INTEGRATED HIV PREVENTION AND CARE PLAN

TAMPA- ST. PETERSBURG ELIGIBLE METROPOLITAN AREA

CY 2017-2021

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

SECTION I: STATEWIDE COORDINATED STATEMENT OF NEED / NEEDS ASSESSMENT

Introduction

The Tampa- St. Petersburg Eligible Metropolitan Area (EMA) is located on the west central coast of Florida. It includes Hernando, Hillsborough, Pasco and Pinellas Counties.

Local partner agencies have a rich history of collaborating on HIV prevention, surveillance, care, and treatment issues throughout the Tampa-St. Petersburg EMA. This Integrated Prevention and Care Plan was written by the Tampa- St. Petersburg EMA in conjunction with the Part A Recipient, Part B Lead Agency, and the local prevention and patient care planning bodies. It will be included as a Chapter of the larger Integrated Plan for the State of Florida.

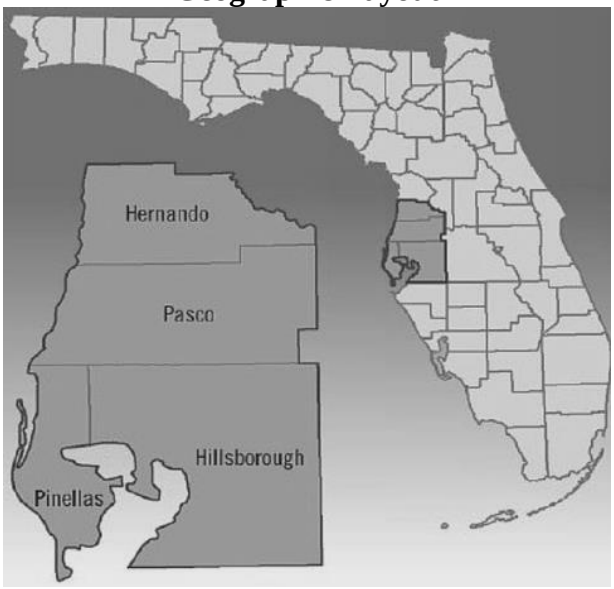
Subsequent to the writing of this Plan, the epidemiological data for 2014 was measurably adjusted (lowered) by the State of Florida. The data adjustment is currently under discussion between the State and the Federal Government. The Tampa- St. Petersburg EMA is using the un-adjusted data in the Plan. The EMA will update all epidemiological data, if needed, once a resolution is reached and all data is finalized.

A. Epidemiologic Overview

Geographic Region

The Tampa-St. Petersburg Eligible Metropolitan Area (EMA)'s total population is approximately 2.8 million, of which 66% are White (non-Hispanic), 18% are Hispanic and 12% are Black (non-Hispanic). Women represent 51.5% of the total population. The image below depicts the geographic layout of the EMA.

Tampa-St. Petersburg EMA
Geographic Layout



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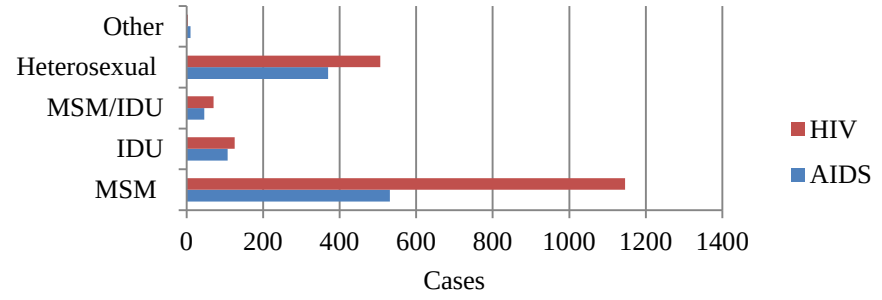
Socio-demographic Characteristics

The following data provides a description of the socio-demographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, and persons at higher risk for infection. This information is used by the local area to set priorities, identify interventions and services, and to allocate resources to HIV prevention to care. This overview focuses on the most recent year for which data is available.

The socioeconomic status of individuals living in the EMA varies greatly throughout the four county area. According to the Florida Department of Health's 2013 Division of Public Health Statistics and Performance Management Report, the median household income of residents living in Hillsborough and Hernando Counties is roughly $35,500 compared to the higher median household income of Pinellas ($45,500) and Pasco Counties ($43,900). The percentage of individuals living below the federal poverty level ranges from 13.9% in Pasco County to 16.8% in Hillsborough County. The percentage of adults in each county who have any type of health care insurance ranges from 80.2% in Pinellas to 87.2% in Hernando. The percentage of EMA residents over the age of 25 with a high school diploma is 86.4% and 23% of persons over the age of 25 possess a bachelor's degree or higher.

According to the Florida Department of Health's Epidemiological Profile, the incidence of HIV in the EMA has risen 44% since 2010. New cases of AIDS have increased 11% since 2010. The most common mode of transmission for HIV and AIDS in the EMA is men who have sex with men (MSM) followed by heterosexual transmission and, injection drug use (IDU). A visual account of the different modes of transmission of HIV and AIDS from 2012-2014 follows in Figure 1:

Figure 1: Tampa/St. Petersburg EMA
HIV/AIDS Incidence by Mode of Transmission



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Figure 1 shows the highest mode of transmission for newly diagnosed individuals living with HIV/AIDS is MSM with 531 new cases of AIDS and 1,146 new cases of HIV. Heterosexual contact accounts for 370 new AIDS cases and 506 new HIV cases. IDU transmission is the third highest mode of transmission with 126 HIV cases and 107 AIDS cases.

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The gender, age, and race/ethnicity of new HIV and AIDS cases in the EMA from 2010-2014 are detailed below in Figures 2-7:

Figure 2: Tampa/St. Pete EMA HIV Incidence by Gender

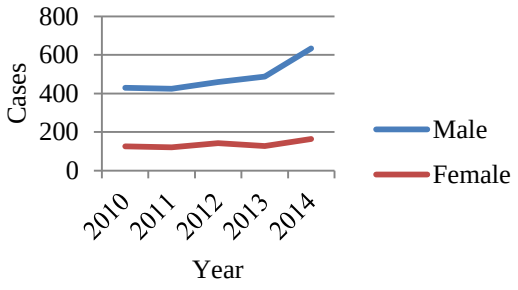
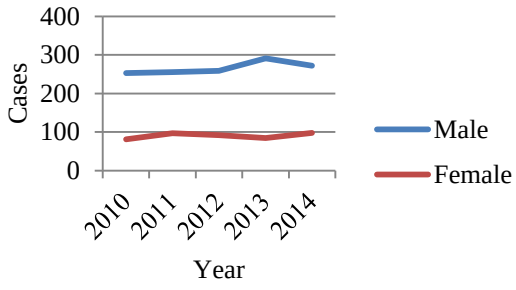


Figure 3: Tampa/St. Pete EMA AIDS Incidence by Gender



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

The incidence of HIV has increased from 430 cases in 2010 to 634 cases in 2014 among males in the EMA. This represents a 47% increase. During the same time frame, female cases increased from 126 to 164, a 30% increase. The incidence of male AIDS cases increased 7%, from 253 to 272 cases. The incidence of female AIDS cases increased 21% from 81 to 98 cases.

