EHE	Ending the HIV Epidemic
EMA	Eligible Metropolitan Areas
FCHAR	Florida Consortium for HIV/AIDS Research
FCPN	Florida Comprehensive Planning Network
FDA	U.S. Food and Drug Administration
FDC	Florida Department of Corrections
FDCF	Florida Department of Children and Families

Acronym	Definition
FDOE	Florida Department of Education
FLHRC	Florida Harm Reduction Collective
FOCUS	Frontlines of Communities in the United States Initiative
FQHC	Federally Qualified Health Centers
FRTA	Faith Responds to AIDS
F.S.	Florida Statute
HAPC	HIV/AIDS Program Coordinator
HBCU	Historically Black Colleges and Universities
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIP	High-Impact Prevention
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HRSA	Health Resources and Services Administration
IDU	Injection Drug Use
HUD	U.S. Department of Housing and Urban Development
IBM	Insurance Benefits Management
IDEA	Infectious Disease Elimination Act
IPC	Integrated Prevention and Care
JLP	Jail Linkage Program
MAI	Minority AIDS Initiative
Marketplace®	Affordable Care Act Health Insurance Marketplace®
MAT	Medication Assisted Treatment
MHS	Molecular HIV Surveillance
MMP	Medical Monitoring Project
MMSC	Male-to-Male Sexual Contact
MSM	Men who have Sex with Men
NHAS	National HIV/AIDS Strategy

Acronym	Definition
NCHHSTP	National Centers for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NHBS	CDC National HIV Behavioral Surveillance
OD2A	Overdose Data to Action
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PRPP	Pre-Release Planning Program
PWH	People (or Person) with HIV
PWID	Persons Who Inject Drugs
RFA	Request for Application
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSN	Statewide Coordinated Statement of Need
SDOH	Social Determinants of Health
SPNS	Special Projects of National Significance
SSP	Syringe Services Program
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
T&T	Test and Treat
TCE	Targeted Capacity Expansion
TH	Telehealth
TIC	Trauma Informed Care
TOPWA	Targeted Outreach for Pregnant Women Act
U=U	Undetectable=Untransmittable
UM-AETC	University of Miami AIDS Education and Training Center
USPSTF	U.S. Preventive Services Task Force
US	United States
VA	Veteran’s Administration
VL	Viral Load
WCBA	Women of Childbearing Age
WICY&F	Women, Infants, Children, Youth, and Families

1 Executive Summary and Statewide Coordinated Statement of Need (SCSN)

The United States (U.S.) has taken on a bold plan to end the HIV epidemic by the year 2030. In order to reach national goals of reducing new HIV infections by 75% by 2025 and by 90% by 2030, the country must take aggressive actions by scaling up key HIV prevention and treatment strategies. The presentation of **Florida's HIV Integrated Prevention and Care (IPC) Plan, 2022–2026** is the culmination of several local (rapid HIV antiretroviral start programs), state (Data to Care programs), and federal initiatives including:

- *National HIV/AIDS Strategy, 2022–2025 (NHAS)*
- *Ending the HIV Epidemic (EHE) in the United States* (2019)
- *National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021–2025*

These plans work in unison to achieve national goals. This plan builds upon the previous work in Florida's Statewide Integrated HIV Prevention and Care Plan, 2017–2021 and Florida's Unified Ending the HIV Epidemic (EHE) Plan, 2020.

The impact of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) in Florida is far reaching with 120,502 persons with HIV (PWH) living in the state as of 2021, which represents only 86% of PWH—the remainder of whom are unaware of their status (approximately 14%). We believe people in Florida have the right to:

- Know their HIV status.
- Access Pre-Exposure Prophylaxis (PrEP) if they are negative but at risk for developing the disease.
- Receive services needed to achieve or maintain a high quality of life if they have tested positive.
- Obtain health care, free of stigma.
- Be a voice in their local communities to effect positive change.

According to the Centers for Disease Control and Prevention (CDC), in 2020 (the most recent data available), Florida was ranked third highest (15.7 per 100,000 population) for new HIV diagnosis rates in the United States (including the District of Columbia). In 2021, 4,708 persons received an HIV diagnosis in Florida, a 37% increase from the 3,441 HIV diagnoses in 2020. In 2021, 83% of those newly diagnosed were linked to HIV-related care within 30 days of diagnosis. The number of AIDS cases diagnosed in 2012 in Florida was 2,846, and in 2021 case numbers dropped to 1,860. The current estimate of 14% of PWH in Florida not knowing their status, along with the substantial decrease in AIDS cases over a 10-year period, together underscore the importance of HIV prevention and care service delivery in Florida.

The seven Florida EHE counties make up approximately 11% of the total national HIV burden as outlined in the EHE plan and represent 72% of the total persons with an HIV diagnosis in Florida. Five of the EHE

counties, Pinellas (77%), Hillsborough (71%), Orange (72%), Broward (70%), and Duval (69%) had a viral suppression rate equivalent to or greater than the state rate of 69%, while Palm Beach (65%) and Miami-Dade (63%) had lower viral suppression rates than the state at the end of 2021.

Florida is a large and diverse state. It has both rural and metropolitan areas, an extensive mix of cultures, and an oscillating population due to seasonal residents, tourists, and itinerant workers. These factors can challenge the planning processes of disease control. The IPC Plan is designed to demonstrate coordinated HIV prevention and care activities by assessing resources and service delivery needs across HIV prevention and care systems to ensure the allocation of resources based on data.

Florida receives funding for and implements a wide range of programs and services for persons with and those at increased risk for HIV, including: the AIDS Drug Assistance Program (ADAP), Ryan White HIV/AIDS Program (RWHAP) patient care programs, prevention (HIV testing, PrEP, linkage), housing, substance use disorder and mental health, and other programs.

Core medical and support services are provided by the federal RWHAP to low-income Floridians living with HIV or AIDS who have inadequate or no health insurance and are ineligible for Medicaid, Medicare, or any other public insurance programs through different entities. Services such as medical care, pharmaceuticals, dental services, payment of health insurance premiums, laboratory services, counseling and treatment for substance use disorder, and medical case management are provided through the various parts of the RWHAP. Each part has separate eligibility criteria that clients must meet.

Ending HIV requires partnership and collaboration. This IPC Plan was developed through collaborative efforts that span the continuum of HIV prevention and care, and with representatives from the Florida Comprehensive Planning Network (FCPN) and associated advisory groups, local HIV planning bodies, Department of Health staff, and communities living with and affected by HIV/AIDS. The IPC Plan also aligns with the previously submitted Florida EHE Plan (2020), Florida's 4 Key Component Plan (2016), and the NHAS goals and strategies.

Florida's IPC Plan encompasses the state's entire system of HIV prevention and care. The IPC Plan was reviewed with members of Florida's integrated HIV prevention and care planning body, FCPN, during the Fall 2022 meeting held in Lutz, Florida, October 18–19, 2022. During the two-day meeting, FCPN members and other stakeholders in attendance had an opportunity to provide feedback and suggestions on the draft plan. Concurrence for the plan was gained on October 19, 2022, through a vote of FCPN members. The Department of Health (Department) is pleased to present Florida's IPC Plan, which is intended to re-energize and strengthen a whole-of-society response to the epidemic while supporting PWH in Florida and reducing HIV-associated morbidity and mortality.

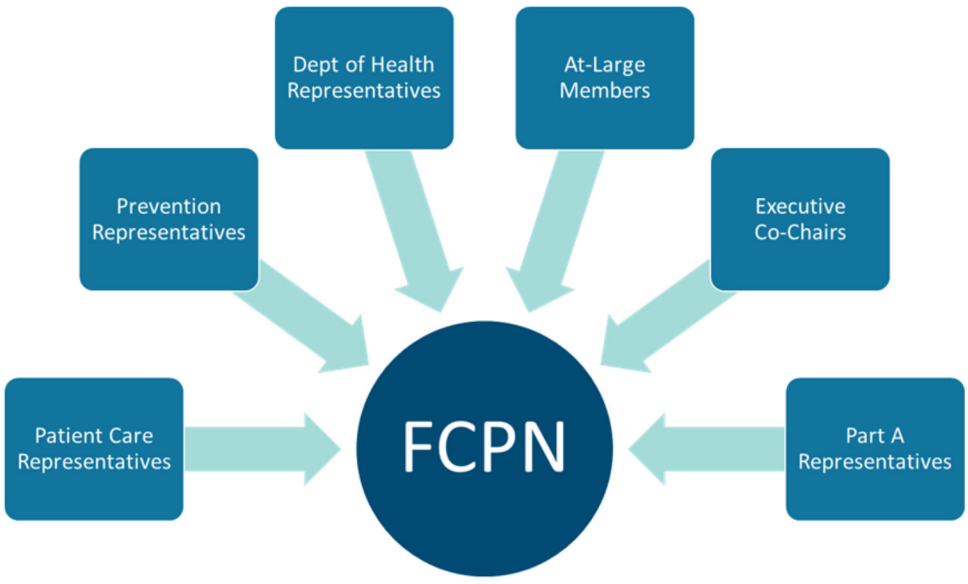
1.1 Approach and Partnerships

Critical information about the IPC Plan has been organized in the following sections:

- Community Engagement and Jurisdictional Planning Process (Section 2)
- Contributing Data Sets and Assessments (Section 3)
- Situational Analysis (Section 4)
- Calendar Year (CY) 2022–2026 Goals and Objectives (Section 5), organized by the goals of the National HIV/AIDS Strategy and inclusive of the four pillars of the EHE initiative: Diagnose, Treat, Prevent, and Respond.
- 2022–2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up (Section 6)

Plan development was facilitated by The AIDS Institute through multiple meetings with the FCPN. The FCPN became an integrated HIV prevention and care planning body in 2017 and is made up of representatives from HIV prevention, care, all parts of the RWHAP, federally qualified health centers (FQHC), state and local government, academia, service providers, consumers, and advocates as seen in the figure below. The FCPN is made up of three representatives per each of Florida's 14 HIV partnership areas—a prevention representative, patient care representative, and a Department representative (42 seats). In addition, there are five at-large representative seats—proposed and voted upon by FCPN—which represent specific populations and/or areas of practice (e.g., behavioral science). Each of Florida's six RWHAP Part A jurisdictions also have a representative at the FCPN table (six seats).

FIGURE 1: FPCN MEMBERSHIP DIAGRAM

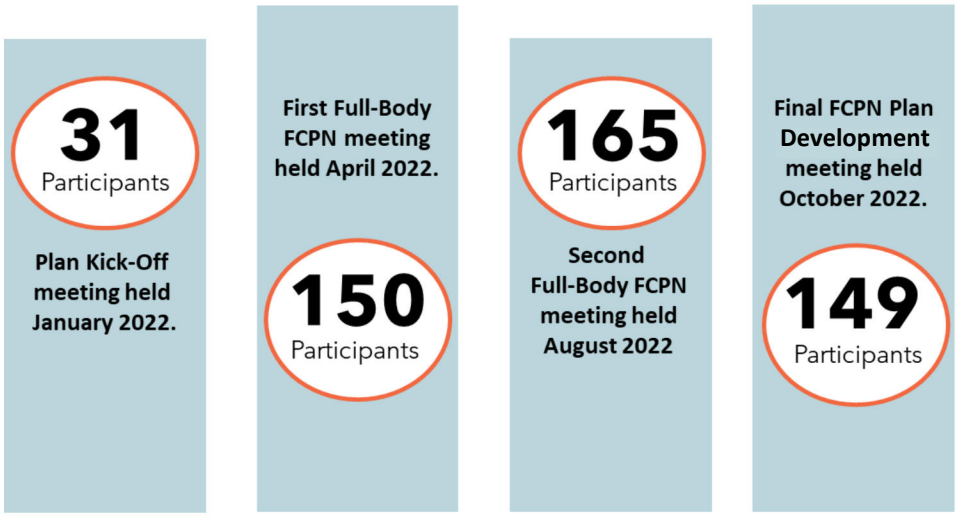


The FCPN typically meets twice per year, in-person (with virtual meeting options for those unable to attend in person) and the FCPN committees (i.e., Membership, Nominations, and Bylaws Committee;

Medication Access Committee; Coordination of Efforts Committee; Needs Assessment Committee; and Executive Co-Chairs Committee) and associated advisory groups (Florida Gay Men's HIV Workgroup, Community HIV Advisory Group) meet monthly via videoconference.

In 2021, in preparation for developing the IPC Plan, the Department, in collaboration with the FCPN and RWHAP Part A partners, hosted a series of virtual webinars delivered statewide to share information from the Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022–2026, released by CDC and Health Resources and Services Administration (HRSA) in June 2021. The figure below summarizes the key meetings held. Detailed descriptions of each meeting are bulleted after the figure.

FIGURE 2: PLAN DEVELOPMENT MEETINGS



- In January 2022, an integrated HIV planning kick-off meeting was held with Florida's State Surgeon General, the FCPN Executive Co-Chairs' Committee, representatives from Florida's six RWHAP Part A areas (Fort Lauderdale, Miami, Tampa/St. Petersburg, Orlando, West Palm Beach, Jacksonville), The AIDS Institute, and the Department's Division of Disease Control and Health Protection leadership, and HIV, sexually transmitted disease (STD), and viral hepatitis staff to discuss Florida's approach to developing the statewide HIV IPC Plan for 2022–2026. There were 31 participants (29 in-person and 2 virtual).
- The first full-body FCPN meeting was held in April 2022 and was an in-person meeting with virtual attendance options. This meeting was used to develop goals, objectives, and strategies that were taken back to local planning bodies for discussion and feedback. There were 150 meeting participants (68 in-person and 82 virtual), representing all 14 HIV partnership areas.
- In August 2022, the FCPN met again as a full body to develop activities for the strategies that aligned with NHAS. This meeting included small-group exercises to ensure everyone around the table and attending virtually could provide input and actively participate in the activity development process. All proposed activities were collected, and a survey was distributed after the meeting to allow all attendees to vote on prioritized activities for inclusion in the IPC Plan.

Additionally, acquired consulting services from ISF, Inc. to assist in stakeholder coordination, research, reporting and writing for the 2022–2026 IPC Plan. ISF performed key stakeholder group interviews in each of Florida's 14 HIV partnership areas and each group included lead representatives for the Department, RWHAP Part A, Part B, and local community planning group members. There were 165 meeting participants (52 in-person and 113 virtual), representing all 14 HIV partnership areas.

- The FCPN fall 2022 meeting was held in October and used to review the first draft of the IPC Plan, solicit public comment, and input, and conduct a concurrence vote with the full membership of FCPN. There were 149 meeting participants (53 in-person and 96 virtual), representing all 14 HIV partnership areas.

Letters of concurrence were drafted in November 2022 and subsequently signed by the community co-chairs of the FCPN for inclusion into the IPC Plan. The Department also worked to finalize and ultimately submit the IPC Plan in January 2023.

The Department prioritizes a collaborative approach and works directly with the six RWHAP Part A areas. Ongoing coordination efforts include monthly calls with RWHAP Part A and B programs which split responsibilities of running calls (each call hosted by one of Florida's Ryan White Part A areas); the monthly calls are used to discuss major issues including the IPC Plan.

A data-informed approach was used to develop the IPC Plan, taking into account data and activities from Florida's approach to HIV prevention and care, including routine HIV screening, rapid access to treatment and care (Test & Treat), epidemiologic data, HIV Care Continuum outcomes, and other data which help identify priority populations and HIV health disparities. The Department's High-Impact Prevention (HIP) funding opportunity was developed with the HIV status-neutral approach at the forefront, and funds 44 community and faith-based organizations statewide to provide HIV testing and linkage to care, prevention, and essential support services. Florida also maintains more than 1,600 registered HIV test sites statewide. The HIV status-neutral approach to reducing new HIV diagnoses involves initial HIV testing services as the entry point to HIV prevention and/or care services irrespective of a positive or negative test result. The Department has also engaged in HIV stigma reduction efforts, participating in the University of Florida (UF) stigma workgroup, and contracting with UF for the provision of evaluation and planning activities that will be used to develop program interventions addressing the stigmas related to HIV. Information from Florida's EHE plan was also used to develop content for the updated IPC Plan.

Florida's RWHAP Part A areas have developed their own local integrated HIV prevention and care plans which, like the state's plan, align with the NHAS goals and objectives, but contain locally developed activities tailored to each geographic region. Florida's statewide IPC Plan and the RWHAP Part A IPC Plans will work in concert to advance the goals and objectives of the NHAS and build a pathway to end the HIV epidemic. Links to each of the RWHAP Part A IPC Plans are provided in Table 1.

TABLE 1: RWHAP PART A IPC PLAN LINKS

Grantee	Link
Fort Lauderdale (Broward County)	https://www.broward.org/RyanWhite/Pages/Default.aspx
Jacksonville (Duval County)	https://www.coj.net/rwpc
Miami (Miami-Dade County)	https://www.miamidade.gov/global/service.page?Mduid_service=ser1482944607068715
Orlando (Orange County)	https://www.ocfl.net/familieshealthsocialsvcs/hiv.aspx#.YFyrkj_-h9A
Tampa/Saint Petersburg (Hillsborough and Pinellas counties)	https://www.hillsboroughcounty.org/en/residents/social-services/health-care-plan/ryan-White-program
West Palm Beach (Palm Beach County)	https://discover.pbcgov.org/communityservices/Pages/Ryan-White-CARE.aspx

HIV service regions are broken down into 14 partnership areas, each with an HIV/AIDS Program Coordinator (HAPC) to oversee prevention and care program operations in the area and assure that program activities are planned in an inclusive and collaborative manner to ensure the other local resources and specific client needs are considered and addressed. They work closely with RWHAP recipients, health district resources, other county programs, and academic and university resources as available.

The HIV/AIDS Section also works closely with many organizations to ensure coordination of effort because of the co-morbidities often associated with HIV/AIDS and their impacts on public health. These organizations include STD, TB, and Viral Hepatitis and Outbreak Response Sections; Children's Medical Services; local community-based organizations (CBOs) and county health departments (CHD); universities; the Florida Department of Corrections; the Department's state laboratories in Jacksonville and Miami; and the Department's central pharmacy.

The six RWHAP Part A Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs), and the RWHAP Part C, D, and F programs collectively bring more than $94.6 million annually to Florida and are key resources in meeting the service needs of PWH in their service area. The RWHAP Part C program directly funds local projects to support service capacity building as well as early intervention services; there are 20 RWHAP Part C programs in Florida. The RWHAP Part D program directly funds a local Tampa project that provides clinical services to women, infants, children and youth (WICY); there are six RWHAP Part D programs in Florida.

The Department HIV Surveillance Program works closely with each local area to provide customized data reports that reflect key information about the epidemic in each area. These data reports are provided to the local CHDs, planning bodies, and each of the RWHAP Part A areas to assist them in preparing grant applications and other reports. Local planning bodies use epidemiologic data, demographic, and service

data, focus groups, resource inventories, and client and provider satisfaction surveys to gauge areas of program strengths and weaknesses.

The Department's HIV Prevention Program collaborates with the Patient Care, ADAP, Medical, and Surveillance programs to deliver comprehensive HIP strategies and services with overarching goals of reducing the number of new HIV transmissions, increasing the proportion of persons living with HIV who know their status, linking PWH to care and support services, and reducing risk behaviors that may lead to HIV and STD diagnoses. Florida's HIP program is multi-faceted and includes HIV testing, linkage to care, peer navigation programs, comprehensive prevention interventions for PWH, partner services, PrEP and post-exposure prophylaxis (PEP), perinatal HIV prevention, corrections initiatives, condom distribution, community outreach (traditional and Internet-based) and engagement, and other services. The Prevention Program also collaborates with the RWHAP Part A programs, FQHCs, CBOs, academia, PWH, and other stakeholders to implement many HIP interventions and strategies. These essential partnerships help to ensure individuals are receiving comprehensive HIV prevention services along the HIV care continuum, leading to improved health outcomes for those living with HIV/AIDS.

Stakeholder engagement occurs on a regular basis through the FCPN and assists the Department in planning patient care and prevention activities. The FCPN is composed of representatives from the Department, all parts of the RWHAP, FQHCs, academia, service providers, CBOs, PWHs, and advocates. The FCPN reviews and gives feedback on projects the HIV/AIDS Section develops, such as the Needs Assessment, the SCSN and statewide IPC Plan, other programs funded with state general revenue, as well as various program standards, and guidelines.

The HIV/AIDS Section routinely communicates with the RWHAP Part A administrators to ensure that they are informed of program activities and have an opportunity to comment and contribute to various projects. Areas of collaboration have been on the transition of RWHAP clients to the Affordable Care Act (ACA) Marketplace® (Marketplace®), work on the Statewide IPC Plan, and development of the ADAP HCV treatment pilot project.

Over the past two years, there have been multiple meetings to plan for a uniform methodology to select insurance plans and move clients to the Marketplace®. Determining eligibility criteria for insurance coverage, planning for the provision of wrap around services, and the potential local coverage of additional clients were main topics of discussion. This project has been very successful; clients, regardless of whether they receive services from RWHAP Part A or Part B ADAP, or are mutual clients, have the same options for insurance selection criteria and process to enroll in the Marketplace® for insurance coverage.

Collaborations, partnerships, and stakeholder engagement exist in many forms throughout Florida; however, opportunities exist to expand partnerships further and engage new and non-traditional partners in more regular communication (for example, Department of Veterans' Affairs and Indian Health Service) to further the objectives and support the strategies of Florida's statewide IPC Plan.

1.2 Documents Submitted to Meet Requirements

In order to meet the submission requirements of the IPC Plan, as outlined in the CDC and HRSA Integrated HIV Prevention and Care Planning Guidance (2021), Table 2 provides descriptions for each document referenced in the IPC Plan. Documents have also been flagged where new material was created specifically for the IPC Plan or where existing material was used. These documents have also been linked in the Appendix, Section 9.5.

TABLE 2: SUPPORTING DOCUMENTATION

Document	Description	Developed for this plan?
CDC and HRSA Integrated HIV Prevention and Care Planning Guidance, 2022–2026	Developed to support the submission of the IPC Plan for each state for the 2022–2026 cycle.	No (Existing)
Florida's Unified EHE Plan, 2020	Unified plan representing the state and the seven counties identified as Phase 1 EHE jurisdictions: Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, and Pinellas.	No (Existing)
State of Florida IPC Plan, 2017–2021	Developed collaboratively across Florida stakeholders to eliminate HIV transmission and reduce HIV related deaths for the 2017–2022 cycle.	No (Existing)
Meeting Notes from the August and October FCPN Meetings	The August FCPN meeting was used to identify Florida specific activities to address the Goals, Objectives and Strategies identified by the CDC. The October FCPN meeting was used to review the IPC Plan DRAFT with stakeholders, receive their feedback, and incorporate that feedback into the FINAL version of the IPC Plan.	Yes (New)
Local Area Resource Inventories	Includes recipients' and community resources for prevention and patient care across 14 partnership areas in the state of Florida.	No (Existing)
Local Area Interview Questionnaires	Interviews were held with all 14 partnership areas and questions were raised to gather feedback in supporting multiple areas of the IPC Plan.	Yes (New)
Local Area Engagement Activities	Provided meeting summaries and feedback from a variety of engagement activities such as local area town halls.	No (Existing)
Documentation of Community Engagement	Describes Florida's partners and the voices engaged along with engagement efforts at the statewide level and seven major metropolitan areas. Interviews were held with all HIV partnership areas to identify community groups active on local planning councils.	No (Existing)
Florida HIV Continuum of Care Dashboards	Consolidates "Resource Inventories" across the state.	No (Existing)

Document	Description	Developed for this plan?
Florida's Ryan White (RW) HIV Care Needs Assessment: Key Findings 2019	Survey to determine met and unmet service needs for PWH in Florida.	No (Existing)
RWHAP Part A Plans	Represents the latest collaborative effort for each Part A partnership area in developing their unique IPC Plan	No (Existing)
PS19-1906 EHE Plan Executive Summary Florida	Key points, including strategic partnerships and planning support, from Florida's EHE Plan	No (Existing)

2 Community Engagement and Jurisdictional Planning Process

Community engagement is an overarching element of Florida's 4 Key Component Plan which intersects with the four pillars of the EHE initiative and the NHAS. Community members were engaged in all phases of the planning process and will continue with the implementation of strategies and activities to build a pathway to eliminate HIV transmission in Florida.

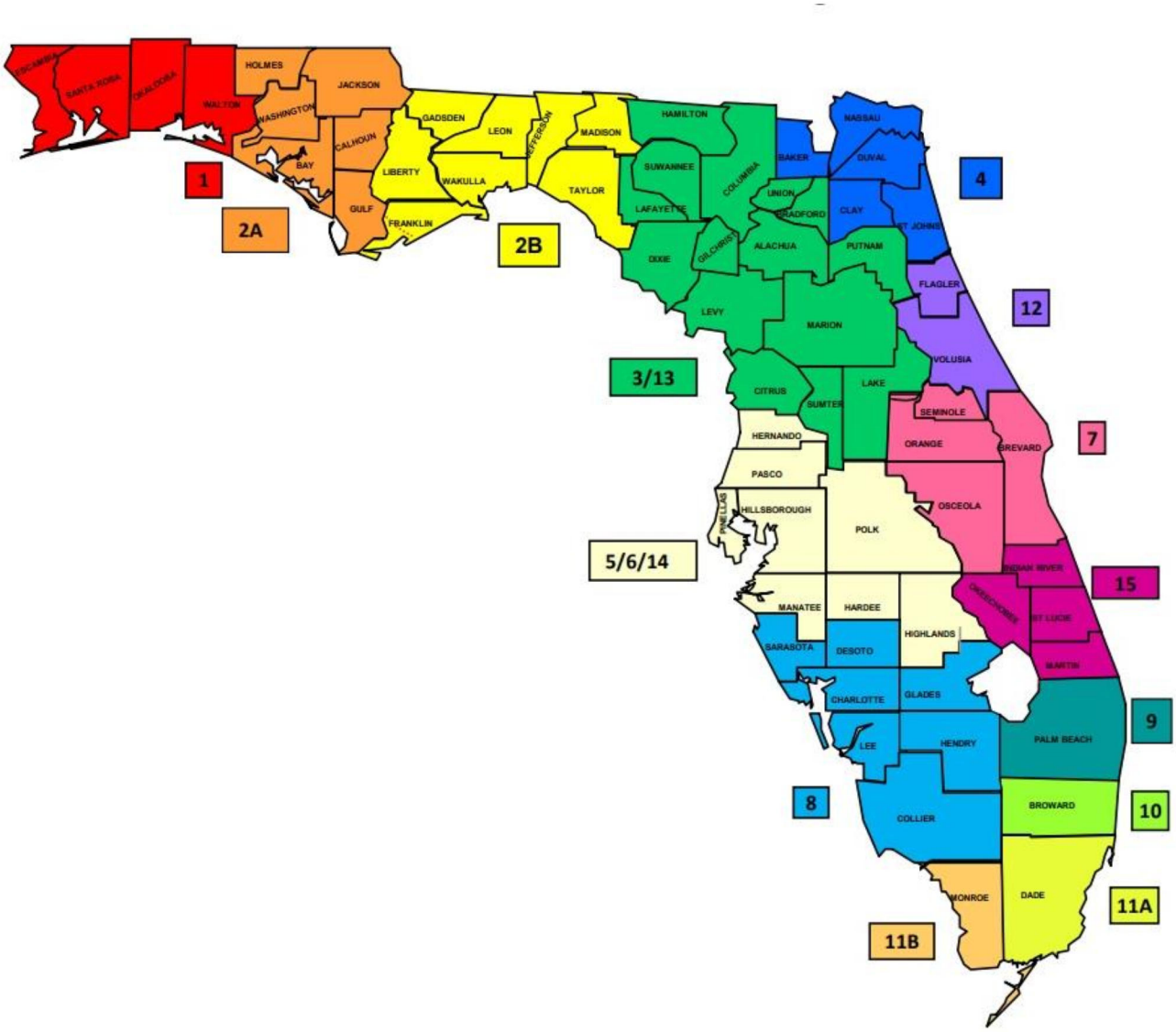
During 2021 and 2022, varying degrees of community engagement took place at state and local levels in preparation for developing the IPC Plan. In addition to community engagement activities performed October 2019 through October 2020 for EHE planning and implementation, additional community engagement activities were conducted in each HIV partnership area to ensure stakeholders were included in the integrated HIV planning process.

The HIV Planning Process

Florida's HIV planning process operates with the principle that determining the best way to support HIV prevention and care needs is through coordinated decision making with local entities, which collectively informs the overall statewide IPC Plan. As such, the Department engaged stakeholders and community members to create an IPC Plan for HIV efforts across the state. The remainder of this section outlines the planning process, inputs into the IPC Plan, analysis performed, priority goals and objectives, and a detailed plan to support successful implementation.

The Department arranges the state into 14 HIV partnership areas (shown in Figure 3), each with an HAPC to oversee prevention and care program operations in each HIV partnership area. HAPCs ensure that program activities are planned in an inclusive and collaborative manner to ensure other local resources and specific client needs are considered and addressed.

FIGURE 3: FLORIDA HIV PARTNERSHIP AREAS



Consortia are community-based regional planning entities established by RWHAP Part B recipients. The consortia plan and prioritize RWHAP Part B funds allocated to their area, promote coordination of services, and serve as a community forum. Representatives of local public and non-profit health and support service providers serve as consortium members. Lead agencies are member agencies in the consortium designated to perform contract administration as a fiscal agent.

Local jurisdictions around the state drive community engagement with the goal to educate and raise awareness about HIV and ensure programs and services are culturally and linguistically appropriate and developed with input from the populations intended to be reached. The local jurisdictions host focus groups, town halls, events for HIV/AIDS observance days, multiple outreach events, media interviews; teach public health classes at local universities; and use their social media presence.

Table 3 provides an example of different groups that participate in the community engagement and planning processes.

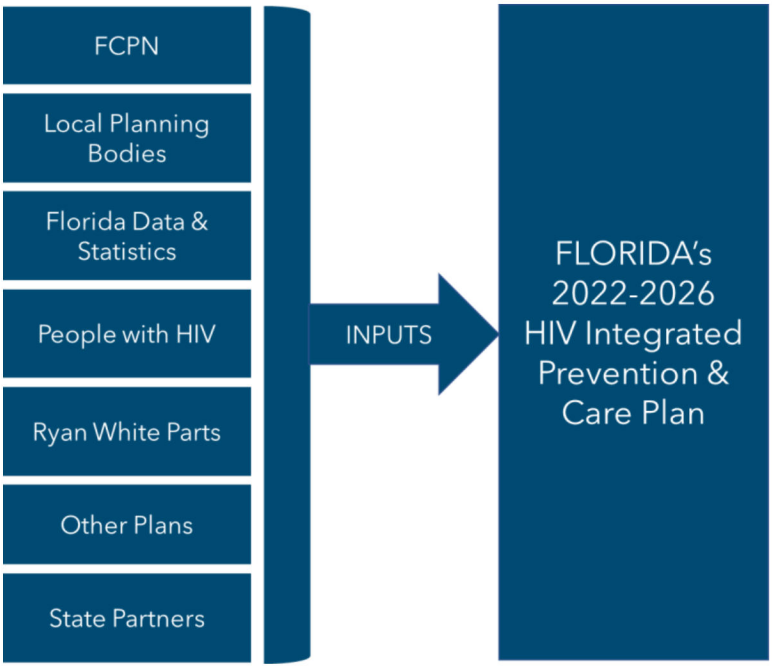
TABLE 3: HIV PREVENTION AND CARE PLANNING PARTICIPANTS

Local Jurisdiction Partnership Groups
• Existing community advisory boards • Community members resulting from new outreach efforts • Community members that represent the demographics of the local epidemic (e.g., race, ethnicity, gender, age, and others.) • Community members unaligned or unaffiliated with agencies currently funded through HRSA and CDC • STD clinics and programs • City, county, tribal, and other state public health department partners • Local, regional clinics, and school-based health care facilities; clinicians; and other medical providers • Behavioral health care agencies • Federally qualified health centers and community health centers • Medicaid/Medicare partners and private payors • Strategic planning and quality management collaboratives • Correctional facilities, juvenile services, local law enforcement and related service providers • Community- and faith-based organizations, including civic and social groups • Professional associations • Local businesses • Local opioid advisory groups • Local academic institutions • Commercial and retail pharmacies • Pharmaceutical and biomedical industry partners • Diagnostic industry partners • Digital media service providers • Adult entertainment industry partners

For a full list of specific community resources by partnership area, please refer to Appendix Section 9.3: Partnership Area Resource Inventories.

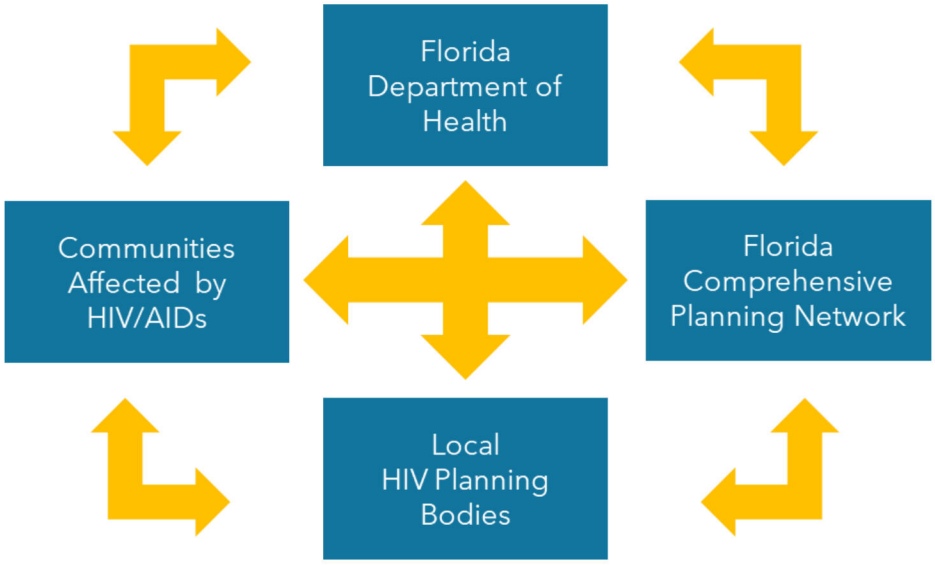
Florida's new IPC Plan for 2022–2026 was built upon the foundational goals, strategies and activities from the Florida Statewide Integrated HIV Prevention and Care Plan, 2017–2021; Florida's Unified Ending the HIV Epidemic Plan, 2020; the National HIV/AIDS Strategy; and input from local planning bodies and community members. Figure 4 shows the different inputs used to develop the 2022–2026 IPC Plan.

FIGURE 4: INPUTS TO THE 2022–2026 INTEGRATED HIV PREVENTION AND CARE PLAN



The Department's HIV/AIDS Section works in partnership with Florida's statewide integrated HIV planning body, FCPN. Members of FCPN include PWH and representatives across the state representing patient care and prevention groups, local planning bodies, state and local advisory groups, CBOs, academic institutions, local and regional clinics, city, and county governments, RWHAP programs and recipients, advocacy groups, substance use, mental health and social service providers and behavioral science groups. Figure 5 shows a representation of the community engagement and planning groups involved across the state.

FIGURE 5: COMMUNITY ENGAGEMENT AND PLANNING



In describing how the jurisdiction approached the planning process, the subsequent sections address steps used in the planning process, the groups involved, and representation from the priority populations:

- Entities Involved in the Process (Section 2.1)
- Role of Planning Bodies and Other Advisory Groups (Section 2.2)
- Engagement of People with HIV (Section 2.3)
- Social Determinants of Health (Section 2.4)
- Priorities (Section 2.5)
- Updates to Other Strategic Plans Used to Meet Requirements (Section 2.6)

2.1 Entities Involved in the Process

Florida has a long history of both engaging PWH and the broader community in developing plans for prevention and care services. This has been accomplished primarily through what is now known as the FCPN, which has been in existence since 1993. The available seats for FCPN are made up of three representatives from each of Florida's 14 HIV partnership areas—one representative each for prevention, patient care, and the Department of Health (total of 42 seats). Additionally, there are five at-large representative seats—proposed and voted upon by FCPN—which represent specific populations and/or areas of practice (e.g., behavioral science, substance use). Each of Florida's six RWHAP Part A jurisdictions also has a representative at the FCPN table (6 seats). There is a combined total of 53 representative, at-large, and RWHAP Part A seats available on the FCPN. Currently, 41 of the 53 FCPN representative seats are filled. Members of FCPN include PWH and other individuals across the state representing local partnerships. FCPN members are recruited statewide to represent local or at-large positions from patient care and prevention groups, local planning bodies, community and faith-based organizations, academic institutions, recipients of HIV prevention and care services, local and regional clinics, city, and county governments, RWHAP recipients, advocacy groups, substance use disorder and social service providers and behavioral science groups. The Department, in collaboration with the FCPN Membership, Nominations and Bylaws Committee will develop a plan of action to recruit for the remaining vacant seats.

Of the current FCPN member base—10 members disclosed living with HIV, 28 members disclosed they were not living with HIV, and 3 chose not to disclose their HIV status altogether. Nearly 60% of the current FCPN members are from the ages of 50 to 60+ years of age; followed by 30 to 39 years of age (20%); 40 to 49 years of age (15%); and 20 to 29 years of age (7%). Of the 41 current members, 49% are male, 46% female, and 5% are transgender. Approximately 54% of members reported their sexual orientation as heterosexual; 41% reported as gay, bisexual, and/or lesbian; and 5% chose not to disclose their sexual orientation. Race/ethnicity for members is as follows: White (52%), Black (18%), Hispanic/Latino (20%), Asian/Pacific Islander (6%), multi-racial/other (2%), and American Indian/Alaskan Native (2%).

Prior to 2017, the FCPN was made up of two planning bodies: the Patient Care Planning Group and the Prevention Planning Group. In 2017, the FCPN became fully integrated—merging prevention and care

planning bodies. Membership of the integrated planning body is made up of persons with and those affected by HIV; Department staff; representatives from mental health and substance use organizations; psychologists; social workers; case managers; AIDS service organizations; CBOs; RWHAP Part A, B, C, and D providers; RWHAP Part B lead agencies; advisory groups; and FQHCs. The FCPN maintains a biannual, integrated meeting structure and members are responsible for disseminating information from the meetings back to their respective areas of representation, as well as bringing concerns from those same areas to such meetings, ensuring that the voice of PWH in Florida are part of the integrated planning process. The HIV/AIDS Section oversees the composition of these groups, ensuring that they are representative of Florida's HIV epidemic in the various geographic regions, using the principle of Parity, Inclusion and Representation.

The Department routinely communicates and coordinates with other state partners such as The AIDS Institute; health planning councils; Medicaid/Medicare; Agency for Health Care Administration; Department of Corrections (FDC); Department of Children and Families (FDCF); Department programs such as the STD, Viral Hepatitis, and TB programs and other state partners; and the Florida HIV/AIDS Advocacy Network (FHAAN). The AIDS Institute is a national nonprofit organization that promotes a full spectrum of HIV activities including prevention, care, and treatment, through public policy, research, advocacy, and education. Medicaid, FDC, FDCF, and the STD, Viral Hepatitis, and TB programs are all state programs that impact and serve PWH. Medicaid is the single largest funder of HIV care in Florida. The HIV/AIDS Section contracts with FDC for pre-release planning services that link discharged inmates with HIV services upon release. FDCF oversees mental health services and several housing and homeless programs. The STD Section is a key partner to the HIV Prevention Program, with Disease Intervention Specialists (DIS) providing partner services and following up with newly diagnosed individuals. FHAAN is a statewide effort comprising of PWHs, community advocates, HIV/AIDS and industry professionals, and anyone wanting to be involved to coordinate HIV advocacy efforts.

Collaborations, partnerships, and stakeholder engagement exist in many forms throughout Florida; however, opportunities exist to expand partnerships further and engage new and non-traditional partners in more regular communication (for example, federal Department of Veterans' Affairs and Indian Health Service) to further the objectives and support the strategies of Florida's statewide IPC Plan.