Figure 4: Tampa/St. Pete EMA HIV Incidence by Age

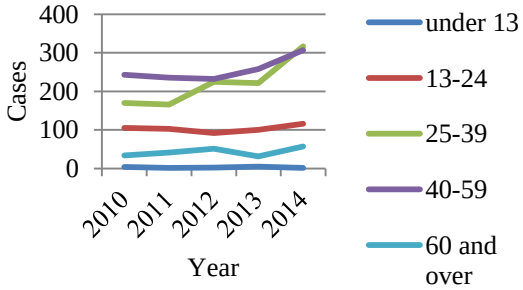
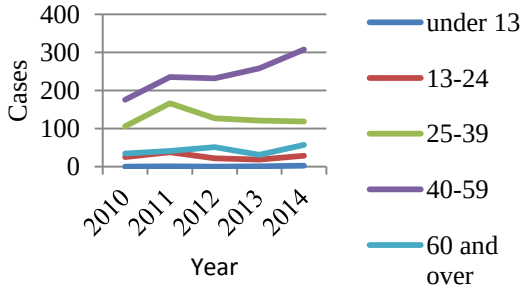


Figure 5: Tampa/St. Pete EMA AIDS Incidence by Age



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The 40-59 age group experienced the highest increase in new AIDS cases from 2010 to 2014 at 75%. The same age group experienced a 26% increase in new HIV cases. The 25-39 age group had the highest rate of new HIV cases, increasing from 170 cases in 2010 to 317 cases in 2014. This represents an 86% increase.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Figure 6: Tampa/St. Pete EMA HIV Incidence by Race/Ethnicity

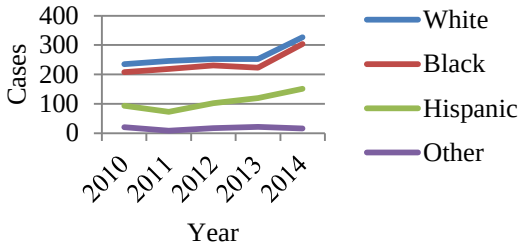
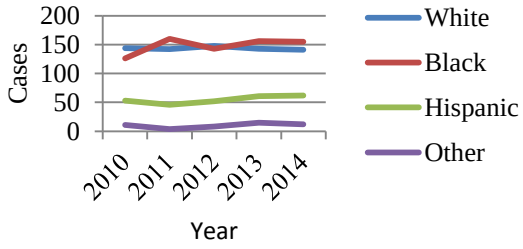


Figure 7: Tampa/St. Pete EMA AIDS Incidence by Race/Ethnicity



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

The past 5 years presented an increase in the incidence of HIV for Whites, Blacks, and Hispanics in the EMA. The incidence has risen 40%, 46%, and 62% respectively. From 2010 to 2014, the incidence of AIDS among Blacks in the EMA has risen 23%. The incidence of AIDS among Hispanics in the EMA has risen 17% during the same time from. The incidence of AIDS among Whites in the EMA has remained the same.

Burden of HIV

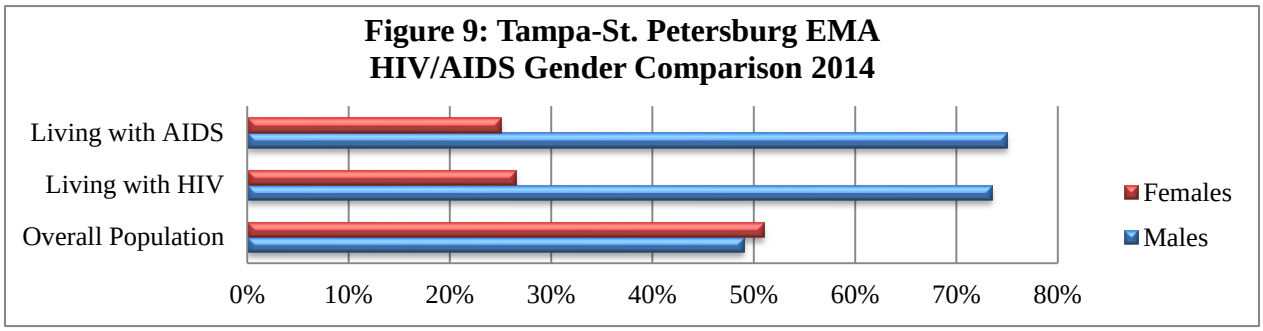
Total HIV and AIDS cases are on the rise in the Tampa/St. Petersburg EMA. The number of persons living with HIV in the EMA has increased 12% since 2010. The prevalence of AIDS has increased 15% since 2010. A table of the incidence and prevalence of HIV and AIDS in the EMA over the past five years is detailed in Figure 8.

Figure 8: Tampa/St. Petersburg EMA Epidemiological Profile

	CY 2010		CY 2011		CY 2012		CY 2013		CY 2014	
	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence
HIV	556	4,688	658	4,448	602	4,392	615	4,674	798	5,260
AIDS	334	5,986	352	5,820	351	5,953	375	6,187	370	6,898
TOTAL	890	10,674	1,010	10,268	953	10,345	990	10,861	1,168	12,158

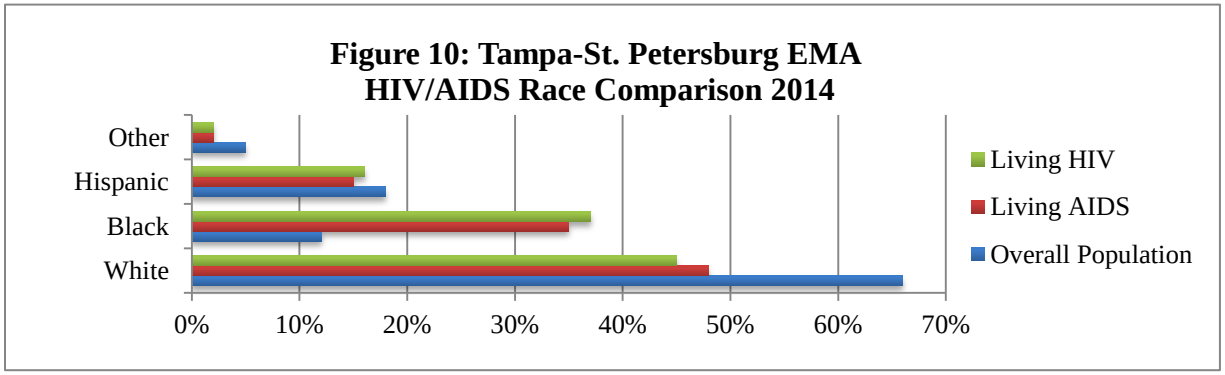
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013 and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

In 2014, men represented 73.5% and 75% of HIV and AIDS cases respectively. In the EMA, men comprise approximately 49% of the population but disproportionately represent a majority of HIV and AIDS cases. Women represented 26.5% and 25% of HIV and AIDS cases respectively.



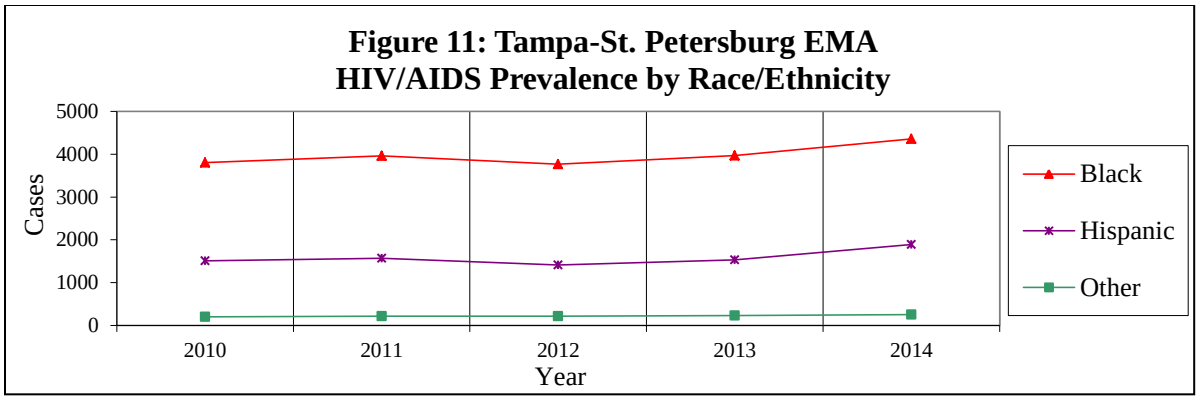
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

The 2014 calendar year saw only minor shifts in demographics of HIV and AIDS prevalence. Whites in the EMA represented two thirds of the population and have the highest percentage of HIV cases at 45%. Blacks account for 37% and Hispanics represent 16% of HIV cases. Whites represent the largest prevalence of AIDS cases in the EMA with 48% followed by Blacks with 35% and Hispanics with 15%. Blacks were disproportionately impacted by HIV/AIDS because although Blacks made up only 12% of the population within the EMA in 2014, they represented 37% of HIV cases and 35% of the AIDS cases.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Overall, the past 5 years presented an increase in HIV/AIDS prevalence in every race/ethnicity category. Hispanics in the EMA saw the greatest increase in HIV/AIDS prevalence, from 1,531 cases in 2010 to 1,892 cases in 2014.