2.2 Role of Planning Bodies and Other Advisory Groups

The Department's HIV/AIDS Section receives advisement on HIV programs and services from various community partners and workgroups, some of which report out directly to the FCPN. These various groups consist of both members of the community, as well as PWH. These groups consist of the Florida Gay Men's HIV Workgroup, the HIV Section Medication Formulary Workgroup, and the Community HIV Advisory Group. Other groups operating in the state but not directly under the FCPN include the Florida Harm Reduction Collective, the Florida Black Leaders Group, and the Florida HIV Justice Coalition. The Department will develop a plan to ensure these groups have a representative at the FCPN table.

For the workgroups that report directly to the FCPN—the Florida Gay Men's HIV Workgroup, the HIV Section Medication Formulary Workgroup, and the Community HIV Advisory Group—each group consists of PWH who use HIV services and community members selected through an application process and reflective of the profile of the HIV/AIDS epidemic in Florida. Members are appointed for a period of two years and may reapply for subsequent terms. These groups exist to provide a mechanism in which PWH and the community have meaningful input into the development of policies and programs to address their needs with and under the auspices of the Department and the HIV/AIDS Section.

Local Area Interview Results

To better understand the process of community engagement at the local level, interviews were held with each HIV partnership area, with a total of 72 participants. Participants included local Department staff, RWHAP Part A and B representatives, lead agencies, and other community planning body members. During each interview, participants were asked to report on membership, community engagement, outreach activities and keys to success.

Membership: Membership in area partnerships is consistent with all 14 partnership areas having county health departments and CBOs serving populations affected by HIV, as well as HIV service providers. Thirteen out of 14 areas include populations at risk for or with HIV representing priority populations, STD clinics and programs, and HIV clinical care providers and clinicians as part of their voting membership. Only 3 out of 14 partnership areas have epidemiologists and only 4 have representatives from state or local law enforcement or correctional facilities among voting members.

When asked about entities or organizations they would like to have in their planning body, but have not yet been able to secure, areas reported: pharmacists, a school system representative, local school-based clinics, elected officials, representatives from youth organizations, colleges and universities, health promotion groups, an epidemiologist, transportation agencies; faith-based organizations, the Association of Free and Charitable Clinics, and more staff to coordinate the planning body.

Community Engagement: All partnership areas report robust, comprehensive community engagement in each of their counties. All but one area reports challenges with maintaining representation from PWH receiving HIV care services (e.g., RWHAP Part A or B services). Most local areas report having PWH represent approximately 33% of their voting membership; however, these individuals may be staff at local community- and faith-based organizations or on local boards and not necessarily receiving HIV care services through the RWHAP. Several strategies have been used to try and encourage "everyday PWH" to become part of the local planning bodies. Many areas offer incentives and others send out mailers to PWH emphasizing the opportunity to have their voice heard and help the greater good. Other members that areas have difficulty recruiting and keeping are elected officials, faith-based leaders, hospital and health care planning agencies, and law enforcement.

One area restructured planning body meetings from formal events to more informal meetings using lay language and fewer acronyms. They reported that building planning activities around less structure

creates more freedom to speak. Additionally, the planning body keeps meetings to no longer than two hours, food is provided, and agenda items are suggested by members, so they drive future meetings.

To incorporate the perspective of PWH, almost every area sends surveys to clients about services they received and how satisfied they were with those services. This information is used to determine whether some services need to be enhanced, reworked, or streamlined. It is also used for gap analysis purposes and to determine future funding.

About half of the areas report a working relationship with local prisons and jails but felt more could be done to increase testing and treatment efforts. Areas overwhelmingly found value in monthly calls hosted by the Department's HIV/AIDS Section and saw them as a chance to exchange best practices.

Outreach Activities: Partnership areas report hosting focus groups and town hall meetings. Twelve areas held topic-focused community discussions and collaboration building meetings with new partners. Areas also rely on social media to reach PWH engaged in services; however, three areas report that different local restrictions present challenges. Some examples of outreach activities include harm-reduction events, annual surveys to RWHAP recipients, surveys to funded providers, local street fairs and block parties, and events planned around World AIDS Day and other key HIV observance days.

Keys to Success: Partnership areas identified several different ways they have built successful programs:

- Ability to work together to make service delivery appear seamless to clients, regardless of what organization was providing the service.
- Longevity in leadership positions and the sharing of funds between services.
- Consulting with adjacent partnership areas and assisting when possible.
- Having a continuous calendar of events and meetings.
- Participation in statewide calls.
- Collaboration and cohesiveness among partners.
- Cultivating a culture of trust and transparency.

Department Collaboration with RWHAP Parts

RWHAP Parts A, B, C, and D and ADAP programs are key local partners and are at the table as planning activities are performed since no single RWHAP part can meet the needs for all services. The RWHAP Part F program collectively funds Special Projects of National Significance (SPNS), as well as the AIDS Education and Training Centers (AETC) that provides support and training to the medical community in treating patients, and dental programs for PWH.

The planning process is guided by local resource inventories, demographics, satisfaction surveys and service needs expressed locally by PWH who use services. Given the multitude of RWHAP parts, as well as programs funded by other federal, state, and local sources, funding allocation necessitates collaboration and coordination at the local planning body level. Therefore, consortia and planning councils require coordination in RWHAP planning, which involves consideration of other programs in

such areas as assessment of needs, priority setting and resource allocation. Planning bodies must analyze existing resources, regardless of funding stream, to identify areas of unmet need. Likewise, in setting priorities, other resources must be considered in terms of how they help meet service demands so that RWHAP resources can be used to fill gaps.

The Department's HIV/AIDS Section routinely communicates with the RWHAP Part A administrators to ensure they are informed of program activities and have an opportunity to comment and contribute to various projects. Regular monthly calls are used to communicate program updates and policy changes, opportunities for collaboration, and solicitation of feedback. The hosting of the calls rotates, with one of the six RWHAP Part A areas leading the call each month. Examples of collaboration include the transition of RWHAP clients to the Marketplace®, work on the statewide IPC Plan, developing the ADAP HCV treatment project, developing reciprocal eligibility and Notice of Eligibility, data sharing, coordination with ADAP related to the changes in the pharmacy benefits manager, and ADAP formulary updates.

The Department's HIV/AIDS Section allocates RWHAP Part B funding for administration, planning and evaluation, clinical quality management and core medical and support services to 14 lead agencies annually to perform planning activities in their respective areas. Upon receiving RWHAP Part B funds from the Department, each lead agency is required to provide administrative assistance to the planning body (consortium) in the program area. The planning bodies serve as the entities that meet the RWHAP planning requirements for the program area and advise the lead agencies during the priority setting and resource allocation process. Lead agencies facilitate a provider selection process (internal services, external vendors, or competitive procurement process) through a network of local partners (CBOs, CHDs, consumers, planning bodies, and others).

There has also been collaboration with RWHAP Part A partners through EHE initiatives, as RWHAP Part A partners receive EHE funding directly from HRSA to address pillars 2 and 4 (Treat and Respond). The Department receives EHE funding directly from CDC and distributes the funds to the seven EHE counties (county health departments and community and faith-based organizations). Throughout the EHE planning and implementation process (2019 to present), it has been imperative that the Department and RWHAP partners coordinate to maximize efforts, promote information sharing, and ensure resources are used efficiently.

As the recipient of RWHAP Part B funds, the Department is required to develop and maintain a clinical quality management (CQM) program to ensure quality health care services are provided to persons living with HIV. The purpose of the HIV/AIDS Patient Care CQM Program is to provide a systematic approach for planning, measuring, implementing, evaluating, and improving the quality of RWHAP-funded care services delivered to PWH in Florida. Routine review of established performance measures leads to the identification of specific CQM goals for each quality improvement project. Stakeholders who are internal and external to the CQM committee review measures through formally established mechanisms using evidence-based quality improvement methods. This CQM requirement is also mandated by HRSA for each sub-recipient, at the local level. This includes having a formal quality committee and a local CQM plan. For 2019–2022, the following CQM goals were identified:

- **Percentage of Patients on ART (Antiretroviral Therapy)**—Ensure equitable access to RWHAP-funded HIV services in the state for PWH and ensure equitable results in HIV health outcomes; patients receiving ambulatory outpatient care are also on ART.
- **Improving Viral Suppression for PWH—**Drive maximum viral suppression for PWH in the state, with 90% of PWH achieving viral suppression by 2022.
- **Eligibility**—Ensure PWH in the state have complete eligibility documentation for all services received. Complete eligibility documentation prevents gaps in care and can help identify additional services for which the client has need. The goal is 90% of all clients having accurately completed eligibility documentation by 2022.

2.3 Engagement of People with HIV

Florida strives to actively involve key partners, stakeholders, and PWH and, in doing so, incorporates feedback received, for the IPC Plan, on an ongoing basis. The jurisdiction understands that to best serve those most marginalized, their voices must be involved in all aspects of the process. “Nothing about us, without us” is a call to action that informs the need for cultural shifts in programming, provisions of services, and community engagement. Changes have already been made to the planning process with a greater focus placed on creating an environment that is more welcoming to prospective members who represent communities most affected by HIV.

PWH were influential in the development of the statewide IPC Plan. PWH contributed by participating in the Statewide Needs Assessment and serving on local RWHAP Part B consortia, local prevention planning bodies, RWHAP Part A planning councils as well as RWHAP Parts C and D consumer advisory boards. There are also many robust peer-driven navigation and prevention programs that contribute greatly to PWH involvement on many different levels. They have helped identify what is working well (or not), barriers to care, and in accessing prevention and patient care services, and helping to develop the state’s unmet need matrix.

Further, PWH have participated widely in providing feedback to the Department by attending various town hall meetings that have helped develop goals and improve service delivery around eligibility, medical case management guidelines, HIP, PrEP, post-exposure prophylaxis (PEP), ADAP and many of the other programs overseen by the state. They have also played a key role in the success of the medical monitoring project (MMP) in Florida by willingly volunteering their time to be interviewed for this significant program. Florida has a very active Community HIV Advisory Group (CHAG) which also serves as the MMP’s Community Advisory Board. Proposed changes in policy are reviewed and feedback is provided by this group of dedicated individuals. Table 4 shows some of the community engagement and planning efforts across the state.

TABLE 4: COMMUNITY ENGAGEMENT EFFORTS

Location	Involvement
Statewide	Community engagement activities including: five ad-hoc consultations with representatives from priority populations (30+ participants per session) and launched Florida's Undetectable=Untransmittable (U=U) campaign. The Department's HIV/AIDS Section hosted virtual meetings (180+ reached) for FCPN and community guests to refine the elements of the unified EHE plan from a statewide perspective.
Area 1 **Counties:** Escambia, Santa Rosa, Okaloosa, Walton	Community engagement activities were conducted, including the implementation of a U=U campaign, launched with a press conference inviting local civic leaders and community partners. A meeting was also held with the superintendent of schools and a school board member to provide information on local HIV data.
Area 2A **Counties:** Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Partnered with BASIC NWFL for HIV and HCV testing and condom distribution. PanCare of Florida (FQHC) conducted mobile HIV testing.
Area 2B **Counties:** Franklin, Gadsden, Jefferson, Leon, Liberty Madison, Taylor, Wakulla	Partnered with 4 community resources for the provision of ART, 3 community resources for HIV testing and diagnosis, 1 partner for HIV education/community outreach, town hall meeting (10 clients attended), and mailed 14 surveys
Area 3/13 **Counties:** Alachua, Citrus, Lake, Marion, Putnam, Hamilton, Suwannee, Columbia, Lafayette, Gilchrist, Dixie, Levy, Bradford, Sumter	Conducted a town hall meeting in Area 3/13 and results were shared at the April 2022 FCPN meeting. Draft goals and objectives were sent out to the local consortium via email for review and then discussed at the June 2022 consortia meeting.
Area 4 **Counties:** Nassau, Baker Duval, Clay, St Johns	Community engagement activities such as: 2 provider meetings and town halls, the creation of a local EHE committee, provider survey (68 reached), community-wide listening sessions (115+ reached), faith-based workshops to address stigma and the social justice aspect of the HIV epidemic, and exclusive focus groups (50+ reached) with priority populations.
Area 5/6/14 **Counties:** Hernando, Pasco, Pinellas, Hillsborough, Manatee, Polk, Hardee, Highlands	Community engagement activities such as: an online community survey (72 reached), focus groups (8 reached) with youth, community members, and private sector leaders; individual phone interviews (39 reached); virtual town hall meetings per pillar (34 across all meetings); and an HIV care needs survey (600+ reached). Additional activities included: focus groups facilitated by representatives of key priority populations (55 reached across all sessions); a virtual interview with local radio station to engage the community (1,000+ reached); virtual EHE Advisory Council meetings to engage new and existing stakeholders; Teen Talk Thurzdaze, monthly webinars facilitated by representatives revered by youth (50+ reached per meeting) and listening sessions with HIV service providers (45 reached).

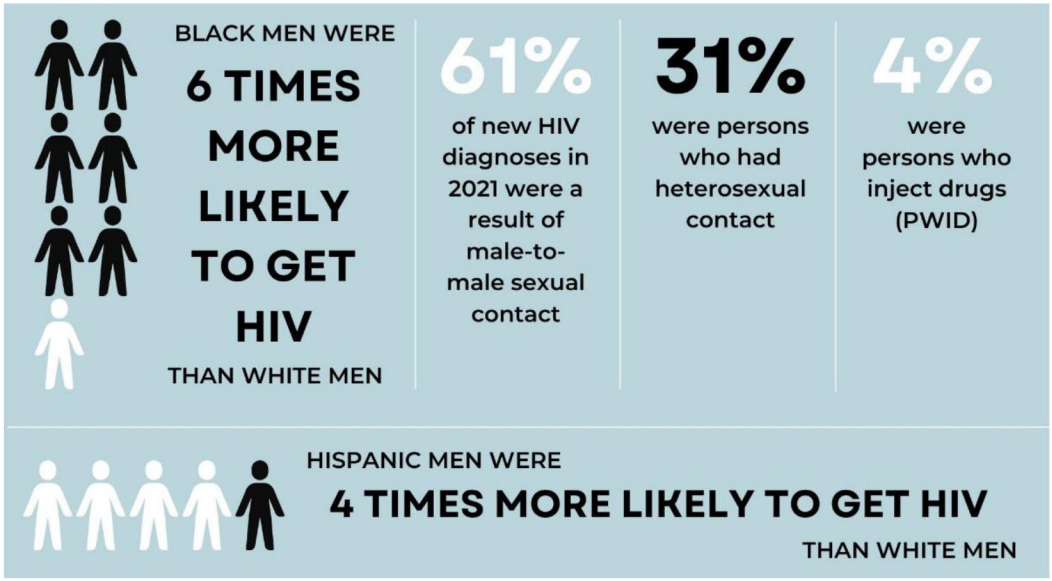
Area 7 **Counties**: Seminole, Orange, Osceola, Brevard	Community engagement activities such as: conducted 3 town hall meetings; key informant interviews (27 reached); EHE and HIV stigma conversations on Facebook Live with iHeart Media; 8 virtual town hall meetings with key priority populations (98 individuals participated across all town halls, viewed by 3,356 individuals on Facebook Live); quarterly provider meetings to discuss EHE plans and implementation; 8 pop-up HIV testing events; listening sessions with HIV service providers; and community-wide surveys (300+ reached)—one tailored to the community members and the other tailored to providers.
Area 8 **Counties:** Sarasota, Desoto, Charlotte, Glades, Lee, Hendry, Collier	Community engagement activities were conducted throughout the area, including health education and outreach, community forums and meetings, and testing events.
Area 9 **County:** Palm Beach	Community engagement activities such as: service provider interviews (19 reached); focus groups with PWH (10 reached); and Palm Beach resident phone interviews in English, Haitian-Creole, and Spanish (253 reached).
Area 10 **County:** Broward	Community engagement activities such as: 28 community presentations; community-wide listening session; listening session with youth (9 reached); outreach sessions with college students (40+ reached); 5 focus groups with providers, transgender individuals, men who have sex with men (MSM), Black heterosexual women, and Latino individuals; student survey (130 reached); 40 key informant interviews with community members and service providers; and needs-based surveys for providers (430 reached) and community members (1,780 reached) in multiple languages.
Area 11A **County:** Miami-Dade	Community engagement activities including: several listening sessions at different venues; met with workgroups; and focus groups outside the RWHAP or the Miami-Dade CHD. Additional activities included: key informant interviews with local CBOs and local government (23 reached); 2 needs-based surveys tailored to HIV service providers (37 reached) and community members (1,158 reached) in multiple languages; online community forums and focus groups representing priority populations (250+ reached); 11 community listening sessions with community mobilization groups that primarily serve Black and Latino populations. Mobilization also occurred among transgender individuals.
Area 11B **County:** Monroe	Engagement activities including quality management patient surveys in ADAP, customer satisfaction surveys in RWHAP Part B, focus group activities in the Client Advisory Board, multiple discussions in the Florida Keys Community Planning Partnership, and monthly Teams meetings, in which all prevention providers meet to discuss awareness day activities, nationally recognized testing day activities and ongoing local prevention activities (e.g.,

	testing sites, outreach activities and involvement and partnership with the Gay Men's Health Summit and Miami-Dade County).
Area 12 **Counties:** Volusia, Flagler	Various community engagement activities were conducted throughout the area and included numerous health fairs and HIV observance day events (e.g., health fairs at Bethune Cookman University, Stetson University and Daytona Beach College; HIV Testing Day; World AIDS Day; New Smyrna Beach Senior Summit; One Voice Volusia Health Summit; and HOPE Fest Community Outreach with Hope Church).
Area 15 **Counties:** Indian River, Okeechobee, St. Lucie, Martin	Conducted focus groups with PWH (25 reached); facilitated HIV needs assessment survey (175 reached); partnered with United Against Poverty St. Lucie County for HIV and sexually transmitted infection (STI) screenings and condom distribution (20+ reached); facilitated an HIV/AIDS symposium where attendees were community members, PWH, and service providers (100 reached); participated in Annual Showcase of Services community event and provided resource information to local social service agencies and community members (70 reached); conducted HIV and STI screening at local substance use disorder treatment centers (20 reached); participated in community health resource fair and provided HIV and STI screenings as well as condom distribution (100+ reached); hosted National Latino AIDS Awareness Day testing event (6 reached); and facilitated weekly HIV and STI testing and awareness events in 4 area counties (number reached varied), where all events were conducted in multiple languages.

2.4 Social Determinants of Health

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 levels, including by CHDs, RWHAP partners, CBOs, and health care providers are an integral part of ending the HIV epidemic in Florida. 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. Lower health literacy has been tied to poorer health outcomes in PWH; therefore, ensuring basic levels of health literacy is essential to ensure medication and treatment adherence and ultimately, viral suppression. Social determinants of health (as shown in Figure 6) include food and housing insecurity, geographic location, educational status, poverty, racism, violence, and stigma.

FIGURE 6: DEMOGRAPHIC HIV STATISTICS



In the past decade, Florida has seen a general decline in HIV diagnoses in Florida; however, Black and Hispanic/Latino populations are disproportionally impacted with higher rates of new diagnoses compared to the White population. Additionally, late-stage HIV or AIDS is also higher in the Black population. For males diagnosed with HIV in 2021, Black males were 6 times more likely to be diagnosed with HIV compared to the White males; additionally, Hispanic/Latino males were 4 times more likely to be diagnosed with HIV compared to White males. Similar trends are observed for females, where Black and Hispanic females were 12 and 3 times, respectively, more likely to be diagnosed with HIV compared to White females.

With respect to mode of transmission, in 2021, the majority (61%) of new HIV diagnoses were a result of male-to-male sexual contact (MMSC), followed by 31% who were persons who had heterosexual contact, and 4% who were persons who inject drugs (PWID). Through the identification of priority populations disproportionately impacted by HIV, Florida will continue to engage with and seek input from members of those communities to address health disparities and social determinants of health.

Florida's incorporation of the status-neutral approach and Undetectable=Untransmittable (U=U) into HIV prevention and care service delivery is a key component in addressing social determinants of health and stigma that may prevent individuals from engaging in HIV care services. In June 2020, the Department announced its endorsement of the Prevention Access Campaign's U=U. In becoming a U=U partner, the Department joined nearly 1,000 organizations around the world supporting the science-backed message that PWH who use antiretroviral therapy and have an undetectable viral load in their blood have effectively no risk of sexually transmitting HIV.

Florida will work to ensure programs and services for PWH and those at increased risk for acquiring HIV align with the National Culturally and Linguistically Appropriate Services (CLAS) Standards

(https://thinkculturalhealth.hhs.gov/Assets/Pdfs/EnhancedNationalCLASStandards.Pdf), which provide a structure to implement culturally and linguistically appropriate services, and increase the ability of the state to address health care disparities.

2.5 Priorities

The IPC Plan priorities are based on the four goals of the NHAS, 2022–2025:

1. Prevent new HIV infections.
2. Improve HIV-related health outcomes for people with HIV.
3. Reduce HIV-related disparities and promote diverse community wellness.
4. Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders.

For the complete list of unique activities to support each strategy, please refer to Appendix Section 9.1 Strategy and Activity Table.

Additionally, the RWHAP Part A's local priorities align with the NHAS, and the four pillars outlined in the EHE: diagnose, treat, prevent, and respond. All goals and objectives include various local initiatives with some overlap between several CDC and HRSA grants.

Based on the most recent HIV data trends for the state (2017–2021) and feedback from community engagement activities conducted in preparation for the IPC development, Florida's integrated HIV prevention and care planning body (FCPN), along with the RWHAP Part A partners, has determined to focus on PWH, Black and Latino populations, LGBTQ communities, PWID, and youth populations.

The planned outcomes of the IPC include reducing HIV-related disparities and promoting diverse community wellness by expanding targeted efforts to prevent HIV transmission using innovative and evidence-based approaches, decreasing the annual HIV diagnosis rate, ensuring early linkage to care, and increasing the number of PWH who are retained in care and virally suppressed. Progress on these outcomes will be ongoing throughout the project period and will benefit the overall community by improving population-level health and reducing the incidence of HIV/AIDS.

While setting goals and priorities, *Demanding Better: An HIV Federal Policy Agenda by People Living with HIV* (https://www.pwn-usa.org/wp-content/uploads/2021/07/Networks-Policy-Agenda-FINAL.pdf) was referenced to ensure the Meaningful Involvement of People with HIV/AIDS (MIPA)in decision-making, at every level of the response. In *Demanding Better*, the U.S. People Living with HIV Caucus outlines five recommendations which must be included in every aspect of the federal HIV response:

1. Concretely elevating the meaningful involvement of people living with HIV and disproportionately impacted communities in the HIV response.
2. Proactively creating an affirming human rights environment for people living with HIV.

3. Addressing inequities in the federal response by attending to racial and gender disparities.
4. Adding sex workers and immigrants living with HIV as priority populations.
5. Affirmatively committing to improving quality of life for people living with HIV.

MIPA requires dedication, planning and assessment, organizational buy-in, and a champion to help usher its development and continued assessment. Although the U.S. Department of Health and Human Services (HHS) *National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021–2025* (https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf) largely did not address these recommendations in the final version, Florida's statewide IPC Plan will do so to the greatest extent possible, as they were created by and for people living with HIV.

2.6 Updates to Other Strategic Plans Used to Meet Requirements

Local jurisdictions perform an annual needs assessment, based on core questions developed through the FCPN Needs Assessment Committee. The needs assessments are created using multiple sources of information from PWH and other stakeholders. Interviews are conducted with PWH and stakeholders to incorporate their feedback and needs. Additionally, surveys are sent out to clients and focus groups are held with the community to understand any changing of needs and priorities. Ongoing feedback of PWH and stakeholders is accomplished by broadly advertising public meetings, allowing public access to all draft, and completed reference documents through online postings, and encouraging participation by members and guests at all meetings. Following completion, the IPC Plan will be presented to the groups who contributed to ensure ongoing community engagement. With greater representation comes additional perspectives that are pivotal to evaluating and improving all planning processes, including the IPC Plan.

Florida's new IPC Plan for 2022–2026 was built upon the foundational goals, strategies, and activities from the Florida Statewide Integrated HIV Prevention and Care Plan, 2017–2021, Florida's Unified Ending the HIV Epidemic Plan, 2020, the National HIV/AIDS Strategy, and input from local planning bodies and community members.

3 Contributing Data Sets and Assessments

In analyzing contributing data sets and assessments used to describe how HIV impacts the jurisdiction, the subsequent sections will detail HIV prevention services, barriers to accessing those services, and gaps in the service delivery system:

- Epidemiological Snapshot (Section 3.1)
- Data Sharing and Use (Section 3.2)
- HIV Prevention, Care and Treatment Resource Inventory (Section 3.3)
- Gaps, Needs and Barriers (Section 3.4)
- Needs Assessment including Methodology, Approach, Priorities, and Actions Taken (Section 3.5)

3.1 Epidemiologic Snapshot

The full Epidemiological Profile of HIV in Florida, 2017-2021 will be provided separately. Below is a brief snapshot of the key points.

According to the CDC, in 2020,[42] Florida had the third highest number of HIV diagnoses and was the third highest for new HIV diagnosis rates per 100,000 population in the U.S., including the District of Columbia. In 2021, 4,708 persons received an HIV diagnosis in Florida, a 37% increase from the 3,441 HIV diagnoses in 2020; however, these data should be interpreted with caution due to impacts from the COVID-19 pandemic which impacted testing, access to care and surveillance activities. In 2021, 83% of those newly diagnosed were linked to HIV-related care in 30 days of diagnosis. There were 120,502 PWH, regardless of AIDS status, living in Florida through 2021 which represents only 86% of all the PWH in Florida. The remainder of whom are living with the disease but are unaware of their HIV status. Among the PWH, 73% were retained in care and 69% had a suppressed viral load at the end of the year. Twenty percent (20%) of PWH had no care in 2021.

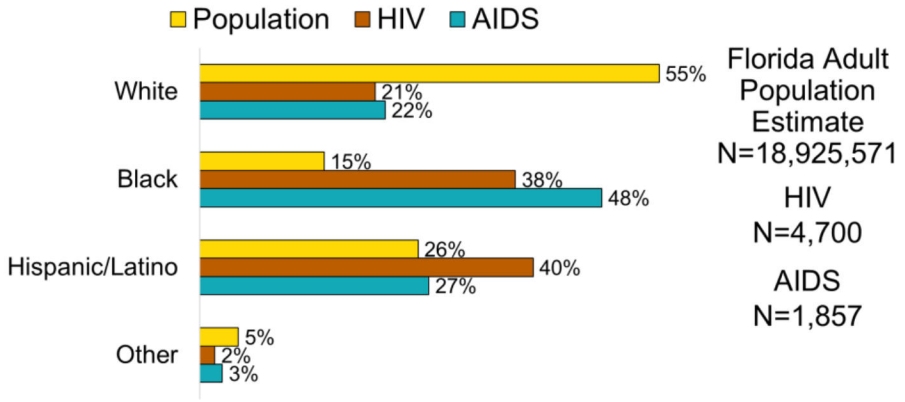
Geographical Region and Socio-Demographic Characteristics of Florida

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 2021 population in Florida was 22.0 million residents, with an average of 410 residents per square mile. Approximately 20% of the population is under the age of 18 and 21% is over the age of 65. According to the U.S. Census Bureau, in 2020, 12.4% of Floridians were living in poverty and 16% of Floridians under the age of 65 were without health insurance. The population of Florida is very diverse, with approximately 20.8% of persons residing in the state being foreign born (born outside the continental U.S.). Although most new HIV diagnoses in 2021 were among those born in the U.S. (58.1%), 41.9% of people newly diagnosed with HIV in Florida were born outside the U.S. mainland.

The racial distribution among the adult population (age 13 and above) in Florida in 2021, was 55% White, 15% Black, 26% Hispanic/Latino, and 5% other races including American Indian, Asian, or

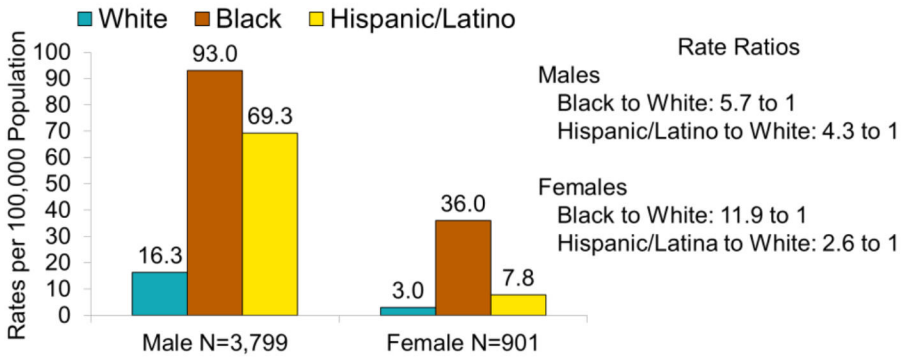
multiracial. There were 4,708 HIV diagnoses among adults in 2021. The greatest burden was among the Black population, which received 38% of the new HIV diagnoses in 2021 despite only representing 15% of the adult population in Florida. Hispanic/Latino people were also disproportionately represented for new HIV diagnoses, with 40% of the new HIV diagnoses, compared to 21% among White people as shown in Figure 7.

FIGURE 7: ADULT (AGE 13+) HIV AND AIDS DIAGNOSES AND POPULATION BY RACE/ETHNICITY, 2021, FLORIDA



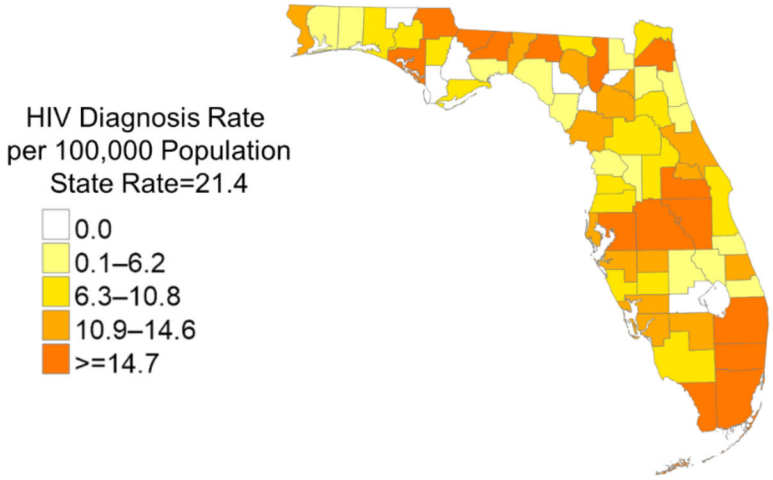
In 2021, Florida continued to see disparities in HIV diagnoses among adults, despite an annual decrease in the HIV diagnosis rate among Black persons in the past five years. The HIV diagnosis rate per 100,000 population among Black males (93.0) was nearly six times higher than for White males (16.3) and the rate for Hispanic/Latino males (69.3) was more than four times higher than for White males. The HIV diagnosis rate among Black females (36.0) was 12 times higher than for White females (3.0); the rate for Hispanic/Latina females (7.8) was more than two times higher than for White females (see Figure 8). Black persons had a lower statewide viral suppression (<200 copies/mL) rate of 64% compared to 77% for White persons and 71% for Hispanic/Latino persons.

FIGURE 8: ADULT (AGE 13+) HIV DIAGNOSIS RATES BY SEX AND RACE/ETHNICITY, 2021, FLORIDA



In 2021, there was at least one HIV diagnosis in all but 7 counties in Florida and the state HIV diagnosis rate was 21.4 per 100,000 population (see Figure 9). Miami-Dade (42.1), Broward (33.5), Orange (30.3), Duval (30.2), and Palm Beach (21.7) counties had rates higher than that for the state in 2021. The greatest numbers of HIV diagnoses were from the seven counties identified in the national EHE initiative: Miami-Dade (N=1,204), Broward (N=652), Orange (N=439), Hillsborough (N=323), Duval (N=300), Palm Beach (N=322) and Pinellas (N=130). These seven counties diagnosed a combined total of 3,370 cases in 2021, or 72% of the statewide total.

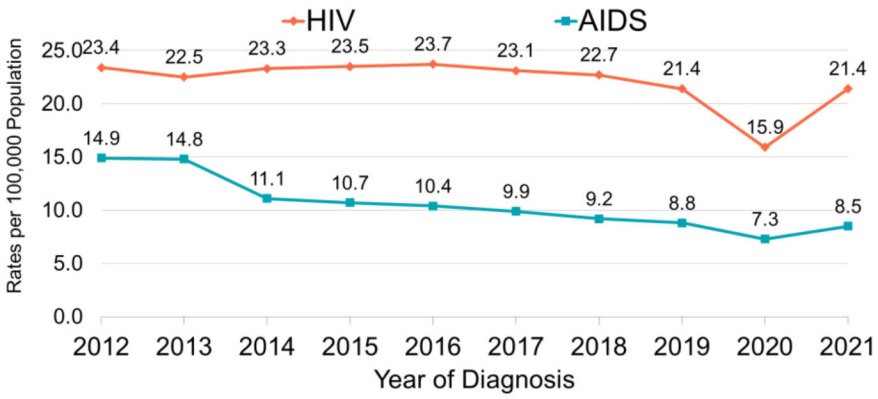
FIGURE 9: HIV DIAGNOSIS RATE BY COUNTY IN 2021, FLORIDA



Trends in HIV Diagnosis

Data for 2020 and 2021 should be interpreted with caution due to the impact of COVID-19 on HIV testing, care-related services, and case surveillance activities in state and local jurisdictions. Figure 10 shows that over the past 10 years (2012–2021), the rates of diagnosed HIV and AIDS in Florida have decreased 9% and 43%, respectively.

FIGURE 10: TEN-YEAR TREND (2012–2021) OF HIV AND AIDS RATES PER 100,000 POPULATION IN FLORIDA



The number of HIV diagnoses decreased by 4% from 2018 to 2019 and increased by 3% from 4,556 (2019) to 4,708 (2021). Additionally, the number of new HIV diagnoses increased by 6% among adult men and decreased by 6% among adult women from 2019 to 2021. The number of new HIV diagnoses over the past 5 years (2017–2021) decreased among all but two age groups: persons aged 30 to 39 (15% increase) and persons aged 40 to 49 (2% increase). The number of new HIV diagnoses over the past five years decreased among all race/ethnicity groups except Hispanic/Latino persons, where a 25% increase was observed.

With respect to mode of exposure, male-to-male sexual contact continues to be the primary mode of exposure for HIV among males (77% in 2021), followed by heterosexual contact (18%) and injection drug use (IDU) (3%). Over the past five years (2017–2021), transmissions among males that observed an increase in HIV diagnoses were MMSC (1%) and IDU (28%), whereas transmissions that decreased were MMSC/IDU (12%) and heterosexual contact (1%).

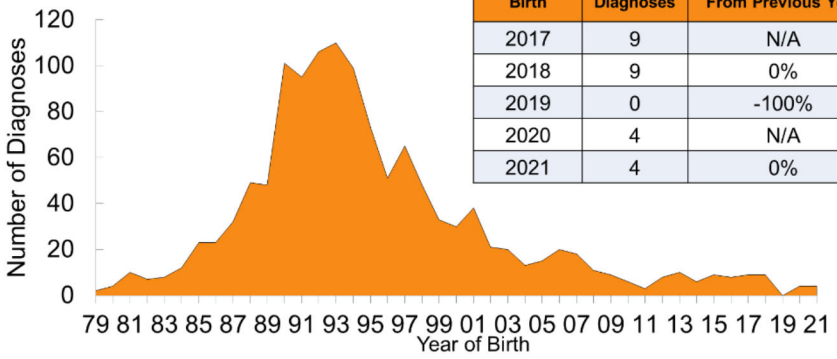
Among females, heterosexual contact is the primary mode of exposure for HIV (92% in 2021), followed by IDU (8%). Over the past five years (2017–2021), decreases in HIV diagnoses among females were observed among both transmissions: heterosexual contact (11%) and IDU (13%).

Thirty-eight out of the 67 counties (57%) saw a decrease in new diagnoses of HIV from 2018 to 2019. Twenty-eight out of the 67 counties (42%) saw a decrease in new diagnoses of HIV from 2019 to 2021. All but two of the seven EHE counties in Florida saw a decrease in HIV diagnoses from 2019 to 2021 (Pinellas [32%], and Orange [5%]). Palm Beach County saw a 31% increase from 2019 (N=245) to 2021 (N=322), and Hillsborough County saw a 12% increase from 2019 (N=288) to 2021 (N=323). The three remaining EHE counties (Duval, Miami-Dade, and Broward) all saw a 3% increase from 2019 to 2021. Challenges exist with many new HIV diagnoses being among people who may be new to the county, state, or country and who may not have benefited from the robust prevention activities available throughout Florida; yet the new (or re-diagnoses) count toward new HIV diagnoses for local jurisdictions and the state.

Perinatal HIV Transmission

A strategic long-term goal in Florida is to reduce or eliminate the annual number of babies born in Florida with perinatally acquired HIV. Since the introduction of azidothymidine (AZT) in 1994, perinatally acquired HIV diagnoses have drastically declined (see Figure 11). Over the past three years (2019 to 2021), there were eight perinatally acquired HIV diagnoses with an average transmission rate of 0.006. For the first time in the history of the HIV epidemic, there were no perinatally acquired HIV diagnoses born in Florida in 2019. There were four in 2020, and four in 2021.

FIGURE 11: PERINATALLY ACQUIRED HIV DIAGNOSES, 1979–2021, BABIES BORN IN FLORIDA



Year of Birth	Number of Diagnoses	Percentage Change From Previous Year
2017	9	N/A
2018	9	0%
2019	0	-100%
2020	4	N/A
2021	4	0%

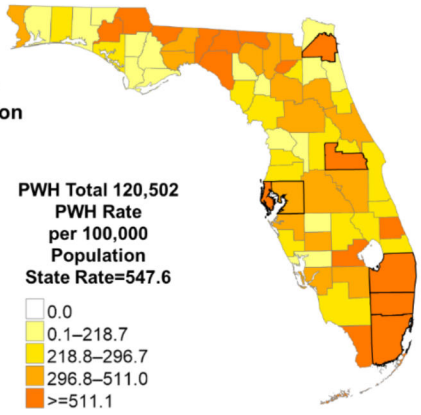
[1]AZT, short for azidothymidine, is an antiretroviral medication used during childbirth to prevent vertical transmission of HIV.

Prevalence of PWH in Florida

The rate of PWH in Florida in 2021 was 547.6 per 100,000 population, with the majority of PWH living in the large metropolitan areas and the seven counties outlined in the EHE plan. However, there is also a high rate of PWH living in smaller, more rural counties, such as those in northern Florida (see Figure 12). There were 120,502 PWH living in Florida in 2021. Among the adult PWH (N=120,379), 44% were Black, 28% were White, 26% were Hispanic/Latino, and 2% were American Indian, Asian, or multiracial. More than one-half (57%) were over the age of 50. MMSC was the mode of exposure for 71% of males. Heterosexual contact was the mode of exposure for 86% of females. Ten percent (10%) of PWH had a history of IDU. Among the PWH in 2021, 503 (0.4%) were transgender individuals and the primary mode of transmission was sexual contact (90%).

FIGURE 12: PWH, LIVING IN FLORIDA, BY COUNTY OF RESIDENCE, YEAR-END 2021

7 EHE Counties	Number of PWH	PWH Rate per 100,000 Population
Miami-Dade	27,782	971.2
Broward	21,014	1079.4
Orange	9,703	669.7
Palm Beach	8,417	565.9
Hillsborough	7,742	511.0
Duval	6,754	678.9
Pinellas	5,065	511.6



Late HIV Diagnosis and Resident Deaths Due to HIV/AIDS

HIV/AIDS-related deaths in Florida decreased markedly (30%) from 1995 (N=4,004) to 1996 (N=2,796) after the advent of highly active antiretroviral therapy (HAART) in 1996. Furthermore, HIV-related deaths in Florida from 2012 to 2021 decreased 34% over the past 10 years, 16% over the past five years, and 7% in the past year from 659 in 2020 to 612 in 2021. The Black community has been disproportionality affected by HIV in Florida since the epidemic began in 1981 and despite a large decrease in the rate of HIV-related deaths among Black persons (43% since 2012), HIV disparities still exist among Florida's Black population. In 2021, rates of HIV-related deaths were five times higher for Black males (11.9 per 100,000 population) compared to White males (2.6 per 100,000 population) and nearly 11 times higher for Black females (7.5 per 100,000 population) compared to White females (0.7 per 100,000 population) with HIV.

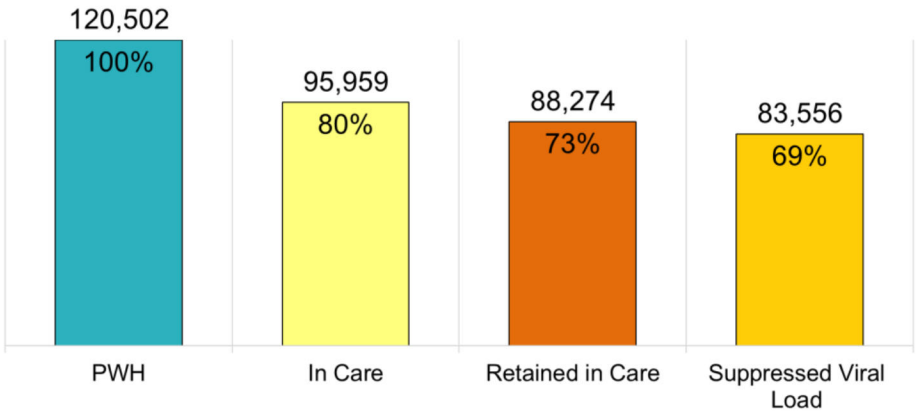
Of the 4,708 HIV diagnoses in 2021, 19% (N=895) were late diagnoses, which are defined as persons receiving an AIDS diagnosis within 90 days of their confirmed HIV diagnosis. By race/ethnicity, 20% of Black persons, 21% of White persons, and 16% of Hispanic/Latino persons were late diagnoses. Among adults (age 13+), the two groups with the highest proportion of late diagnoses by age and mode of exposure were persons aged 50 and over (29%) and males with a history of IDU (29%), respectively.

HIV Care Continuum

The HIV Care Continuum is a diagnosis-based model that reflects the series of stages from initial diagnosis to being retained in care and achieving viral suppression. The HIV Care Continuum has four main stages: HIV diagnosis, linkage to care, retention in care, and viral suppression. It demonstrates the proportion of individuals diagnosed and 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 PWH across the entire continuum.

In 2021, despite the COVID-19 pandemic, of the 120,502 PWH in Florida, 80% (N=95,959) were reported to be in care (received at least one documented VL (viral load) or CD4 lab, medical visit, or HIV-related prescription in 2021), 73% (N=88,274) were retained in care (had HIV-related care two or more times at least three months apart), and 69% (N=83,556) were virally suppressed. As Figure 13 shows, of the persons retained in care, 90% had a suppressed viral load (<200 copies/mL). Twenty percent (20%) (N=24,543) did not receive any HIV-related care in 2021.

FIGURE 13: PWH LIVING IN FLORIDA ALONG THE HIV CARE CONTINUUM, YEAR-END 2021



Note: 90% of persons retained in care had a suppressed viral load.

The seven EHE counties make up approximately 11% of the total national HIV burden as outlined in the EHE plan and represent 72% of the total persons living with an HIV diagnosis in Florida.

Five of the EHE counties, Pinellas (77%), Hillsborough (71%), Orange (72%), Broward (70%) and Duval (69%) had a viral suppression rate equivalent to or greater than the state rate of 69%, while Palm Beach (65%) and Miami-Dade (63%) had lower viral suppression rates than the state at the end of 2021. It's important to note that PWH who receive services from the RWHAP and ADAP tend to have better results of viral suppression. For example, although Miami's overall viral suppression rate was 63%, approximately 82% of the 8,418 clients served by Miami's RWHAP Part A and Minority AIDS Initiative (MAI) program in fiscal year 2021 were virally suppressed.

The five populations ranked lowest in the percentage of suppressed VL (<200 copies/ml) in 2021, in descending order, were as follows:

1. Male PWID (58%)
2. Black Males with Heterosexual Contact (59%)
3. Black Males with MMSC (65%)
4. Persons 25–39 years of age (66%)
5. Persons 13–24 years of age (67%)

When compared with the HIV Care Continuum for Florida, the above five populations demonstrated disparities, particularly in the last stage, suppressed VL (<200 copies/ml). In 2021, 69% of PWH in Florida had a suppressed viral load. The five populations of concern in this section show suppressed VL percentages below 69%. This is significant to note in observing the ultimate health outcome of treatment adherence and an individual living with HIV leading a healthier life.

HIV-Related Co-Morbidities

STIs and hepatitis B virus (HBV) and (HCV have been steadily increasing in Florida over the past five years, including a 4% increase in chlamydia, a 40% increase in gonorrhea, and an 88% increase in early syphilis. Co-infection of PWH with STIs also increased during this same time period, with an increase of 67% for HIV/gonorrhea, 72% for HIV/chlamydia, and 76% for HIV/early syphilis. In 2021, there were 302 adults who were also co-infected with HBV, 86% of whom were male; 59% of the males reported MMSC exposure, and 30% of females reported IDU exposure. There were 537 PWH who were coinfected with HCV in 2021, the majority of whom were males (82%) with MMSC (66%), IDU (13%), or heterosexual (11%) exposure. Forty-eight percent (48%) of female PWH with a co-occurring HCV diagnosis had IDU exposure. An increase in routine screening of all STIs, HIV, and hepatitis is needed to capture and prevent disease burden.

HIV Transmission Clusters and Networks

One aspect of the Florida IPC and the Florida EHE plans is to detect and respond to rapidly growing HIV transmission clusters and networks and prevent future HIV diagnoses using data and laboratory results collected through routine public health surveillance. Transmission cluster network analyses are conducted using data from point-of-care HIV-1 genotypic resistance testing to identify genetic (molecular) links of similar virus strains by comparing those with similar HIV genetic sequences. Those data are then used to identify networks of recent and rapid transmission for prevention and linkage-to-care interventions. The observed HIV transmission rate in molecular clusters identified across the U.S. is, on average, 11 times higher than the transmission rate in the general HIV population, thus indicating the importance of quickly using proven interventions to stop further transmission of HIV. HIV molecular clusters are considered rapidly growing when there have been five or more new HIV diagnoses in the previous 12 months. The Department is actively conducting surveillance and investigation for HIV clusters. The Department routinely conducts monthly analysis to detect rapidly growing molecular clusters and time-space clusters of public health significance. Additionally, a state level HIV cluster review committee is convened monthly to review cluster data, discuss challenges, and brainstorm strategies to improve the statewide response. Since fall 2021, the Department's Bureau of Communicable Diseases has established routine communication with CHDs experiencing clusters to coordinate and guide local responses to investigate and respond to clusters. Florida's updated HIV Cluster Detection and Response plan was submitted to CDC in fall 2021 and will be updated in 2023.

Since the beginning of the Department's HIV transmission cluster detection program in November 2017, the HIV/AIDS Section has identified 64 clusters at a 0.5% genetic distance between strain of HIV demonstrating rapid growth. These molecularly linked transmissions comprise a total of 772 persons receiving an HIV diagnosis in Florida with a much larger, often underdefined transmission and risk network. Though members of molecular clusters live across the state, 554 (72%) have a current residence in one of the seven EHE counties. The state has also taken a collaborative approach to responding to other outbreaks that impact the care and treatment of PWH (e.g., COVID-19, Mpox, hepatitis A, and meningococcal disease), providing trainings, developing messaging, and promoting health resources and services.

3.2 Data Sharing and Use

De-identified HIV, viral hepatitis, STD, and TB data are routinely shared via ad-hoc requests to surveillance programs with outside entities including, but not limited to, academic institutions, community partners, RWHAP parts, internal agency partners and collaborators, and the public. Each of these programs provide annual data which are uploaded into FLHealth CHARTS (Florida Community Health Assessment and Resource Tool Set) (https://www.flhealthcharts.gov/charts/CommunicableDiseases/default.aspx). In addition, the Department is updating the FLHealth CHARTS website (a web-based platform that provides easy access to health indicator data at the community and statewide level for the state of Florida from a multitude of sources) with a new dashboard (at the county level) that will incorporate a multitude of HIV/AIDS indicators including but not limited to, demographic and socio-economic indicators, partner services data, testing and treatment facilities, PrEP, and other data not previously included on FL Health CHARTS.

By ensuring all these data and information are made readily accessible and user-friendly, the new dashboard will help local and state planning bodies develop more effective and efficient programs and corresponding activities and monitor progress of IPC strategies and activities. All data are protected securely and confidentially, adhering to the Department's internal policies and strictly adhering to CDC's, *National Centers for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Data Security and Confidentiality Guidelines*.

Summarized ad-hoc data requests are honored based on the ability of the program to generate the requested data within the time constraints of the request. Data requests for ZIP code data will receive suppressed data (data by ZIP code with three or more cases) based on internal Department ZIP code suppression rules.

Epidemiologic Data

Summarized annual data are uploaded to the Department's HIV/AIDS Section web page (http://floridaaids.org) and are also available on a SharePoint site for internal use at the state and CHD level. Annual data releases include a comprehensive epidemiological profile for the state and for each partnership area, a state slide set presented annually to FCPN, and other annual data products. The epidemiological profiles are an expanded Excel workbook with multiple tabs containing 5-year trend analyses of HIV (demographics, diagnosis, AIDS, deaths, and continuum of care), STIs, HBV, HCV, and TB.

Factsheet and Slide Sets to Support Stakeholder Engagement and Planning

Various factsheets are generated to portray epidemiology and disease highlights for a demographic population. These fact sheets address various HIV/AIDS awareness day topics as well as highlight summary data for high-risk population groups. These fact sheets are updated annually, shared with community stakeholders, and uploaded to the Department's external web and internal SharePoint sites. Integrated slide sets and epidemiological profile tables are generated to support stakeholder engagement and planning. The Department's HIV/AIDS Section has generated comprehensive slides sets

and epidemiologic profiles specifically for each of the 14 partnership areas each year since the 1990s. These slide sets and profiles are shared with the RWHAP Part A entities, community stakeholders, field surveillance staff, and others who may request these data. These data are frequently used as tools for program planning and evaluation.

Other Data Sources

Along with HIV data, the Department summarizes data from MMP and CDC's National HIV Behavioral Surveillance (NHBS) surveillance project, along with Department PrEP, Test and Treat, and HIV counseling and testing data. Data from the needs assessments are also shared in reports sent out to FCPN membership. Other data sources include the RWHAP Eligibility Portal, CAREWare, and Provide Enterprise (an online care management system).

Data Sharing Agreements

For persons requesting de-identified data in a database format that can be analyzed for public health research purposes, the researcher must first submit a concept proposal with research aims, benefit to public health, and required data variables and time frame for the requested data. An internal Department research committee reviews the feasibility of the project, including for potential human subjects impacts and ethical considerations. Once approved, the requestor must complete a Data Use Agreement (DUA) and obtain a study approval or study exemption letter from the Department's Institutional Review Board. Once received, the DUA is routed for legal review and signatures. Data are provided via secure FTP format and can only be housed on secure servers as part of the DUA.

Any program outside of the Department that is approved to receive HIV data through a Data Sharing Agreement (DSA) for the purpose of linking or re-engaging HIV clients into care must be in full compliance with the NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, STD, and TB Programs, Department security and confidentiality policies, Health Insurance Portability and Accountability Act (HIPAA) guidelines and have documented active-client consent to share. Data sharing with programs outside the Department requires approval of the overall responsible party, HIV/AIDS Section administrator and legal counsel. A memorandum of understanding or DSA must be completed between the Department and the program requesting data. The HIV Surveillance Program will provide only the minimum data required to conduct linkage and reengage to HIV care and services.

In partnership with the six RWHAP Part A programs located in the seven EHE counties and through funding received by Georgetown University, the Department has developed and is preparing to implement a data sharing and Data to Care (D2C) effort to improve linkage to HIV care for persons out of care in those jurisdictions.

Some challenges exist with data sharing; for example, the Department's data sharing agreement with the Florida Agency for Health Care Administration (AHCA) for Medicaid does not allow the Department to share data on Medicaid enrollments of the same clients receiving services in and from the RWHAP

Part A jurisdictions. This leads to duplicative and sometimes costly efforts for the RWHAP Part A programs to run Medicaid verification checks on the clients for eligibility assessments.

3.3 HIV Prevention, Care, and Treatment Resource Inventory

To ensure that the state is meeting the goals and objectives set forth to best address the needs of PWHs, Florida must prioritize the financial resources and assess the capacity to provide the services outlined. The following section provides a comprehensive HIV financial resources inventory for Florida. Components include, but are not limited to, statewide public and private funding sources for HIV prevention, care, and treatment services; the dollar amount and the percentage of the total available funds for each funding source; program or service delivery; and what step of Florida's HIV Care Continuum is impacted.

Resource inventories have been provided by all 14 HIV partnership areas in the state of Florida. Each partnership area provided separate inventories for prevention and patient care, which can be found in Appendix Section 9.3 Partnership Area Resource Inventories. Table 5 represents Florida-specific funding from various sources for HIV-related services statewide, where available, for FY 2021.

TABLE 5: FUNDING RESOURCE INVENTORY

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
HRSA RWHAP Part A (EMA/TGA)[2]	**$76,146,512**	**12.67%**		
Fort Lauderdale	$15,724,848		Medical case management (including treatment adherence), oral health care, EIS, mental health services, substance abuse treatment (outpatient), case management (nonmedical), food bank/home-delivered meals, health education/risk reduction, housing services, legal services, medical transportation services, psychosocial support services	2,3,4,5
Jacksonville	$5,886,669			
Miami	$26,432,895			
Orlando	$10,445,207			
Tampa	$10,352,255			
West Palm Beach	$7,304,638			
HRSA EHE–RWHAP Part A Jurisdictions[2]	**$10,780,783**	**1.79%**		
Fort Lauderdale	$2,075,933		Linkage services for PWH who are either newly diagnosed or are diagnosed but currently not in care, to essential HIV care and treatment and support services.	2,3,4,5
Jacksonville	$1,086,820			
Miami	$2,887,384			
Orlando	$1,667,000			
Tampa	$1,667,000			
West Palm Beach	$1,396,646			
HRSA RWHAP Part B[3]	**$282,240,453**	**46.96%**		
Base	$30,031,995		Medical case management services (including treatment adherence), case management (non-medical), food bank/home-delivered meals, health education/risk reduction, psychosocial support services, quality management, and evaluation	2,3,4,5
MAI	$1,253,307		Increase in enrollment in health care services, ADAP, Medicaid, or other health care coverage	2,3,4,5
ADAP Earmark	$84,839,389		ADAP medications, Insurance Continuation	4
ADAP Rebates	$165,647,438		ADAP medications, Insurance Continuation	4
Emerging Communities	$468,324			4
HRSA RWHAP Part B[3] – Supplemental	**$2,888,725**	**0.48%**	ADAP medications	3,4,5
HRSA RWHAP Part B[3] – ERF	**$5,211,950**	**0.87%**	ADAP medications	3,4,5

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
HRSA RWHAP Part C -Early Intervention	**$10,668,448**	**1.78%**		
Borinquen Health Care Center, Inc. (Miami)	$699,183		EIS (management and administration EIS), core medical services, support services, quality management and administration.	1,2,3,4,5
Empower U (Miami)	$679,903			
University of Miami (Miami)	$933,332			
Charlotte De Soto County Health Department (Arcadia)	$273,835			
Collier Health Services (Immokalee)	$468,290			
Duval County Health Department (Jacksonville)	$300,912			
Hendry County Health Department (Labelle)	$317,459			
Manatee County Rural Health Services, Inc. (Palmetto)	$499,050			
Monroe County Health Department (Key West)	$521,839			
Neighborhood Medical Center, Inc. (Tallahassee)	$545,577			
North Broward Hospital District (Fort Lauderdale)	$875,925			
Okaloosa County Health Department (Fort Walton Beach)	$306,167			
Orange County Health Department (Orlando)	$1,072,229			
Pancare of Florida, Inc. (Panama City)	$300,000			
Polk County Health Department (Bartow)	$546,633			
St. Johns County Health Department (St. Augustine)	$357,926			

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
The McGregor Clinic, Inc. (Fort Myers)	$339,544			
Unconditional Love, Inc. (Melbourne)	$346,828			
University of Florida (Gainesville)	$350,484			
HRSA RWHAP Part D	**$7,593,769**	**1.26%**		
Bond Community Health Center, Inc. (Tallahassee)	$493,499		Medical services, clinical quality management, support services, and administration.	1,2,3,4,5
Children's Diagnostic & Treatment Center, Inc. (Fort Lauderdale)	$2,016,919			
Florida Department of Health (Tallahassee)	$829,678			
University of Florida (Gainesville)	$729,616			
University of Miami (Miami)	$2,058,949			
University of South Florida (Tampa)	$1,465,108			
HRSA RWHAP Part F				
NOVA Southeastern University, Inc. (Fort Lauderdale)	$219,230	**0.04%**	Assistance for accredited dental schools, post-doctoral dental programs, and dental hygiene education programs for uncompensated costs incurred in providing oral health treatment to patients with HIV infection.	3
CDC Integrated Prevention and Surveillance	**$38,756,445**	**6.45%**		
Florida Department of Health in Tallahassee (State Health Office)	$30,671,550		Core prevention and surveillance programs including HIV testing and linkage to care; comprehensive prevention services for HIV-positive individuals; condom distribution; policy initiatives; interventions for at-risk populations; social marketing, media, and mobilization; HIV prevention planning; PrEP and PEP initiatives; capacity-building and technical assistance; program planning, monitoring, and evaluation; and quality assurance.	1,2,3,4,5
The Department's Statewide total distribution (counties)	$8,084,895			
CDC Ending the HIV Epidemic (EHE)	**$11,280,419**	**1.88%**		
State Health Office	$2,613,537			1,2,3,4,5

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
Broward	$1,949,187		Prevention and surveillance programs which complement existing work under the state's HIV prevention and surveillance cooperative agreement (CDC-PS18-1802) and use innovative strategies addressing ending the HIV epidemic.	
Duval	$615,372			
Hillsborough	$674,419			
Miami-Dade	$2,624,940			
Orange	$880,968			
Palm Beach	$794,010			
Pinellas	$457,986			
CDC Medical Monitoring Project	**$861,929**	**0.14%**	Population-based project which provides information about the behaviors, clinical outcomes, quality of care, and barriers to care and viral suppression among people with diagnosed HIV.	4,5
CDC National HIV Behavioral Surveillance (NHBS)	**$433,710**	**0.07%**	National HIV Behavioral Surveillance Study (Miami)	1,2
CDC Integrated Hepatitis Surveillance Prevention	**$774,500**	**0.13%**	Improve hepatitis surveillance data collection systems to systematically collect, analyze, interpret, and disseminate data. Increase hepatitis testing and vaccination for high-risk populations.	1,2
CDC STD Grants	**$35,813,552**	**5.96%**		
Strengthening STD Prevention and Control for Health Departments (STD PCHD)	$5,696,617		Surveillance, investigation and intervention for syphilis, gonorrhea, chlamydia, and HIV. Limited clinical support.	1,2,3
DIS Workforce Development Supplement	$29,068,863		Expanding public health workforce capacity to respond to infectious disease outbreaks.	1,2,3,4
STD Surveillance Network (SsuN)	$340,000		Enhanced surveillance of gonorrhea via extended patient and provider interviews.	1,2
Epidemiology and Laboratory Capacity (ELC)	$633,071		Routine syphilis screening at non-traditional venues (hospital emergency department and syringe services program) to reduce congenital syphilis rates.	1,2
Childbearing Capacity in Jails (NACCHO)	$75,000		Routine syphilis screening for women of child-bearing age to reduce congenital syphilis rates.	1,2
State General Revenue	**$42,210,855**	**7.02%**		

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
State Health Office	$22,748,209		HIV prevention and care staff, services, and supplies.	1,2,3,4,5
County Health Departments[4]	$12,427,076			
Pharmacy	$7,035,570		HIV prevention and treatment medications	4
State Line-Item Appropriations	**$1,739,000**	**0.29%**		
UM Center for AIDS Research	$1,000,000		HIV cure research.	
TOPWA	$500,000		Perinatal HIV prevention services.	1,2,3,4,5
Hispanic & Haitian Outreach	$239,000		HIV outreach and education to Hispanic and Haitian communities.	1,2
HOWPA (HUD)-State				
The Department Statewide	$8,364,929	**1.39%**	Housing assistance and related support services for low-income persons with HIV/AIDS and their families.	3,4,5
HOWPA (HUD)-Direct Funding to Cities	**$34,257,931**	**5.70%**		
Fort Lauderdale	$7,088,032		Housing assistance and related support services for low-income persons with HIV/AIDS and their families.	3,4,5
Jacksonville	$2,601,336			
Miami	$11,924,914			
Orlando	$4,586,699			
Tampa	$4,378,068			
West Palm Beach	$3,202,608			
Key West (competitive)	$476,274			
DIRECTLY-FUNDED ORGANIZATIONS				
CDC Directly-Funded HIV Service Providers				
CDC-PS21-2102[5]	**$4,857,875**	**0.81%**	Comprehensive high-impact HIV prevention programs for community-based organizations	1,2,3,4,5
AIDS Service Association of Pinellas, Inc. dba EPIC (Clearwater)				
BASIC NWFL, INC. (Panama City)				
Borinquen Health Care Center, Inc. (Miami)				
Care Resource Community Health Centers, Inc. (Miami)				

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
FoundCare Inc. (West Palm Beach)				
Health Care Center for the Homeless, Inc. dba Orange Blossom Family Health (Orlando)				
Hope and Help Center of Central Florida, Inc. (Winter Park)				
Latinos Salud, Inc. (Wilton Manors)				
Metropolitan Charities dba METRO Inclusive Health (St. Petersburg)				
Treasure Coast Health Council, Inc dba Health Council of Southeast Florida (Palm Beach Gardens)				
Village South, Inc. (Pembroke Pines)				
CDC-PS17-1704	**$1,063,791**	**0.18%**	Comprehensive high-impact HIV prevention programs for young MSM and transgender individuals of color.	1,2,3,4,5
Care Resource Community Health (Miami)	$354,597			
Jacksonville Area Sexual Minority Youth Network (JASMYN) (Jacksonville)	$354, 597			
Latinos Salud (Miami Beach)	$354, 597			
CDC Division of Adolescent School Health (DASH), CDC-PS-18-1807[6]	**$2,100,000**	**0.35%**	Promoting adolescent health through school-based HIV prevention through HHS, CDC, NCHHSTP.	1
Broward County				
Duval County				
Hillsborough County				
Orange County				
Pasco County				
Palm Beach County				
HRSA Directly-Funded HIV Service Providers				

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
HRSA EHE Primary Care HIV Prevention	**$6,361,483**	**1.06%**	Funding provided to health centers to expand access to medication to prevent HIV (including PrEP and related services), connect people to care, and ensure care services are well coordinated.	1,2,3,4,5
Agape Community Health Center, Inc. (Jacksonville)	$254,811			
Borinquen Health Care Center, Inc. (Miami)	$284,779			
Broward Community and Family Health Centers, Inc. (Hollywood)	$266,341			
Care Resource Community Health Centers Inc. (Miami)	$269,322			
Citrus Health Network, Inc. (Hialeah)	$270,825			
Community Health Centers of Pinellas, Inc. (St. Petersburg)	$286,640			
Community Health South Florida, Inc. (Miami)	$300,697			
Empower U, Inc. (Miami)	$253,689			
Florida Community Health Centers, Inc. (West Palm Beach)	$276,697			
FoundCare Inc. (West Palm Beach)	$268,470			
Health Care Center for the Homeless, Inc. (Orlando)	$263,810			
I.M. Sulzbacher Center for the Homeless, Inc. (Jacksonville)	$254,995			
Jessie Trice Community Health System, Inc. (Miami)	$284,758			
Miami Beach Community Health Center, Inc. (Miami)	$308,991			
North Broward Hospital District (Fort Lauderdale)	$251,614			

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
Pinellas, County of (Clearwater)	$162,412			
Tampa Family Health Centers, Inc. (Tampa)	$305,605			
Banyan Community Health Center (Miami, FL)	$343,379			
Central Florida Family Health Center (Sanford, FL)	$361,799			
Community Health Centers (Winter Garden, FL)	$373,076			
Genesis Community Health (Boynton Beach, FL)	$340,385			
Suncoast Community Health (Ruskin, FL)	$378,388			
Substance Abuse and Mental Health Services Administration (SAMHSA) FUNDING				
Florida Department of Children and Families (FDCF)				
Substance Abuse Prevention and Treatment Block Grant, HIV Early Intervention Services Set Aside	$ 5,569,266	**0.93%**	Funding for HIV testing in substance use disorder treatment facilities.	1,2,3
SAMHSA-Directly Funded Organizations	**$9,814,811**	**1.63%**		
Broward House, Inc. (Fort Lauderdale)	$485,000		Minority AIDS Initiative-service Integration	1,2,3,4
FoundCare Inc. (West Palm Beach)	$445,987		Minority AIDS Initiative-service Integration	
Guidance/Care Center, Inc. (Key West)	$479,325		Minority AIDS Initiative-service Integration	
Banyan Community Health Center, Inc. (Miami)	$257,354		Capacity Building Initiative (CBI-HIV) for substance abuse and HIV prevention services for at-risk racial/ethnic minority youth and young adults.	1,2,3,4
BASIC NWFL, Inc. (Panama City)	$255,000		CBI-HIV	
Bethel Family Enrichment Center, Inc. (Miami Gardens)	$257,166		CBI-HIV	

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
Gang Alternatives, Inc. (Miami)	$257,245		CBI-HIV	
26 Health, Inc. (Orlando)	$199,774		Substance Abuse (SA) and HIV Prevention Navigator Program	1,2,3,4
Aspire Health Partners, Inc. (Orlando)	$200,000		SA and HIV Prevention Navigator Program	
Borinquen Health Care Center, Inc. (Miami)	$200,000		SA and HIV Prevention Navigator Program	
Community Rehabilitation Center, Inc. (Jacksonville)	$200,000		SA and HIV Prevention Navigator Program	
Orange County (Orlando)	$200,000		SA and HIV Prevention Navigator Program	
Gang Alternatives, Inc. (Miami)	$199,996		SA and HIV Prevention Navigator Program	
New Breed Creation Life Center, Inc. (Jacksonville)	$200,000		SA and HIV Prevention Navigator Program	
Pridelines Youth Services, Inc. (Miami)	$200,000		SA and HIV Prevention Navigator Program	
River Region Human Services, Inc. (Jacksonville)	$200,000		SA and HIV Prevention Navigator Program	
Aspire Health Partners, Inc. (Orlando)	$525,000		Targeted Capacity Expansion (TCE-HIV) HIV Program: substance use disorder treatment for racial/ethnic minority populations at high risk for HIV/AIDS	1,2,3,4
Bethel Family Enrichment Center, Inc. (Miami Gardens)	$461,175		TCE-HIV	
Borinquen Health Care Center, Inc. (Miami)	$525,000		TCE-HIV	
Broward House, Inc. (Fort Lauderdale)	$520,693		TCE-HIV	
Community Rehabilitation Center, Inc. (Jacksonville)	$425,000		TCE-HIV	
Gateway Community Services, Inc. (Jacksonville)	$525,000		TCE-HIV	
Guidance/Care Center, Inc. (Key West)	$499,179		TCE-HIV	
Health Care Center for the Homeless, Inc. (Orlando)	$525,000		TCE-HIV	
Lakeview Center, Inc. (Pensacola)	$521,965		TCE-HIV	

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
Metropolitan Charities, Inc. (dba Metro Inclusive Health) (St. Petersburg)	$525,000		TCE-HIV	
The Village South, Inc. (Miami)	$524,952		TCE-HIV	
Veteran's Affairs[7]	**—**		Funding to support services for Florida veterans	1,2,3,4,5
Medicaid-funded HIV Services[7]	**—**		Funding to support PWH medical services	1,2,3,4,5
Indian Health Service		**0.16%**	Funding to support services for Florida's federally-recognized tribes and tribal organizations	1,2,3,4,5
Seminole Tribe of Florida (HHS Substance Abuse and Mental Health Services Projects of Regional and National Significance)	$402,265		Funding to support services for tribal opioid response.	
Seminole Tribe of Florida (HHS, CDC Funds for Public Health Response, COVID-19)	$311,730		Funding to support tribal response to public health or health care crises (COVID-19 response funds).	
Miccosukee Tribe of Indians of Florida (HHS, CDC Funds for Public Health Response, COVID-19)	$259,456		Funding to support tribal response to public health or health care crises (COVID-19 response funds).	
PRIVATE FOUNDATIONS[8]				
The Campbell Foundation	**$20,000**	**0.003%**		
AH Monroe, Inc. (Key West)	$2,000		HIV-related services	
Broward House, Inc. (Fort Lauderdale)	$2,000			
Care Resource, Inc. (Miami, Fort Lauderdale)	$2,000			
Children's Diagnostic & Treatment Center, Inc. (Fort Lauderdale)	$2,000			
Compass, Inc. (West Palm Beach)	$2,000			

Funding Source and Area/Jurisdiction	Funding Amount ($)	Percentage of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted[1]
Empath Health/EPIC, Inc. (St. Petersburg)	$2,000			
Latinos Salud, Inc. (Wilton Manors, Miami)	$2,000			
McGregor Clinic, (Fort Myers)	$2,000			
Poverello, Inc. (Wilton Manors)	$2,000			
SunServe, Inc. (Wilton Manors)	$2,000			
TOTAL	**$601,003,817**			

[1] HIV Care Continuum: 1 = HIV Testing and Diagnosis: Staff, services and systems that help to identify and test persons who are unaware of their HIV status; 2 = Linkage to Care: Staff, services, and systems that help connect newly diagnosed PWHA to care; 3 = Retention in Care: Staff, services, and systems that help PWH remain engaged in care and treatment services; 4 = Provision of ART: Staff, services, and systems that help PWH access and remain adherent to antiretroviral medication; 5 = Viral Suppression: Staff, services and systems that help PWH achieve and maintain viral suppression.

[2] RWHAP Part A figures represent FY2021 funding amounts.

[3] The State Health Office is the recipient of HRSA RWHAP Part B funds.

[4] State General Revenue to County Health Departments includes 4B000, 4BNWK, and 4BAPS.

[5] CDC-PS21-2102: Unable to obtain exact funding amounts. Average funding award for each provider was approx. $441,625.

[6] CDC-PS18-1807: Unable to obtain exact funding amounts. Average funding awards approx. $350,000.

[7] Unable to obtain Florida-specific funding levels.

[8] Additional private foundation awards exist; however, recipients and award amounts are unknown.

Other sources of funding include funds from the state of Florida general revenue, Housing Opportunities for Persons with AIDS (HOPWA), U.S. Department of Housing and Urban Development (HUD), RWHAP all parts, CDC Integrated HIV Prevention and Surveillance, CDC MMP, CDC NHBS, CDC and HRSA EHE funds, SAMHSA, tribal organization funding, and private foundation funding, where available. More work is needed to identify Florida-specific funds related to HIV services from the Veteran's Administration (VA) and Medicaid.

The Florida HIV Care Continuum Dashboard Tool was developed as a mechanism to gather information related to how funds are distributed statewide and RWHAP services are delivered by geographic area. The purpose and goal of the tool was to provide a snapshot of HIV prevention and patient care funding and assess HIV prevention and patient care activities across the care continuum by each of the 14 HIV partnership areas.

The tool provides a listing of resources in CHDs and local communities, as well as illustrating gaps and unmet needs by contrasting regional differences and highlighting areas of need. The information in the Florida HIV Care Continuum Dashboard Combined Tool was self-reported by each local area; therefore, slight differences may appear in terms of funding or data reported. Additionally, specific caveats may apply since they may have alternate funding streams coming into their local areas or enhanced best practices or collaborative efforts which result in increased funding as reported by the state.

The purpose of this inventory is to provide a snapshot of HIV prevention and patient care funding by area. The goal of this inventory is to help assess HIV prevention and patient care activities across the continuum of care by area. The inventory provides a snapshot of resources in CHDs and communities. Individual area resource inventories can be found in Appendix Section 9.3 Partnership Area Resource Inventories.

3.4 Gaps, Needs and Barriers

Through the development of Florida's Unified EHE Plan and through local community engagement activities, additional gaps, needs, and barriers were identified which span across all pillars as described in Table 6:

TABLE 6: GAPS, NEEDS AND BARRIERS

Summary	Description
Meaningful Community Engagement with Priority Populations	The Department received feedback from community partners on the perceived effectiveness of current public health initiatives. Partners identified across all IPC pillars determined there is a need for increased and meaningful community engagement with all of Florida's populations that are disproportionately affected by and living with HIV, including Black and Hispanic/Latino populations and the LGBTQ community. The Department recognizes that Florida's racial/ethnic minority populations continue to increase in size and continues to address gaps in diverse community

Summary	Description
	wellness throughout the state. Improvements in HIV outcomes over the last decade have had great strides. However, populations of racial and ethnic minorities should continue to be prioritized to improve prevention and care access. For Florida's racial/ethnic minority populations, HIV outcomes should improve among all populations at the same rate – especially among Florida's diverse population. 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 indicates there would be a benefit for leaders of faith-based institutions to engage in HIV education and awareness. Challenges exist around maintaining community engagement with and representation from PWH who receive services directly through the RWHAP, both at state and local levels.
Geography and Transportation	Whereas 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.[39] 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.[20] County size and lack of affordable, safe, and timely transportation options are also factors contributing to barriers in accessing care. For example, in Miami-Dade County, some clients who live in far south Dade, and fear stigma of accessing HIV care closer to home, opt to ride hours on public transportation, often in inclement weather, to access services near downtown Miami.
Poverty and Education	In 2020, 13% of people living in Florida reported living below the federal poverty level.[20] Counties with the highest poverty rates included DeSoto, Hamilton, Hardee, Hendry, and Madison. In 2016–2020, 88.5% of people aged 25 years and older living in Florida had at least graduated from high school (compared to 89.4% for the U.S.).[20] Counties with the fewest individuals with at least a high school diploma included DeSoto, Glades, Hamilton, Hendry, and Lafayette. Counties with the lowest education levels were found in central and northern Florida.
Mental Health and Substance Use Disorders	Persons experiencing mental health and substance use disorders are at increased risk for HIV and frequently lack access to HIV and STI education, prevention, and care services.[22] In 2020, nearly 18% (7,842) of the 44,577 reported drug overdose deaths in Florida involved opioids.[23] There was an approximate 28% increase in the number of persons treated for addiction with self-reported IDU between 2014 and 2018.[24] There was a 2% increase in HIV diagnoses from 2017–2021 among persons with an IDU-related mode of exposure.[6] Over that same time period, acute HCV infections

Summary	Description
	increased by 366% in Florida; injection drug use is the primary mode of exposure among persons diagnosed with acute HCV. Efforts are needed to ensure organizations providing behavioral health and substance use treatment services are providing education around HIV, STIs, and HCV and are knowledgeable about local testing and treatment resources. According to the FDCF, 2020 Florida Youth Substance Abuse Survey (FYSAS) State Report, substance use among students in Florida continues to decline. Among middle and high school students in Florida, between 2010 and 2020, the prevalence of lifetime alcohol use decreased from approximately 52% to 35% and the past-30-day prevalence of alcohol use decreased from 29% to 15%. Regarding marijuana use, the prevalence of lifetime and past 30-day marijuana use among middle and high school students also decreased between 2010 and 2020. According to estimates from the 2022 FYSAS among high schoolers, the lifetime prevalence is 2.8% for opioid misuse, 4.1% for stimulant misuse, and 5.7% for opioid and stimulant misuse.[45] Methadone- or buprenorphine-assisted maintenance treatment (including psychosocial support as needed and if desired) is the evidence-based standard of care used to treat opioid use disorders. According to an analysis of 25,866 Florida Medicaid enrollees diagnosed with opioid use disorders only about 28% go on to initiate medication-assisted treatment. About 56% of newly diagnosed individuals who began methadone treatment continued for 180 days, compared about 19% of newly diagnosed individuals who began treatment with buprenorphine.[46]
Multicultural and Multilingual Issues	Florida population estimates for 2020 show racial/ethnic distributions as follows: 51.5% White (non-Hispanic), 14.5% Black (non-Hispanic), 3.0% Asian American, and 0.2% Native American. Hispanic/Latino persons make up over a quarter (26.5%) of the population. Florida ranks in the top five states with the highest Hispanic/Latino populations in the U.S. and has one of the largest Black/African American populations in the country. Florida's Asian population is growing, particularly in Gulf Coast locations. The state is home to two federally recognized American Indian tribes (the Seminole and the 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% of Caribbean immigrants in the U.S. living in these two metro areas. Just over 20% of Florida's population is foreign-born and nearly 30% of households in Florida speak a language other than English.[5] There is a lack of bilingual and multilingual health care providers and media and marketing messages in certain regions of the state.[25] Florida works to ensure programs and services for PWH and those at increased risk for acquiring HIV align with the National CLAS Standards and that translation services are made available to all clients receiving services at CHD clinics and through funded HIV prevention and care service providers.

Summary	Description
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.[26] Medical mistrust tends to be higher among Black and American Indian populations in Florida. The Tuskegee Study conducted by the U.S. Public Health Service left lasting impacts on the way Black persons view health care, particularly public health.[27] Similarly, studies have shown the sterilization of American Indian women by the Indian Health Service in the 1960s and 1970s created a culture of distrust of government-funded health care services.[28]
In-Migration, Tourism, Seasonal, and Mobile Populations	Florida sees more than one-hundred million tourists each year, many of whom are drawn to popular beach towns and cities like Miami, Fort Lauderdale, and Key West.[29] Its many theme park attractions and over 8,400 miles of coastline make Florida a destination for tourists from around the world. According to VISIT FLORIDA's latest estimates, during Quarter 1 of 2022 (January–March), Florida saw a total of 36 million visitors. This represents a 14% increase from Q4 2021, and the third consecutive quarter that overall visitation has surpassed pre-pandemic levels. Approximately 34.1 million domestic visitors traveled to Florida in Q1 2022, and there were approximately 1.3 million travelers from overseas who visited the state during that same time period (represents an increase of nearly 169% from Q1 2021).[47] The state also has a large population of seasonal residents—students, seasonal workers (in industries such as hospitality, agriculture, and tourism), and persons 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 and Universities (HBCUs). These colleges and universities are often located in Florida's major metropolitan areas, which have higher than average HIV incidence. If tourists, visitors, and persons migrating into the state receive their original HIV diagnosis in Florida, that case counts toward Florida's overall HIV prevalence. The Department's surveillance unit works with other states and jurisdictions to perform deduplication efforts to ensure that persons initially diagnosed in another state or jurisdiction are not counted toward Florida's overall prevalence.
Immigration and Refugee Services	Over the past few years, foreign-born individuals and individuals born in U.S.-dependent areas immigrating to Florida have accounted for roughly half of the population's growth; more than one in five Florida residents is an immigrant.[30] Individuals born outside the continental U.S. comprise roughly 20% of the state's population, and in Miami-Dade County, more than 60% of the population is foreign-born. Among non-U.S. born residents in Florida, persons born in Haiti, Cuba, Venezuela, and Colombia experienced the highest numbers of HIV diagnoses in 2021. This presents a need for increased cultural humility to ensure health education, prevention, and care services are delivered in a culturally and linguistically appropriate manner (i.e., National CLAS Standards).