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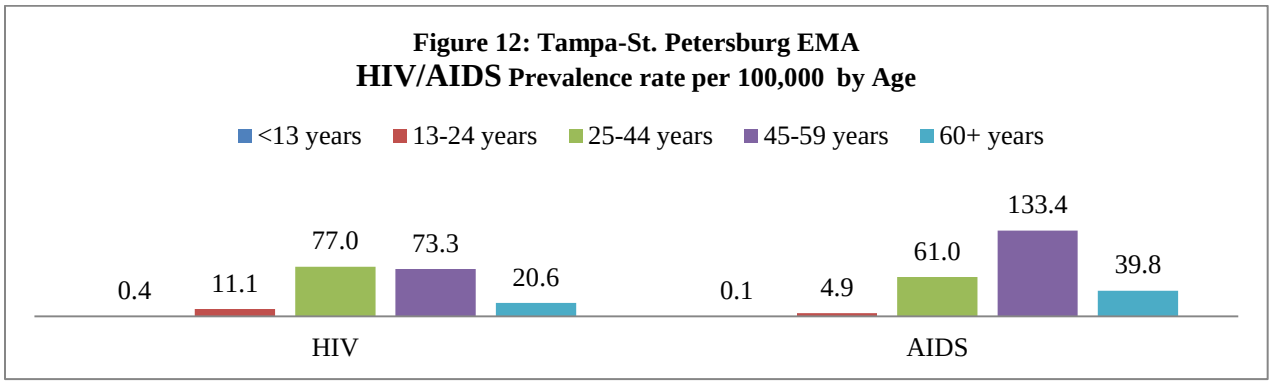
The 45-59 age group had the largest rate of AIDS prevalence reported at 133.4 per 100,000, followed by the 25-44 age group at 61.0. HIV prevalence rate was highest in the 25-44 age group at 77.0 per 100,000, followed by 45-59 age group at 73.3.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Figure 13 depicts the presumed living HIV/AIDS cases in each of the EMA's four counties as of 9/30/15. The EMA's urban counties (Hillsborough and Pinellas) experience a greater number of HIV/AIDS cases compared to the rural counties (Hernando and Pasco).

Figure 13:
Tampa-St. Petersburg EMA
HIV/AIDS Cases per County

Source: Florida Department of Health, Monthly Surveillance Report, October 2015

Indicators of Risk

The various indicators of risk for the EMA are identified by exposure category in Figure 14. Other indicators of risk are considered to be: HIV testing, unwanted sexual experiences, healthcare-seeking behaviors, and sexually transmitted infections such as Chlamydia, Syphilis and Gonorrhea.

Figure 14 highlights possible HIV exposure categories as acknowledged by individuals while getting tested. Over a five year period (2010-2014), the highest tested exposure category is heterosexual contact. The second highest exposure category is STD diagnosis, followed by Men who have Sex with Men (MSM). Although the heterosexual exposure category had the highest number of tests, MSM had the highest number of positive tests in the 2010 – 2014 timespan.

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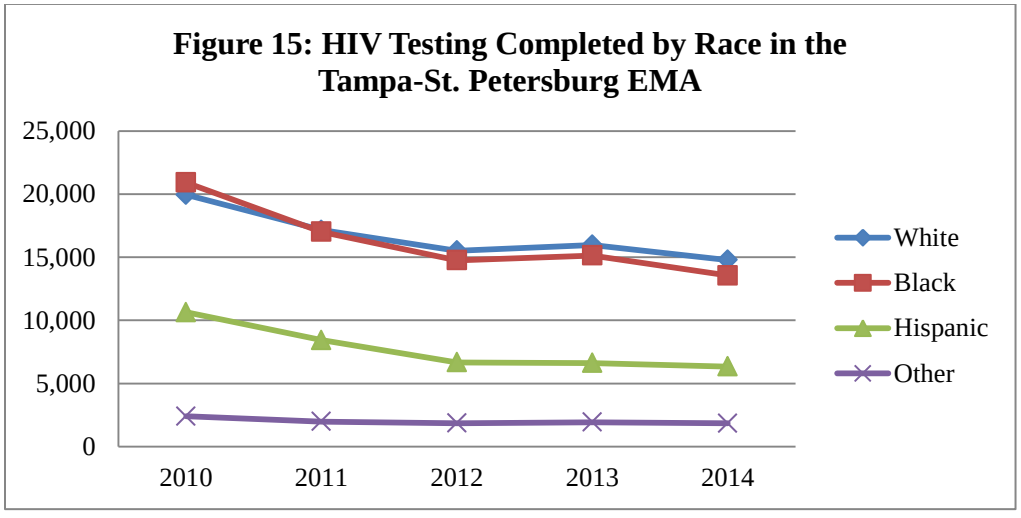
Figure 14: Testing in the EMA by Possible Exposure Category

Exposure Category	2010		2011		2012		2013		2014	
	Number of Tests	Positive Tests	Number of Tests	Positive Tests	Number of Tests	Positive Tests	Number of Tests	Positive Tests	Number of Tests	Positive Tests
MSM/IDU	181	15	148	22	178	18	240	19	250	18
MSM	3,198	249	3,600	234	3,752	226	4,456	220	4,514	215
IDU	2,768	27	2,861	25	2,699	20	3,012	24	3,076	20
Sexual Partner at Risk	1,625	88	2,353	98	2,724	48	2,404	67	1,822	78
Child of Women with HIV/AIDS	142	2	122	1	89	4	54	0	10	0
STD Diagnosis	9,975	45	8,564	38	7,806	37	7,524	31	7,873	37
Sex for Drugs or Money	409	3	408	4	337	2	316	4	262	4
Hemophilia/ Blood Recipient	0	0	0	0	0	0	0	0	0	0
Victim of Sexual Assault	1,485	7	1,388	7	1,187	10	567	4	150	1
Health Care Exposure	900	7	0	0	0	0	0	0	0	0
Heterosexual	29,536	106	23,272	75	18,089	76	18,712	67	16,617	79
No Acknowledged Risk	700	0	421	1	384	5	413	4	1,491	8
Unknown	2,976	21	1,429	12	1,539	20	1,957	15	447	1
Total	**53,895**	**570**	**44,566**	**517**	**38,784**	**466**	**39,655**	**455**	**36,512**	**461**

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Figure 15 depicts HIV testing in the Tampa- St. Petersburg EMA from 2010-2014. It indicates a general decrease in testing by all races. Although all races were tested in high numbers in 2010, there has been a decrease for the subsequent four years.



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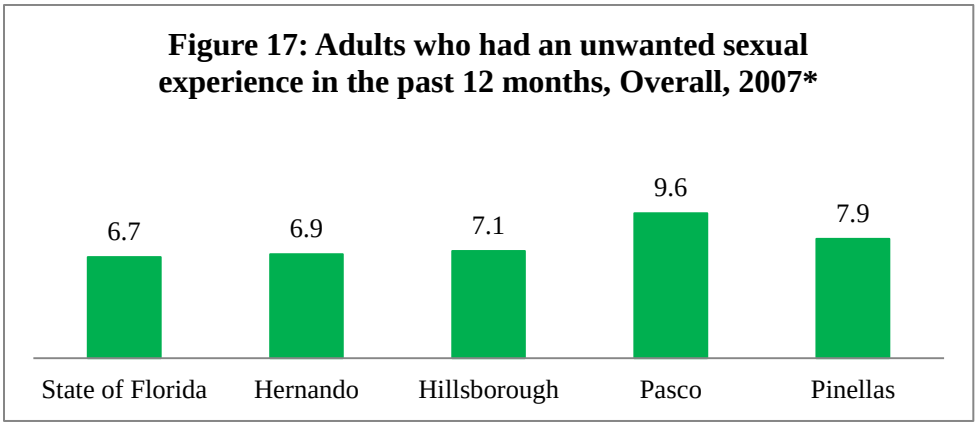
Illustrated in Figure 16 is the percentage of adults less than 65 years of age who have had a HIV test in the past 12 months. Two of the counties in the EMA, Pasco and Hernando, have significantly lower testing rates compared to the state. Pasco County has a testing rate of 8.4% and Hernando County has a testing rate of 10.15% compared to the state's rate of 15.6%.

Figure 16: Percentage of Adults less than 65 years of age who had an HIV test in the past 12 months, Overall, 2013

Source: Florida Behavioral Risk Factor Surveillance System County-level telephone survey conducted Centers for Disease Control and Prevention (CDC) and Florida Department of Health Bureau of Epidemiology.

Figure 17 shows that all parts of the Tampa – St. Petersburg EMA have higher rates than the State of Florida for Adults who had an unwanted sexual experience in the past 12 months in 2007. Pasco County has that highest rate at 9.6% almost a full 3% higher than the state of Florida.

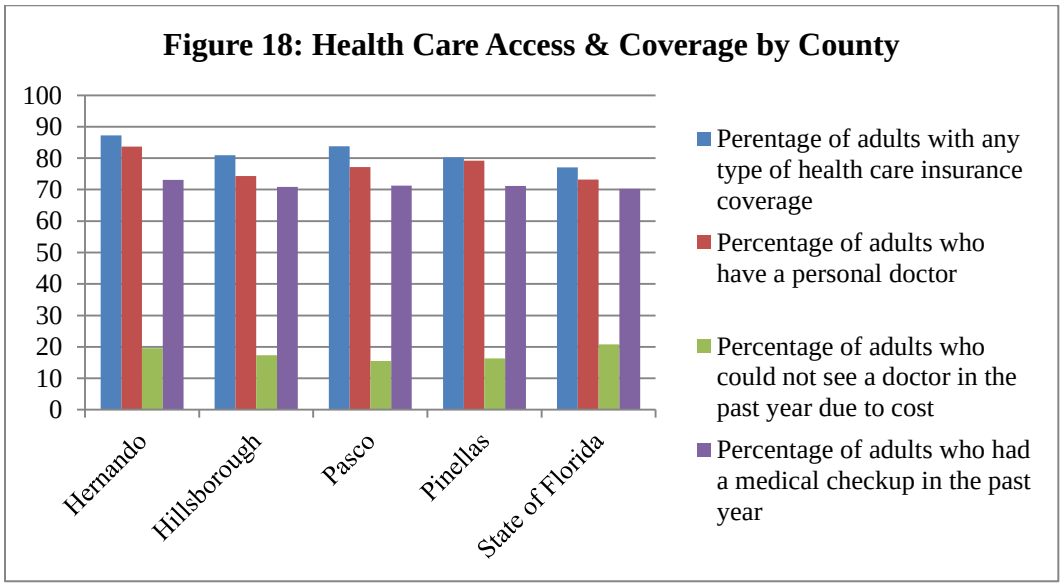
Figure 17: Adults who had an unwanted sexual experience in the past 12 months, Overall, 2007*



*2007 is the most current survey on unwanted sexual experience in the past 12 months.
Source: Florida Behavioral Risk Factor Surveillance System county-level telephone survey conducted by the Centers for Disease Control and Prevention (CDC) and Florida Department of Health Bureau of Epidemiology.

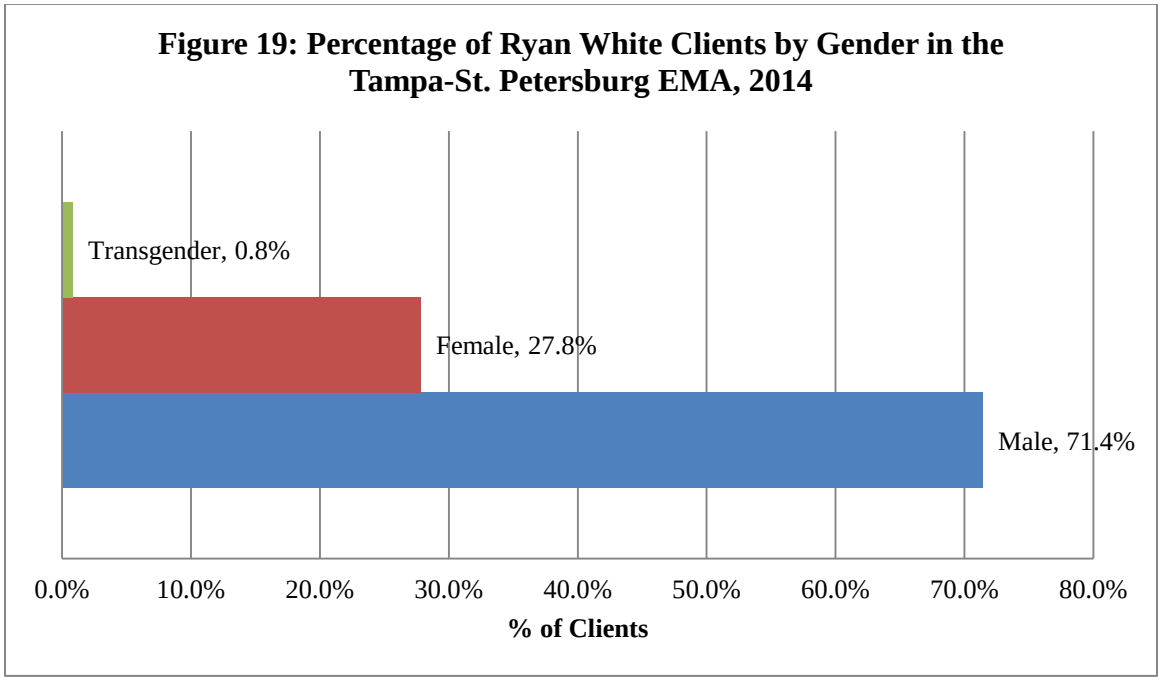
Figure 18 depicts the healthcare-seeking behavior for individuals in the EMA. All counties in the EMA are just above the State of Florida for adults with any type of health care insurance coverage. Although at least 80% of adults in the EMA have some type of health insurance,

15.5% - 19.6% of adults are not able to see a doctor due to cost, and 70.9% - 73.1% of adults have had a medical checkup in the last year.



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2013 County Level Reports.

Figures 19, 20, and 21 depict Ryan White HIV/AIDS Program Services Report (RSR) data for calendar year 2014. The data are representative of Ryan White providers in the Tampa – St. Petersburg EMA. The data are not Part-specific; that is, all tables include clients served across Ryan White HIV/AIDS Program (RWHAP) funding streams. These tables include RWHAP clients who are HIV-positive.



Source: Ryan White HIV/AIDS Program Services Report (RSR), Tampa-St. Petersburg EMA CY 2014.