Summary	Description
	FDCFs Refugee Services Program is federally funded by the Office of Refugee Resettlement in HHS to assist refugees to achieve economic self-sufficiency and social adjustment in the shortest possible time after their arrival in the United States. While in recent years the number of arrivals has decreased nationwide, the state of Florida's refugee program is the largest in the nation, receiving more than 5,000 refugees, asylees, and Cuban/Haitian entrants each year. Eligibility for programs of Refugee Services is determined by federal law and includes the following: Refugees; Cuban/Haitian Entrants; Asylees; Afghan and Iraqi Special Immigrants; and Certified Victims of Human Trafficking.[51] FDCF Refugee Services currently manages more than a dozen refugee services contracts with state agencies, local governments, and community-based organizations. Through their Refugee Health Program, the Department's CHDs provide health screenings to ensure newly arrived refugee clients do not have communicable diseases and to identify health issues. AHCA provides payment for Refugee Medical Assistance services with federal funding and in accordance with Medicaid rules. Of Florida's 67 counties, approximately 32 counties receive refugees for health services on a regular basis. Geographically, new arrivals tend to resettle more frequently in one of the nine following Florida counties: Miami-Dade, Hillsborough, Duval, Palm Beach, Broward, Orange, Collier, Lee, or Pinellas.[52] From the latest data available from FDCF, in 2021, 30,092 refugees arrived or became eligible for Refugee Services in Florida. Additionally, over the last five years (2017–2021), 97,492 refugees arrived or became eligible for Refugee Services. Florida received refugees from 47 different countries last year, of which 72% of refugees were Cubans, and 50% of refugees settled in Miami-Dade County. Cuban, Haitian, Afghan, Mexican, and Chilean were the top nationalities of new refugees in 2021.[53]
Criminal Justice	According to the National Corrections Institute, Florida's incarceration rate (prisons and jails) was 371 per 100,000 population in 2020.[48] In 2020, the U.S. Bureau of Justice Statistics ranked Florida eleventh among states in terms of incarceration rates.[32] Most incarcerated PWH were diagnosed prior to entering the correctional system; however, HIV testing in a correctional setting may be the first time persons who are incarcerated take advantage of testing and prevention education. Although condom provision is one of the simplest harm-reduction interventions to control HIV, STIs, and viral hepatitis, condoms are prohibited in correctional settings. Section 945.355, Florida Statutes (F.S.), requires inmates of FDC to be offered HIV testing prior to release, while jails (which are governed by each county) do not have uniform statewide HIV testing policies. Over time, the Department 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.

Summary	Description
HIV Criminalization	Established in 1990, section 384.24, F.S., criminalizes non-disclosure of STI status, and separately HIV status, prior to sex. The offense requires the person to be aware of their STI and HIV status, to be informed of the risks of transmission through sex, and to go on to have sex with another person. At the time the law was established there was a modest understanding of how HIV transmission occurred, and treatment options were limited. After 30 years of research and advancements in HIV treatment, the law does not take into account the latest science and measures to prevent transmission (e.g., viral suppression, U=U). Persons with HIV and other community members have reported that criminalization laws may be discouraging HIV testing and perpetuating stigma against persons with HIV.
Environmental Impacts	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 many residents were displaced. PWH in the area had trouble accessing services and medications due to widespread devastation. Many people were forced to find housing elsewhere in Florida or even in other states. Emergency medication fills were available through the Department's ADAP program; however, increased efforts are needed to identify PWH in need of reengagement in care and ancillary services following a natural disaster. Most recently, on September 28, 2022, Hurricane Ian made landfall on Florida's southwest coast (Fort Myers area) as a category 4 storm, with Lee and Charlotte counties bearing the greatest impacts. More than 100 people lost their lives in Hurricane Ian, with most deaths being attributed to drowning—the record-breaking storm surge reached as high as 18 feet in some areas. Hurricane Ian is being categorized as the deadliest storm to hit Florida since the 1935 Labor Day Hurricane. The Department used the federal emergency declaration to ensure that ADAP clients had access to medication refills ahead of the storm and worked with ADAP staff statewide to communicate to clients that they had the ability to get prescriptions filled at any pharmacy location in their local areas.
Homelessness and Housing Instability/Insecurity	In 2021, the Florida Housing Coalition reported Florida having the third-highest homeless population of any state in the nation, with 27,640 people living in homeless shelters and on the streets. Before the COVID-19 pandemic, 875,259 very low-income Florida households—including hardworking families, seniors, and people with disabilities—paid more than 50% of their incomes for housing. For PWH, housing is one of the primary predictors of their access and adherence to treatment, other health outcomes, and life expectancy. There are several definitions of homelessness or unstable housing, such as lacking a fixed, regular, or adequate nighttime residence, but also including residing in a motel, doubling up with friends or family, or "couch-surfing." People fleeing domestic violence are also considered unstably housed if they do not have the resources and support to obtain other

Summary	Description
	permanent housing. Responses from Florida's 2019 HIV Care Needs Assessment survey indicated that, of persons who experienced housing-related barriers, the top three barriers were not having money to pay rent, being afraid of others knowing their HIV status, and not having enough food to eat.[55]
Food Insecurity	The latest data from Feeding America show that in 2020, Florida's overall food insecurity rate was 10.6% (approximately 2.3 million people). Although Florida's overall food insecurity rate is lower than the U.S. average of 11.8%, 42 out of 67 Florida counties (63%) have food insecurity rates at or above the national average (>11.8%). Florida's 2019 HIV Care Needs Assessment Survey revealed that for PWH who reported experiencing housing-related barriers, one of the top three issues reported included not having enough food to eat. Many antiretroviral medications used to treat HIV require they be taken with food and ensuring proper nutrition for PWH is paramount to medication adherence and improved health outcomes.[56]
Persons with HIV Aged 50+	Improvements in ART for HIV over the years have led to people with diagnosed HIV living longer and healthier lives, especially when diagnosed early, maintained on ART, and virally suppressed. In 2021, persons with HIV aged 50 and older living in Florida made up nearly 57% of the state's total population of persons diagnosed and living with HIV. Persons aged 50 and older living with HIV face several health challenges—HIV-related and other comorbidities (e.g., cardiovascular and liver disease, neurocognitive impairment), concurrent use of multiple medications (i.e., polypharmacy), oral health problems (e.g., tooth loss), and mental health and substance use disorders.
Outbreak Response for Syndemics	Over the past several years, the state has taken a collaborative approach, with RWHAP and other community-based partners, to responding to other outbreaks that impact the care and treatment of PWH (e.g., COVID-19, Mpox virus, hepatitis A, and meningococcal disease), providing trainings, developing messaging, and promoting access to available health resources and services (e.g., vaccine promotion events for hepatitis A and meningococcal disease). Greater coordination is needed to ensure these intersecting conditions are addressed holistically (e.g., whole-person care).
HIV Workforce Infrastructure (public and private)	Current challenges exist with the HIV workforce—both public and private. The Department's Bureau of Communicable Diseases experienced a high degree of turnover in key leadership positions in 2022, beginning in spring and continuing into fall 2022. Key positions such as the Bureau Chief of Communicable Diseases, HIV/AIDS Section Administrator, Statewide HIV Planning/EHE Coordinator, HIV Patient Care unit manager, Communications unit manager, and Clinical Quality Management Liaison all became vacant during that time. Other positions that had

Summary	Description
	been vacant prior to 2022 are still in need of being filled and include the Performance and Quality unit manager and Statewide Minority AIDS Coordinator. High turnover and staff reaching retirement age have led to gaps in historical program knowledge and staff having to assume interim roles or double-up on responsibilities. Staffing shortages and recruiting challenges have also been reported from CBOs and private sector agencies (e.g., difficulties recruiting health care professionals).
Vulnerable Populations—Human Trafficking, Domestic/Intimate Partner Violence	According to the Florida Alliance to End Human Trafficking, Florida ranks third in the nation for the number of human trafficking cases reported and ranks second in the nation for the number of labor trafficking cases reported. The majority (71.4%) of cases are sex trafficking cases, followed by labor trafficking (14.3%), unspecified trafficking (9.0%), and sex/labor trafficking (5.1%). Persons experiencing exploitation are particularly vulnerable to exposure to HIV, STIs and viral hepatitis due, in part, to substance use, lack of access to health care, lack of autonomy, and exposure to violence.[57] In 2020, 106,515 crimes of domestic violence were reported to Florida law enforcement agencies and during FY 2020–21 and Florida's certified domestic violence centers provided 412,360 nights of emergency shelter to 10,287 survivors of domestic violence and their children. Many more survivors of domestic violence are not reporting their abusers to the police or accessing services at domestic violence services due to reasons such as shame, fear, or being prevented from doing so by their abusers. For this reason, the number of cases is thought to be underreported. Women in violent relationships are at a four times greater risk for contracting STIs, including HIV, than women in non-violent relationships and women who experience intimate partner violence are more likely to report risk factors for HIV.[58]

3.5 Needs Assessment

The information gained from the 2019 HIV Care Needs Survey represents a statewide comprehensive assessment of the needs of PWH in Florida. Survey questions were designed to better understand the current demographics of PWH in Florida and the HIV medical care, patient care services, jail and prison release services, and housing services that were needed and delivered during the 12 months prior to the time the survey was taken.

To ensure that services provided through the Patient Care Program are appropriate and contribute to improving health outcomes for PWH, the HIV/AIDS Section conducted the 2019 HIV Care Needs Survey throughout the state. The primary focus of the survey was to determine met and unmet service needs for PWH in Florida. Data collected from this survey are intended to help statewide and local planning stakeholders determine the best ways to distribute funds and resources. This survey was launched on

May 28, 2019, and continued to completion on September 6, 2019. The survey was delivered via Survey Gizmo and paper to Floridians living with HIV who sought HIV care services in each of the 14 program areas of the Ryan White Patient Care Program.

Limitations

Using the convenience sampling method to collect input for this type of assessment has its advantages, disadvantages, and limitations. Surveys collected using this method can yield rich qualitative data for review and planning in a comparatively cost-efficient manner. Data are available relatively quickly to match the pace of planning needs and are useful to signal changes or shifts in attitudes, behaviors, and outcomes. Among the disadvantages of collecting assessment data via convenience sampling are the potential for bias in data collection and sampling errors that could introduce inaccuracies. Surveying processes that use the convenience sampling method have limitations. Survey participants were self-selected.

3.5.1 Methodology

Survey questions were grouped into sections that included general demographics, HIV medical care, and patient care, jail and prison release, housing, and prevention services. Questions were related to the past 12 months of service. Distribution of the survey was facilitated by the 14 consortia lead agencies throughout Florida. A sample size for each county was calculated based on the number of PWH. Each county was provided the minimum number of surveys to be sent to reach 25% of total PWH at a 10% response rate. RWHAP Part B lead agencies, in collaboration with RWHAP Part A recipients, worked with local providers, community members, and other stakeholders to obtain the survey responses. The survey was made available in three languages: English, Haitian-Creole, and Spanish. Paper surveys were collected locally and mailed to the HIV/AIDS Section for data entry and analysis.

A total of 4,114 surveys were conducted by the end of the survey period: 3,758 in English, 334 in Spanish, and 22 in Haitian-Creole. Of these, 3,777 were complete, 147 were partial, and 190 were disqualified. Respondents were required to answer the demographic questions about age, gender, race, and county.

This document presents the key findings of the 2019 HIV Care Needs Assessment. Results from this survey will be used to help guide service implementation and resource allocation in Florida's HIV/AIDS Patient Care Program.

Survey respondents' counties of residence were reported for 66 of Florida's 67 counties. Union County was not surveyed because there are no reported PWH in that county. A total of 3,879 respondents answered the question about residence. Table 7 lists the number of respondents from each county.

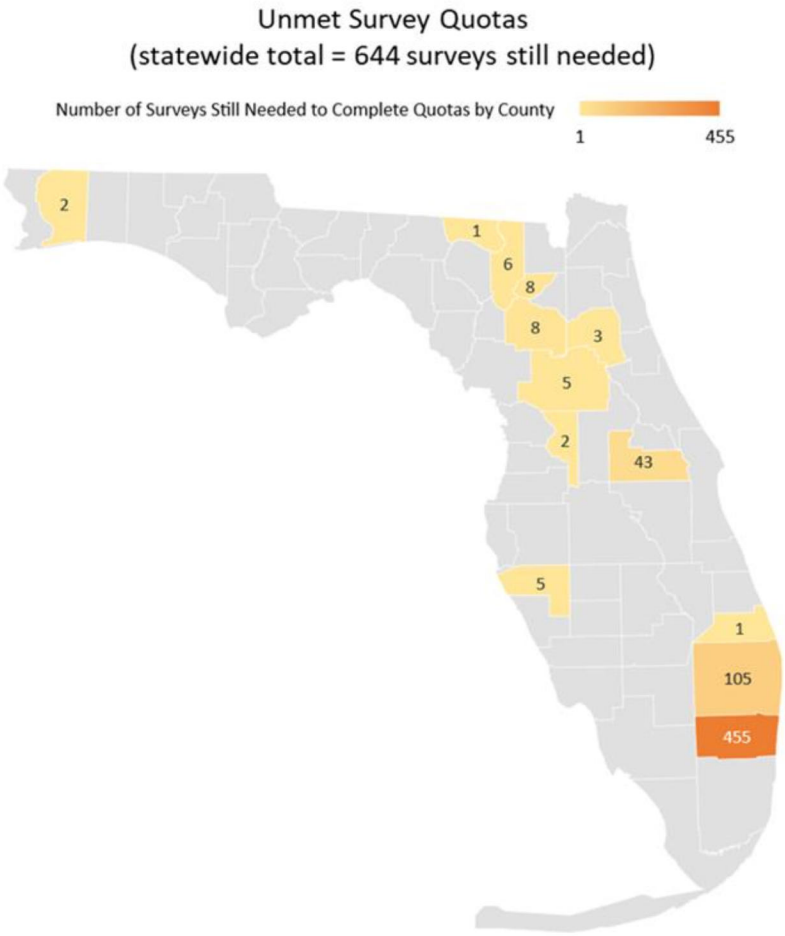
TABLE 7: FLORIDA COUNTY OF RESIDENCE

County	Count	Percent	County	Count	Percent
Alachua	20	0.52%	Lake	45	1.16%
Baker	3	0.08%	Lee	76	1.96%
Bay	29	0.75%	Leon	221	5.70%
Bradford	3	0.08%	Levy	5	0.13%
Brevard	244	6.29%	Liberty	4	0.10%
Broward	65	1.68%	Madison	11	0.28%
Calhoun	1	0.03%	Manatee	22	0.57%
Charlotte	24	0.62%	Marion	23	0.59%
Citrus	8	0.21%	Martin	22	0.57%
Clay	16	0.41%	Miami-Dade	765	19.72%
Collier	29	0.75%	Monroe	37	0.95%
Columbia	3	0.08%	Nassau	4	0.10%
DeSoto	14	0.36%	Okaloosa	17	0.44%
Dixie	3	0.08%	Okeechobee	7	0.18%
Duval	230	5.93%	Orange	187	4.82%
Escambia	47	1.21%	Osceola	53	1.37%
Flagler	25	0.64%	Palm Beach	107	2.76%
Franklin	5	0.13%	Pasco	78	2.01%
Gadsden	49	1.26%	Pinellas	319	8.22%
Gilchrist	1	0.03%	Polk	76	1.96%
Glades	2	0.05%	Putnam	3	0.08%
Gulf	1	0.03%	Santa Rosa	5	0.13%
Hamilton	3	0.08%	Sarasota	68	1.75%
Hardee	2	0.05%	Seminole	51	1.31%
Hendry	7	0.18%	St. Johns	12	0.31%
Hernando	37	0.95%	St. Lucie	63	1.62%
Highlands	13	0.34%	Sumter	5	0.13%
Hillsborough	475	12.25%	Suwannee	5	0.13%
Holmes	2	0.05%	Taylor	5	0.13%
Indian River	18	0.46%	Volusia	164	4.23%
Jackson	14	0.36%	Wakulla	9	0.23%
Jefferson	3	0.08%	Walton	5	0.13%
Lafayette	2	0.05%	Washington	7	0.18%
			Total	3,879	

A sample size for each county was calculated based on the number of PWH. Each county was provided the minimum number of surveys to be sent to reach 25% of total PWH at a 10% response rate. As shown in the figure below, the three counties with highest unmet quotas were:

- Broward
- Palm Beach
- Orange

FIGURE 14: UNMET SURVEY QUOTAS BY COUNTY



3.5.2 Approach

The FCPN Needs Assessment Committee has worked diligently since 2019 to develop the 2022 HIV Care Needs Survey and Needs Assessment Toolkit; releasing it in October 2022. The purpose of the toolkit is to familiarize areas statewide with the importance, components, and processes of needs assessment. The toolkit provides the information needed for active involvement in the needs assessment process by individuals with little or no prior experience in community planning or community-based assessments. The needs assessment process is designed to gather data to inform patient care services both locally and statewide with meaningful input from people impacted by HIV. The survey remained open through December 31, 2022. Once results are received and analyzed, this information will be used to update the SCSN.

The 2019 survey questions were grouped into sections that included general demographics, HIV medical care, and patient care, jail and prison release, housing, and prevention services. Questions were related to the past 12 months of service. Distribution of the survey was facilitated by the 14 consortia lead agencies throughout Florida. A sample size for each county was calculated based on the number of

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3.5.3 Priorities

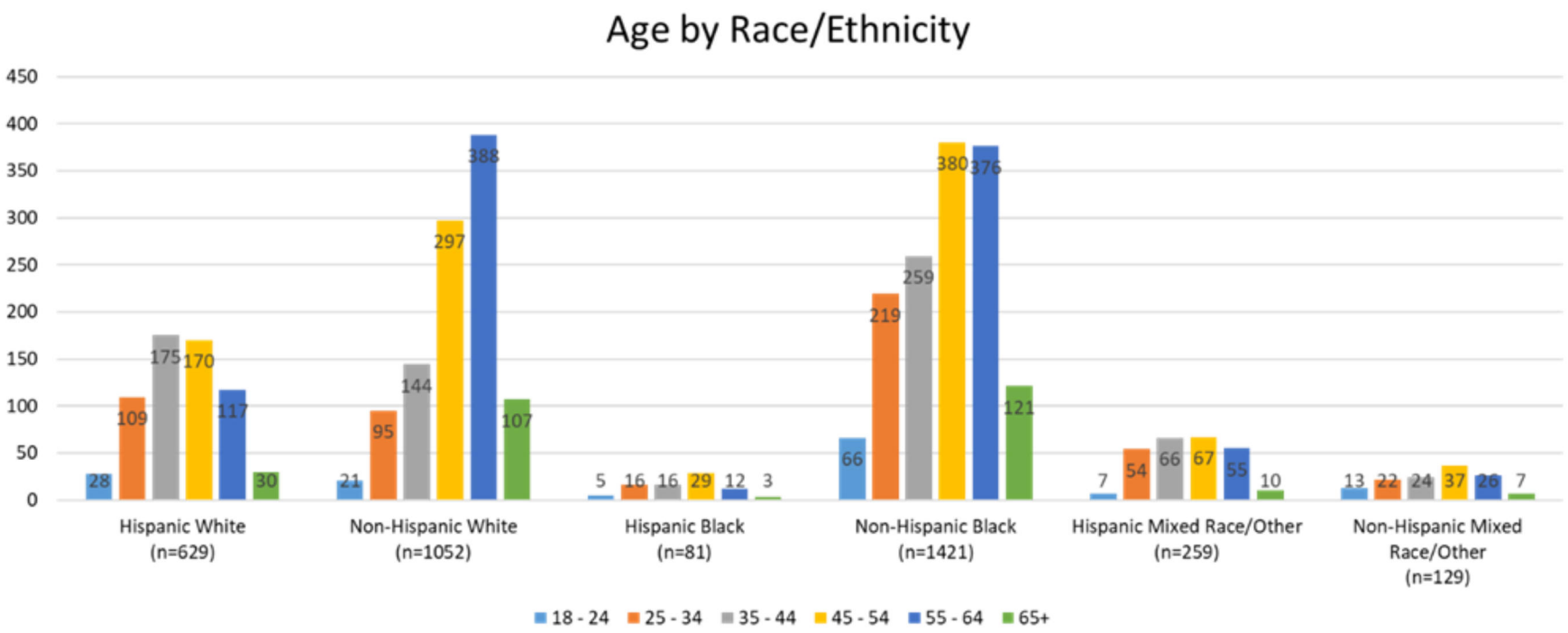
The needs assessment process identified the following key priority areas: Demographics, HIV Medical Care, Patient Care Services, Jail and Prison Release Services, and Housing.

Demographics Summary

Appropriate sample sizes for each county were calculated based on the number of PWH. Each county was provided the minimum number of surveys to be sent to reach 25% of total PWH at a 10% response rate. The five counties with the most survey respondents were Miami-Dade, Hillsborough, Pinellas, Brevard, and Duval. Most counties met their quotas, but 13 did not. The three counties with highest unmet quotas were Broward, Palm Beach, and Orange.

Overall, most survey respondents fell into two age groups: 55 to 64 years old and 45 to 54 years old. Stratified by race/ethnicity (see Figure 15), this trend held true for those who identified as non-Hispanic White, non-Hispanic Black, and non-Hispanic multiracial/other. However, for those who identified as Hispanic White, Hispanic Black, and Hispanic multiracial/other, the trend showed that most fell into the 35 to 44 years old and 45 to 54 years old categories as seen in Figure 15.

FIGURE 15: HIV CARE NEEDS SURVEY RESPONDENTS (PWH) BY AGE AND RACE/ETHNICITY

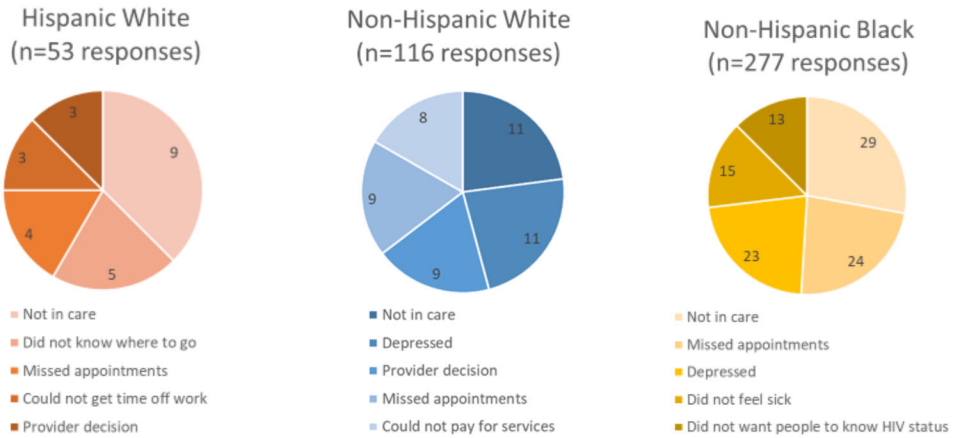


Most survey respondents reported working a full-time job for the past 12 months. The second largest group reported not being able to work due to disability. Approximately half of respondents reported that their 2018 household gross income (before taxes) was less than $15,000 and roughly one-third reported incomes that were between $15,000 and $30,000. Stratified by race/ethnicity, most of those categorized as earning less than $15,000 and those earning between $15,000 and $30,000 were non-Hispanic Black. Most of those categorized as earning between $30,000 and $50,000, between $50,000 and $100,000, and more than $100,000 were non-Hispanic White.

HIV Medical Care Summary

Most survey respondents reported that they had seen a doctor about their HIV during the past 12 months. When asked about the frequency of HIV-related care, most reported receiving care two or three times during the past 12 months. For respondents who reported that they had not received HIV-related care or had received care fewer than two times in the past year, the most common reasons overall were that they were not in care, were depressed, or missed their appointments, as shown in Figure 16. When stratified by race/ethnicity, the most common reason given by Hispanic White, non-Hispanic White, and non-Hispanic Black persons remained that they were not in care. The second and third most common reasons given by Hispanic White persons were not knowing where to go and missing their appointments, respectively. For non-Hispanic White persons, the second and third most common reasons were that they were depressed and that this was their provider's decision, respectively. For non-Hispanic Black persons, the second and third most common reasons were that they missed their appointments and were depressed, respectively. The total numbers of responses from those who identify as Hispanic Black, Hispanic multiracial/other, and non-Hispanic multiracial/other about reasons for not receiving care were very low (8, 31, and 8, respectively).

FIGURE 16: TOP 5 REASONS RESPONDENTS HAD NOT BEEN IN CARE BY RACE/ETHNICITY



*Hispanic Black, Hispanic Multiracial/Other, and Non-Hispanic Mutliracial/Other not shown due to low number of responses.

The overwhelming majority of survey respondents received HIV-related medical care in the county where they live. For the small number of respondents who received care in a different county from where they live, the most common reasons given were that doctors or services were not available in their county of residence, preference and better doctors in a different county, continuity of care with an established provider, convenience and closer to home, and confidentiality.

Most survey respondents reported that they always take their HIV medications just as their doctor prescribed them. For those who reported that they did not always take their medications as prescribed, the reasons given included that the medication made them feel bad or sick, they could not afford the cost, they were on a medication break as directed by their physician, they did not know where to get medication, and forgetting.

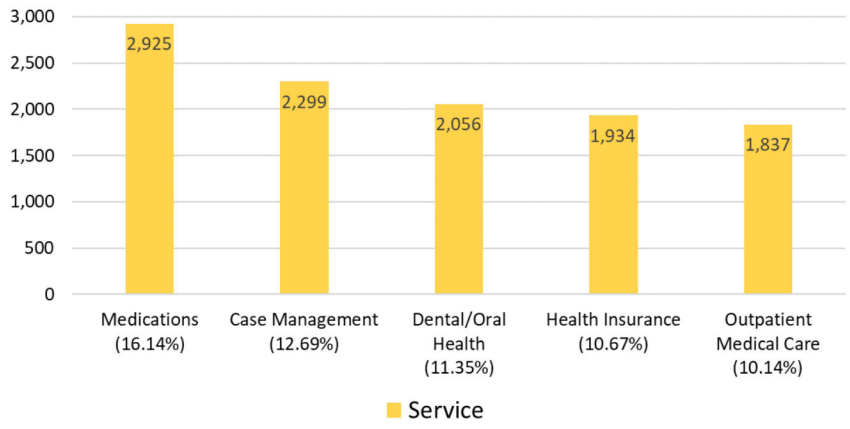
Patient Care Services Summary

Most survey respondents reported that they did get the patient care services they needed during the past 12 months. For those who did not get needed services, the five most common barriers listed were not knowing where to get services, being depressed, not having transportation, not being able to pay for services, and missing appointment(s). When stratified by race/ethnicity, the most common barrier listed for all race/ethnicity categories (except Hispanic Black persons) was not knowing where to get services. The top barrier to care for Hispanic Black persons was depression.

As shown in Figure 17, the top five patient care services deemed by respondents as most important for the state to provide for PWH were (in order of priority):

1. Medications
2. Case management
3. Dental and oral health
4. Health insurance
5. Outpatient medical care

FIGURE 17: TOP FIVE PATIENT CARE SERVICES MOST IMPORTANT TO SURVEY RESPONDENTS

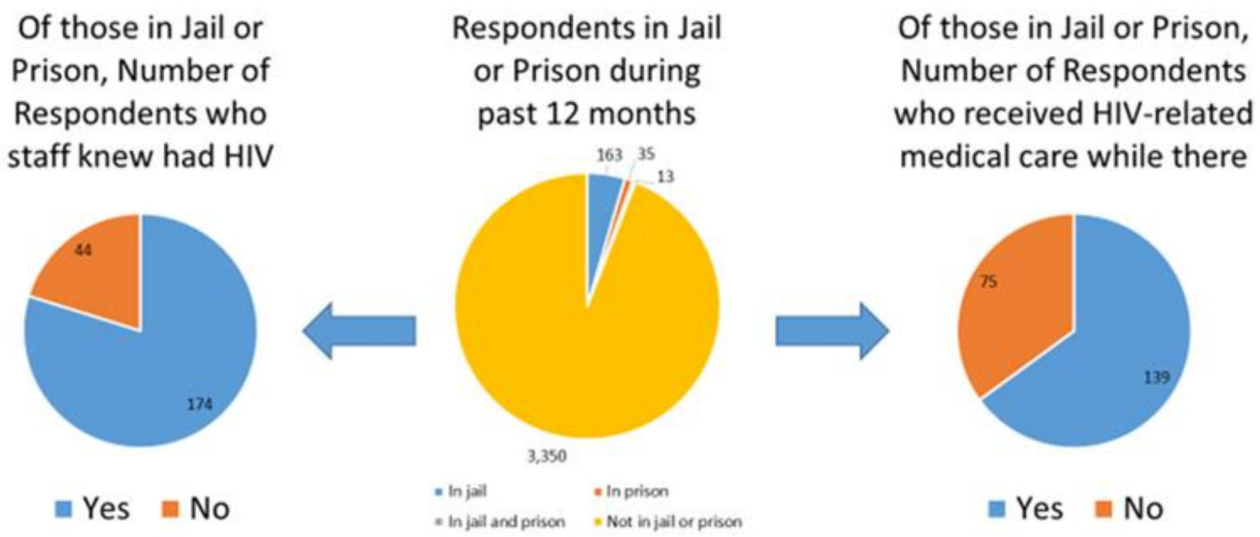


When stratified by race/ethnicity, the top two services reported by respondents as most important remained medications and case management across all race/ethnicity categories, but the priorities for dental and oral health, health insurance, and outpatient medical care were ranked differently (though they remained in the top five).

Jail and Prison Release Services Summary

The overwhelming majority of survey respondents reported that they had not been in jail or prison during the past 12 months as shown in Figure 18. Of the 211 who reported having been incarcerated (5.9% of all respondents), 82.5% reported that the jail or prison staff knew of their HIV status and most (65.9%) reported that they did receive HIV-related medical care. Upon release from jail/prison, 40.3% of respondents reported that they did not receive any HIV-related information or assistance. Of those who did receive care and assistance, 29.4% received a supply of HIV medication to take with them, 24.2% received referral to medical care, 22.3% received referral to case management, and 10.9% received information about finding housing.

FIGURE 18: SURVEY RESPONDENTS IN JAIL AND PRISON DURING THE PAST 12 MONTHS AND WHETHER SERVICES WERE RECEIVED WHILE INCARCERATED



Of the 240 respondents who answered the question about barriers to getting needed HIV services after release from jail or prison, most (59.6%) indicated that this question did not apply to them because they did get needed services. For those who experienced barriers to care, the most frequent barriers reported were:

- No insurance or financial reasons.
- No transportation to services.
- Did not know where to go for services.
- Could not get away from drugs.
- Had trouble finding trustworthy friends.

- Did not want others to know of their HIV status

Housing Summary

Overall, survey responses indicated that most respondents did not experience barriers to HIV-related care due to their current housing situation as shown in Table 8. Of those who did experience housing-related barriers, the top three barriers were not having money to pay rent, being afraid of others knowing their HIV status, and not having enough food to eat. When stratified by race/ethnicity, barriers varied in rank, but the top three barriers from the overall responses consistently remained in the top three across race/ethnicity categories.

TABLE 8: HIV HOUSING SERVICES RESPONDENTS NEEDED OR RECEIVED IN THE PAST 6 MONTHS

	Received Needed Services		Needed Service, But Could Not Get Service		Needed Service, But Did Not Know About Service		Did Not Need Service		Total Responses
	Count	Row %	Count	Row %	Count	Row %	Count	Row %	Count
Help finding an affordable place to live	357	11.26%	345	10.88%	303	9.56%	2,165	68.30%	3,170
Permanent, independent housing	258	8.62%	312	10.42%	266	8.88%	2,158	72.08%	2,994
Temporary short-term housing	141	4.91%	181	6.30%	152	5.29%	2,397	83.49%	2,871
Housing where my child(ren) can live with me	108	3.80%	69	2.43%	98	3.45%	2,567	90.32%	2,842
Nursing home	81	2.88%	48	1.71%	53	1.88%	2,633	93.53%	2,815
Money to pay utilities	281	9.49%	289	9.76%	319	10.78%	2,071	69.97%	2,960
Money to pay rent/mortgage	304	10.20%	319	10.70%	343	11.51%	2,015	67.59%	2,981
Housing for persons living with HIV	174	5.91%	249	8.46%	237	8.05%	2,285	77.59%	2,945
Assisted living facility	99	3.49%	82	2.89%	91	3.20%	2,568	90.42%	2,840
Column Totals	1,803		1,894		1,862		20,859		26,418

	Received Needed Services		Needed Service, But Could Not Get Service		Needed Service, But Did Not Know About Service		Did Not Need Service		Total Responses
% of Overall Total	6.82%		7.17%		7.05%		78.96%		100.00%

Overall, most survey responses indicated that respondents did not need any of the available housing services offered through Florida's HIV/AIDS Patient Care Program. For those who were in need, the services most frequently reported as being received, needed but unable to get, or needed but unaware of where to get (approximately 30% of all the survey responses given for each of the following services) were:

- Help finding an affordable place to live.
- Money to pay rent or mortgage.
- Money to pay utilities.
- Permanent, independent housing.

Between 65% and 70% of respondents in need of these services either could not get them or did not know about them. When stratified by race/ethnicity, non-Hispanic Black persons represented the largest number of responses across the board for all services respondents needed but could not get. This same trend held true for all services respondents needed but did not know about.

Overall, for those who needed services, most survey responses (approximately 60%) indicated that respondents did not experience barriers to getting needed housing services and were able to get them. But a sizeable proportion of responses (nearly 40%) indicated barriers to getting needed housing services. The top three barriers reported were that the respondent:

1. Did not know where to get services.
2. Did not qualify for services.
3. Was put on a waiting list.

3.5.4 Actions Taken

The following recommendations were developed to identify key activities to address needs and barriers of the key priority areas:

Demographics Recommendations

It is of concern that the three counties with the largest unmet survey quotas are also three of the counties that have high prevalence of PWH. Collectively, those counties were 603 surveys below quota. Given that this represents 20.6% of the total number of surveys needed to meet quota, it may present a significant deficit of information that is important to consider regarding allocation of resources for HIV

care and services. Going forward, planning for increased staffing and concentrated efforts ahead of survey implementation may help mitigate unmet quotas in counties with high prevalence of PWH.

If survey results are representative of PWH in Florida, they indicate that most are non-Hispanic Black males between the ages of 45 and 64 who have fulltime employment but are living below the poverty level. This highlights the continued disparities minorities face and the economic disadvantage of populations most affected by HIV. Giving priority to this priority population for outreach, staffing, and resources may be warranted to promote diverse community wellness.

With the development and release of the 2022 HIV Care Needs Survey and Needs Assessment Toolkit in October, Florida hopes to increase the number of surveys completed by PWH.

HIV Prevention

One of the priorities for the Department's HIV/AIDS Section is the development of a comprehensive HIV prevention needs assessment through surveys administered to and through HIP providers to address services provision (PrEP, HIV testing, Test & Treat, harm-reduction needs) for persons at risk for HIV. Other entities to be included in the needs assessment include CHDs and operational syringe services programs (SSPs). The Department hopes to accomplish this in 2023.

Policy Barriers

Currently, Florida laws do not present barriers to HIV prevention or patient care services. Minor limitations exist in state laws allowing for syringe exchange programs and include prohibitions on using state, county, or municipal funds to support the operation of the program and permitting a one-to-one exchange of syringes. Florida is also a Medicaid non-expansion state and this may have implications for HIV-related service coverage levels for persons who are eligible for Medicaid.

HIV Medical Care Recommendations

The top reasons given for not receiving care or receiving less frequent care were missed appointments and not in care. To ensure that all PWH in Florida receive the appropriate frequency of HIV-related care, it may be necessary to determine why they were not in care and why they missed appointments. Depression was another top reason given for not receiving care. This points to the importance of educating care providers to be aware of potential mental health and HIV comorbidities and the possible need to implement a protocol for mental health screening along with HIV care visits. To best address these needs and allocate resources appropriately, detailed attention to the top reasons for not receiving care in race/ethnicity categories may be helpful.

In counties where providers and services for HIV-related care are not available, the magnitude of those affected should be investigated and solutions to this problem should be explored. The desire for confidentiality was reported as a reason for seeking HIV-related care in a county other than the

respondent's county of residence. More efforts are needed to address HIV stigma and normalize HIV prevention and care seeking behaviors.

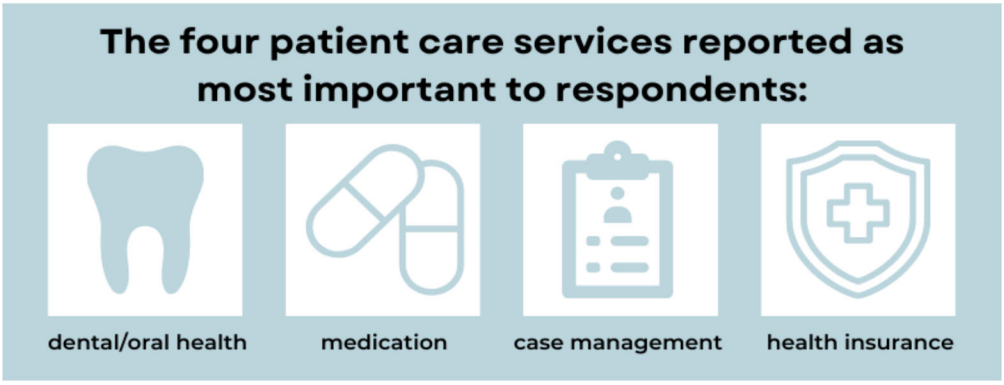
Because HIV medications, when taken as prescribed, are highly effective in attaining VLs that are undetectable and therefore not transmittable, it is imperative that all PWH receive appropriate medication and take it as directed by their physician. It is encouraging that most survey respondents reported that they always take their medications just as prescribed. However, even though the number of those who reported noncompliance with taking their medications is low (12.9%), other personal or biological issues may hinder persons from achieving sustained viral suppression. Reasons given by respondents for not taking medications as prescribed should be investigated further, and solutions or services should be found to overcome these barriers.

Patient Care Services Recommendations

Although most respondents received patient care services they needed, a large proportion (43.4%) did not. Barriers to care centered mostly around logistics, depression, and personal finances. To address logistics and personal finance barriers, allocating more resources for outreach and public information campaigns providing awareness of available HIV/AIDS services for those with low or no income may be helpful. Regarding depression, again we stress the importance of educating care providers to be aware of potential mental health and HIV comorbidities and the possible need to implement a protocol for mental health screening along with HIV care visits. Stigma may prevent persons with HIV from seeking mental health services. Additionally, partnering and finding more accessible mental health service providers is key.

As seen in Figure 19, of the four patient care services reported as most important to respondents, (1) dental and oral health, (2) medication, (3) case management, and (4) health insurance was also high on the list of needed services that respondents reported they could not get or did not know about. This is an area of concern; further investigation into this issue is warranted.

FIGURE 19: PATIENT CARE SERVICES



Jail and Prison Release Services Recommendations

Based on survey responses, the HIV status of 17.5% of those respondents who were incarcerated was not known to jail or prison staff. In addition, 34.1% of those incarcerated did not receive HIV-related medical care while in jail or prison, and 40.3% did not receive HIV-related information or assistance upon release. These numbers represent care intervention opportunities lost. Improvement for collaboration with jail and prison systems to improve continuity of HIV care and post-release accessibility is needed.

Housing Recommendations

Overall, survey results show that most respondents did not need housing services. This is likely a limitation of the persons who responded to the needs assessment. An opportunity could be to ensure that there is a separate avenue with HOPWA to address this in the future. Most who did need services did not experience barriers to getting these services, nor did they experience barriers to taking care of their HIV that were related to their current housing situation. But for those who needed housing services, most centered around needing help to find housing and help to pay for housing and utilities. Because needed housing services for a sizeable proportion of survey respondents were unmet, with the race/ethnicity category most represented in this proportion being non-Hispanic Black, further investigation focusing on this disparity is warranted.

Lastly, the most frequently reported barriers to getting needed housing services reveal distinctly different issues. The most common barrier was not knowing where to get services, which may indicate that public awareness campaigns for this may be needed. Florida does have a HOPWA campaign (Housing for Better Health-Assistance for Persons with HIV/AIDS in Florida); however, its effectiveness and reach may need to be evaluated. The second most common barrier was that respondents did not qualify for services. This may indicate a disconnect between actual need and the program criteria currently in place to determine need. The third most common barrier to getting housing services was that the respondent was put on the waiting list. Causes for this may include limited housing availability and resources and a need for more staffing to process housing services.