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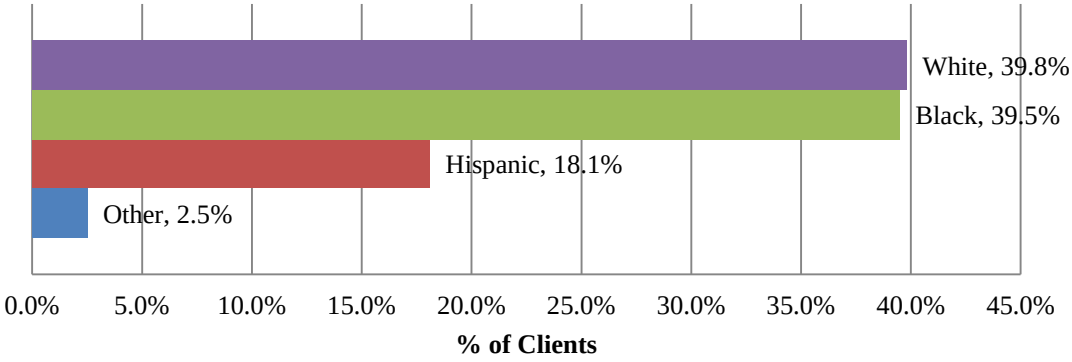
The demographic characteristics of the EMA's RWHAP clients are similar to the overall prevalence of HIV/AIDS in the EMA by gender and race as highlighted in previous Figures 9 and 10. One disparity between those served by RWHAP and the HIV/AIDS prevalence in the community exists. Whites in the EMA account for 45% of HIV and 48% of AIDS cases yet are 39.8% of clients who receive RWHAP services. Ryan White utilization by gender as well as by Blacks and Hispanics are within 3.5% variance of the categories' respective prevalence in the EMA.

Figure 20: Percentage of Ryan White Clients by Race in the Tampa-St. Petersburg EMA, 2014



Source: Ryan White HIV/AIDS Program Services Report (RSR), Tampa-St. Petersburg EMA CY 2014.

Figure 21 highlights RWHAP clients' health care coverage. Over one-third of clients have no health care coverage despite changes in the health care landscape in recent years. Over half of RWHAP clients are covered by some form of health care coverage.

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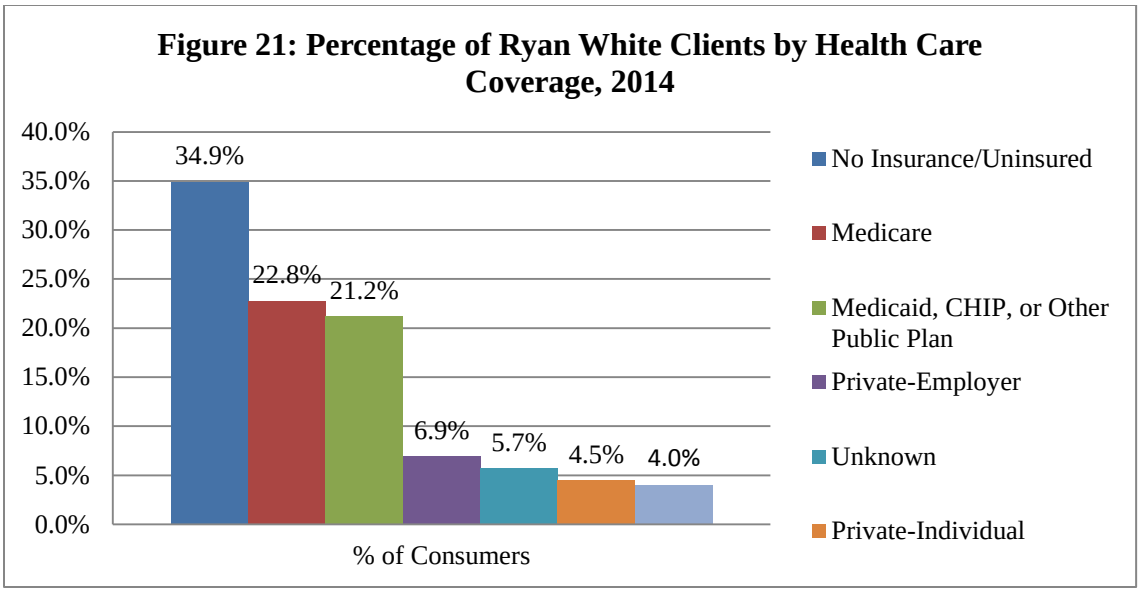
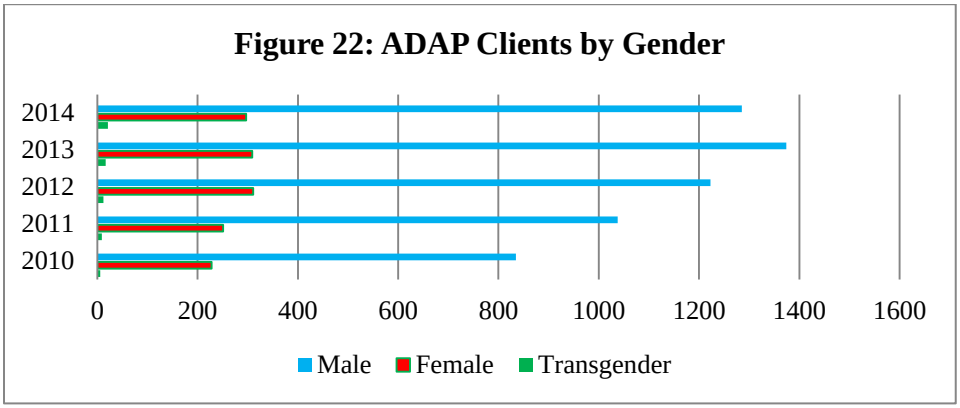


Source: Ryan White HIV/AIDS Program Services Report (RSR), Tampa-St. Petersburg EMA CY 2014.

The percentage of Ryan White clients with a suppressed viral load (less than 200 ml/copies) in the EMA was 78% for calendar year 2015. The average viral load for clients in 2015 was 14,853 ml/copies. The average CD4 count was 588.74 cells/mm^3. Approximately 57% of all RWHAP clients had a CD4 count of 500 cells/mm^3 in 2015. This data was captured from Part A and Part B funded Outpatient Ambulatory Medical Care (OAMC) providers.

The Florida AIDS Drug Assistance Program (ADAP) provides AIDS-specific medications at no cost to residents who qualify. Figure 22 depicts ADAP clients by gender in the EMA. From 2010-2014 male clients are the majority of the clientele ranging from 78.11% - 80.82% of total clients. Females have ranged from 18.17% - 21.32% of clients and the remaining amount are Transgender. The transgender community utilizing ADAP services is slowly growing in the EMA from 0.56% - 1.31% of clients.



Source: Florida Department of Health, 2015.

Demographic disparities exist in the EMA among racial and ethnic minorities with regards to accessing ADAP services. Minority populations represent a greater proportion of HIV/AIDS

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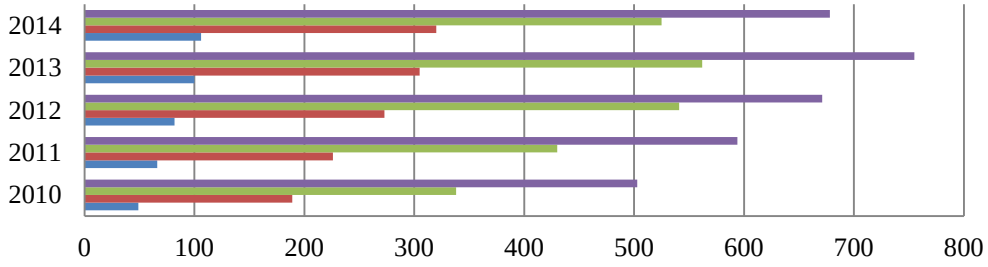
cases within the EMA, but are accessing ADAP services in smaller numbers. Figure 23 shows the breakdown of ADAP clients by race. Since 2010 the number of Black clients enrolled in ADAP rose from 338 to 525, which is the largest increase among the races.

Figure 23: ADAP Demographics by Race



	2010	2011	2012	2013	2014
White	503	594	671	755	678
Black	338	430	541	562	525
Hispanic	189	226	273	305	320
Other	49	66	82	100	106

Source: Florida Department of Health, 2015.

Figure 24 shows that the EMA has had a steady increase of Chlamydia and Syphilis from 2010 – 2014. The rates have gone down for Tuberculosis, Hepatitis, and Gonorrhea in the same five year period. The positive test results indicate similar risky behaviors that have tested positive for HIV/AIDS.

Figure 24: Positive Test Results in the EMA

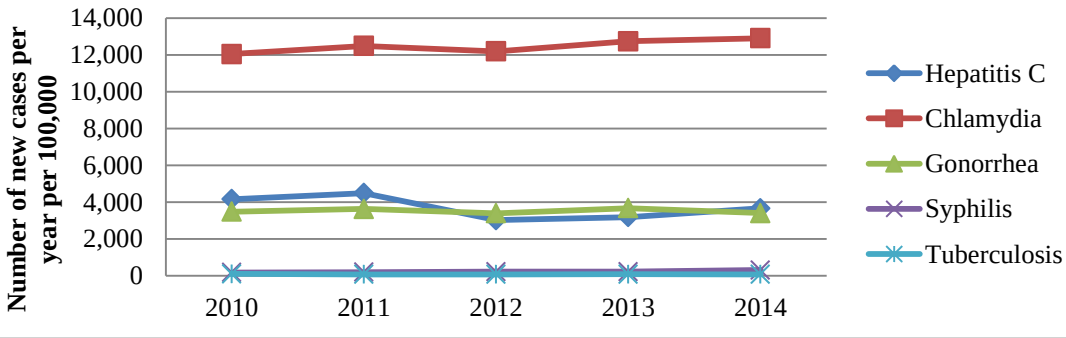


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Figure 25 represents the live births for the EMA. The Live Birth Rate is per 1,000 of the total population by year and separated by county of residence of the mother. The two counties that have the lowest birth rate in the EMA are Hernando and Pinellas with an average of 8.5 live births per 1,000 and 9.2 live births per 1,000.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Figure 25: Live Birthrate (per 1,000 of total population) for Tampa – St. Petersburg EMA, 2010-2014

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Hernando	8.5	9.0	7.9	8.5	8.4
Hillsborough	13.3	13.3	13.1	13.0	12.9
Pasco	10.3	10.1	10.0	10.1	10.0
Pinellas	9.2	9.0	9.2	9.3	9.2
State of Florida	**11.4**	**11.3**	**11.2**	**11.1**	**11.2**

Source: Florida Department of Health, 2015.

Figure 26 represents the Resident Age Adjusted Death rate per 100,000 population by year and by Residence County. In each year of the five year timespan the EMA has measured a higher age adjusted death rate than the state of Florida.

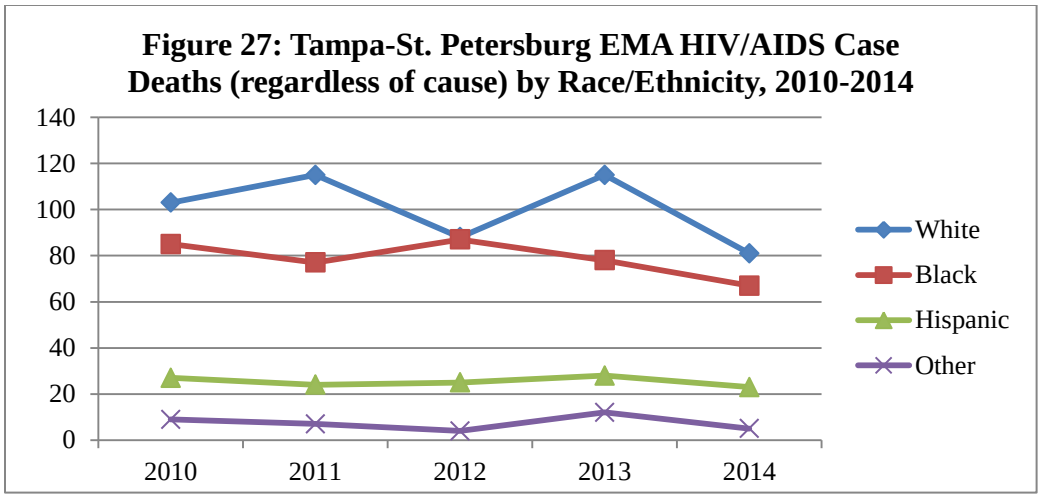
Figure 26: Resident Age Adjusted Death Rate (per 100,000 of total population) for Tampa – St. Petersburg EMA, 2010-2014

	CY 2010	CY 2011	CY 2012	CY 2013	CY 2014
Hernando	798.3	817.7	799.0	786.2	758.9
Hillsborough	735.3	723.0	748.7	750.3	745.8
Pasco	722.7	779.6	766.3	763.8	767.2
Pinellas	742.6	722.9	713.9	711.8	715.6
State of Florida	**687.4**	**677.9**	**680.7**	**679.3**	**683.5**

Source: Florida Department of Health, 2015.

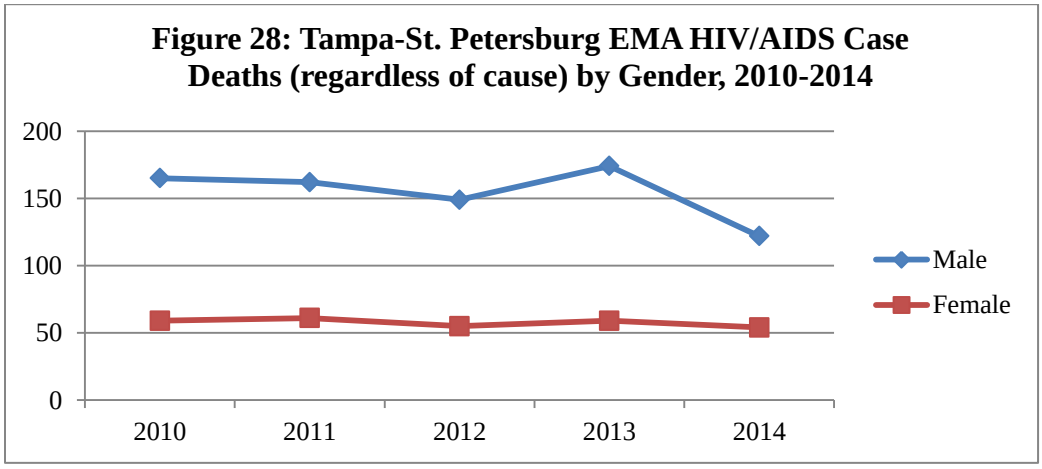
Figure 27 shows the number of HIV/AIDS case deaths by race/ethnicity across the span of five years. All race/ethnicity categories experienced a lower number of deaths in 2014 compared to the preceding four years, with the exception of the year 2012 for the "Other" race/ethnicity category.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Figure 28 depicts the number of HIV/AIDS case deaths by gender across the span of five years. The largest drop in deaths for males occurred from 2013 to 2014, decreasing from 174 deaths in 2013 to 122 deaths in 2014. Female deaths have remained relatively stable among the last five years in the EMA.



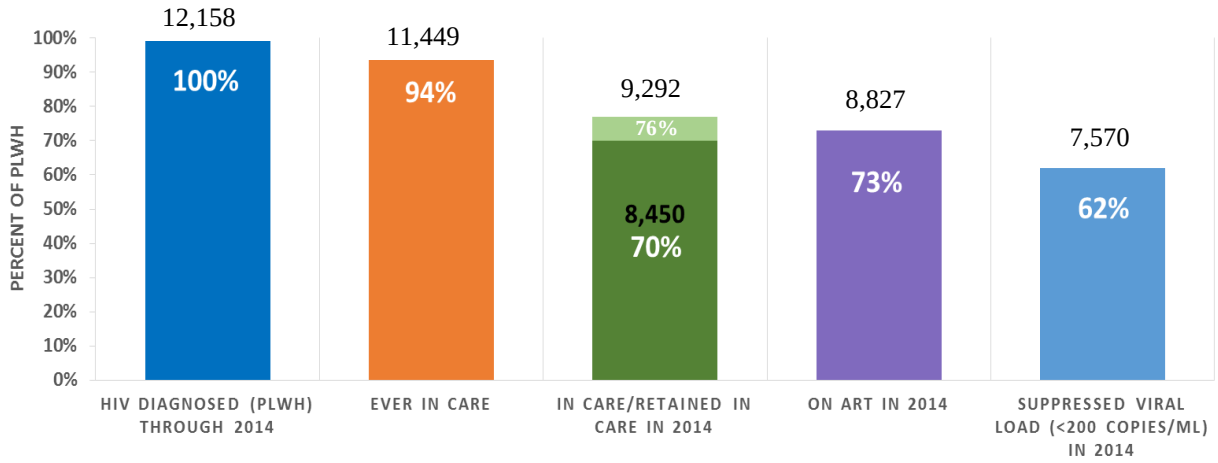
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2010, 2011, 2012, 2013, and 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Overall, the numbers of persons living with HIV have been on the rise in the Tampa – St. Petersburg EMA. Since 2010 the EMA's incidence rate of HIV has risen 44% as previously indicated. By utilizing the indicators of risk the EMA can better plan where to focus its attention to decrease the number of persons living with HIV.