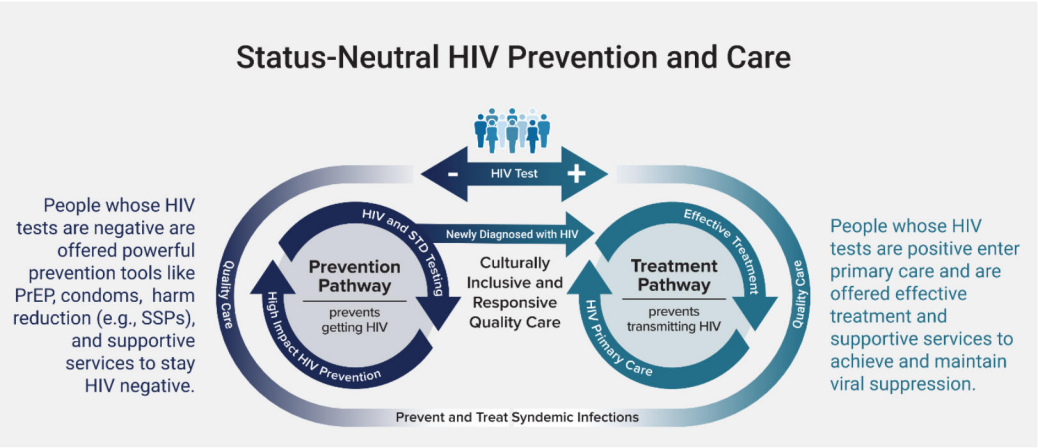
4 Situational Analysis

Florida is one of the most culturally diverse states in the nation with a vast array of residents from a wide variety of ethnic, racial, national, and religious backgrounds. The state has long attracted immigrants, particularly from Cuba, Haiti, Colombia, Venezuela, and Mexico. In fact, almost 21% of Florida's population are foreign-born persons (US Census Data - Quick Facts - Florida, 2021). With this diversity comes a higher incidence of disease burden from those in the emerging racial/ethnic minority populations from rural, socio-economically disadvantaged, and medically underserved backgrounds.

Florida continues to implement the best strategies to build a path to improve HIV prevention and care access, specifically among racial/ethnic minorities and other underserved groups. Specific demographics of racial and ethnic minorities and communities experience more barriers to accessing prevention and care services. For persons who are already diagnosed and living with HIV in Florida, activities centering around access to HIV care, including ART, retention in HIV care, and viral suppression, should be focused on such priority populations, including: Black heterosexual individuals (with added focus on Black WCBA), gay and bisexual males of all races/ethnicities, and transgender individuals of all races/ethnicities.

To further move the needle in reducing new HIV diagnoses in Florida, the Department's HIV/AIDS Section is proposing several high-impact initiatives based on the status-neutral approach to HIV prevention and care. The HIV status-neutral approach to reducing new HIV diagnoses involves initial HIV testing services as the entry point to HIV prevention and care services irrespective of a positive or negative test result. See Figure 20.

FIGURE 20: STATUS-NEUTRAL APPROACH TO HIV PREVENTION AND CARE



Source: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf

The strategies proposed include:

1. Statewide expansion of routine HIV, HCV and syphilis screening in hospitals, emergency departments and other health care settings.
2. Increasing PrEP and PEP awareness and uptake.
3. Expansion and awareness of rapid antiretroviral therapy (ART) starts, i.e., Test and Treat.
4. Improving stigma, social determinants of health through awareness and education.
5. Improving health outcomes in aging populations with HIV.

To implement HIV prevention and care services based on the status-neutral approach, Florida will employ the initiatives and strategies which align with the EHE pillars below. The information below also highlights the strengths, challenges, and identified needs related to HIV prevention and care in Florida, the subsequent sections describe each of the following areas:

- DIAGNOSE all people with HIV as Early as Possible (Section 4.1)
- TREAT people with HIV rapidly and effectively to reach sustained viral suppression (Section 4.2)
- PREVENT new HIV transmissions by using proven interventions, including PrEP, and SSP (Section 4.3)
- RESPOND quickly to potential HIV outbreaks to get prevention and treatment services to people who need them (Section 4.4)
- Priority populations (Section 4.5)

4.1 DIAGNOSE People with HIV as Early as Possible

Routine HIV, STI, and HCV 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, Rule 64D-2.004, Florida Administrative Code (FAC), 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 the CDC's HIV Screening Recommendations.[44]

Since 2015, the Department, including CHDs, has developed a collaborative model for routine communicable disease screening with the Gilead Sciences' Frontlines of Communities in The United States (FOCUS) initiative. The FOCUS program is a public health initiative that enables partners to develop and share best practices in routine blood-borne virus (HIV, HCV, HBV) screening, diagnosis, and linkage to care in accordance with screening guidelines promulgated by CDC, the U.S. Preventive Services Task Force (USPSTF), and state and local public health departments. FOCUS funding supports HIV, HCV, and HBV screening and linkage to the first appointment after diagnosis. FOCUS partners do not use FOCUS awards for activities beyond linkage to the first appointment.

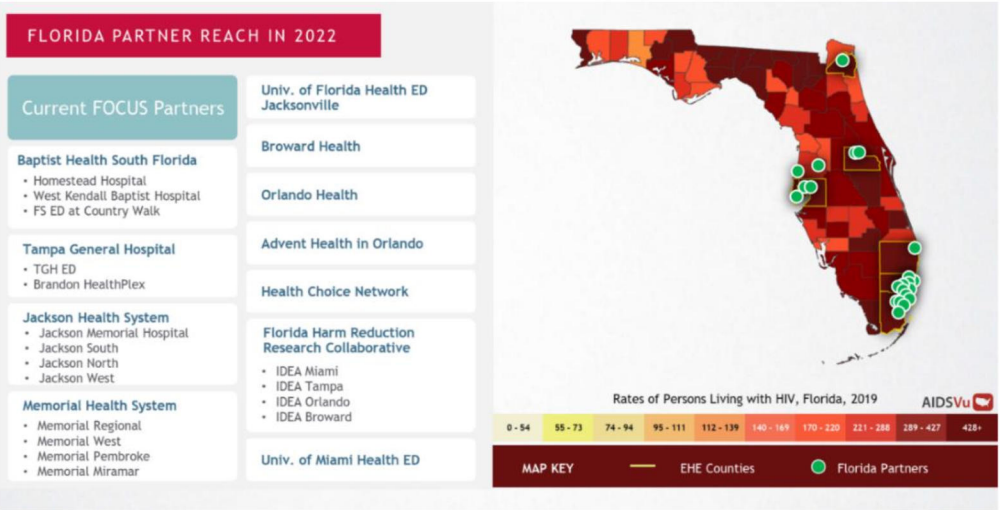
Florida FOCUS partners include FQHCs and large hospital systems. The Department's public-private partnership with Gilead's FOCUS initiative began in 2016 with the establishment of the very first site—Homestead Hospital in Miami-Dade County. A Department DIS or Linkage to Care Coordinator works with each FOCUS emergency department partnership to assist with linkage to care and other services. The partnership with Homestead was expanded to include syphilis screening and the Department supports the cost of these screenings.

Currently, the Florida FOCUS program has 22 partners across the state (see map in Figure 21) and in 2021, institutions that have implemented the FOCUS program conducted 156,288 HIV tests (1.2% positivity), with 86% linked to care. Additionally, 74,910 HCV tests (4.6% HCV Ab positivity) were conducted and 75% linked to care. In 2022, Florida FOCUS projects plan to complete 187,000 HIV tests and 104,500 HCV tests and commits to onboard facilities to also conduct syphilis testing.

There is no monetary relationship between the Department and Gilead Sciences and as the partners age out of their relationship with Gilead, the Department has developed a cost-sharing model to continue to support testing and linkage to care at these sites by assisting with the costs of testing and reagents.

Current efforts to support expansion include the inclusion of this initiative as an objective in the State Health Improvement Plan where, by December 31, 2026, the Department and external partners aim to increase the number of emergency room or acute care hospitals that are conducting opt-out HIV screening, routine HCV screening, and syphilis testing with a smart screen algorithm from 1 (2021) to 15. Figure 21 visualizes 2022 partner reach for the state of Florida.

FIGURE 21: FLORIDA PARTNER REACH IN 2022



Gaps still exist in the implementation of routine HIV, STI, and HCV testing in hospital emergency departments (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. Approximately 7 in 10 PWH saw

a health care provider in the 12 months prior to diagnosis and failed to be diagnosed.[59] Additionally, reimbursement by Medicaid for HIV testing in hospital EDs is a challenge as we move forward with routinizing testing in EDs; in some cases, testing may not be covered unless deemed medically necessary or clinicians may be less likely to bill when they frequently receive rejections.

From June 2019 to April 2020, 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 a quarter (20%) 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% reported that they test patients based on symptoms and demographics and 30% reported testing only those who requested an HIV test. Among barriers to rapid HIV testing, most practices indicated that they never considered rapid HIV testing as a service (30%). Other barriers to providing rapid HIV testing were the perceived need to obtain consent, staff lacking training for administering and billing, the concern that testing would not be reimbursed by payors, and uncertainty about the implementation of in-office rapid testing.

To eliminate these barriers, the Department has done or will do the following:

- Conducted a Routine Screening Expansion Roundtable, which took place May 26, 2022. The purpose of this meeting, hosted by the Lieutenant Governor, was to bring together a wide variety of external stakeholders to discuss how to expand routine opt-out HIV, syphilis, and HCV screenings in EDs and acute care settings and move toward ending these syndemics in Florida.
- Update Chapter 64D-3, FAC, to include the mandatory reporting of all HIV test results. 64D-3 is titled “Control of Communicable Diseases and Conditions which may Significantly Affect Public Health”. Currently, providers and laboratories are required to report only positive HIV test results to the Department.
    1. Improve the reporting and surveillance of stage zero or acute diagnoses to understand the burden of recent transmission for intervention and prevention.
    2. Understand the scope and total HIV testing being conducted in Florida and calculate a state positivity rate that can be used to drive future interventions and prevention efforts.
- Conduct an assessment on current Florida FOCUS partners to understand who is aging out of the program, and when, and use current funding to support testing and linkage to care efforts.
- Work with directly funded RWHAP Part A programs in the six metropolitan areas of the state to collaborate on supporting routine screening efforts in those areas.
- Collaborate with AHCA to develop a Dear Colleague letter from Medicaid to clarify reimbursement support for routine HIV and HCV screening in hospital EDs.

- Explore leveraging Opioid Settlement Funds to help support the expansion of medication-assisted treatment pathways in hospitals.

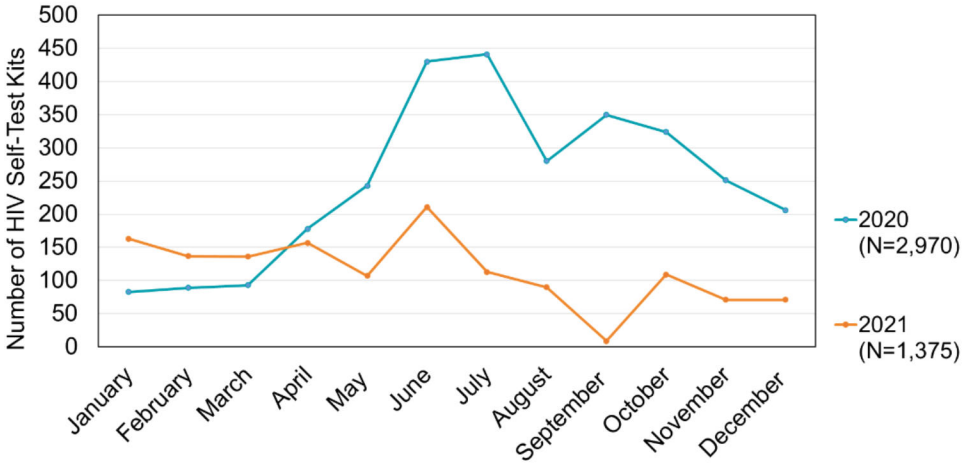
In addition to the FOCUS program, the HIV/AIDS Section also has a contract funded through federal grants with the University of Central Florida HealthARCH program that aims to assess the readiness of health systems in the seven metropolitan counties of high-HIV burden and onboard them to modify their electronic health records and offer routines screening for HIV.

Rapid HIV Testing through Non-Traditional Settings and Modalities

Considering Florida's percentage of PWH unaware of their status (14%), increased access to rapid HIV testing is required. Feedback received through community engagement indicated a need for expanded use of mobile testing units, HIV self-test kits, social and sexual network screening, and testing at non-traditional settings and hours. The Department currently supports more than 1,600 registered HIV testing sites around the state that conduct targeted HIV testing in non-health care settings in areas and communities with high HIV incidence. The Department supports these sites with rapid HIV test kits at no cost to the site. Sites must register with the Department and submit HIV testing data as criteria to receive rapid HIV test kits. In 2021, the Department conducted 73 rapid test trainings and certified 1,032 individuals to perform rapid HIV testing. The Department will continue to conduct rapid HIV testing trainings to certify individuals to perform rapid HIV testing in non-health care settings.

In June 2019, the Department began an HIV self-test kit distribution program to provide rapid HIV self-test kits to individuals, at no cost, and through an online request form (available at KnowYourHIVStatus.com). This program was particularly important as COVID-19 closures and restrictions fueled increases in the demand for alternative options for HIV testing. As shown in Figure 22, monthly requests for HIV self-test kits rose sharply beginning in April 2020 and continued through July 2020. Monthly requests tapered slightly from September through December 2020. In 2021, monthly requests for HIV self-test kits decreased but are still higher than pre-COVID levels. Since the program's inception, more than 4,600 rapid HIV self-test kits have been distributed. The HIV/AIDS Section continues to look for opportunities to collaborate, especially with internal Department partners such as the Bureau of Tobacco Free Florida to advertise the availability of free, in-home testing kits.

FIGURE 22: HIV SELF-TEST KITS DISTRIBUTED THROUGH KNOWYOURHIVSTATUS.COM, FLORIDA, 2020 VS. 2021



Additional funds will be needed to support and sustain the expansion of the 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.

Partner Notification Services

Per section 384.26, F.S., the Department is the only entity authorized to perform HIV and STI partner services and notification, and these activities are carried out by trained 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% annually over the past five years, but also impact the effectiveness of partner elicitation. Numbers of claimed partners have decreased as numbers of anonymous partners reported through mobile dating applications has increased, creating challenges for intervention. In 2017, the Department piloted the use 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. Since summer 2022, the Bureau of Communicable Diseases has been working to secure approval to allow for text messaging by the DIS workforce as a tool to initiate confidential first contact with clients and enable DIS to conduct partner services for STI/HIV partner notification.

Florida is unique in that there are now four qualified staff to teach the week-long Passport to Partner Services training. In 2022, the STD Section will enter a contract with the University of South Florida to establish a learning academy and completely revamp the existing core training curriculum for DIS and STD program supervisors.

Billing and Reimbursement

In April 2013, the USPSTF gave routine HIV screening of all adolescents and adults, ages 15 to 65, an "A" rating, aligning the rating with the CDC's HIV screening guidelines. The "A" rating has further implications given the ACA, which requires or incentivizes new private health plans, Medicare, and Medicaid to provide preventive services rated "A" or "B" at no cost to patients. Challenges exist with reimbursement by Medicaid for routine HIV screening in hospital EDs and some facilities report only being able to reimburse for those tests deemed medically necessary. As the state moves forward with expanding routine HIV screening in hospital EDs, more work is needed to ensure these facilities have the ability to bill and receive reimbursements from Medicaid for these screenings.

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

Stigma

Stigma around HIV affects health care-seeking behavior. Stigma related to HIV/STI screening can occasionally 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 (i.e., explanation of benefits). Fear of disclosure of confidential health information can deter youths and adults from seeking out HIV/STI screening and PrEP services. 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 integration of HIV testing locations with other health care services and screenings to minimize stigma.

The MMP surveillance system also conducts a self-reported survey to understand the various types of stigmas PWH have experienced, including anticipated, enacted, and internalized HIV-related stigma using a 10-item scale ranging from 0 (no stigma) to 100 (high stigma) that measures four dimensions of HIV stigma: personalized stigma since HIV diagnosis, current disclosure concerns, current negative self-image, and current perceived public attitudes about people living with HIV. Analysis of the 2015–2020 Florida MMP data found that females (n=44) reported experiencing a higher level of stigma compared to males (n=32). Additionally, thirty-nine (n=39) transgender individuals reported experiencing stigma.

Thirty-seven (n=37) Black persons reported experiencing HIV-related stigma, compared to White (n=32) and/or Latino (n=32) survey respondents.

Thirty-eight (n=38) heterosexual people reported experiencing HIV-related stigma, compared to bisexual survey respondents (n=36).

Lastly, it was found that those ages 18–29 experienced a higher level of stigma (n=43) than ages 40–49 (n=36), and ages 30–39 (n=35). It was also found that ages 50 and higher experienced the lowest level of stigma (n=32).

Findings from a Department project with the University of Florida [43] (a Bayesian spatial-temporal analysis of racial disparities in HIV clinical outcomes and a pilot stigma intervention protocol for people living with HIV in Florida) indicate that disparities in immune restoration and viral suppression vary by county. Identification of counties where these disparities are most severe provides useful information for the Department and other decision makers to reduce racial disparities in HIV clinical outcomes by implementing targeted interventions, with the ultimate objective of achieving HIV elimination goals in Florida. Stigma remains a key barrier to care engagement and ultimately achieving viral suppression and immune restoration. The preliminary work in this project outlines the development and validation of an updated measure of stigma, which could be implemented to better monitor stigma and its impacts, and an intervention to improve patient-provider communication about HIV-related stigma. The intervention was generally well received by participants and several potential routes of dissemination were identified.

4.2 TREAT People with HIV Rapidly and Effectively to Reach Sustained Viral Suppression

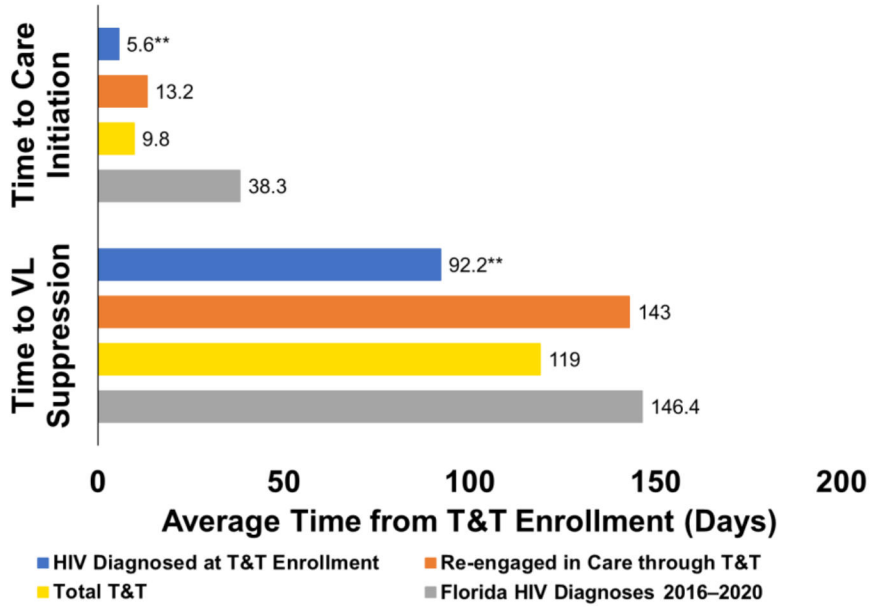
Access and adherence to HIV treatment is important to promote optimal health outcomes for PWH and harnessing the benefits of "treatment as prevention"—when someone takes their HIV medications as prescribed and the amount of HIV in the body is kept at such a low level, they reach viral suppression. Those virally suppressed essentially have no risk of sexually transmitting HIV to others. Treating PWH rapidly after diagnosis will help PWH to achieve and maintain viral suppression, which is part of the current HIV treatment guidelines and is a major pillar in EHE. According to the CDC, approximately 80% of new HIV transmissions occurring annually are from persons who are not receiving HIV-related care and medications. One issue is that the availability of treatments is not evenly accessible or distributed, compounding health disparities and the social determinants of health that fuel further transmission of HIV in the community. This represents a need for expanded access points, hours of operation (to include non-traditional hours and locations) and telehealth capabilities to reach persons with transport or other access issues. Other challenges exist around identifying and re-engaging PWH who are not in care to ensure medical adherence and viral suppression. All areas of the state have dedicated the Department's linkage staff to not only link persons newly diagnosed with HIV but also identify PWH currently not in care and reengage them into HIV care and treatment.

Test and Treat Program and Rapid Access to ART

Since 2016, Florida has had a robust rapid access to ART program called Test and Treat (T&T). This program offers patients newly diagnosed 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 ART, combined with a support system of retention-in-care specialists, to reduce barriers to care engagement. In this

expedited "red-carpet" scenario, PWH have immediate access to a medical provider who can start them on ARV (antiretroviral) medications immediately. T&T has assisted in engaging individuals in care at a much faster rate than those not diagnosed through the program. Since the program's inception, Florida's T&T program has enrolled more than 7,374 clients statewide (comprising of 3,342 newly diagnosed individuals and 4,032 previously diagnosed individuals returning to care). Compared to persons diagnosed in Florida who are not enrolled in T&T (see Figure 23), it takes on average 38.3 days to initiate treatment compared to 5.6 days for those newly diagnosed through T&T. Furthermore, the average time to achieve viral suppression is much lower for those who initiate treatment rapidly through T&T—92.2 days compared to 146.4 days for those not engaged in T&T. Wider expansion and adoption of this strategy is needed to impact linkage, retention, and VL suppression rates. Almost all of Florida's 67 counties have a 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 expanded 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.

FIGURE 23: TIME FROM T&T ENROLLMENT TO CARE INITIATION AND VL SUPPRESSION, MARCH 2016–DECEMBER 2020, FLORIDA



Below are activities that can help overcome the challenges related to T&T:

- Address gaps in the level of knowledge about the RWHAP system of care among non-RWHAP network health care providers. More education and training are needed for providers on the services available to clients (including ADAP), eligibility requirements, and access points in their service regions.

- Address the need for more training and resources for health care providers related to trauma-informed care (TIC) and intersectionality. Past and current traumatic experiences have an impact on whether a person acquires HIV, is diagnosed, is linked to care, is retained, and maintains viral suppression. Because HIV disproportionately impacts marginalized communities, it is important to consider intersectionality in concert with TIC.

- 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. Examples of social categorizations that inform identity include race/ethnicity, class, gender, sexual orientation, poverty and homelessness, and substance use.

Housing

Many Floridians experience homelessness or unstable housing, which presents a barrier to wellness for PWH 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. Florida's Council on Homelessness annual report showed that prior to the emergence of the COVID-19 pandemic, homelessness in Florida has declined steadily from 57,551 identified as homeless in January 2010 to 28,328 in January 2020—a 50.8% reduction in homelessness over the last 10 years. In 2021, the Florida Housing Coalition reported Florida having the third-highest homeless population of any state in the nation, with 27,640 people living in homeless shelters and on the streets. It is important to consider the spectrum of housing instability for PWH—traditional definitions of homelessness or unstable housing—but also takes into account situations where individuals and families are residing in temporary residences (e.g., motels), staying with friends or family, or "couch-surfing." While the federal Fair Housing Act makes it illegal to discriminate against PWH in the provision of housing, consumers frequently cite discrimination, fear of disclosure, and stigma as barriers to safe and affordable housing.[35]

To meet the housing needs of low-income PWH and their families, the Department administers the HOPWA program. The HOPWA program is a federally-funded initiative through HUD that helps people with HIV/AIDS maintain stable housing and have access to treatment and support services—which can all lead to better health. In Florida, through the State HOPWA Program, 11 regional agencies and 6 cities deliver HOPWA-funded housing services. In addition to the state HOPWA Program, there are 6 non-state funded city HOPWA programs administered locally.

The Department oversees the state HOPWA program and contracts with local community organizations and CHDs as project sponsors to provide HOPWA services in 11 Ryan White Part B consortium geographical areas and six cities throughout the state. Six non-state funded cities redesignate their funds to the state for distribution and fund management by the state HOPWA program. However, the re-designated funds are to be spent in the Eligible Metropolitan Statistical Areas (EMSAs) on housing services in those areas, not the state at large. These cities (counties) include City of Palm Bay (Brevard), City of Cape Coral (Lee), City of Lakeland (Polk), City of Sarasota (Sarasota), City of Port Saint Lucie, (Saint Lucie), and City of Deltona (Volusia).

Additionally, six cities or EMSAs receive and retain management of HOPWA funds they receive directly from HUD; the Department does not manage the HOPWA programs for Jacksonville, Tampa, Orlando, West Palm Beach, Fort Lauderdale, and Miami-Dade. The Florida State HOPWA Program serves those areas of the state that do not directly qualify for HOPWA funding. Between 2020 and 2021, over 2,034 individuals received HOPWA services to ensure they could access and maintain a stable living environment for themselves and their immediate families. An assessment of the state's HOPWA program is needed to identify gaps and barriers in order to make changes to the program in 2023.

With EHE funding received directly through HRSA, RWHAP Part A programs are also exploring ways to leverage funds to assist with paying for housing and rental assistance for persons with HIV.

Patient and Peer Navigation

HIV health navigators (both patient and peers) have a positive impact on the health and well-being of people living with HIV. 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. The lived experiences of peers, "near-peers," and community health workers are drivers for meeting the diverse needs of 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. Expanded patient navigation is also needed for HIV-negative partners of PWH seeking services. Florida plans to establish and disseminate a statewide peer certification training program.

People with Co-Occurring HIV and Hepatitis C

The current opioid and crystal methamphetamine epidemics are fueling the number of co-infections. It is estimated that 60 to 90% of people who contracted HIV from intravenous drug use also have HCV.[36] 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 to 12 weeks. ADAP clients living with HCV have access to assistance with HCV treatments. The ADAP formulary was updated in 2017 to include HCV treatments without the need for prior authorizations. Between 2020 and 2021, the ADAP assisted over 650 ADAP clients with access to HCV treatment supported by ADAP. There are opportunities for more 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 Pharmacy Benefits Manager (PBM) for Uninsured or Underinsured ADAP Clients

Clients enrolled in ADAP realize important health benefits. ADAP provides access to U.S. Food and Drug Administration (FDA)-approved medications to low-income individuals with HIV who have limited or no coverage from private insurance, Medicaid, Medicare, or the federally facilitated Marketplace®. About

53% of ADAP clients are uninsured or under-insured and receive medication assistance through the ADAP direct-dispense program. These clients receive assistance with approved ADAP formulary medications directly from the program's contracted pharmacy network. The remaining 47% of ADAP clients obtain access to ADAP formulary medications through supported health insurance plans. These clients are enrolled in the ADAP insurance program and receive assistance with insurance premiums as well as prescription co-pays and deductibles associated with ADAP formulary medications. The ADAP aims to achieve at least 95% of clients who achieve viral suppression regardless of their insurance status. For those in the ADAP insurance program, approximately 97% achieved viral suppression in 2021; however, for those enrolled in the ADAP direct-dispense program, there is a clear disparity with only 89% achieving viral suppression in 2021.

In October 2022, ADAP implemented a PBM network of pharmacies to its uninsured direct-dispense client population. With this initiative, ADAP will increase equity among insured and uninsured clients by providing expanded access to medications through a network of independent pharmacies and commercial chains. The PBM will provide the network of 340B pharmacies and manage the claims using a replenishment model in which direct-dispense clients can access ADAP medications statewide with the main goal of increasing access points and convenience for ADAP clients in Florida. The PBM pharmacy network will ensure access to ADAP formulary medications for enrolled clients served in the direct-dispense in 24 hours. ADAP eligibility files are shared with the contracted PBM entity multiple times throughout the day to ensure newly enrolled clients can access ADAP services during the same day they enroll in the program. The PBM entity will assist clients with their prescriptions by reviewing use data, addressing medication adherence issues, and collaborating with prescribers to resolve incorrect regimens and drug interactions. The PBM entity will also develop and provide training to case managers and health care providers, develop educational materials for providers and clients, and maintain a program information website for providers and clients.

Case Management

Case management plays a critical role in the care coordination of PWH as it assists patients in accessing services, identifying needs, and addressing gaps in services. Case managers also perform important functions such as ensuring rapid access to ART; providing medication samples, where appropriate and feasible; and determining eligibility and enrollment into services. Case manager caseloads are high and continue to increase, impacting the ability to effectively manage complex issues, such as providing medication adherence counseling, helping navigate the health care system, and staying informed and educating PWH on available health care coverage plans. There is a need for additional resources and training to support the case management workforce.

Injectable ART

In May 2021, Florida's ADAP added Cabenuva, the first long-acting injectable antiretroviral to the formulary. Uninsured and insured clients are able to access the medication with coordination between their practitioner's office and a specialty pharmacy. The program provided a series of technical

assistance presentations to providers, staff, and case managers to increase awareness and provide best practices for client adherence. Over 500 ADAP clients have accessed Cabenuva since its addition to the formulary in 2021.

Minority AIDS Initiative (MAI)

As shown in Figure 5 (Section 3.1), Florida continues to experience disparities in HIV diagnoses among adults, despite an annual decrease in the HIV diagnosis rate among Black persons in the past five years. MAI seeks to address the gaps in medical care capacity and increase the accessibility and availability of HIV medical care and related HIV services in minority communities through outreach and education. MAI funds are received from HRSA and are designed to improve linkage and reengagement to comprehensive care and ADAP for low-income racial and ethnic minorities who are living with HIV/AIDS. The Department receives the MAI funding allocation through the state's RWHAP Part B grant and these funds support six community-based providers in Florida counties with the highest HIV incidence. In FY 2021, Florida's funded MAI providers enrolled 1,033 clients, of which 64% were Black and 32% were Hispanic/Latino, a 28% increase from the previous fiscal year which saw 806 clients enrolled, of which 62% were Black and 31% were Hispanic/Latino. Many participants are individuals who had a previous HIV diagnosis but have fallen out of care and have not received care for more than six months. The Department's HIV/AIDS Section will continue to look for ways to strengthen the network of MAI providers with the development and release of the next funding solicitation.

Correctional Settings Initiatives

The Department continues to support treatment and prevention services for incarcerated individuals living with HIV. Persons with HIV in prisons and jails are disproportionately represented compared to the general population. The Department addresses this through the following corrections initiatives: the Pre-Release Planning Program (PRPP), the Peer Education Program (Peer-Ed), and Jail Linkage Programs (JLP). The Department maintains two interagency agreements with the Florida Department of Corrections (FDC) to provide PRPP and Peer-Ed.

JLP is concentrated in the higher populated metropolitan areas in Florida. Fourteen CHDs work to provide services to at-risk inmates and PWH inside the county jails. JLP functions include HIV testing and education in the facility, linkage to care following release from jail, linkage to support services, and follow up with individuals for up to three months following release to ensure medication and treatment adherence. In 2021, approximately 1,755 inmates were tested for HIV, of whom 31 had a positive result.

PRPP provides services to inmates with HIV who are preparing to return to their communities. In 2021, the PRPP provided linkage services to 644 inmates, of whom 305 were linked to care and 160 (52%) kept their appointments upon returning to their community. Recidivism, housing, and transportation are recurring barriers to recently released individuals accessing medical care. In addition, FDC conducts peer education train-the-trainer programs for select inmates at FDC's Central Florida Reception Center and Florida Women's Reception Center (the two largest reception centers in the state). In 2021, 53 inmates completed training to become inmate peer educators and conducted 146 peer-led HIV/STD prevention

and risk-reduction sessions to approximately 5,170 inmates. As a result of the peer education training session, 266 inmates requested an HIV test upon completion.

Expansion of Telehealth

The HIV/AIDS Section began offering telehealth (TH) services in January 2018. The TH program provides on-demand and scheduled PrEP, PEP, same-day or rapid ART and HIV and STD primary care evaluation and treatment visits. The HIV TH service is available to all 67 CHDs. As of May 2021, the Department is averaging over 100 services per month and has provided TH services to 1,604 CHD patients. In 2020, the Department launched a TelePrEP program where patients can access PrEP services through the CHD system via a dedicated telehealth practitioner team. Further credentialing of the HIV TH team of three providers in other CHDs is occurring to allow for these services to be provided by the team. Florida plans to expand and promote the use of telehealth and other new technologies to help alleviate barriers and improve access to HIV prevention and care services.

Insurance Coverage and Affordable Health Care

Florida remains a non-Medicaid expansion state and from 2015 to 2020, an average of 12.7% of people in Florida did not have health insurance coverage (compared to 8.7% for the U.S.).[38] The ACA has 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 and need health care are often forced to make difficult choices based on competing life priorities.

As a Part B grant recipient through the RWHAP HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), the Department administers the ADAP program. Florida ADAP provides FDA-approved medications to low-income PWH between 0 and 100% FPL who have limited or no health coverage from private insurance, Medicaid, or Medicare. ADAP assists with some premiums and with out-of-pocket costs for drugs on the program formulary. Out-of-pocket costs can be deductibles, co-pays, coinsurance, or similar costs for Medicare Part C or D. Health insurance assistance funded through ADAP is part of ADAP, not a separate program. ADAP provides premium assistance for ACA Marketplace® plans for people with HIV whose income is between 75 and 400% of the FPL. The strategy of enrolling these clients in the direct-dispense program is more cost-effective than enrolling them in the insurance program. Clients in the direct-dispense program have access to the RWHAP system of care, which includes access to outpatient ambulatory health services, case management, and other allowable services. ADAP clients enrolled in the direct-dispense program achieved a VL suppression rate of 89%.

In addition, approximately 93% of ADAP clients enrolled in the program for at least six months have undetectable HIV VL, indicating their HIV disease is under control and unlikely to be spread sexually. The ADAP program aims to achieve at least 95% of clients enrolled in the program at least 6 months who achieve viral suppression regardless of their insurance status. For those in the insured program, approximately 98% achieved viral suppression in 2021, however, for those not insured, there is a clear disparity with only 89% achieving viral suppression in 2021. The approach that Florida ADAP takes

constitutes a close working relationship between the ADAP state health office team, Florida's 67 CHDs, and 3 contracted statewide service providers: CVS Caremark for PBM services for ADAP insured clients, Magellan Rx for PBM services for ADAP uninsured and underinsured clients and Broward Regional Health Planning Council for Insurance Benefits Management (IBM) services for clients seeking enrollment and premium assistance with health insurance coverage. The Department's ADAP is operationalized at the CHDs, where ADAP staff assist clients with enrollment by ensuring eligibility determinations and re-certifications. ADAP staff at CHDs use the ADAP database, called Provide, to upload client eligibility documentation. Eligibility files are shared with the contracted PBM and IBM providers multiple times throughout the day to ensure newly enrolled clients can access ADAP services during the same day they enroll in the program. Provide also helps ADAP staff keep track of their client caseload; the system helps identify clients who should be enrolled in the direct-dispense or insurance program based on the information presented during their enrollment. CHD ADAP staff also work closely with the provider community and RWHAP case managers to coordinate efforts with clients to promote medication adherence and retention in care.[16]

Additional Unmet Needs of Persons with HIV

Further work is needed to address the unmet needs of PWH identified through various mechanisms—including needs assessment surveys and Florida's MMP project. The MMP is a surveillance system designed to understand the met and unmet needs of PWH. Among those surveyed in Florida from 2015 to 2020, the most common unmet need was access to dental services (24%), followed by shelter or housing services (14%), SNAP or WIC (12%), and meal or food services (9%). Other unmet needs included mental health services (8%) transportation assistance (8%), HIV case management services (8%), HIV peer group support (6%), medicine through ADAP (4%), and patient navigation services (5%).

4.3 PREVENT New HIV Transmissions by Using Proven Interventions, Including PrEP and Syringe Services Programs (SSPs)

Access to PrEP and PEP

The use of ARV medications to prevent HIV transmission in persons at risk for acquiring HIV is an effective prevention tool. Part of CDC's HIP approach includes PrEP; 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 sero-different relationships, gay and bisexual men who have sexual partners of unknown HIV status, and PWID. As of December 2018, the Department's CHDs in each of Florida's 67 counties 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. Since the launch of the Department's PrEP drug assistance program in 2018 over 11,319 CHD clients have received PrEP medications. Current challenges to PrEP delivery through the CHDs include clinician

and staffing shortages and limited capacity for clinicians in smaller CHDs (e.g., fewer clinicians performing multiple duties in the clinic).

The Department's publicly funded PrEP drug assistance program only accounts for a small portion of all PrEP services statewide. Numerous private-sector partners—including private physicians, FQHCs, community health centers, sexual health clinics, community-based organizations, HIP providers—are screening, prescribing, and maintaining people on PrEP throughout Florida. Also, over the past two years, HRSA has funded approximately 22 FQHCs through their EHE Primary Care HIV Prevention funding opportunity for health centers to expand access to medication to prevent HIV (including PrEP and related services), connect people to care, and ensure care services are well coordinated. According to the latest data available on AIDSVu, Florida has seen an increase in the rate of PrEP users per 100,000 population since 2016; as of 2021, the rate was 226 per 100,000. Florida now ranks third among states and jurisdictions with the highest rate of PrEP users, behind Washington D.C. and New York. PrEP data from AIDSVu reflect the number of people prescribed PrEP in a calendar year. AIDSVu uses data from a database that contains anonymized individual-level prescription records collected electronically from U.S. retail pharmacies, traditional pharmacies, specialty mail-order pharmacies, long-term care facilities, and other pharmacies (e.g., in-hospital pharmacies, HMO pharmacies).[49]

Disparities in the uptake of PrEP and PEP still exist among key priority populations (e.g., Black, and Hispanic males and females, and transgender individuals). 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 the 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 and PEP access. In 2020, by leveraging the existing state telehealth practitioner team, the Department launched a TelePrEP program where patients can access PrEP services through the CHD system.

Currently, federal funding requires the implementation of PrEP and PEP services but does not allow states to allocate funding for medications and limitations for covering associated clinical costs exist. While there are patient assistance programs available to offset the cost of medications, medical visits, 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. As a result, more clinics and pharmacies have started to offer non-traditional and after-hours services to increase access to PrEP and PEP. In late December 2021, Apretude (cabotegravir extended-release injectable suspension) received FDA approval for HIV PrEP. Injectable PrEP provides a new option to prevent HIV that does not involve taking a daily pill—which for some people presents

challenges. In summer 2022, the Department initiated a pilot project to test the feasibility of delivering Apretude through CHD clinics. Three CHD clinics (Alachua, Hillsborough, and Miami-Dade) were chosen to participate in the pilot project and represent geographic areas with varying HIV incidence.

In 2019, the USPSTF issued a Grade A recommendation for offering PrEP with effective antiretroviral therapy to persons at increased risk of HIV acquisition. Under the ACA, most private insurance plans must cover preventive services with an "A" or "B" recommendation from the USPSTF without copays or deductibles. This means that at least one PrEP option should be available at no cost to qualifying individuals on these plans.

Increased public and private partnerships are needed to fill gaps in access to PEP services. Many CHD clinics have traditional hours, making them ill-suited as delivery points. Access to PEP is needed quickly after exposure to HIV (in 72 hours) to prevent seroconversion. Clients requesting PEP 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 PEP.

Substance Use Disorders, Syringe Service Programs, and Health Care Access

The past-year prevalence of substance use disorders among adults in Florida was 14.8% in 2019–2020, and the prevalence of needing but not receiving treatment for substance use was 7.5%. According to the Florida Association of Managing Entities, 5,117 adults were added to a waitlist for substance use services in FY 2020–2021.[50]

The most recently published prevalence rates for various substances and substance use disorder among young adults (ages 18–25) and adults in Florida are presented in Table 9 below:

TABLE 9: PREVALENCE OF SUBSTANCE USE AND SUBSTANCE USE DISORDER IN THE PAST YEAR, IN FLORIDA BY ADULT AGE GROUP (2019–2020)

	18 and Older	18–25	26 and Older
Marijuana Use	16.6%	32.9%	14.5%
Cocaine Use	1.7%	4.4%	1.4%
Methamphetamine Use	0.6%	0.6%	0.6%
Heroin Use	0.2%	0.1%	0.2%
Prescription Pain Reliever Misuse	3.6%	4.8%	3.4%
Alcohol Use Disorder	9.5%	13.6%	9.0%

According to FDCF, 2020 Florida Youth Substance Abuse Survey State (FYSAS) report, substance use among students in Florida continues to decline. Among middle and high school students in Florida, between 2010 and 2020, the prevalence of lifetime alcohol use decreased from approximately 52% to 35% and the past-30-day prevalence of alcohol use decreased from 29% to 15%. Regarding marijuana use, the prevalence of lifetime and past-30-day marijuana use among middle and high school students also decreased between 2010 and 2020. Lifetime prevalence decreased from approximately 24% to 20% and past 30-day prevalence decreased from 13% to 11%. According to estimates from the 2022 FYSAS, among high schoolers the lifetime prevalence is 2.8% for opioid misuse, 4.1% for stimulant misuse, and 5.7% for opioid and stimulant misuse.[45]

Section 381.0038(4), F.S., or the Infectious Disease Elimination Act (IDEA), was passed by the Florida Legislature in 2016 and in 2019, the Governor signed a bill amending IDEA to allow county commissions to authorize syringe exchange programs in their county by way of county ordinance. The IDEA legislation mandates that SSPs operate a one-to-one exchange; provide or make referrals for HIV and HCV testing; provide access to substance use prevention, education, and treatment; and provide emergency opioid antagonist kits (naloxone kits). A CDC Determination of Need for Florida for SSPs was approved on February 1, 2020. The CDC Determination of Need supports federal funding applications for SSPs and other organizations. In Florida, there are five approved and currently operational SSPs: IDEA Exchange Miami (located in Miami-Dade County) operated by the University of Miami Miller School of Medicine, the SPOT (in Broward County) operated by Care Resource, the Rebel Recovery SSP (in Palm Beach County) implemented by Rebel Recovery FL, IDEA Exchange Tampa (in Hillsborough County) implemented by Tampa General Hospital and the University of South Florida, and IDEA Orlando (in Orange County) implemented by Hope and Help. An SSP in Pinellas County will be opening their doors in 2022.

Apart from federal funds, grants and donations are the only authorized funding sources for SSP operations in Florida. The five currently operating SSPs receive funding for harm-reduction supplies and services from private grants, donations, and foundations. FDCF donates naloxone nasal spray kits to the SSPs. All sites report that the biggest barrier to effective implementation and operation of their program is funding for harm-reduction supplies. Current funding is inadequate to support the foundational operation of the exchanges, with one site reporting continuous supply shortages that have led to the SSP closing on certain days of the week at a time when the program was experiencing rapid growth.

Since the inception of FDCF's Overdose Prevention Program, the five operational SSPs have distributed over 30,000 naloxone kits and reported 5,602 reversals or rescues. About 29% of all reversals reported to FDCF are through the SSPs. Supplying SSPs with naloxone kits therefore remains a top priority. As other harm-reduction organizations, recovery community organizations, and peer networks, expand and evolve in ways that engage and maintain relationships with the hardest to reach, most at risk individuals in their communities, they should also receive priority support for naloxone distribution. Additionally, in March 2022, the Florida Harm Reduction Collective (FLHRC) established a mail-based naloxone distribution program. The FLHRC comprises of recovery community organizations, overdose prevention programs, SSPs, CBOs, and other stakeholders working to decrease the harms of drug use and eliminate

the stigma associated with harm-reduction. Since March 2022, FLHRC has distributed 1,482 naloxone kits and received 104 reports of overdose reversals through their mail-based naloxone distribution efforts.

Florida's overdose epidemic continues to pose a considerable challenge that the Department addresses through surveillance, prevention, education, and policy efforts. The Florida Overdose Data to Action (OD2A) program has a direct connection to the State Health Improvement Plan and the Department's Strategic Plan. The Department also recently launched an initiative to make naloxone kits available at all 67 CHDs. In 2021, as part of the nationwide opioid litigation undertaken by more than a dozen states, Florida was able to secure more than $1 billion in settlement funds which will be used to support prevention, treatment, and recovery related services.

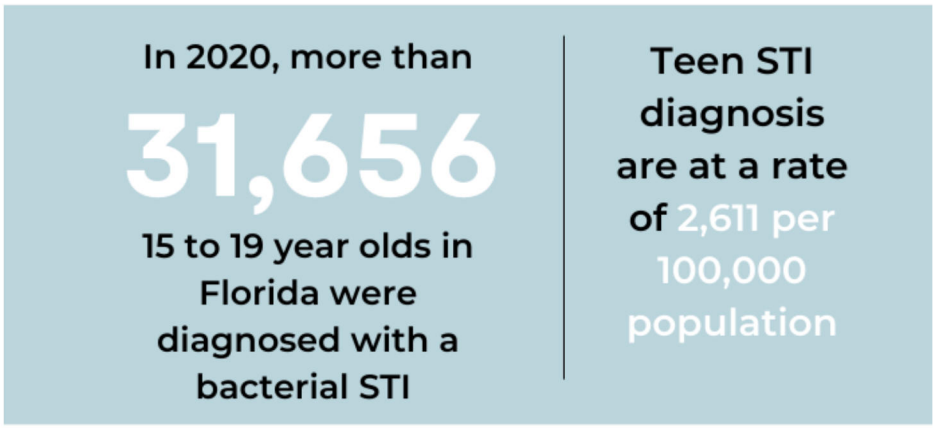
The Department supports the IDEA Exchange Miami to provide training and technical assistance to new SSPs, as well as education to local communities on the evidence behind SSPs in the prevention of HIV, HCV, and overdose. Another project, supported by the congenital syphilis grant routinely screens women who inject drugs for HIV and syphilis to reduce the likelihood of babies born with congenital syphilis and link women to treatment and care. Lastly, we will create tangible and measurable steps in addressing viral hepatitis statewide by developing a robust hepatitis elimination plan. We will focus on priority populations disproportionally affected by hepatitis A, B, and C through improving access to prevention, diagnosis, and treatment and increasing vaccination among those priority populations. Also, we will increase access to medication-assisted therapies and linkage to HCV treatment among PWID.

During FY 2021–2022, FDCF deployed HIV Early Intervention Services set-aside funding from the SAMHSA Substance Abuse Prevention and Treatment Block Grant to conduct 18,313 HIV tests across 47 treatment provider sites. A total of 163 tests were positive for HIV.

Comprehensive Health Education and Interventions for Youth

In 2020, more than 31,656 persons between 15 and 19 years of age in Florida were diagnosed with a bacterial STI (syphilis, chlamydia, gonorrhea), for a rate of 2,611 per 100,000 population as shown in Figure 24. These numbers are down slightly from previous years due to the lack of testing and access to testing during the COVID-19 crisis. The presence of an STI increases a person's risk of acquiring HIV. The teen birth rate in Florida has decreased by 59.7%, from 37.2 per 1,000 population in 2009 to 15.0 per 1,000 population in 2020. Of the 4,708 HIV diagnoses in Florida in 2021, 13% (634) were among 13 to 24-year-olds, of whom 53% were Black, 33% were Hispanic/Latino, 12% were White, and 2% were multiracial/other. Most youth diagnoses were attributed to sexual contact, with only 2% attributed to other risks. Of the 2,678 young PWH in Florida in 2021, 67% had a suppressed viral load (versus 69% for all PWH in Florida).

FIGURE 24: TEEN STI RATES



Section 1003.42(2)(n), F.S., requires comprehensive health education that incorporates disease prevention and includes language on the benefits of sexual abstinence and the consequences of teenage pregnancy. Additionally, section 1003.46, F.S., allows school boards to include additional instruction regarding HIV/AIDS. Such instruction may include information about "means used to control the spread of [AIDS]." As outlined in section 1003.42, F.S., parents may submit a written request to the school principal to exempt their child from "the teaching of reproductive health or any disease, including HIV/AIDS, its symptoms, development, and treatment." 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. Florida plans to look for alternative settings in which to provide HIV education to youth such as recreation centers, after-school programs, faith-based programs, youth coalitions, and juvenile justice facilities.

Perinatal HIV Prevention Efforts

Perinatal transmission of HIV is when HIV is passed from a woman with HIV to her child during pregnancy, childbirth, or breastfeeding. The use of HIV medicines and other strategies have helped to lower the rate of perinatal transmission of HIV to 1% or less in the US and Europe.[37] In Florida, the Dpeartment is actively managing the following perinatal HIV initiatives:

- **Targeted Outreach for Pregnant Women Act (TOPWA)** – Section 381.0045, F.S., also known as the "Targeted Outreach for Pregnant Women Act of 1998" provides a state funding appropriation for programs to provide outreach and linkage services to pregnant women who may not seek proper prenatal care, who suffer from substance-use disorders, or who are living with HIV or are at increased risk for HIV acquisition. TOPWA providers serve pregnant women who are HIV negative and those living with HIV to ensure they are linked to and receive adequate prenatal care and adhere to medical treatment to prevent perinatal transmission. There are seven funded TOPWA programs in Florida and they provided services to 1,772 clients in 2021. Black females represented 45% of enrollees, Hispanic females represented 44%, and White females represented 7%. Females living with HIV made up just under 8% of TOPWA enrollments.

- **Fetal Infant Mortality Review (FIMR)/HIV Prevention Methodology** – The Department is developing a FIMR/HIV Prevention Methodology in conjunction with a Community Action Team. These efforts are part of a larger effort the Department is undertaking to reduce communicable diseases in WCBA to include congenital syphilis, HBV, and HCV.

- **Baby Rxpress** – The Department's Baby Rxpress program provides a six-week course of ARV medication to newborns with HIV exposure, lowering the risk of mother-to-child HIV transmission to less than 1%. In 2020, Baby Rxpress filled 344 prescriptions for ARV medications for 256 newborns with HIV exposure at a cost of $13,556.00, or just under $53 per baby. Baby Rxpress maintains over 85 participating pharmacies across the state. Participating partners include Empath Health Pharmacy, Health Matters Pharmacy, Walgreens Co., Jackson Pharmacy (three specialty locations), Scripts Pharmacy, and Jackson Drugs.

HIV High-Impact Prevention (HIP) Provider Network

In early 2019, the Department made awards for HIP Request for Applications (RFA) 18-001. HIP RFA 18-001 was released in fall 2018 and provided non-profit organizations an opportunity to apply for funding provided by the Department through the state's integrated HIV prevention and surveillance grant. A total of $10 million from this grant was allocated and 44 awards were made to organizations throughout the state that serve Florida's priority populations. Three-year contracts were executed beginning January 1, 2019, and ending on December 31, 2021, with the option for up to three, one-year renewals. These awards have the ability to be continued through December 31, 2024.

Funded HIP providers deliver a wide array of services, depending on the category of funding and includes, but are not limited to, routine and prioritized testing; integrated STI screening, linkage and reengagement to prevention and care services; interventions for PWH and persons at increased risk of acquiring HIV; PrEP and PEP services; condom distribution; outreach, education, and community engagement; social media and marketing; and essential support services.

In 2021, a total of 12,281 PWH received risk-reduction interventions through contracted HIP providers. Of the PWH receiving risk-reduction interventions, 39.5% identified as MSM, 29% identified as heterosexual males, 28.7% identified as heterosexual females, and 2.8% identified as transgender. Interventions for PWH include Partnership for Health, CLEAR, ARTAS, Healthy Relationships, Connect, Peer Support, and personalized risk-reduction counseling.

Forty-one of the 44 funded HIP providers deliver PrEP screening and referrals and 16 of the providers are able to prescribe for PrEP onsite. In 2021, approximately 42,138 clients of HIP providers were found to be eligible for PrEP services, and, of those, 24,562 were referred for PrEP services and 1,211 were prescribed PrEP.

Risk-reduction interventions for HIV-negative persons at increased risk for acquiring HIV are also delivered by contracted HIP providers. In 2021, a total of 16,235 HIV-negative persons received risk reduction interventions through contracted HIP providers and of those, 43% identified as heterosexual

females, 38% identified as heterosexual males, 18% identified as MSM, and 1% identified as transgender. Interventions for persons with a negative or unknown HIV status include VOICES, CLEAR, Social Network Strategy, Mpowerment, Popular Opinion Leader, Personalized Cognitive Counseling, RESPECT, Community PROMISE, HIV and STD educational sessions, and personalized risk reduction counseling services.

HIP providers are also required to screen clients and refer them to essential support services to assist with housing, transportation, mental health, substance use disorder, and other barriers to care. In 2021, HIP providers screened 51,306 clients for essential support services; 21,224 were referred to services and 2,032 were linked to essential support services.

HIV Minority Media Campaign

In 1999, the Department established a statewide minority media campaign for HIV prevention, as required by section 381.046, F.S. This campaign was most recently rebranded in 2017 with the theme "Protect Yourself." In 2020, the campaign evolved to include the stories and testimonials of real individuals from Florida impacted by HIV. Figure 25 provides an example of how the Protect Yourself campaign images were used.

FIGURE 25: PROTECT YOURSELF CAMPAIGN IMAGE

The Protect Yourself campaign is implemented across all industry standard platforms including broadcast radio and television, digital and mobile advertising, out-of-home advertising (billboards, bus stops), a dedicated website, social media, and public outreach events. The Department works with local areas to supplement media buys as applicable. The Department updates the campaign annually with input from local and statewide advisory and work groups. During COVID-19, the HIV media campaign was instrumental in getting out social media messaging and website content to populations at risk for or living with HIV. More recently, the HIV media campaign was used to quickly disseminate information and messaging for HIV priority populations related to hepatitis A, meningococcal disease, and Mpox virus. Moving forward, the Department plans to broaden the scope of the campaign to address syndemics (STIs, viral hepatitis).

As previously discussed in Section 2.5, the Department announced its endorsement of the Prevention Access Campaign's U=U in June 2020. In becoming a U=U partner, the Department joined nearly 1,000 organizations around the world supporting the science-backed message that PWH who use antiretroviral

therapy and have an undetectable viral load in their blood have effectively no risk of sexually transmitting HIV.

4.4 RESPOND Quickly to Potential HIV Outbreaks to Get Needed Prevention and Treatment Services to People Who Need Them

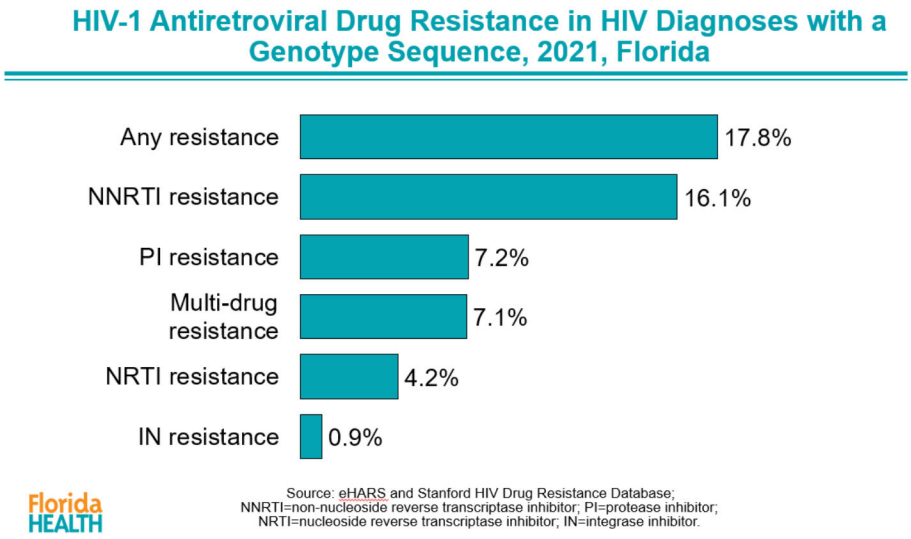
Cluster Detection and Response Plan

The Department is actively conducting surveillance and investigation for HIV clusters. The Department routinely conducts monthly analysis to detect rapidly growing molecular clusters and time-space clusters of public health significance. Additionally, a state level cluster review committee is convened monthly to review cluster data, discuss challenges, and brainstorm strategies to improve the statewide response. Since fall 2021, the state health office has established routine communication with CHDs experiencing clusters to coordinate and guide local responses to investigate and respond to clusters. Florida's updated HIV Cluster Detection and Response plans were submitted to CDC in fall of 2021 and will be updated in 2023. The Department's Bureau of Communicable Diseases plans to engage community stakeholders in further development of the cluster detection and response plan and will accomplish this through the FCPN and associated workgroups, RWHAP partners, and other stakeholders.

Increase Receipt of Genotype Test Results

As the number of analyzable HIV-1 genotype sequences reported to the state has decreased and the number of physicians ordering those tests has also decreased, the Department will enhance physician capacity to order genotype testing for those newly diagnosed or those not on ART returning to care. Figure 26 breaks out resistance type with a genotype sequence.

FIGURE 26: HIV-1 ANTIRETROVIRAL DRUG RESISTANCE IN HIV DIAGNOSES WITH A GENOTYPE SEQUENCE 2021, FLORIDA



The Department is engaging laboratories to improve the completeness and timeliness of electronic laboratory reporting of all reportable HIV lab results including genotype consensus sequences used in transmission network analyses. To increase the receipt of genotypes test results, the Department and its partners are:

- Developing a protocol with the Department's Bureau of Public Health Laboratories to facilitate access to HIV genotype testing.
- Engaging and educating providers on current HRSA recommendations to order baseline genotypes for newly diagnosed and those returning to care and increase understanding of clinical and epidemiological importance of these tests.
- Educating providers and laboratories on statutory reporting requirements for HIV.
- Educating provider population on response and genotype testing.
- Creating a health care provider letter demonstrating the importance of genotype testing.
- Collaborating with the University of Florida to conduct focus groups on molecular surveillance.
- Conducting laboratory survey on current types and volume of HIV testing in Florida.
- Conducting provider survey on current test ordering strategies.
- Creating of a laboratory report card for laboratories and providers to facilitate improvements.

Data to Care (D2C)

HIV is a reportable disease where routinely collected surveillance data are used as a strategic tool to trigger HIP activities. The D2C initiative is a HIP activity that relies on the use of surveillance data to generate lists of persons living with HIV not in care in Florida. Linkage services are offered to those not receiving treatment by connecting them with HIV care. Florida is a high-morbidity state that has implemented a statewide D2C program since 2015, with the goal of reaching individuals who were not linked to HIV care in one month of diagnosis or if not virally suppressed and part of an HIV transmission cluster and network. In partnership with the six RWHAP Part A programs located in the seven EHE counties and through funding received by Georgetown University, the Department is embarking on a data sharing effort to improve linkage to HIV care for persons out of care in those jurisdictions. Enhancing and expanding on the prioritization of D2C activities by focusing on priority populations that need linkage to care, for example, homeless persons, non-White minorities, non-U.S. born, and persons who inject drugs are populations with the highest rate (>21%) of being out of care (no care in the past 12 months) in 2021, compared to the state (20%). Furthermore, males with IDU, Black men, and persons aged 13 to 39 are populations with the lowest percentage of viral suppression rates (<68%) in 2021, compared to the state (69%). The Department is also increasing linkage-to-care staff training to promote diverse community wellness.

Education and Outreach

As part of the ongoing efforts to respond to HIV transmission clusters and outbreaks, the Department collaborates to provide education, outreach, and community engagement with Floridians at risk for HIV or currently living with HIV, informing them of available HIV prevention and treatment options and

other resources in their area. The Department will complete the following activities to improve awareness of HIV-related services and cluster detection and response actions:

- Generate an annual surveillance summary detailing the community-level response to transmission networks in areas of high HIV burden.
- Create and develop education materials to improve awareness and reduce anxiety surrounding HIV transmission network response activities citing standard public health practice.

Additionally, several of the RWHAP Part A jurisdictions receiving EHE funding from HRSA have purchased mobile medical units to improve their ability to take services and education to populations and communities.

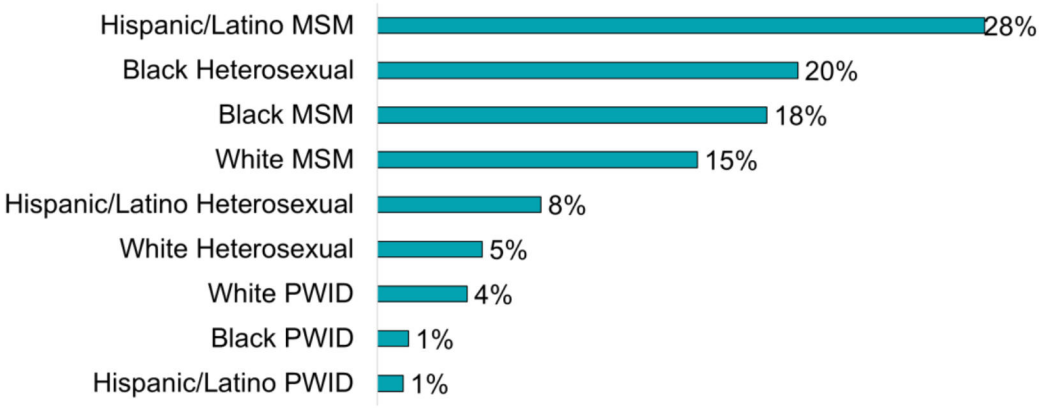
HIV Criminalization

While molecular HIV surveillance (MHS) cannot determine the directionality of disease transmission, it remains a public and community concern that MHS data could be used in criminal transmission prosecutions. 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 routine public health surveillance practices and the use of these data for improving HIV detection and prevention efforts.[54] In October 2022, the President's Advisory Council on HIV/AIDS convened and developed recommendations related to MHS such as: local adaptations of MHS must be responsive to the needs in a given jurisdiction based on reviews of state and local HIV criminalization laws; establishment of community advisory boards focused on MHS and cluster detection and response; and plain language notifications be available to PWH about the types of surveillance being conducted and safeguards in place to protect access to and usage of those data. Education to the community at-large is needed on the recent advancements in biomedical interventions, since PWH on medication and virally suppressed (i.e., U=U) have effectively no risk of transmitting the virus to others through sex.

4.5 Priority Populations

Priority populations for primary HIV prevention are derived from the average proportion of each of the race and mode of exposure groups diagnosed with HIV in the last three years (2019–2021). This information is used to address those at the highest risk of acquiring HIV and with the greatest need for primary prevention services (i.e., services directed toward people who have a negative or unknown HIV status). As shown in Figure 27, the top five priority populations are Hispanic/Latino MSM (28% of new diagnoses over the past three years), Black heterosexuals (20%), Black MSM (18%), White MSM (15%), and Hispanic/Latino heterosexuals (8%).

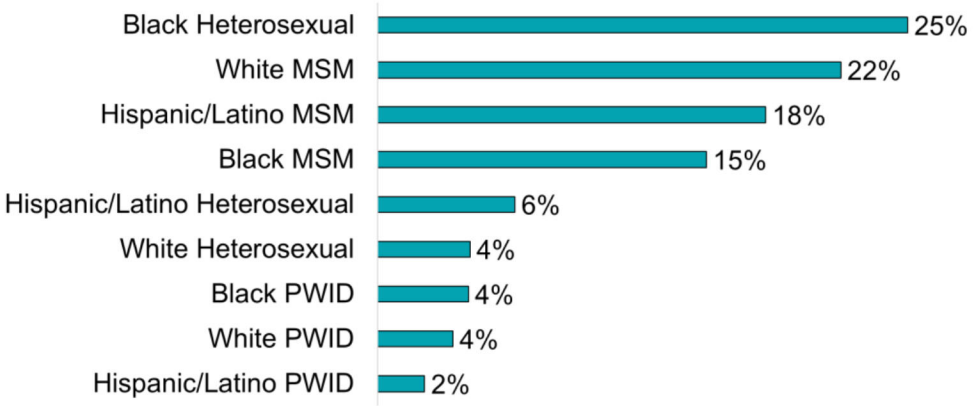
FIGURE 27: PRIORITY POPULATIONS FOR PRIMARY HIV PREVENTION, FLORIDA, 2021



MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive. Data is for HIV diagnoses 2019–2021. Rounding may cause percentages to total more or less than 100.

Priority populations for secondary prevention for PWH represent the proportion of each of the race and mode of exposure groups to the total PWH. Secondary HIV prevention activities are directed toward people with HIV, with the intention of preventing transmission to those who are HIV negative. This information is used to prevent HIV transmission through services provided to PWH in these affected demographic groups. As shown in Figure 28, for 2021, the top priority groups include Black heterosexuals (25%), White MSM (22%), Hispanic/Latino MSM (18%), Black MSM (15%), and Hispanic/Latino heterosexuals (6%). Efforts to reduce the transmission of HIV include improving viral suppression among Black males and females and among WCBA (aged 15 to 44).

FIGURE 28: PRIORITY POPULATIONS FOR SECONDARY HIV PREVENTION FOR PWH, FLORIDA, 2021



MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive. Rounding may cause percentages to total more or less than 100.

There were 120,502 persons with an HIV diagnosis living in Florida through 2021 which is estimated to represent only 86% of persons with HIV—the remainder of whom are unaware of their status (approximately 14%, based on the current CDC methodology used to calculate percentage unaware). Persons living with HIV but unaware of their status also need to be prioritized and underscore the

importance of implementing a status-neutral approach to HIV prevention and care. Routine screening is needed to diagnose persons with HIV who are unaware of their status and rapidly link them to care and treatment to achieve viral suppression.

The full Epidemiological Profile for HIV in Florida, 2021, will be provided as a separate attachment. It was developed in accordance with the Integrated HIV Prevention and Care Plan Guidance, including the SCSN, CY 2022–2026 issued by the CDC and HRSA in June 2021. This document provides a comprehensive data overview of HIV, STDs, and HCV in Florida. The full Epidemiological Profile for HIV in Florida, 2021, will also be used to address CDC-PS18-1802 grant requirements.

5 2022–2026 Goals and Objectives

In January 2021, HHS released the HIV National Strategic Plan: A Roadmap to End the Epidemic 2021–2025 which creates a collective vision for HIV service delivery across the nation. IPC Plans created for every jurisdiction address four goals:

- Prevent new HIV infections.
- Improve HIV-related health outcomes for people with HIV.
- Reduce HIV-related disparities.
- Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders.

Objectives have been identified for each of the four goals, and the details of such are outlined in the subsequent section.

Table 10 outlines the goals and objectives for how Florida will address the strategies to diagnose, treat, prevent, and respond to HIV; the goals and objectives align with the NHAS. Actionable activities have been identified to address each of the goals and objectives, along with other pertinent information to inform a plan of action. Those additional details are described in Appendix 9.1 Strategy and Activity Table.

TABLE 10: GOALS AND OBJECTIVES

Goal	Objective
Goal 1: Prevent New HIV Infections	Objective 1.1. Increase awareness of HIV.
	Objective 1.2. Increase knowledge of HIV status.
	Objective 1.3: Expand and improve implementation of effective prevention Interventions.
	Objective 1.4 Increase capacity of health care delivery systems, public health, and health workforce to prevent and diagnose HIV.
Goal 2: Improve HIV-Related Health Outcome of PWH	Objective 2.1. Link people to care rapidly after diagnosis and provide low-barrier access to HIV treatment.
	Objective 2.2: Identify, engage, or reengage people with HIV who are not in care or not virally suppressed.
	Objective 2.3: Increase retention and adherence to treatment to achieve and maintain long-term viral suppression.

Goal	Objective
	Objective 2.4: Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV.
	Objective 2.5 Expand capacity to provide whole-person care to older adults with HIV and long-term survivors.
	Objective 2.6: Advance the development of next-generation HIV therapies and accelerate research for HIV cure.
Goal 3: Reduce HIV-related Disparities	Objective 3.1. Reduce HIV-related stigma and discrimination.
	Objective 3.2. Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum.
	Objective 3.3. Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV.
	Objective 3.4: Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities.
	Objective 3.5: Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations.
	Objective 3.6: Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and health care mistrust.
Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Interested Parties	Objective 4.1. Integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and institutional factors including stigma, discrimination, and violence.
	Objective 4.2 Increase coordination among and sharing of best practices from HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with public and private health care payers, faith-based and CBOs, the private sector, academic partners, and the community.
	Objective 4.3 Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continua data and social determinants of health data.
	Objective 4.4: Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances.

6 2022–2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up

To break down the approach for Integrated Planning Implementation, Monitoring and Jurisdictional follow up, the subsequent sections will detail how best to ensure the success of IPC Plan goals and objectives through the following five key phases:

- Implementation (Section 6.1)
- Monitoring (Section 6.2)
- Evaluation (Section 6.3)
- Improvement (Section 6.4)
- Reporting and Dissemination (Section 6.5)

6.1 Implementation

The Department will continue to coordinate and collaborate with internal and external partners and stakeholders to meet the objectives of the IPC Plan. The Department's RWHAP Part B; RWHAP Part A, C, D, and F programs; PWH; and other members of the FCPN-associated committees, workgroups, and advisory groups (e.g., FL Gay Men's HIV Workgroup, Community HIV Advisory Group, Florida Black Leaders Group, CQM Committee); EHE-funded jurisdictions and directly-funded providers; HIV prevention and care providers; state and local agency administrators; and persons at increased risk for HIV will be included in each step of the IPC Plan implementation, monitoring and evaluation. Through this coordinated implementation approach, the Department and partners can explore opportunities to better leverage funding streams supporting Florida's HIV prevention, care, and treatment services (e.g., CDC and HRSA funding to state and local entities). Implementation progress of the IPC Plan will also be used to identify where more resources (e.g., funding, staffing) may be needed to ensure IPC Plan objectives are met.

6.2 Monitoring

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

- Completion of stated strategies and activities.
- 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 biannual meetings and monthly committee calls, the Department's HIV/AIDS Section and the FCPN will actively participate in regular monitoring of strategies and activities set forth in the unified IPC

Plan. The Department, in collaboration with the FCPN Coordination of Efforts Committee, will establish mechanisms and time frames the state will use to monitor, evaluate, and update the IPC Plan, as necessary. This committee leads efforts to ensure data indicators for plan activities are being tracked and that progress is communicated with appropriate programs and partners to meet plan objectives. Data on performance indicators will be collected and disseminated through a status report to statewide partners. Local planning body feedback will also be collected and shared by FCPN representatives for each respective area. The Department currently uses an electronic dashboard tool to collect EHE-related activity information and consideration is being given to using this tool to collect activity-related information for the IPC Plan. Regular FCPN meetings are the principal 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. A standing agenda item to review IPC activity progress will be added to the state's FCPN meetings. After each FCPN meeting, a summary report is provided to all attendees and shared with community partners; this mechanism will be used to share information on the IPC Plan's progress toward completing activities and achieving objectives.

The IPC Plan will receive a detailed annual review by the Department 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 Department's 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 IPC 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 IPC Plan objectives more effectively than each program could on its own. This approach will align with, support, and advance the goals of the IPC initiative, the NHAS, and the Department, 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 IPC Plan is essential. These opportunities will ensure that plan implementers are working with the best available evidence to work toward ending the epidemic.

6.3 Evaluation

Meaningful measures and indicators will be used to monitor both operational performance and progress on objectives, strategies, and activities in the strategic plan. Data are used to make program decisions and direct efforts to ensure the state achieves the intended results and also to help identify additional operational and process improvement opportunities.

The IPC Plan will receive a detailed annual review by HIV/AIDS Section leadership subsequent to Florida's legislative session and the Department's budget planning process. As part of the annual review, the section will use surveillance and program data to assess health outcomes along the HIV Care Continuum which 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 for input and feedback to the FCPN.

Strategic planning, the process generating the statewide IPC Plan, helps focus resources on vital objectives chosen to move the Patient Care and Prevention programs toward fulfillment of the NHAS goals. The IPC Plan identifies key objectives that Florida will pursue in the next five years, along with strategies and activities that will guide and facilitate the necessary actions required to achieve the desired outcomes. Plan objectives each have a corresponding measure for ongoing monitoring. Using meaningful measures and data indicators will ensure Department HIV/AIDS Section leadership, RWHAP Part A partners and the FCPN planning body members are able to manage and track efforts toward the intended results, while identifying improvement opportunities over the course of the five-year period.

Evaluation ensures the strategies and activities are making changes that positively affect outcomes of the IPC Plan objectives. Evaluation that focuses on project outputs, provides accountability for public resources relating to specific actions. It establishes the empirical basis needed for the ongoing cycle of collaborative planning and the actions that need to be accomplished. The evaluation component is an extension of the integrated Plan, Do, Study, Act cycle which is a continuous process. The IPC Plan must be flexible to allow for adjustments as there are changes to external or internal conditions; yet a meaningful evaluation must be integrated in the planning process and include a review and analysis of the intended outcome. The HIV/AIDS Section, with the engagement of stakeholders, will review the strategic plan using meaningful performance measures and indicators to analyze, assess and evaluate outcomes and determine whether modifications to the IPC Plan are necessary. Through participatory evaluation and diverse range of perspectives, knowledge, values, needs, and abilities of stakeholders will be applied to the planning and evaluation process.

6.4 Improvement

Through routine (biannual) monitoring and communication of progress in achieving the goals and objectives outlined in the IPC Plan, the state will identify areas in need of improvement and make necessary adjustments to the IPC Plan. Revisions will be made on an annual basis and items for proposed revision will be reviewed with RWHAP Part A jurisdictions, members of the FCPN and associated workgroups and advisory bodies, and other key stakeholders, voted on, and implemented. The collaborative approach—structured and arranged to interweave state and community partnerships with shared discretion and responsibilities—will help to achieve the IPC Plan objectives more effectively than each program could on its own. This approach will align, support, and advance the goals of the NHAS, the Department, as well as meet CDC and HRSA requirements, to ensure improvement in the access to and quality of HIV prevention and care services throughout Florida.

6.5 Reporting and Dissemination

Summarized annual data are uploaded to the Department's HIV/AIDS Section web page (http://floridaaids.org/) and are also available on an internal SharePoint site for internal use at the state and CHD level. Annual data releases include a comprehensive epidemiological profile for the state and for each partnership area, a state slide set presented annually to FCPN and RWHAP partners, and other annual data products. The epidemiological (epi) profiles are an expanded Excel workbook with multiple tabs containing 5-year trend analyses of HIV (demographics, diagnosis, AIDS, deaths, and continuum of care), STIs, HBV, HCV, and TB.

Various factsheets are generated to portray epidemiology and disease highlights for a demographic population. These fact sheets highlight summary data for priority population groups and are updated annually, shared with community stakeholders, and uploaded to the Department's external web and internal SharePoint sites. Integrated slide sets and epidemiological profile tables are generated to support stakeholder engagement and planning. The Department's HIV/AIDS Section has generated compressive slides sets and epi profiles specifically for each of the 14 partnership areas each year since the 1990s. These slide sets and epi profiles are shared with the RWHAP Part A entities, community stakeholders, field surveillance staff, and others who may request these data. These data are frequently used as tools for program planning and evaluation.

Data Sharing and Use

De-identified HIV, viral hepatitis, STD, and TB data are routinely shared via ad-hoc requests to surveillance programs with outside entities including, but not limited to, academic institutions, community partners, RWHAP Parts, internal agency partners and collaborators, and the public.

Each of these programs provide annual data which are uploaded into FLHealth CHARTS (https://www.flhealthcharts.gov/charts/CommunicableDiseases/default.aspx). In addition, FL Health CHARTS is updating the FLHealth CHARTS website (a web-based platform that provides easy access to health indicator data at the community and statewide level for the state of Florida from a multitude of sources) with a new dashboard (at the county level) that will incorporate a multitude of HIV/AIDS indicators including, but not limited to, demographic and socio-economic indicators, partner services data, testing and treatment facilities, PrEP, and other data not previously included on FL Health CHARTS. By ensuring all these data and information are made readily accessible and user friendly, the new dashboard will help local and state planning bodies develop more effective and efficient programs and corresponding activities and monitor progress of IPC strategies and activities.

Along with HIV data, the Department also summarizes data from MMP and NHBS surveillance along with the Department's PrEP, Test and Treat, and HIV counseling and testing data. Data from the needs assessments are also shared in reports sent out to FCPN membership.

7 Letter of Concurrence

For the purpose of this plan, the FCPN membership served as the designated entity to certify concurrence with the content, strategies and activities included in the IPC Plan. The FCPN membership held the concurrence session on October 19, 2022, to officially adopt Florida's Statewide Integrated HIV Prevention and Care Plan, 2022–2026. Moving forward, all updates to concurrence will be completed through the state's integrated HIV planning process and with the FCPN.

The concurrence process included:

- Several virtual IPC Planning sessions that reflected the progression of the statewide IPC Plan to ensure that members of the planning body and other community stakeholders had an opportunity to provide input into the development of goals, objectives, strategies, and activities proposed in the IPC Plan.
- Opportunities for FCPN members and community stakeholders to submit their feedback to the state health office representatives with a response to their inquiries and recommendations.
- An opportunity for the FCPN to vote to accept the IPC Plan for submission to HRSA and CDC.

FIGURE 29: LETTER OF CONCURRENCE

F C P N

Florida Comprehensive Planning Network

Dear Colleague:

The Statewide Florida Comprehensive Planruing Network (FCPN) concurs witti 1he following submission by (be Florida Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention {DHAP) and HRSA's HMAIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including tbe Statewide Coordinated Statement of Need {SC5N) for calendar year (CY) 2022–2026.

Members of FCPN include PWH and representatives across the state representing patient care and prevention groups, Ideal planning bodies, CEOs, academic institutions, local and regional clinics, city, and county governments, RWHA Program recipients, the transgender community, advocacy groups, substance use and social service providers and behavioral science groups.

After a year of collaboration with our planning body members, federal/state/local partners, and community stakeholders, this plan reflects Florida's commitment to eliminating new HIV transmissions and reducing HIV related deaths in our state. FCPN members and guests helped to develop and prioritize the proposed strategies and activities far inclusion into the plan during the Summer 2022 meeting. FCPN members and guests reviewed and made suggestions to Ihe first draft of the plan during the Fall 2022 in-person/virtual meeting. Comments and suggestions from FCPN members were then incorporated into the final draft of the plan.

The FCPN has reviewed the Integrated HIV Prevention and Care Plan submission to (he CDC and HRSA to verify that it desciibes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV.

The planning body concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by Ihe CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and Hie Ftyan White HIWAIDS Program legislation and program guidance.

Asttie Co-Chairs of the FCPN, the signatures below confirm the concurrence of (he planning body with the Integrated HIV Prevention and Cane Plan 2022-2D26.

Ken Bargar
FCPN Community Co-Chair

1/5/23
Date

Daniel Wall
FCPN Community Co-Chair

1/5/23
Date

Florida Comprehensive Flaiming Network
c/o The AIDS Enstitut*
17 Davis Elvd., Ste. 403
Tampa, FT 33606

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9 Appendix

9.1 Strategy and Activity Table

The table below provides details on the activities suggested to address each strategy. Strategies are categorized by the goal and objective that they fall in.