B. HIV Care Continuum

The following graph depicts the EMA's HIV Care Continuum. The graph was developed using HIV/AIDS Surveillance data from the Florida Department of Health. Definitions and data sources for the Care Continuum are detailed in the "Data: Access, Sources, and Systems" section of this Integrated Plan. The diagnosed-based HIV Care Continuum approach was utilized as the estimated number of those who have not been diagnosed with HIV in the EMA is unavailable at this time.

Figure 29: Number and Percentage of Persons Diagnosed and Living with HIV Engaged in Selected Stages of the Continuum of HIV Care Tampa / St. Petersburg EMA (excl. DOC), 2014

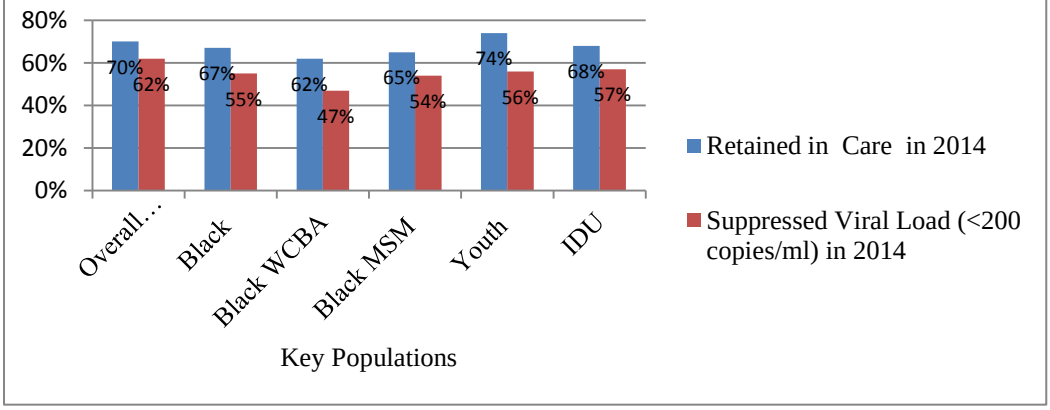


Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014.
*The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Disparities in Engagement among Key Populations

The EMA identified disparities among the following populations: Blacks, Black Women of Child Bearing Age (WCBA), Black Men who have Sex with Men (MSM), Youth 13-24 years old, and Injection Drug Users (IDU). When comparing the data for these populations to Tampa/St. Petersburg continuum of care data, it is apparent that these sub-populations have significantly lower rates of viral suppression. Data for subpopulations with very small numbers are not included in Figure 30 due to variability in percentages resulting from such small numbers. The EMA focuses resources on linkage, engagement, and retention in care programs for these populations. The EMA works with the local HIV Planning Partnership on joint efforts to address these disparities.

Figure 30: Disparities in Viral Load Suppression among Key Populations
Tampa / St. Petersburg EMA (excl. DOC), 2014



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2014. *The DOH measurably adjusted the epidemiological data for 2014. The EMA is using the unadjusted data in the Plan. Data will be updated with future plans, as needed.

Using the Continuum in Planning, Prioritizing, Targeting, and Monitoring Resources

The EMA's Ryan White Planning Council incorporates the HIV Care Continuum into its prioritization and monitoring discussions. The Council's committees utilize the Care Continuum to assess community need and to analyze gaps in service. The Care Continuum is used as a reference tool in Planning Council meetings as well as its Planning and Evaluation, Resource Prioritization and Allocation Recommendations (RPARC), Women, Infant, Children, Youth and Families (WICY&F) committees. The planning process accentuates the need to fund categories such as medical case management that help navigate clients along the HIV Care Continuum. The Planning Council has full participation of those entities within the jurisdiction that constitute key points of access to the health care system for individuals with HIV/AIDS, from those that facilitate early intervention for individuals newly diagnosed with HIV/AIDS to those that reach out to individuals aware of their HIV status, but not in care. The EMA established linkages between the local HIV Planning Partnership and the Planning Council, which promotes comprehensive prevention and care planning activities.

Improving Engagement and Outcomes at Each Stage

The EMA utilizes an integrated service network that meets the following goals: coordination among service providers, seamless transition across levels of care and coordination of present and past treatment. The Ryan White Part A Program strives to accelerate improvements in HIV prevention and care and is firmly committed to improving access to all individuals living with HIV in the EMA. Without community partnerships, opportunities arise for clients to forgo HIV testing and engagement in care. Coordinated efforts address the needs of People Living with HIV/AIDS (PLWHA) across all life stages, from those unaware of their HIV status, through HIV counseling and testing, early intervention and linkage to care, retention in care, and treatment adherence to support improved health outcomes.

The following interventions are aimed at addressing the gaps along the HIV Care Continuum for each stage:

Diagnosed-
Public and private providers offer HIV testing to bring those unaware of their status into the continuum. Various coordinated Department of Health and Human Services (HHS) funding streams provide entry to the HIV Care Continuum in the EMA through any of the 57 Florida Department of Heath licensed testing sites, hospital emergency rooms, private physician's offices, and outreach programs. Both confidential and anonymous testing are available. More than half of all HIV tests utilize rapid test technologies, allowing those clients who test preliminarily positive to learn their results in the same session.

Linked to Care-
The Florida Department of Health adopted a policy on April 11, 2013 to allow linking those clients testing preliminarily positive to a care provider without delay for confirmatory testing. For those sites not using rapid technologies, when a client returns for his or her lab confirmed results, the linkage to Ryan White eligibility and medical care begins. Ambulatory/outpatient medical care is available in all counties in the EMA. Early entry into care can have a positive impact on the overall length and quality of life of PLWHA. Each county in the EMA employs a Linkage to Care (LTC) Coordinator through the Department of Health to help address the needs of newly diagnosed individuals entering into the HIV Care Continuum. The LTC Coordinator receives a list of newly diagnosed individuals via the Patient Reporting Investigation Surveillance Manager (PRISM) database. The goal is to link these individuals to HIV care within 90 days of diagnosis. In addition, the LTC Coordinator works with the HIV Surveillance Data-to-Care project to determine if previously HIV positive individuals are engaged in medical care. The LTC Coordinator investigates whether or not the individual has received a CD4 count, Viral Load test, or HIV medical visit within the last year. If the person has no evidence of care, the LTC Coordinator contacts them and provides referrals for local providers and assistance with obtaining Ryan White eligibility

Retained in Care-
Medical case management services are utilized to retain clients in care. These services are client centered with collaborations and linkages to health care, psychosocial, and other services to ensure timely, coordinated access to medically appropriate levels of health and support services and continuity of care. Services are available throughout the EMA and take place at the client's home, hospital, and clinic or provider offices.

Mental health services and substance abuse treatment are also utilized to keep clients retained in care. Feelings of anger, fear, guilt, denial and sadness can overwhelm a newly diagnosed person. Individuals who have lived with an HIV diagnosis for a long time also have to face additional stress in coping with the disease, and may have frequent episodes of bereavement following the loss of friends and family members. Pressure regarding who to disclose one's HIV status to, as well as the impact of HIV on establishing or maintaining close relationships can contribute to the need. Linkage to Care Coordinators throughout the EMA work to re-engage those clients who have fallen out of care through supported referrals and multi-session follow-up counseling for HIV-positive individuals.