9.1.1 Goal 1: Prevent New HIV Infections

9.1.1.1 Objective 1.1. Increase awareness of HIV

TABLE 11: STRATEGIES AND ACTIVITIES

<table>
<tr><th>Strategy 1.1.1</th><th colspan="2">Develop and implement campaigns and resources to provide education about comprehensive sexual health; HIV risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of campaigns developed
• Number of publicly funded HIV tests
• Number of areas engaging with law enforcement
• Stigma measure to be developed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• Case managers
• Health educators
• Peer workers
• Community health workers
• Linkage Coordinators
• Faith-based Organizations</td><td>• Develop stigma toolkit and campaign and localized stigma task forces.
• Engage with law enforcement around HIV awareness and stigma, and HIV information in their curriculum for youth intervention programs.
• Increase culturally competent sexual health education outside of schools.
• Increase the use of digital media resources to include messaging on dating apps (e.g., Grindr) and social media apps (e.g., TikTok).
• Solicit and execute agreement with new media vendor to deliver HIV media services statewide and to add campaign material to increase awareness of HIV testing, PrEP, treatment, prevention, and stigma awareness among priority groups.</td></tr>
</table>

<table>
<tr><th>Strategy 1.1.2</th><th colspan="2">Increase awareness of HIV among people, communities, and the health workforce in geographically disproportionately affected areas.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of publicly funded HIV tests
• Number of BRTA/FRTA partnerships
• Number of outreach and education efforts to specific priority populations
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth; sex workers and human trafficking victims</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• Case managers
• Health educators
• Peer workers</td><td>• Increase targeted outreach and education efforts specific to specialized groups, (e.g., FQHCs, local gang taskforces, and other geographically disproportionate communities).
• Increase the number of BRTA and FRTA initiatives and partners statewide to increase HIV awareness and reach in communities.
• Offer in-person learning opportunities for basic HIV 101 education and increase the number of trained HIV 101 educators (as a result of increased HIV 101 train the trainer opportunities).
• Provide HIV education and information to school district stakeholders to encourage buy-in and adoption of culturally competent sexual health education curriculum.
• Develop education materials that are both age appropriate and language appropriate.</td></tr>
</table>

<table>
<tr><th>Strategy 1.1.3</th><th colspan="2">Integrate HIV messaging into existing campaigns and other activities pertaining to other parts of the syndemic, such as STIs, viral hepatitis, and substance use and mental health disorders.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of campaigns with integrated messaging addressing syndemics
• Number of new or non-traditional partnerships established to deliver education around syndemics
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth; individuals with dual diagnoses</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance use treatment settings
• Mobile units
• STD clinics
• SSPs
• Drug treatment programs
• Case managers
• Health educators
• Peer workers
• Community health workers</td><td>• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV messaging in messaging related to other communicable disease areas.
• Increase awareness and collaboration with existing SSP to incorporate viral hepatitis, STIs, mental health and substance use disorder messaging in campaigns.
• Collaborate with non-traditional and new partners to deliver HIV, STI, viral hepatitis, substance use disorder and mental health messaging across multiple platforms (e.g., radio, print, digital, social media, out-of-home, venue/event-based). Ensure all messaging is culturally and linguistically appropriate.
• Identify and engage with other organizations and coalitions that have existing campaigns for STIs, viral hepatitis, substance use, mental health, behavioral health, etc. to encourage these groups to include HIV prevention and care messages in their efforts.
• Partner with SAMHSA funding recipients update or create messaging related to the nexus between HIV/STIs and HCV, substance use, and/or mental health.
• Collaborate with other local EMAs, RWHAP providers (e.g., Part C clinics), and FQHCs to incorporate additional HIV messaging into existing activities and/or campaigns.</td></tr>
</table>

9.1.1.2 Objective 1.2. Increase knowledge of HIV Status

<table>
<tr><th>Strategy 1.2.1</th><th colspan="2">Test all people for HIV according to the most current USPSTF recommendations and CDC guidelines.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of publicly funded HIV tests
• Number of HIV self-test kits distributed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Develop messaging that normalizes routine HIV testing and reduces stigma surrounding HIV testing. Utilize peers and popular opinion leaders to increase testing in communities.
• Ensure providers are kept up to date through education and communication.
• Implement routine HIV and STIs screening in health care settings and priority testing in non-health care settings. Expand routine HIV testing to include additional medical settings (e.g., EDs, urgent care facilities, OB/GYN, and primary care providers).
• Increase opportunities for HIV testing and address barriers to testing in traditional and non-traditional settings.
• Increase testing accessibility through increased partnerships with outside-the-box providers, such as non-traditional medical settings, civic groups, local papers, event planners, FBOs, population-based care providers, and others. Ensure testing is where people are.</td></tr>
</table>

<table>
<tr><th>Strategy 1.2.2</th><th colspan="2">Develop new and expand implementation of effective, evidence-based or evidence informed models for HIV testing that improve convenience and access.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of publicly funded HIV tests
• Number of HIV self-test kits distributed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs</td><td>• Assess current HIV testing laws for opportunities to consider increasing testing requirements in additional circumstances.
• Decrease barriers to testing by increasing testing beyond traditional venues and work hours and normalizing knowing your status.
• Identify barriers to testing and care from people with lived experience and develop improvements to delivery.
• Provide easy access to home test kits, including through self-serve vending machines and as add-ons to other self-tests (such as COVID, pregnancy); improve reporting structures to increase self-test linkage.
• Routinize HIV testing as part of the standard of care during an annual physical as well as during other health or wellness visit appointments or opportunities.</td></tr>
</table>

<table>
<tr><th>Strategy 1.2.3</th><th colspan="2">Incorporate a status neutral approach to HIV testing, offering linkage to prevention services for people who test negative and immediate linkage to HIV care and treatment for those who test positive.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of publicly funded HIV tests
• Number of HIV self-test kits distributed
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care in 30 days of diagnosis
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Develop and provide status-neutral resources around testing, treatment, prevention, and other services.
• Educate private providers about status neutral HIV prevention and care services.
• Ensure strong linkage to PrEP and PEP infrastructure that exists.
• Increase the use of combined testing and vaccination efforts as a means of destigmatizing HIV prevention and testing services.
• Support and expand the use of a “no wrong door” approach for HIV prevention and care services in a variety of organizations.</td></tr>
</table>

<table>
<tr><th>Strategy 1.2.4</th><th colspan="2">Provide partner services to people diagnosed with HIV or other STIs and sexual or needle sharing partners.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of people receiving HIV partner services interviews
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care in 30 days of diagnosis
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Increase collaboration with needle exchange/harm-reduction programs.
• Increase partner services capacity, whether by increasing funding for DIS positions, allowing additional Department staff to provide partner services, or allowing non-Department organizations to provide partner services.
• Provide partner services during non-traditional hours and via telehealth to reduce barriers.
• Reduce barriers around partner disclosure and referral.
• Use partner services to provide negative partners access to PrEP, educational materials, and other preventative resources and services.</td></tr>
</table>

9.1.1.3 Objective 1.3: Expand and Improve Implementation of Effective Prevention Interventions

<table>
<tr><th>Strategy 1.3.1</th><th colspan="2">Engage people at risk for HIV in traditional public health and health care delivery systems, as well as in nontraditional community settings.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of publicly funded HIV tests
• Number of HIV self-test kits distributed
• Number of people receiving prescriptions for PrEP
• Number of primary care visits (AHCA report)
• Number of FQHC visits for priority populations
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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• Mobile units
• STD clinics
• Drug treatment programs
• Correctional health settings
• SSPs
• AHCA (Medicaid/Medicare)</td><td>• Create local Prevention Interventions Taskforces to work collaboratively to raise awareness (e.g., utilizing non-health care events), share resources, and provide referrals.
• Incorporate additional public health professionals in care settings
• Increase academic detailing in Primary Care, Urgent Care, and Emergency Department settings to raise awareness for prevention interventions.
• Increase the number of community mobilization initiatives and partnerships in communities, (e.g., FRTA and BRTA).
• Partner with additional social service organizations, (e.g., domestic violence care providers, human trafficking organizations, United Way, YMCA, Boys and Girls club, and others) to expand HIV testing, prevention, and care services.</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.2</th><th colspan="2">Scale-up treatment as prevention/U=U by diagnosing all people with HIV, as early as possible and engaging them in care and treatment to achieve and maintain viral suppression.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of publicly funded HIV tests
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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• Drug treatment programs
• Correctional health settings
• SSPs</td><td>• Use existing planning bodies to work collaboratively to expand and increase rapid ART access programs.
• Increase viral suppression rates by increasing the use of peers in programs and using messaging that focuses on living a healthy life.
• Review programs with low VL suppression to identify areas for technical assistance and increase the number of trained evidence-based Intervention (EBI) providers in those programs to assist in navigation services and other interventions to reduce community VL.
• Scale up of injectable ARV programs (i.e., PrEP and HIV treatment).</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.3</th><th colspan="2">Make HIV prevention, including condoms, PrEP, PEP, SSPs easier to access and support continued use.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of condoms distributed statewide
• Number of people receiving prescriptions for PrEP
• Number of people receiving PEP
• Number of operational SSPs
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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• Mobile units
• STD clinics
• Drug treatment programs
• Correctional health settings
• SSPs</td><td>• Use existing planning bodies to work collaboratively to raise awareness and share resources on PrEP, PEP, condoms, and SSP, in order to provide referrals and increase accessibility of services.
• Increase the number of PrEP providers through academic detailing and education.
• Encourage that SSPs (including clean-needle distribution and exchange) are placed in proximity of known overdose events or deaths.
• Increase awareness and promote the use of the Provider PrEP hotline.</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.4</th><th colspan="2">Implement culturally competent and linguistically appropriate models and other innovative approaches for delivering HIV prevention services.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of cultural humility trainings performed
• Number of engagement activities with local and state civic, community and spiritual leaders
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• Correctional health settings
• SSPs</td><td>• Embrace the adoption of assessing quality of life instead of limiting approach to focusing on health outcomes only.
• Engage with local and state civic, political, community, and spiritual leaders to increase awareness of HIV and populations living with and affected by HIV.
• Increase cultural humility trainings and other linguistically appropriate trainings for delivering HIV prevention services.
• Partner with the Florida Department of Education (FDOE) to open conversations on how to evaluate outcomes of current health education programs for success.
• Provide HIV messaging in English, Spanish, and Haitian-Creole.</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.5</th><th colspan="2">Support research into the development and evaluation of new HIV prevention modalities and interventions for preventing HIV transmissions in priority populations.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of partnerships with HIV-related research entities
• Number of HIV research sharing events and opportunities
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Academia
• SSPs</td><td>• Expand frameworks for evaluation of EBIs through collaborative efforts and partnerships.
• Expand the use of economic modeling to optimize public health strategies and interventions (e.g., PrEP 2-1-1) in additional jurisdictions.
• Strengthen partnerships with HIV-related research entities (e.g., Florida Consortium for HIV Research [FCHAR]) to increase knowledge sharing and build expertise. Encourage attendance at Florida HIV Community, Providers & Researchers Conference.</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.6</th><th colspan="2">Expand implementation research to successfully adapt EBIs to local environments to maximize potential for uptake and sustainability.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of partnerships with HIV-related research entities
• Number of HIV research sharing events/opportunities
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
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<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Academia
• SSPs</td><td>• Adapt interventions frameworks to be more inclusive of all communities.
• Conduct listening sessions with those currently implementing interventions and those participating in interventions to uncover best practices and lessons learned.
• Increase collaboration with state and national entities, subject matter experts (SMEs) and CBA and TA providers to share information and findings that may lead to innovation and strategies.</td></tr>
</table>

9.1.1.4 Objective 1.4 Increase capacity of health care delivery systems, public health, and health workforce to prevent and diagnose HIV

Strategy 1.4.1	**Provide resources, incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible HIV testing, prevention, and supportive services especially in areas with shortages that are geographic, population, or facility based.**	
Data Indicators	• Number of cultural humility trainings performed • Number of public health workforce trainings on PrEP and PEP, mental health, and substance use and misuse • Number of partnerships with rural health networks • Additional specific, quantifiable measures for each activity (TBD)	
Priority Populations	Community-based organizations, health care delivery systems, public health, and health workforce	
Timeframe	**Critical Partners**	**Activities**
By 12/31/2026 **Planning Areas** Statewide	• The Department • Community- and faith-based organizations • Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites • Behavioral health care and substance abuse settings • STD clinics • Drug treatment programs • Correctional health settings • SSPs • Case managers • Health educators • Peer workers • Linkage coordinators	• Collaborate with local, state, and national training partners to increase and expand training cultural humility trainings. • Collaborate with local, state, and national training partners to provide additional training for the public health workforce and front-line staff on PrEP and PEP prescribing, mental health, and substance use and misuse. • Expand awareness and use of the Collaborative Pharmacy Practice Agreement which gives pharmacists authority to provide specific patient care services, including PrEP. • Expand partnerships with rural health networks. • Explore opportunities to incentivize the expansion of the health care workforce and health care facilities. • Identify language barriers and use stigma-free language for vulnerable populations.

<table>
<tr><th>Strategy 1.4.2</th><th colspan="2">Increase the diversity of the workforce of providers who deliver HIV prevention, testing, and supportive services.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of cultural humility trainings performed
• Number of HIV testing providers in rural areas
• Number of partnerships with rural health networks
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Community-based organizations, health care delivery systems, public health, and health workforce</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• STD clinics
• Drug treatment programs
• SSPs
• Case managers
• Health educators
• Peer workers
• Linkage coordinators</td><td>• Determine areas that lack providers and find ways to incentivize organizations to serve as HIV CBOs.
• Encourage HIV testing as a workplace activity.
• Engage community hubs and community leaders to broaden their social services by provided HIV testing.
• Use all available training resources (local and national) to create a diverse testing force across the state in both traditional and non-traditional settings.</td></tr>
</table>

<table>
<tr><th>Strategy 1.4.3</th><th colspan="2">Increase inclusion of paraprofessionals and SMEs on prevention teams by advancing training, certification, supervision, financing, and team-based care service delivery.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of partnerships with private entities
• Assessment of ART barriers conducted
• Number of peer navigators or near-peers
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Community-based organizations, health care delivery systems, public health, paraprofessional, and health workforce</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
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• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Case managers
• Health educators
• Linkage coordinators
• Peer and near-peer workers
• CHWs</td><td>• Assess barriers to antiretroviral therapy (HIV treatment or PrEP) in communities
• Develop a community-based workforce that is able to provide more services in a single visit
• Find creative ways to combat critical workforce attrition
• Increase the number of peer navigators providing services.
• Leverage partnerships with private entities to increase access to prevention services.
• Develop pathways which promote career growth for paraprofessionals.</td></tr>
</table>

<table>
<tr><th>Strategy 1.4.4</th><th colspan="2">Increase the diversity and capacity of health care delivery systems, community health, public health, and the health workforce to prevent and diagnose HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of academic institutions receiving education and outreach
• Number of local providers, peer navigators and near-peers that reflect priority populations
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Community-based organizations, health care delivery systems, public health, paraprofessional, and health workforce</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
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• Drug treatment programs
• SSPs
• Case managers
• Health educators
• Linkage coordinators
• Peer workers, Near Peers
• CHWs</td><td>• Increase the number of local care providers, peer navigators, and SMEs of color in order to reflect the burden of the epidemic in a county.
• Increase the number of inclusive sexual health services being offered by providing training on sexual orientation and gender identity.
• Provide education and outreach to academic institutions (e.g., public health programs, nursing, other paramedical programs) to encourage integration of testing and prevention training into curriculum to increase the number of certified testers.
• Require HIV education and training of school personnel.
• Require HIV education in clinical licensure.
• Establish best practices for responsible parties to hire and retain employees that reflect the epidemic.</td></tr>
</table>

9.1.2 Goal 2: Improve HIV-Related Health Outcomes of Persons with HIV (PWH)

9.1.2.1 Objective 2.1. Link people to care rapidly after diagnosis and provide low-barrier access to HIV treatment

<table>
<tr><th>Strategy 2.1.1</th><th colspan="2">Increase linkage to HIV medical care in 30-days of diagnosis, as early as the same day.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH engaged in care through T&T
• Number of PWH engaged in care through telehealth
• Number of PWH linked to same-day treatment (rapid ART)
• Percent of newly diagnosed PWH linked to HIV medical care in 30 days of diagnosis
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
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• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Local RWHAP Part A and EHE partners</td><td>• Facilitate the ability of peers, medical providers, and eligibility staff to link clients to care and access rapid ART medications.
• Collaborate with local partners and providers across multiple platforms to incorporate more T&T facilities that will offer rapid access to ART and PrEP and PEP medications.
• Increase awareness with local providers to incorporate messaging on T&T and rapid ART protocols.
• Support the use of incentives such as food and transportation vouchers and phones to assist with linkage to care activities.</td></tr>
</table>

<table>
<tr><th>Strategy 2.1.2</th><th colspan="2">Provide same-day initiation or rapid start (within 7 days) of ART for those who are able to take it.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH engaged in care through T&T
• Number of PWH engaged in care through telehealth
• Number of PWH linked to same-day treatment (rapid ART)
• Percent of newly diagnosed PWH linked to HIV medical care in 7 days of diagnosis
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<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV</td></tr>
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Planning Areas

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• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Local Part A and EHE programs</td><td>• Establish youth ambassadors and advocates; collaborate with academic institutions (e.g., Scale It Up Florida).
• Expand routine HIV and STI testing to include additional medical settings (e.g., pediatricians, primary care, and student health centers).
• Increase targeted outreach and education efforts specific to specialized youth and teen groups.
• Increase the number of culturally competent sexual health education in educational, recreational, and faith-based organizations, facilities, and groups.</td></tr>
</table>

9.1.2.2 Objective 2.2: Identify, engage, or reengage people with HIV who are not in care or not virally suppressed

<table>
<tr><th>Strategy 2.2.1</th><th colspan="2">Expand uptake of data-to-care models using data sharing agreements, integration and use of surveillance, clinical services, pharmacy, and social/support services data to identify and engage people not in care or not virally suppressed.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH linked to same-day treatment (rapid ART)
• Number of PWH reengaged through D2C
• Number of PWH engaged in care through telehealth
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV</td></tr>
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• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Local RWHAP Part A and EHE partners</td><td>• Collaborate with local partners and providers across more platforms to incorporate more T&T facilities that will offer rapid ART and PrEP and PEP medications.
• Develop a single-point eligibility data system that will support all RWHAP partners to assist with linkage and retention services.
• Execute cooperative agreements and data sharing agreements with local providers, jails, and prisons to link and refer clients to care who are soon to be released from an institution.
• Support data sharing efforts and educate peers, DIS, medical providers, pharmacists, and eligibility and outreach staff on how to assist in linking clients to care and accessing rapid ART medications.</td></tr>
</table>

<table>
<tr><th>Strategy 2.2.2</th><th colspan="2">Identify and address barriers for people who have never engaged in care or who have fallen out of care.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH linked to same-day treatment (rapid ART)
• Number of PWH reengaged through D2C
• Number of PWH engaged in care through telehealth
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Local RWHAP Part A and EHE partners</td><td rowspan="2">• Expand opportunities to increase awareness and education of local providers on how to incorporate messaging and services for mental health, substance use, homelessness, and other wrap-around services.
• Expand routine HIV/STI testing, and substance use counseling to additional settings such as homeless shelters, urgent care centers, substance use treatment centers.
• Expand RWHAP drug formularies to include more treatment drugs for comorbidities.
• Expand the use of mobile units to assist with linkage and reengagement efforts.
• Support the use of peers to assist with linkage, reengagement, and retention efforts.</td></tr>
<tr><td>Planning Areas</td></tr>
<tr><td>Statewide</td></tr>
</table>

9.1.2.3 Objective 2.3: Increase retention and adherence to treatment to achieve and maintain long-term viral suppression.

<table>
<tr><th>Strategy 2.3.1</th><th colspan="2">Support the transition of health care systems, organizations, and clients to become more health literate in the provision of HIV prevention, care, and treatment services.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">Number of in-person and virtual learning opportunities for staff providing prevention, care, and treatment services
Number of plain language processes and materials developed to assist clients who are newly diagnosed or returning to care
Number of peers and near-peers providing linkage, reengagement, or retention efforts
Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, health care systems, community-based organizations</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>The Department
Community- and faith-based organizations
Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
Behavioral health care and substance abuse settings
Mobile units
STD clinics
Drug treatment programs
SSPs
Local Part A and EHE programs</td><td>Develop plain language processes and materials to assist clients who are newly diagnosed or returning to care.
Offer in person and virtual learning opportunities for basic HIV 101 education and increase the number of trained HIV 101 educators and clients (as a result of increased HIV 101 train the trainer opportunities).
Support the use of peers and near-peers to assist with linkage, reengagement, and retention efforts.</td></tr>
</table>

<table>
<tr><th>Strategy 2.3.2</th><th colspan="2">Develop and implement effective, evidence based or evidence-informed interventions and supportive services that improve retention in care.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of peers, near-peers, and/or CHWs providing retention support
• Number of peer programs implemented
• Number of provider educational opportunities around syndemics
• PWH reengaged through D2C
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Peers and near-peers
• CHWs
• Linkage coordinators
• Local RWHAP Part A and EHE partners</td><td>• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) into primary care practice.
• Expand the use of peers, linkage coordinators and CHWs to implement the ARTAS intervention strategies and adherence measures.
• Identify and integrate best practices for peer programs from similar states and jurisdictions.
• Review EBIs for effectiveness by using validated tools to predict engagement. Ensure EBIs include target audience. Establish rapid response protocols.
• Streamline clinical protocols to eliminate client burden by reducing the frequency of CD4/VL labs, providing 3–6 months of medications at one time, and offering telehealth clinical and case management services.</td></tr>
</table>

<table>
<tr><th>Strategy 2.3.3</th><th colspan="2">Develop and implement effective, evidence-based, or evidence-informed interventions such as HIV telemedicine, accessible pharmacy services, CHWs and peer navigators, and others, that improve convenience and access, facilitate adherence, and increase achievement and maintenance of viral suppression.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of PWH linked to same-day treatment (rapid ART)
• Number of PWH reengaged through D2C
• Number of PWH engaged in care through telehealth
• Number of peers, near-peers, and CHWs providing linkage and retention support
• PWH reengaged through D2C
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, health care systems, academic institutions, community-based organizations</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• Pharmacies
• Peers and near-peers
• Case managers
• CHWs
• Linkage coordinators
• SSPs
• Local RWHAP Part A and EHE partners</td><td>• Allow 3–6 months of ART medications to be dispensed at one time.
• Create funding opportunities for community-based providers to support recruitment and retention of staff.
• Develop a single-point eligibility data system integrated with multi-data systems that will support all RWHAP parts. Implement a centralized eligibility determination system for all RWHAP Parts.
• Expand access to health insurance coverage to eligible clients.
• Provide training to health workers and peers that will support or increase adherence measures.</td></tr>
</table>

<table>
<tr><th>Strategy 2.3.4</th><th colspan="2">Support ongoing clinical, behavioral, and other research to support retention in care, medication adherence and durable viral suppression.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of collaborations with academic institutions engaged in HIV research
• Number of updates to providers on ongoing or recruiting efforts on clinical trials
• Number of FQHCs and other community health settings engaged in research
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, health care systems, academic institutions, community-based organizations</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td rowspan="2">• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia
• Local RWHAP Part A and EHE partners</td><td rowspan="2">• Encourage persons living with HIV to participate in the research by making research findings easier to understand.
• Engage and collaborate with local colleges and universities to increase research opportunities at the local level.
• Engage local organizations such as FQHCs to assist with research and interventions.
• Provide paid incentives to encourage persons living with HIV, students, or researchers to get involved in the research.
• Provide updates to providers on ongoing or recruiting efforts on clinical trials.</td></tr>
</table>

9.1.2.4 Objective 2.4: Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV

<table>
<tr><th>Strategy 2.4.1</th><th colspan="2">Provide resources, value-based and other incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent and linguistically appropriate care, treatment, and supportive services especially in areas with shortages that are geographic, population, or facility based.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of cultural humility trainings performed
• Number of public health workforce trainings on PrEP and PEP, mental health, and substance use or misuse
• Number of PWH engaged in care through telehealth
• Number of peers, near-peers, and CHWs providing linkage and retention support
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, community-based organizations, health care delivery systems, public health, and health workforce</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• Pharmacies
• Peers and near-peers
• Case managers
• Linkage coordinators
• CHWs
• SSPs
• Local RWHAP Part A and EHE partners</td><td>• Collaborate with the AETC to assist with training efforts.
• Establish a statewide conference for medical providers.
• Expand telehealth to increase capacity for services and use mobile units to increase outreach efforts.
• Increase culturally competent HIV trainings to local providers.
• Increase targeted outreach and education efforts specific to specialized providers.</td></tr>
</table>

<table>
<tr><th>Strategy 2.4.2</th><th colspan="2">Increase the diversity of the workforce of providers who deliver HIV and supporting services.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of public health workforce trainings on basic HIV education
• Number of peers, near-peers, and/or community health workers providing linkage and retention support
• Number of provider educational opportunities around syndemics
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, community-based organizations, health care delivery systems, public health, and health workforce</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• Peers and near-peers
• Case managers
• CHWs
• SSPs
• Local RWHAP Part A and EHE partners</td><td>• Facilitate the ability of peers, medical providers, and eligibility staff to link clients to care and access rapid ART medications.
• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) into primary care practice.
• Increase providers of color in communities.
• Offer in-person and virtual learning opportunities for basic HIV 101 education and increase the number of trained HIV 101 educators (as a result of increased HIV 101 train the trainer opportunities).
• Modify contractual language in HIV contracts to encourage staffing reflects the local demographics of the HIV population.</td></tr>
</table>

<table>
<tr><th>Strategy 2.4.3</th><th colspan="2">Increase inclusion of paraprofessionals on teams by advancing training, certification, supervision, reimbursement, and team functioning to assist with screening/management of HIV, STIs, viral hepatitis, and mental and substance use disorders and other behavioral health conditions.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of peer navigators or near-peers
• Number of public health workforce trainings on basic HIV education
• Number of peers, near-peers, and CHWs providing screening and adherence support
• Number of provider educational opportunities around syndemics
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, community-based organizations, health care delivery systems, public health, paraprofessional, and health workforce</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• Peers and near-peers
• Case managers
• CHWs
• SSPs
• Certified addiction professionals and counselors
• Local RWHAP Part A and EHE partners</td><td>• Collaborate with social service organizations on screening and management of HIV, STIs, viral hepatitis, and mental and substance use disorders and other behavioral health conditions.
• Identify support staff who can be trained to provide support services in a range of industries (i.e., medical COE).
• Develop and implement a statewide peer certification program.
• Increase training and inclusion opportunities for CHWs.
• Collaborate with other social service providers to increase screening and management of HIV, STI, viral hepatitis, and mental and substance abuse.
• Expand collaborations with school health services to provide support to the younger population.
• Identify and promote trainings for paraprofessionals regarding social determinants of health and the syndemics facing Florida.</td></tr>
</table>

9.1.2.5 Objective 2.5 Expand capacity to provide whole-person care to older adults with HIV and long-term survivors

Strategy 2.5.1	**Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure quality of care across services.**	
Data Indicators	• Number of partnerships with organizations that serve PWH aged 50+ • Assessment of barriers to care for PWH aged 50+ • Number of educational opportunities for PWH aged 50+ • Number of collaborations with service providers that specialize in services for the aging population • Number of educational opportunities in settings where persons aged 50+ may reside or congregate (senior centers, retirement communities) • Additional specific, quantifiable measures for each activity (TBD)	
Priority Populations	Persons over the age of 50 living with diagnosed HIV	
Timeframe	**Critical Partners**	**Activities**
By 12/31/2026 **Planning Areas** Statewide	• The Department • Community- and faith-based organizations • Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites • Behavioral health care and substance abuse settings • Mobile units • STD clinics • Drug treatment programs • SSPs • Academia • Local RWHAP Part A and EHE partners	• Broaden the scope of partnerships to include established entities who serve PWH over the age of 50 providing primary, specialty and pharmacy services. • Utilize statewide advisory groups to identify barriers in models of care for PWH who are aging. • Collaborate with existing service providers (e.g., Eldersource, Department of Elder Affairs, Visiting Angels) that work with the elderly to integrate in HIV prevention, care, and support services. • Increase HIV and aging education in senior centers, assisted living facilities, retirement communities, and others. • Collaborate with geriatric care providers to educate on risk of aging PWH. Also educate them on risk for older patients who may be at risk of acquiring HIV, e.g., how to talk to and engage older adults in sexual health conversations.

<table>
<tr><th>Strategy 2.5.2</th><th colspan="2">Identify and implement best practices related to addressing psychosocial and behavioral health needs of older people with HIV and long-term survivors including substance use treatment, mental health treatment, and programs designed to decrease social isolation.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of partnerships with organizations which address psychosocial and behavioral health for PWH aged 50+ and long-term survivors.
• Number of educational opportunities on substance use and mental health for PWH aged 50+
• Number of educational opportunities in settings where persons aged 50+ may reside or congregate (senior centers, retirement communities)
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons over the age of 50 living with diagnosed HIV</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• The Department
• FDEA
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia
• Area Agencies on Aging
• Local RWHAP Part A and EHE partners</td><td>• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) and behavioral health into primary care practice.
• Increase provider knowledge on the aging HIV population and the effects on dementia.
• Expand partner networks to include organizations already addressing psychosocial and behavioral health for persons with HIV aged 50+ and long-term survivors.
• Engage national aging institutions to advise on establishing the most effective program design to address psycho-social and behavioral needs of the aging population including substance use and mental health treatment.
• Review existing research and evidence-based practices from mainstream non-HIV oriented care providers and integrate into HIV-oriented care.
• Establish Long Term Survivor Empowerment Teams which can foster individual virtual or in-person mental health sessions assessing the needs of patients and ensuring their needs are met accordingly.
• Reach out to existing elder services providers to learn more about what they offer and what’s working and ask how HIV prevention and support could be added into their efforts.</td></tr>
</table>

<table>
<tr><th>Strategy 2.5.3</th><th colspan="2">Increase HIV awareness, capability, and collaboration of service providers to support older people with HIV, including in settings such as aging services, housing for older adults, substance use treatment, and disability and other medical services.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">Number of partnerships with organizations which address psychosocial and behavioral health for PWH aged 50+ and long-term survivors.
Number of educational opportunities on substance use and mental health for PWH aged 50+
Number of educational opportunities in settings where persons aged 50+ may reside or congregate (senior centers, retirement communities)
Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons over the age of 50 living with diagnosed HIV</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>The Department
FDEA
Community- and faith-based organizations
Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
Behavioral health care and substance abuse settings
Mobile units
STD clinics
Drug treatment programs
SSPs
Academia
Area Agencies on Aging
Local RWHAP Part A and EHE partners</td><td>Collaborate with local Area Agencies on Aging.
Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) and behavioral health into primary care practice.
Establish a long-term survivor peer empowerment team (statewide).</td></tr>
</table>

<table>
<tr><th>Strategy 2.5.4</th><th colspan="2">Promote research, cross-agency collaborations, and sharing of research discoveries that address specific aging-related conditions in people with HIV, and other comorbidities and coinfections that can impact people with HIV of all ages.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of collaborations with service providers that specialize in services for the aging population
• Number of educational opportunities on substance use and mental health for PWH aged 50+
• Number of educational opportunities provided by HIV long-term survivor groups
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, academic institutions, community-based organizations, health care delivery systems, and public health systems</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• FDEA
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia
• Academy of HIV Medicine
• Area Agencies on Aging
• Association of Nurses in AIDS Care
• Local RWHAP Part A and EHE partners</td><td>• Create housing opportunities for the aging HIV population.
• Expand funding to allow medical and support care for comorbidities.
• Integrate cross-agency collaborations to include access to all client-level data to all RWHAP parts.
• Provide education around HIV and aging to local partners and service organizations
• Provide HIV education to the Florida Insurance Commission’s office to promote less insurance burdens on HIV care.
• Collaborate with HIV long-term survivor’s groups to provide education to various stakeholder groups.</td></tr>
</table>

<table>
<tr><th>Strategy 2.5.5</th><th colspan="2">Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing people living with HIV at various life stages to support healthy aging with HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number RWHAP programs offering geriatric case management services
• Number of collaborations with service providers that specialize in services for the aging population
• Number of educational opportunities on substance use and mental health for PWH aged 50+
• Number of educational opportunities provided by HIV long-term survivor groups
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, academic institutions, community-based organizations, health care delivery systems, and public health systems</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td rowspan="2">• The Department
• FDEA
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia
• Area Agencies on Aging
• Assisted living and skilled nursing facilities
• Local RWHAP Part A and EHE partners</td><td rowspan="2">• Expand RWHAP services to offer geriatric case management and offer partner prevention services.
• Explore opportunities to educate local and state legislators on the important role medical marijuana plays in the management of HIV disease.
• Increase awareness with local providers to incorporate messaging on T&T and rapid ART protocols, HIV stigma and care, and aging HIV population.
• Increase provider knowledge on aging HIV population, including persons with perinatally-acquired HIV
• Revise service delivery models to address healthy aging and address comorbidities.</td></tr>
</table>

9.1.2.6 Objective 2.6: Advance the development of next-generation HIV therapies and accelerate research for HIV cure.

<table>
<tr><th>Strategy 2.6.1</th><th colspan="2">Promote research and encourage public-private partnerships to accelerate new therapies to achieve sustained viral suppression and to address drug toxicity, viral resistance, adherence, and retention in care and stigma associated with ART use.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number RWHAP programs offering geriatric case management services
• Number of collaborations with service providers that specialize in services for the aging population
• Number of collaborations with academic institutions focusing on HIV therapies and HIV cure research
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, academic institutions, community-based organizations, health care delivery systems, and public health systems</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Local RWHAP Part A and EHE partners</td><td>• Collaborate with academic institutions to explore opportunities for research around HIV therapies and an HIV cure.
• Explore ways to leverage RWHAP Part A funding to support services for aging PWH.
• Provide HIV education to the Florida Insurance Commission’s office to promote less insurance burdens on HIV care.</td></tr>
</table>

<table>
<tr><th>Strategy 2.6.2</th><th colspan="2">Increase investment in innovative basic and clinical research to inform and accelerate a research agenda to discover how to sustain viral suppression, achieve ARV-free remission, reduce, and eliminate viral reservoirs, and achieve HIV cure.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Percent of ADAP clients using injectable ART
• Number of collaborations with academic institutions focusing on HIV therapies and HIV cure research
• Number of collaborations with academic institutions engaged in clinical research and ART clinical trials
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV, academic institutions, community-based organizations, health care delivery systems, and public health systems</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Local RWHAP Part A and EHE partners</td><td>• Engage with medical providers and insurance companies to on ways to reduce the burden of medication interruption.
• Collaborate with academic partners and institutions on clinical research and ART clinical trials.
• Collaborate with academic partners and institutions to explore opportunities for research around HIV therapies and an HIV cure.
• Increase access to ART injection medications through ADAP and other payer sources.</td></tr>
</table>

9.1.3 Goal 3: Reduce HIV-related Disparities and Health Inequities

9.1.3.1 Objective 3.1. Reduce HIV-related stigma and discrimination

<table>
<tr><th>Strategy 3.1.1</th><th colspan="2">Strengthen enforcement of civil rights laws (including language access services and disability rights), reform state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, and sexism.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of educational and skills building opportunities for PWH
• Stigma indicator to be developed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Advocates
• Local and state law enforcement
• First responders
• Department of Justice and U.S. Immigration and Customs Enforcement satellite offices
• Correctional facilities
• HIV Justice Coalitions
• RWHAP partners</td><td>• Educate local and state law enforcement agencies on culturally competent HIV basics, civil rights, and trauma informed care.
• Educate local and state legislators, political and civic. Leaders and organizations, and policy makers on basic HIV transmission, prevention, and care; include HIV data specific to local areas.
• Support education and skill building opportunities for PWH to promote understanding of civil rights and engagement in policy making.</td></tr>
</table>

<table>
<tr><th>Strategy 3.1.2</th><th colspan="2">Ensure that health care professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or at risk for HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of continuing education opportunities and trainings for health care professionals and front-line staff
• Number of HIV stigma materials developed and/or disseminated
• Stigma indicator to be developed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• State and local law enforcement
• First responders
• RWHAP partners</td><td>• Develop and/or identify and disseminate HIV stigma materials and resources for health care professionals and front-line staff.
• Identify and disseminate continuing education opportunities and training for health care professionals and front-line staff on HIV stigma; include working with the AETC and Area Health Education Centers.
• Work with professional organizations to encourage the adoption of HIV stigma training as part of professional standards for health care professionals and front-line staff.</td></tr>
</table>

<table>
<tr><th>Strategy 3.1.3</th><th colspan="2">Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of outreach and education opportunities to recruit peers
• Number of community and faith-based leaders engaged in trainings that address HIV stigma and misconceptions
• Stigma indicator to be developed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• RWHAP partners</td><td>• Conduct outreach and education campaigns to train and employ peers to provide education, navigation, and support services.
• Create opportunities and invite marginalized individuals to speak and join virtually (and anonymously) to present their perspectives, educate, and stay protected.
• Engage community- and faith-based leaders at local and state levels to develop and host culturally tailored trainings that address stigma and HIV misconceptions.
• Support local areas to develop general education and social media campaigns and materials to de-stigmatize HIV and those living with or affected by HIV.</td></tr>
</table>

<table>
<tr><th>Strategy 3.1.4</th><th colspan="2">Ensure resources are focused on the communities and populations where the need is greatest, especially Black, Latino, and American Indian/Alaska Native and other people of color, particularly those who are also gay and bisexual men, transgender people, people who use substances, sex workers, and immigrants.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new diagnoses in communities and priority populations at increased risk for HIV
• Number of mobile medical units providing services to priority populations
• Number of ongoing and new initiatives for priority populations
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• RWHAP partners</td><td>• Identify or develop information to educate potential funders and philanthropic organizations to increase awareness of HIV-impacted populations and communities.
• Support ongoing and new initiatives and programs specifically focused on priority populations.
• Use HIV data to target HIV and STI education and outreach to high-priority populations and ZIP codes which reflect the residents and effectively represent the community.
• Use mobile medical units and street outreach to bring services and resources to communities and populations where the need is greatest.</td></tr>
</table>

<table>
<tr><th>Strategy 3.1.5</th><th colspan="2">Create funding opportunities that specifically address social determinants of health (SDOH) as they relate to Black, Latino, and American Indian/Alaska Native and other people of color.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of funding opportunities which support programs that address SDOH in Black, Hispanic and other racial/ethnic communities
• Number of educational opportunities which address SDOH
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Tribal organizations
• RWHAP partners</td><td>• Approach private corporations and other entities for sponsorship and educational opportunities to address SDOH.
• Develop mini grants and create other opportunities to support programs that address SDOH in Black, Hispanic/Latino, and other racial/ethnic communities.
• Explore opportunities to expand the use of MAI funding and assess outcomes.</td></tr>
</table>

9.1.3.2 Objective 3.2. Reduce disparities in new HIV diagnoses, in knowledge of status, and along the HIV care continuum

<table>
<tr><th>Strategy 3.2.1</th><th colspan="2">Increase awareness of HIV-related disparities through data collection, analysis, and dissemination of findings.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of materials developed and disseminated which highlight HIV-related disparities
• Number of HIV data dashboards available
• Number of educational opportunities and listening sessions for impacted communities
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• RWHAP partners</td><td>• Develop and expand the use of easy-to-read materials (e.g., infographics, one pagers) to help audiences of varying types (general public, clients, providers) to highlight HIV-related disparities.
• Expand the use of data dashboards and provide education to relevant groups on how to access and use the information to increase awareness of HIV-related disparities.
• Focus efforts to educate and gather information from populations and communities impacted by disparities. Include client perspectives and needs in addition to quantitative data.</td></tr>
</table>

<table>
<tr><th>Strategy 3.2.2</th><th colspan="2">Develop new and scale up effective, evidence-based, or evidence-informed interventions to improve health outcomes among priority populations and other populations or geographic areas experiencing disparities.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of collaborations with academic institutions and other partners (outside of HIV)
• Number of funding opportunities which focus on improving health outcomes in priority populations
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Community-HIV Advisory Group
• RWHAP partners</td><td>• Collaborate with academic institutions and other partners (outside of HIV) to develop EBIs focused on priority populations and geographic areas impacted by disparities; other partners include mental health, substance use, SAMHSA providers, local homeless coalitions, and others.).
• Develop funding mechanisms to support the development or scale up of interventions to improve health outcomes (e.g., mini-grants, RFAs, purchase orders).
• Support opportunities at local and state levels to develop or scale up EBIs, including developing internship programs to engage young professionals.
• Use local economic modeling to determine those interventions for scale up (e.g., interventions that have the greatest potential to reduce HIV in communities and populations experiencing disparities).</td></tr>
</table>

9.1.3.3 Objective 3.3. Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV

<table>
<tr><th>Strategy 3.3.1</th><th colspan="2">Create and promote public leadership opportunities for people with or at risk for HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of people with or at risk for HIV on planning bodies and other advisory groups
• Establishment of peer navigator certification program
• Number of training and mentorship opportunities for PWH to build leadership and advocacy skills
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• Community-HIV Advisory Group
• SSPs
• Academia
• RWHAP partners</td><td>• Develop and support opportunities for people living with or affected by HIV to serve in leadership roles at state and local levels (e.g., HIV Speaker’s Bureau).
• Establish a statewide peer navigator and educator certification program.
• Increase and expand education, training, and mentorship opportunities for PWH to build skills for engaging in a variety of leadership and advocacy roles (social, political, civic, spiritual).
• Create an inventory of chairs and co-chairs for local area advisory and planning groups</td></tr>
</table>

<table>
<tr><th>Strategy 3.3.2</th><th colspan="2">Work with communities to reframe HIV services and HIV-related messaging so they do not stigmatize people or behaviors.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of HIV-related materials reviewed by the state's educational material review panel
• Number of engagement activities conducted with priority populations and local leaders to develop HIV-related messaging
• Stigma indicator to be developed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Community-HIV Advisory Group
• Educational material review panel
• RWHAP partners</td><td>• Engage with priority populations and local leaders/influencers to develop HIV-related messaging that does not stigmatize.
• Ensure the intentional use of people-first and inclusive language in HIV service delivery, educational materials, and informational campaigns (review existing and incorporate into new products).
• Expand the use the state's health education review panel (i.e., Carlos Alvarez Educational Material Review Panel) to ensure HIV-related messaging and materials are culturally and linguistically appropriate and use people-first language.</td></tr>
</table>

9.1.3.4 Objective 3.4: Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities

<table>
<tr><th>Strategy 3.4.1</th><th colspan="2">Develop whole-person systems of care that address co-occurring conditions for people with HIV or at risk for HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of syphilis diagnoses in communities and priority populations at risk for STIs
• Number of HCV diagnoses in communities and priority populations at increased risk for HCV, including PWID
• STI, HCV, and TB co-infection rates among persons diagnosed with HIV
• Number of new diagnoses in communities and priority populations at increased risk for HIV
• Viral suppression percentages in communities and priority populations at increased risk for HIV
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• RWHAP (all parts) and EHE partners</td><td>• Expand local partnerships and collaborate with local providers to address and alleviate barriers to accessing care.
• Identify opportunities to centralize eligibility, enrollment services, and health care services for PWH (e.g., HOPWA, RW, ADAP).
• Incorporate other health screenings and services into HIV care.
• Pilot health care models and interventions for people at risk for or living with HIV who have co-occurring conditions e.g., SUD and mental health conditions.</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.2</th><th colspan="2">Adopt policies that reduce cost, payment, and coverage barriers to improve the delivery and receipt of services for people with or at risk for HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of HIV service providers offering after hours and weekend services for HIV clients
• Number of training and cross-training opportunities for medical case managers, RWHAP Part B, HOPWA, and CBOs
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• RWHAP Part A and EHE partners
• RWHAP Part B
• Health care and related policy and advocacy orgs.
• Insurance providers
• Pharmaceutical industry partners</td><td>• Centralize eligibility processes and cross-train medical case managers, RWHAP Part B, HOPWA and CBOs.
• Streamline clinical practices, reduce annual number of visits, CDH, PVC tests. Three or 6-month ART prescriptions.
• Explore cost-effective programs that reduce cost, payment, and coverage barriers to improve the delivery and receipt of services for people with or at risk for HIV and use their findings for adopting related policies.
• Create consistencies in the RWHAP system of care (Part A, Part B) to eliminate barriers to HIV care (e.g., longer time in between recertification, reciprocal eligibility).
• Explore the incorporation of afterhours and weekend services for HIV clients to assist with retention in and adherence to care.
• Engage in discussions with Florida Office of Insurance Regulation, Medicaid/Medicare (ACHA), and other entities to identify policies that create barriers for delivery of HIV services for people with or at risk for HIV.</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.3</th><th colspan="2">Improve screening and linkage to services for people with or at risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of educational opportunities for providers specializing in co-occurring conditions
• Number of partnerships with agencies implementing routine screening and linkage services
• Number of mobile units offering HIV/STI screening, treatment, and prevention services during non-traditional hours
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• STD clinics
• Mobile units
• Drug treatment programs
• SSPs
• Academia
• RWHAP and EHE partners</td><td>• Educate providers specializing in co-occurring conditions.
• Expand collaboration with FQHCs (and FQHC look-alikes) at state level to improve screening.
• Expand partnerships with agencies to expand routine screening and linkage to care services for persons newly diagnosed with HIV or for persons previously diagnosed who are returning to care.
• Address challenges and barriers to screening and linkage to services for people with or at risk for HIV who are diagnosed with and are receiving services for co-occurring conditions.
• For those at risk, educate non-HIV providers to conduct sexual health and substance use risk assessments routinely. Work with medical certification boards to ensure ongoing education and compliance.
• Increase the use of mobile units offering HIV and STI screening, treatment, and prevention services beyond traditional testing hours.
• Explore opportunities to modify electronic medical records to increase routine screening and facilitate information sharing</td></tr>
</table>

<table>
<tr><td>Strategy 3.4.4</td><td colspan="2">Develop and implement effective, evidence-based- or evidence-informed interventions that address social determinants of health among people with or at risk for HIV including lack of continuous health care coverage, HIV-related stigma and discrimination in public health and health care systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.</td></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of mobile units providing outreach services to priority populations
• Number of educational materials identified and disseminated on client rights and health literacy
• Stigma indicator to be developed
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Peers and near-peers
• CHWs
• RWHAP (all parts) and EHE partners
• Local and state law enforcement
• Housing coalitions
• Health care and related policy and advocacy orgs.
• Transportation agencies</td><td>• Expand the use of mobile outreach units and telehealth technology to address SDOH and provide linkage referrals.
• Explore opportunities to use peers and CHWs as mentors outside of the health care system.
• Identify and disseminate information and trainings for clients on their rights, grievance policies, customer feedback, and health literacy.</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.5</th><th colspan="2">Develop new and scale up effective, evidence-based/informed interventions to improve health outcomes and QOL for people across lifespan including youth and people over 50 w/ or at risk for HIV, and long-term survivors.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Establishment of telehealth provider network
• Number of cultural humility trainings for providers
• Number of non-traditional HIV/STI testing and treatment sites
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons aged 50+; youth; long-term survivors</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• The Department
• FDEA
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Area Agencies on Aging
• Elder services agencies</td><td>• Develop a telehealth provider network.
• Expand access to HIV/STI testing and treatment outside of public health; include public-private partnerships.
• Identify and disseminate trainings that include cultural humility trainings for providers.
• Identify best practices for consortia to find and identify EBIs.
• Promote long-term survivor groups and the Florida Gay Men’s HIV Workgroup.</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.6</th><th colspan="2">Develop new and scale up effective, evidence-based/informed interventions that address intersecting factors of HIV, trauma and violence, and gender especially among cis- and transgender women and gay and bisexual men.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of trainings identified and disseminated on TIC
• Number of training opportunities for evidence-based interventions addressing mental health
• Number of training opportunities to educate the HIV, STD, hepatitis/substance use, and mental health workforce on intersecting issues
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; persons in high-seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Correctional settings
• RWHAP and EHE partners
• Correctional settings
• Advocacy groups</td><td>• Create opportunities to support providers and agencies implementing EBIs that address trauma and violence.
• Identify and disseminate provider trainings on trauma informed care (TIC).
• Identify and develop training-of-trainers for TIC to ensure all RWHAP are using a TIC approach.
• Provide training opportunities for existing EBIs in the mental health practice.
• Identify existing effective, EBIs that address intersecting factors of HIV, trauma and violence, and gender.
• Recruit staff with lived experience that reflect the PWH they are trying to serve.
• Educate the HIV, STD, hepatitis, substance use, and mental health workforce on the intersecting issues. Ensure diverse organizations are involved in the development of new cross-sectional interventions. Seek out or directly provide funds to support collaborative efforts.</td></tr>
</table>

9.1.3.5 Objective 3.5: Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations.

<table>
<tr><th>Strategy 3.5.1</th><th colspan="2">Promote the expansion of existing programs and initiatives designed to increase the numbers of racial/ethnic minority research and health professionals.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of trainings for HBCUs around HIV prevention, care, and treatment
• Number of partnerships established with HBCUs
• Development of inventory of SPNS projects and opportunities for replication
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Racial/ethnic minority research and health professionals</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• HBCUs
• Health care providers
• Health care professional organizations</td><td>• Create a state-funded program to fill federal gaps.
• Cross-train CHWs.
• Increase promotion of the HIV field in academic institutions (e.g., MPH programs, Schools of Medicine, Pharmacy, Nursing, and Social Work) through career fairs and supporting certifications and training programs.
• Provide training and opportunities for partnership with HBCUs around HIV prevention, care, and treatment.
• Develop an inventory of SPNS and support funding opportunities to replicate effective programs.</td></tr>
</table>

<table>
<tr><th>Strategy 3.5.2</th><th colspan="2">Increase support for the implementation of mentoring programs for individuals from diverse cultural backgrounds to expand the pool of HIV research and health professionals.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of organizations identified that have mentorship programs
• Number of training opportunities identified for PWH to build leadership and advocacy skills
• Number of professional groups and associations engaged
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• HBCUs
• Health care providers
• Health care professional organizations</td><td>• Identify and support the use of mentorship programs for individuals from diverse backgrounds
• Elevate voices of people living with HIV through increased advocacy and training. Encourage their participation through support groups. Ensure people who represent the population are in positions to assist with peer support services.
• Support implementation of mentoring programs for individuals from diverse cultural backgrounds to expand the pool of HIV research and health professionals.
• Identify organizations that have existing mentoring programs and disseminate the information with other agencies to coordinate efforts.
• Reach out to professional groups that emphasize memberships of color like the National Association for Black Social Workers, HBCUs, sororities and fraternities, civic organizations, and others.</td></tr>
</table>

<table>
<tr><th>Strategy 3.5.3</th><th colspan="2">Encourage the implementation of effective recruitment of community partners through community-based participatory research and social networking approaches.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of opportunities to collaborate with the Florida Center for HIV/AIDS Research
• Number of research study opportunities shared with community partners and planning bodies
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWI and persons who use drugs</td></tr>
<tr><th>Timeframe</th><th>Critical Partners</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• HBCUs
• Health care providers
• Health care professional organizations</td><td>• Develop professional articles for publication.
• Identify opportunities to collaborate with the FCHAR.
• Provide information on and encourage community participation in legitimate research studies and grants.
• Recruit youth and young adults to participate in local and state HIV planning bodies and advisory workgroups.
• Support the use of community opinion leaders and social networking strategies.
• Amplify and encourage efforts to share research output with participants.</td></tr>
</table>

9.1.3.6 Objective 3.6: Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and health care mistrust.

<table>
<tr><th>Strategy 3.6.1</th><th colspan="2">Develop and test strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of educational and community sharing opportunities to share information and address misinformation
• Number of anti-stigma campaigns and materials developed to dispel HIV myths
• Assessment of common myths and misconceptions held in and among priority populations
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Peers and near-peers
• CHWs
• Academia
• Media partners
• Digital content providers
• RWHAP and EHE partners</td><td>• Assess common myths and misconceptions in and among priority populations and identify strategies to combat misinformation.
• Promote the use of community sharing experiences and educational opportunities (e.g., community forums, celebrations, observance days).
• Ensure messaging is succinct, culturally appropriate, consistent with HIV treatment guidelines, and delivered by persons credible to diverse populations across the state.
• Develop and disseminate anti-stigma campaigns which focus on dispelling myths and misconceptions about HIV.
• Expand the use of community gatekeepers and social network strategies to deliver HIV information through culturally appropriate methods.
• Use existing workgroups to assist with developing and testing strategies to promote accurate creation, dissemination, and uptake of information and to counter misinformation.</td></tr>
</table>

<table>
<tr><th>Strategy 3.6.2</th><th colspan="2">Increase diversity and cultural competence in health communication research, training, and policy.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of collaborations with HBCU medical colleges and other schools of health
• Number and type of training opportunities for cultural humility in health communication research
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• HBCUs
• Professional and policy organizations and associations</td><td>• Create opportunities for advancement among diverse candidates.
• Identify ways to create more targeted messaging for specific populations of PWH and consistently use language that is both people-first and inclusive.
• Work with HBCU medical colleges such as Pharmacy, Social Work, Nursing, Medical Schools, and others.
• Provide training opportunities for diversity and cultural competence in health communication research, training, and policy (e.g., conferences, webinars, lunch-and-learns).
• Train and hire PWH who are qualified for roles in HIV leadership, research, training, peer support, and others.
• Work with statewide advisory groups and SMEs to identify ways in which diversity and cultural humility can be incorporated into health communication trainings.</td></tr>
</table>

<table>
<tr><th>Strategy 3.6.3</th><th colspan="2">Expand community engagement in health communication initiatives and research.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number and type of engagements with CBOs, social service agencies and community resource centers
• Assessment of populations that may not be receiving accurate health information
• Number of collaborations with academic institutions to solicit feedback on health communication initiatives and research
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Community gatekeepers
• RWHAP and EHE partners</td><td>• Identify ways to engage priority populations and communities in HIV media and messaging initiatives and research.
• Increase engagement with CBOs, community resource centers, and social service agencies to help develop new health communication initiatives; activities could include townhall meetings, focus groups, health fairs, community celebrations, cultural events, and others.
• Assess populations that may not be receiving accurate health communications, recruit leaders from those populations and train them to disseminate communications (through staffing agreement).
• Engage with academic institutions (e.g., HBCUs) to solicit feedback on health communication initiatives and research.
• Amplify and encourage efforts to share research output with participants.</td></tr>
</table>

<table>
<tr><th>Strategy 3.6.4</th><th colspan="2">Include critical analysis and health communication skills in HIV programs to provide participants with the tools to seek and identify accurate health information and to advocate for themselves and their communities.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number and type of needs assessments conducted
• Number of educational opportunities for providers, peers, and staff on health literacy identified and disseminated
• Number and type of health literacy resources identified and developed for clients
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• AETC
• Community gatekeepers
• CHWs
• Peers and near-peers</td><td>• Explore ways in which to incorporate critical analysis and health communication skills into HIV programs and services to increase client skills needed for health literacy and advocacy.
• Ensure that needs assessments are conducted regularly, including questions related to provider communication skills and HIV-related messaging, in order to better respond to community needs and identify areas for improvement.
• Identify and disseminate educational opportunities for providers, peers, and staff on health literacy, and encourage providers to screen clients for health literacy in order to be able to ensure the successful transfer of health information and health communication.
• Identify and develop health literacy resources for clients that are new to care in order to help orient them to ways they can become more knowledgeable about their health and actively participate in their plan of care.
• Increase provider and staff knowledge for strategies to identify and address misinformation and for strategies that increase the sharing of accurate health information.</td></tr>
</table>

<table>
<tr><th>Strategy 3.6.5</th><th colspan="2">Expand effective communication strategies between providers and clients to build trust, optimize collaborative decision-making, and promote success of evidence-based prevention and treatment strategies.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of local leaders, influencers, and gatekeepers recruited to assist with communication initiatives
• Number of CHWs and peers
• Number of education and training opportunities on leading with empathy, active listening, patient experience, and on TIC
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• AETC
• Community gatekeepers
• CHWs
• Peers and near-peers</td><td>• Identify best practices for effective communication strategies between providers and clients to address medical mistrust.
• Recruit local leaders, influencers, and gatekeepers to assist with communication initiatives designed to build trust.
• Use CHWs and peers help to bridge communication gaps between clients and providers.
• Offer education and training on leading with empathy, active listening, patient experience, and TIC to promote understanding amongst clients and providers to build trust in the client to provider relationship.
• Research best practices in effective communication and explore the creation of a health communication resource compendium.
• Increase the reach of messaging and media by engaging with community leaders and expanding partnerships to include organizations and agencies of all size.
• Offer third-party encryption messaging to strengthen consumer trust.</td></tr>
</table>

9.1.4 Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Interested Parties

9.1.4.1 Objective 4.1. Integrate programs to address the syndemic of HIV, STIs, viral hepatitis, and substance use and mental health disorders in the context of social and/or institutional factors including stigma, discrimination, and violence

<table>
<tr><th>Strategy 4.1.1</th><th colspan="2">Integrate HIV awareness and services into outreach and services for issues that intersect with HIV such as intimate partner violence, homelessness/housing instability, STIs, viral hepatitis, and substance abuse/mental health disorders.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Development of community of practice to share expertise and collaborate on focus areas
• Number of trainings identified and disseminated related to human trafficking, domestic violence, and sexual assault
• Number of partnerships with mobile providers
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• PWH engaged in services
• Housing coalitions
• HOPWA providers
• State and local law enforcement</td><td>• Develop a Community of Practice program (HUD, Homeless Coalition, FDOE, FDC) to learn, share expertise, and collaborate on focus areas.
• Expand marketing and advertising campaigns of internal and external partners to promote and increase awareness of resources and services.
• Identify and disseminate trainings and technical assistance on human trafficking, domestic and intimate partner violence and sexual assault for health care staff.
• Increase partnerships with mobile service providers.
• Leverage social media and outreach to disseminate program results and lesson learned.</td></tr>
</table>

<table>
<tr><th>Strategy 4.1.2</th><th colspan="2">Implement a no-wrong-door approach to screening and linkage to services for HIV, STIs, viral hepatitis, and substance use and mental health disorders across programs.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of reciprocal agreements established with local community partners
• Number of HIV service providers using a no-wrong-door approach to screening and linkage services
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Health care providers
• RWHAP and EHE partners</td><td>• Adopt a no-wrong-door approach focused on streamlining referral processes and linkage to care. A no-wrong-door approach provides individuals with or links them to appropriate services regardless of where they enter the system of care. This principle commits all service agencies to respond to the individual’s stated and assessed needs with appropriate treatment or supportive linkage with programs capable of meeting the client’s needs.
• Establish local referral networking system to increases access to care through assignment of health care navigators.
• Establish reciprocal agreements with local community partners.</td></tr>
</table>

<table>
<tr><th>Strategy 4.1.3</th><th colspan="2">Identify and address funding, policy, data, workforce capacity, and programmatic barriers to effectively address the syndemic.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of local information sessions conducted with stakeholders to identify barriers to service delivery
• Analysis of data from the state’s HIV/AIDS hotline
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Health and human rights advocates
• HIV/AIDS policy experts
• Health care providers
• STD clinics
• RWHAP and EHE partners
• Local planning bodies</td><td>• Analyze and explore ways to use data from the state HIV/AIDS hotline to assess barriers.
• Access statewide resources to identify gaps in service and funding opportunities to combat programmatic barriers.
• Conduct local information sessions/workshops with stakeholders to analyze data and identify problematic areas as it relates to the delivery of service.
• Create incident reporting system to identify individuals in need of assistance (e.g., assault, discrimination, housing).
• Engage with local and state legislators to educate and inform on workforce capacity and impacts of staffing shortages.</td></tr>
</table>

<table>
<tr><th>Strategy 4.1.4</th><th colspan="2">Coordinate and align strategic planning efforts on HIV, STIs, viral hepatitis, substance use disorders, and mental health care across national, state, and local partners.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Development of collaborative forum to share and learn about OD2A programs
• Number of local health care facilities participating in local community health needs assessments
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• FDCF
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings and providers
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• RWHAP and EHE partners
• Local planning bodies</td><td>• Ensure the Community Health Improvement Plan and Community Health Assessment is inclusive of internal and external partners.
• Create a collaborative forum to share and learn about (OD2A programs across multi-agencies (e.g., faith-based organizations, CBOs, providers, the Department, FDCF).
• Ensure the State Health Improvement Plan process and planning is inclusive of external groups and partners.
• Establish a role or function in existing local planning bodies to conduct research into opioid initiatives and networks.
• Invite local health care facilities to participate in local community health needs assessments.</td></tr>
</table>

Strategy 4.1.5	Enhance the ability of the HIV workforce to provide naloxone and educate people on the existence of fentanyl in the drug supply to prevent overdose and deaths and facilitate linkage to substance use disorder treatment and harm reduction programs.	
Data Indicators	• Number of opportunities to education state and local legislators on harm-reduction practices • Number of local planning bodies supporting or participating in opioid initiatives • Number and type of naloxone access points • Number of naloxone training courses identified and disseminated • Additional specific, quantifiable measures for each activity (TBD)	
Priority Populations	HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth	
Timeframe	**Critical Partners**	**Activities**
By 12/31/2026 **Planning Areas** Statewide	• The Department • Community- and faith-based organizations • Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites • Behavioral health care and substance abuse settings • Drug treatment programs • SSPs • Academia • Health care providers • State and local law enforcement • Local planning bodies • RWHAP and EHE partners	• Educate local and state legislators on the use of fentanyl test strips and alignment with harm-reduction practices. • Establish a role or function in existing local planning bodies across multiple agencies (CHD, community, state, FCPN, OD2A project opioid providers) to support and/participate in opioid initiatives or the development of an opioid initiative. • Implement Naloxone Training Course and Training Program (CDC) • Increase the number of access points for naloxone (statewide). • Integrate OD2A into RWHAP service delivery system at local levels.

9.1.4.2 Objective 4.2 Increase coordination among and sharing of best practices from HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with public and private health care payers, faith-based and CBOs, the private sector, academic partners, and the community

<table>
<tr><th>Strategy 4.2.1</th><th colspan="2">Focus resources including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Development of interactive locator for mobile service providers
• Number of public-private partnerships established at local levels
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
<tr><th>Timeframe</th><th>Critical Partners</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• RWHAP and EHE partners
• Digital resource providers (e.g., AIDSVu)</td><td>• Develop a mapping tool/interactive map locator/pin map of mobile units.
• Develop regular partnership meetings with internal and external service providers at the local level.
• Foster strong public-private partnerships to accelerate advances in HIV by inviting stakeholders outside of typical HIV partnerships to attend awareness days and generate new approaches to addressing the HIV epidemic.
• Identify best practices and interventions from other jurisdictions that address similar priority populations.
• Increase the use of outreach and education to reach priority populations and geographies.</td></tr>
</table>

<table>
<tr><th>Strategy 4.2.2</th><th colspan="2">Enhance collaboration among local, state, tribal, territorial, national, and federal partners, and the community to address policy barriers that contribute to persistent HIV-related disparities and implement policies that foster improved health outcomes.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Development of centralized information platform to collect integrated HIV planning information
• Number of and type of materials developed and disseminated in three languages (i.e., English, Spanish and Haitian-Creole)
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Health and human rights advocates
• HIV/AIDS policy experts
• Health care providers
• PWH engaged in services
• Tribal organizations
• Minority leadership programs
• RWHAP and EHE partners</td><td>• Appoint community liaisons among local, state, tribal, territorial, national, and federal partners to assess and address barriers and social determinants via policy change and enhanced communication.
• Create a centralized information platform to house local, county, state, consortium planning body meeting information, and proposed activities, and projects.
• Create opportunities to bring a wide variety of partners and stakeholders together to increase cross-collaboration.
• Foster strong public-private partnerships to accelerate advances in HIV by inviting stakeholders outside of typical HIV partnerships to attend awareness days and generate new approaches to addressing the HIV epidemic.
• Incorporate three-language formula in marketing and advertising materials to overcome social barriers in disproportionate communities.</td></tr>
</table>

<table>
<tr><th>Strategy 4.2.3</th><th colspan="2">Coordinate across partners to quickly detect and respond to HIV outbreaks.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number and geographic location of HIV transmission clusters identified
• Number of intersectional teams developed at local levels for outbreak response
• Number of mobile units using HIV transmission cluster data to direct positioning
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• RWHAP and EHE partners</td><td>• Create a centralized system for outbreak detection, reporting, and notification (e.g., meningitis, Mpox, HIV, STD, viral hepatitis).
• Develop intersectional teams and protocols that include Department DIS, RWHAP programs, funded EHE providers, case managers, local medical and support services providers to share information and rapidly identify and link individuals diagnosed with HIV to care and treatment.
• Establish response planning teams across multi-agencies and multi-sectors of the community (e.g., faith-based organizations, CBOs, providers, the Department) to track HIV outbreaks and provide rapid access to HIV treatment and care.
• Use HIV transmission cluster data to direct the positioning of mobile units to respond to clusters of active transmission.</td></tr>
</table>

<table>
<tr><th>Strategy 4.2.4</th><th colspan="2">Support collaborations between CBOs, public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Inventory of multi-agency collaborations at local levels
• Number of partnerships with non-traditional sites to provide HIV awareness, prevention, or linkage services
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM of all races/ethnicities; Black and Hispanic heterosexuals; transgender individuals; PWID and persons who use drugs; youth; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Educational institutions
• Health care providers
• Housing providers
• RWHAP and EHE partners</td><td>• Advocate for the revision of MOAs and contracts to include specific standards, wrap-around services (e.g., housing, mental health services, and participation in planning).
• Assess and review state and national collaborative frameworks to identify and adopt approaches that enhance current and future public-private partnerships that help scale up best practices and advances in HIV prevention and treatment.
• Educate local and state legislators on the state’s priority populations and geographies.
• Form partnerships with non-traditional sites (e.g., gas stations, sporting events, public restrooms, rest stops) for the extension of providing HIV prevention and treatment services or awareness.
• Identify best practices for increasing collaborations among CBOs, public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.</td></tr>
</table>

9.1.4.3 Objective 4.3 Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continua data and social determinants of health data

<table>
<tr><th>Strategy 4.3.1</th><th colspan="2">Promote the collection, electronic sharing, and use of HIV risk, prevention, and care and treatment data using interoperable data standards, including data from electronic health records, in accordance with applicable law.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Development of centralized dashboard to share aggregate HIV-related data
• Number of data sharing agreements developed with RWHAP partners
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• The Department
• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• RWHAP and EHE partners
• AHCA
• Correctional settings
• Community HIV Advisory Group</td><td>• Create centralized system or dashboard to share aggregate HIV-related data (e.g., testing, treatment, surveillance) internally and externally that can be readily used to understand local area disease burden, obtain information for grant requirements and using data for action and response.
• Design a data system and process for improving data sharing amongst all RWHAP Parts, Florida ADAP, and service providers to improve client-level data sharing and HRSA RSR reporting requirements.
• Develop a process to improve and simplify the sharing of HIV-related data both internally and externally to the Department to improve service provision.
• Develop a process to increase working with external partners such as VA, private providers, Medicare, and others to improve data sharing at state and local levels.
• Ensure that forms and polices around release of information and methods for release (e.g., text, email, phone) are continuously updated and shared with providers.</td></tr>
</table>

<table>
<tr><th>Strategy 4.3.2</th><th colspan="2">Use interoperable health information technology, including application programming interfaces (APIs), clinical decision support tools, electronic health records and health IT products certified by the Office of the National Coordinator's Health IT Certification Program, and health information exchange networks, to improve HIV prevention efforts and care outcomes.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Evaluation of digital resources and clinical decision support tools
• Development of reciprocal client-informed consent and release of information
• Number of local areas with electronic referral systems
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
<tr><td>Timeframe</td><td>Critical Partners</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
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• Community- and faith-based organizations
• Health care settings including hospitals, FQHCs, private physician practices, and reproductive health sites
• Behavioral health care and substance abuse settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• RWHAP and EHE partners
• Community HIV Advisory Group
• AHCA
• Correctional settings</td><td>• Assess the ability to create a Health Information Exchange (HIE) and master client index among HIV service providers and link the current Florida HIE to data in the HIV/AIDS Section to improve linkage to care efforts.
• Create a reciprocal (e.g., across agencies and all RWHAP parts) client-informed consent and release of information to acknowledge that data may be shared to improve service provision and linkage to care needs.
• Develop a process and system to initiate and track electronic referrals to HIV-related prevention, treatment services and other ancillary services. Consult with the AIMS workgroup to review current resources.
• Evaluate and promote the use of digital resources and clinical decision support tools.
• Identify ways to improve data collection efforts for HIV prevention efforts (e.g., HIV self-test kit information).</td></tr>
</table>

<table>
<tr><th>Strategy 4.3.3</th><th colspan="2">Encourage and support patient access to and use of their individual health information, including use of their patient-generated health information and use of consumer health technologies in a secure and privacy supportive manner.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Development of client-centered training module around public health data collection and uses of patient information for public health
• Development of reciprocal client-informed consent and release of information
• Number and type of information shared around use of patient portals to facilitate client access to medical information
• Assessment of information sharing methods best suited for rural communities and other areas with limited internet access
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
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• Health care providers
• PWH engaged in services
• RWHAP and EHE partners
• AHCA
• Correctional settings
• Community HIV Advisory Group</td><td>• Create a client-centered training module around public health data collection and uses of patient information for public health purposes to assist with alleviating fears about misuse and privacy concerns.
• Provide guidance and supportive information to encourage the use of patient portals from providers and laboratories to ensure that clients have direct access to their medical information.
• Ensure health communication and messaging from provider to client is private, secure, and accessible, and occurs through a HIPAA-compliant platform or channel.
• Explore the incorporation of a centralized patient portal or health information application.
• Encourage providers currently using patient portals to offer additional client-centered education on patient portal functionality and utilization.
• Explore the increase of in-app or in-portal patient health education opportunities.
• Assess methods to increase information sharing and patient health education opportunities for people living in rural communities or other areas with limited internet access.</td></tr>
</table>

9.1.4.4 Objective 4.4: Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances.

<table>
<tr><th>Strategy 4.4.1</th><th colspan="2">Adopt approaches that incentivize the scale up of effective interventions among academic centers, health departments, CBOs, allied health professionals, people with HIV and their advocates, the private sector, and other partners.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number and type of public-private partnerships established and maintained
• Development of statewide conference on HIV
• Number of non-traditional partners participating in local HIV awareness events
• Number of HIV prevention and treatment sites using ARV starter packs
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
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• Academia
• Health care providers
• PWH engaged in services
• RWHAP and EHE partners
• AHCA
• Correctional settings
• Community HIV Advisory Group</td><td>• Review and assess state and national collaborative frameworks to identify and adopt approaches that enhance current and future public-private partnerships that help scale up best practices and advances in HIV prevention and treatment.
• Conduct an annual statewide conference on HIV and invite a wide range of traditional and non-traditional partners to participate and attend and share best practices.
• Foster strong public-private partnerships to accelerate advances in HIV by inviting stakeholders outside of typical HIV partnerships to attend awareness days and generate new approaches to addressing the HIV epidemic.
• Identify public-private partnership EBIs to scale up the use of ARV starter packs.</td></tr>
</table>

<table>
<tr><th>Strategy 4.4.2</th><th colspan="2">Expand opportunities and mechanisms for information sharing and peer technical assistance in and across jurisdictions to move effective interventions into practice more swiftly.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Development of centralized information repository on best practices programs and interventions for addressing the HIV epidemic
• Number and type of information sharing mechanisms used in local areas
• Number of multi-agency collaboratives supporting data and information sharing
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; HIV research and health care professionals and front-line staff, community-based organizations, health care delivery systems, and public health systems; HIV prevention and treatment providers</td></tr>
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• Drug treatment programs
• SSPs
• Academia
• Health care providers
• PWH engaged in services
• RWHAP and EHE partners
• AHCA
• Correctional settings
• Community HIV Advisory Group</td><td>• Create a centralized information repository to house and disseminate information on best practices, meeting information, and other information that will assist with addressing the HIV epidemic.
• Develop local e-newsletters or other mechanisms to disseminate information quarterly on available resources and EBIs being used in the state.
• Identify and establish local area collaborative coalitions across multi-agencies and multi-sectors of the community (e.g., faith-based organizations, CBOs, providers, the Department and others) to support data and information sharing and identify best practices that address the HIV epidemic.
• Identify state and local subject matter experts and create a state specific technical assistance network.</td></tr>
</table>

<table>
<tr><th>Strategy 4.4.3</th><th colspan="2">Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing persons of all ages living with HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Development of centralized information repository on best practices programs and interventions for addressing the HIV epidemic
• Number and type of information sharing mechanisms used in local areas
• Number of multi-agency collaboratives supporting data and information sharing
• Additional specific, quantifiable measures for each activity (TBD)</td></tr>
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• SSPs
• Health care providers
• Academia
• PWH engaged in services
• RWHAP and EHE partners
• AHCA
• Correctional settings
• Community-HIV Advisory Group</td><td>• Adopt a collaborative implementation science approach to evaluate, design, and implement strategies that improve health-related outcomes and promote the dissemination and replication of successful interventions and best practices locally.
• Create a centralized online platform to collect and respond to complaints, challenges and general inquiries from service providers, clients, stakeholders, and the public.
• Foster new and existing community, private, and cross-sector partnerships through strengthened communication and by supporting increased collaborative opportunities or Memorandums of Understanding centered on sharing information, discussing strategies, and providing education.
• Increase partnerships and collaboration to provide age-appropriate sexual health resources, education, and support services for young people.
• Conduct an annual statewide conference on HIV and invite a wide range of traditional and non-traditional partners to participate and attend and share best practices.</td></tr>
</table>

9.2 Partnership Area Interview Questionnaires

SA1 Interview Questionnaire.dotx
SA 2A Interview Questionnaire.dotx
SA 2B Interview Questionnaire.dotx
SA 3 13 Interview Questionnaire.dotx
SA4 Interview Questionnaire.dotx
SA 5 6 14 Interview Questionnaire.dotx
SA 7 Interview Questionnaire.dotx
SA 8 Interview Questionnaire.dotx
SA 9 Interview Questionnaire.dotx
SA 10 Interview Questionnaire.dotx
SA11 Interview Questionnaire.dotx
SA 11B Interview Questionnaire.dotx
SA 12 Interview Questionnaire.dotx
SA 15 Interview Questionnaire.dotx

9.3 Partnership Area Resource Inventories

Area 2A Resource Inventory 2022.xlsx
Area 2B Resource Inventory 2022.xlsx
Area 3_13 Resource Inventory 2022.xlsx
Area 5.6.14 Resource Inventory
Area 7 Resource Inventory 2022.xlsx
Area 8 Resource Inventory 2022.xlsx
Area 10 Resource Inventory 2022.xlsx
Area 11A Resource Inventory 2022.xlsx
Area 11B Resource Inventory 2022.xlsx
Area 12 Resource Inventory 2022.xlsx
Area 15 Resource Inventory 2022.pdf

9.4 Epidemiologic Profile

The full Epidemiologic Profile of HIV in Florida, 2017–2021 will be made available separately.

9.5 Other Supporting Documentation

20220819-FCPN Meeting Notes.docx
Appendix 3 - Florida HIV Continu
Documentation of Community Engage
Executive Summary_2019_Clier
PS19-1906 EHE Plan Executive Summary_

9.6 Glossary

Acquired Immunodeficiency Syndrome (AIDS): A condition that exists when a person has tested positive for HIV and has one or more of 26 listed opportunistic illnesses/infections and/or a T-cell count of 200 or less per micro-liter of blood.

Business Responds to AIDS (BRTA): Modeled after the CDC initiative by the same name, developed initially in 1992, BRTA programs support targeted HIV prevention efforts through partnerships with local businesses. BRTA programs mobilize businesses and labor organizations to respond to HIV/AIDS in the workplace and the community with subtle, noninvasive approaches to raise awareness, promote services, and break down stigma. BRTA activities involve the use of promotional and incentive items that businesses can use to generate conversations around HIV/AIDS with their customers.

Community-Based Organization: A non-profit organization with a 501(c)(3) designation.

Community Engagement: The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address affecting the well-being of those people.

Community Health Worker: Trusted, knowledgeable frontline health personnel who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes.

Counseling, Testing and Linkage: Provision of counseling, testing and direct assistance in getting a client enrolled into the health and social service system.

Culturally Appropriate: Conforming to a culture's acceptable expressions and standards of behavior and thought. Interventions and educational materials are more likely to be culturally appropriate when representatives of the intended target audience are involved in planning, developing, and pilot testing them.

Epidemic: The occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.

Ethnicity: The cultural characteristics that connect a particular group or groups of people to each other, such as people of Hispanic or Latino origin.

Faith-Based Organization: A non-governmental agency owned by religiously affiliated entities such as (1) individual churches, mosques, synagogues, temples, or other places of worship or (2) a network or coalition of churches, mosques, synagogues, temples, or other places of worship.

Faith Responds to AIDS (FRTA): Built on the same framework as BRTA, FRTA is a Florida adaptation of the BRTA initiative but for faith-based organizations. FRTA programs are faith-based initiatives that mobilize churches and other faith-based institutions to raise awareness and reduce stigma around HIV/AIDS. FRTA programs are particularly effective at reaching minority communities. FRTA activities involve the use of promotional and incentive items that faith-based organizations can use to generate conversations around HIV/AIDS with their members.

Females: Individuals of the sex that produces large and generally immobile gametes (ova or eggs).

High-Impact Prevention (HIP): Using combinations of scientifically proven, cost-effective and scalable interventions targeted towards the highest risk populations in the right geographic areas to reduce new HIV infections.

HIV Mode of Exposure: Specific behaviors or actions that expose people to HIV and can potentially lead to HIV acquisition. Examples include unprotected anal or vaginal sex with a person living with HIV, injecting drugs with non-sterile, shared drug injection equipment, and male-to-male sexual contact.

Human Immunodeficiency Virus (HIV): The retrovirus virus can lead to AIDS, if not treated. The virus occurs in two types—HIV-1 and HIV-2. Both types are transmitted through direct contact (e.g., through sexual intercourse or sharing injection drug equipment) with HIV-infected body fluids, such as blood, semen, and genital secretions, or from an HIV-positive mother to her child during pregnancy, birth, or breastfeeding.

Incidence: The occurrence of new cases of disease or injury in a population over a specified period of time.

Integrated Prevention and Care Plan: A plan based on the Integrated HIV Prevention and Care Plan Guidance that requires a collaborative process between CDC and HRSA to identify and address: statewide goals for HIV prevention and care; emphasize the populations and communities most affected by the epidemic; highlight areas of need, service gaps, and barriers; identify health disparities and social determinants of HIV-related health; outline activities for implementing goals; and, identify factors for measuring success in achieving goals.

Intervention: A specific activity (or set of related activities) intended to reduce the risk of HIV transmission or acquisition. Interventions may be either biomedical or behavioral and have distinct process and outcome objectives and protocols outlining the steps for implementation.

Linkage: Actively assisting clients with accessing needed services through a time-limited professional relationship. The active assistance typically lasts a few days to a few weeks and includes a follow-up component to assess whether linkage has occurred. Linkage services can include assessment, supportive counseling, education, advocacy, and accompanying clients to initial appointments.

Males: Individuals of the sex that produces small, mobile gametes (sperm).

Men who have Sex with Men (MSM): Men who report sexual contact with other men and men who report sexual contact with both men and women (i.e., bisexual contact), whether or not they identify as gay.

National HIV/AIDS Strategy for the United States: A comprehensive plan focused on reducing HIV incidence, increasing access to care and optimizing health outcomes, and reducing HIV-related health disparities.

Navigation Services: Patient navigation assistance is the process of helping a person obtain timely and appropriate medical or social services, taking into account provider preferences,

insurance status, scheduling issues, and other factors that may complicate access or utilization of services.

Navigator: Patient navigators are peers, volunteers, and/or staff members of clinics, health departments, and community-based organizations. Patient navigators may be lay persons, paraprofessionals, or medical professionals (e.g., RNs, LPNs).

Partner Services: A systematic approach to notifying sex and needle-sharing partners of PWH of their possible exposure to HIV so they can be offered HIV testing and learn their status or, if already diagnosed, prevent transmission to others. Partner Services helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.

Peers (or Near-Peers): Specially trained individuals from the community who may or may not be living with HIV/AIDS, but ultimately have lived experience.

Perinatal: Occurring during the period around birth (5 months before and 1 month after)

Post-Exposure Prophylaxis (PEP): The provision of antiretroviral medications to prevent transmission of HIV following an occupational or non-occupational exposure. Non-occupational post-exposure prophylaxis is referred to as nPEP.

Pre-Exposure Prophylaxis (PrEP): Antiretroviral medi0cation taken to prevention acquiring HIV.

Prevalence: The number of people with a specific disease or condition in a given population at a specific time.

Race: A person's self-reported classification of the biological heritage with which they most closely identify.

Rapid HIV Test: A point-of-care HIV screening test used in both clinical and non-clinical settings, usually with blood from a finger stick or with oral fluid.

Ryan White Treatment Modernization Act: The name given to the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act when it was reauthorized in 2006. This is the primary federal legislation that addresses the needs of persons in the United States living with HIV/AIDS and their families. The original CARE Act was enacted in 1990.

Seroprevalence: The overall occurrence of a disease or condition within a defined population at one time, as measured by blood tests.

Sex: Either of the two main biological categories (male and female) into which humans and most other living things are divided on the basis of their reproductive functions.

Social Determinants: The economic and social conditions that influence the health of persons, communities, and jurisdictions and include conditions for early childhood development; education, employment, and work; food security; health services; housing; income; and social exclusion.

Surveillance: The ongoing and systematic collection, analysis, and interpretation of data about occurrences of a disease or health condition.

Syndemic: The aggregation of two or more concurrent or sequential epidemics or disease clusters in a population with biological interactions, which exacerbate the prognosis and burden of disease.

Transgender: A person who does not identify with their sex at birth and may undergo gender transitionary care including hormone therapy and/or surgical procedures. This is also recognized as gender dysphoria.

2022–2026
STATE OF FLORIDA
Integrated HIV Prevention and Care Plan