Prescribed ART and Viral Load Suppression-

HIV-related medications are frequently accessed through the AIDS Drug Assistance Program (ADAP) and Medicaid. Ryan White also funds medication assistance, as do private insurance companies, the Veteran's Administration, and compassionate use programs provided by drug manufacturers. Policy changes, increased co-pays and formulary revisions make medications a service category with the potential for dramatic change and negative financial impact for the Ryan White program.

Ryan White Part A funds are utilized to cover HIV-related medications as well as other types of prescription drugs for treatment of various comorbidities. Regular adherence to ART is hindered if PLWHA are unable to treat comorbidities such as substance abuse, mental illness, and other chronic medical conditions. Regular adherence to medications play a significant role in maintaining health, quality of life, and achieving viral suppression for HIV infected individuals. Medications are the single largest expenditure in the treatment of HIV. In the EMA, medications represented 50.4% of the budgeted figures for all identified funding streams in 2013. This does not include payments for co-pays under the health Insurance Services Program (ISP) or the ADAP Premium Plus program.

The HIV Care Continuum model is used locally to identify issues and opportunities related to improving the delivery of services to PLWHA across the entire HIV Continuum of Care. The EMA utilizes the diagnosed-based HIV Care Continuum approach to capture a detailed image of where the EMA is in terms of moving PLWHA along the Continuum. The local area hopes to increase the overall percentage of persons with diagnosed HIV infection who are linked to care, retained in care, and virally suppressed.

C. Financial and Human Resources Inventory

This section provides an inventory of the financial and service delivery provider resources available in the Tampa-St. Petersburg EMA to meet the HIV prevention, care, and treatment needs of the population. The section describes CDC-funded high impact prevention services and HRSA-funded core medical and support services.

<u>CDC-Funded High Impact Prevention Services</u>

To ensure consistency throughout the state, the EMA implemented the *Florida Jurisdictional HIV Prevention Plan: 2015-2016 Update.* The target populations for high impact prevention interventions in the EMA include the following subset: White MSM 18-40, Black MSM 18-40, and Black Women of Childbearing Age (WCBA) 15-44. The primary interventions and activities include rapid HIV testing, active street outreach, condom distribution, testing in correctional facilities, faith-based initiatives, comprehensive prevention with positives, and prevention with high-risk negatives in the most populated areas. Testing in non-healthcare settings, behavioral interventions, social marketing, and partnerships with linkage to care programs are also direct and indirect prevention activities.

The three target populations were chosen by considering epidemiological data (both incidence and prevalence), unmet need estimates, and historical trending. In addition, the selection of these target groups was influenced by the Florida Department of Health's (FDOH) recent reports *HIV*

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

and AIDS Among Minorities in Florida; Man Up: the Crisis of HIV/AIDS Among Florida's Men; Organizing to Survive: the HIV/AIDS Crisis Among Florida's Women; and *HIV and AIDS Among Adolescent and Young People in Florida.* White MSM remain the largest special population in the EMA. From 2013 to 2014, White MSM showed a 39.7% increase in reported infections. FDOH estimates that 27% (n = 1,179) of White MSM PLWHA were not retained in care in the EMA in 2014.

Black MSM showed a 39.3% increase from 2013 to 2014 in reported HIV infection cases and a 6.6% increase in new AIDS cases during the same time period in the EMA. FDOH estimates that in 2014, 35% (n = 597) of this population were not retained in care. Black WCBA showed a 42.5% increase from 2013 to 2014 in reported HIV infection cases in the EMA. FDOH estimates that 38% (n = 287) of Black WCBA were not retained in care in the EMA in 2014.

One of the main opportunities for working with these populations is to improve linkage to care, engagement in care, and retention in care. Strengthening pre-test counseling sessions to make sure persons are ready for their results, to take action if positive, and educating on the benefits of early intervention are part of the plan to improve linkage to care rates and timeliness. FDOH has also dedicated a Linkage to Care Coordinator and a back-up in each county health department in the EMA. The FDOH in Hillsborough and Pinellas have also hired full-time HIV DIS (Disease Intervention Specialists) to improve the rates and timeliness.

Black MSM and WCBA benefit from the local MAI (Minority AIDS Initiative) programs which use the ARTAS (Anti-Retroviral Treatment and Access to Services) model to find strength-based approaches to move clients along the care continuum. This program is implemented by two agencies in Hillsborough County and one in Pinellas County.

All three target populations include adolescents. Specific challenges for working with adolescents include lack of transportation, stigma, fear of being found out by parents and friends, not feeling sick, and indifference/being unaware of the scope and severity of the epidemic. The EMA is fortunate to have the Connect to Protect Tampa Bay Coalition (C2P) focusing on the needs of adolescents, ages 13 to 24. C2P is a community coalition that works on structural changes that are linkable to HIV transmission and acquisition.

Among Black WCBA, the most common challenges include lack of childcare and lack of transportation. The most common mode of transmission for Black WCBA is heterosexual contact. Lack of healthcare, including contraception, high rates of STI's, and limited role models in the community continue to be challenges. The state and federal Healthy Start programs offer a prenatal screening of all pregnant women in the EMA. Women who are high risk are identified and targeted for services. Hillsborough County has a provider of TOPWA (Targeted Outreach to Pregnant Women Act) services funded by FDOH. Their target population also includes substance abusers and incarcerated women. The state requirement for universal prenatal screening offers the opportunity to identify women who are HIV+ and bring them into a home visiting program, facilitating linkage to care.

Challenges to working with MSM include a mistrust of the healthcare system, particularly for Black MSM, and a higher likelihood of engaging in unsafe sexual behaviors. Men having sex with men remains the highest mode of transmission in the EMA, and MSM continue to be the largest population of PLWHA.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

HRSA-Funded Core Medical and Support Services

Due to the diverse nature of the Tampa-St. Petersburg EMA (two of the counties are urban and two semi-rural), the Planning Council and Recipient recognized that parity must be a primary consideration when allocating funds within the four-county area. All of the counties have the basic services provided, including outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), medical case management, oral health, and health insurance. MAI treatment adherence services are offered in all EMA counties, with this being especially important for the two outlying counties of Hernando and Pasco as they are geographically further from most services, with isolated pockets that have large numbers of targeted clients. Stigma and cultural barriers are more prevalent in these two counties, and there is limited public transportation.

There are five core services that are not funded with Ryan White HIV/AIDS Program funds, including medical nutrition therapy, early intervention services, home heath, hospice services, and home/community based health services. These services are all prioritized by the Planning Council, with no allocations due to the fact that all of the services have other payer sources, such as Medicaid, including the various Medicaid waiver programs. In addition, Florida has not expanded Medicaid under the Affordable Care Act so clients are still receiving primary medical care and other basic services through Ryan White in the EMA and throughout the state. Due to the unmet need in the top priority categories such as outpatient/ambulatory medical care, the Planning Council cannot, with limited funding, expand beyond the top seven funding priorities. It has not funded other supportive services such as legal assistance, food bank, and housing for many years.

All of the planned services are delivered by providers who are culturally competent. This is examined and rated during the application process for all prospective providers. The procurement instrument has a key question for a prospective provider requiring a description of how they will deliver HIV services in a culturally competent manner, including the use of bilingual staff, and staff who culturally reflect the population they serve. This procurement standard, coupled with the Minimum Standards of Care adopted by the Planning Council, helps to ensure that all staff are governed by minimum core competencies and standards of care. In addition to Spanish-speaking staff, some agencies also have Haitian-Creole speaking medical case managers. As part of the ongoing quality management program, the EMA offers satisfaction surveys to clients in multiple languages due to the diverse cultures and populations within the EMA.

The EMA, including the Planning Council and the Recipient, review the annual Women, Infants, Children, and Youth (WICY) expenditure data to ensure that resource allocations to provide services to these subpopulations are consistent and in proportion to the percentages of the EMA's reported AIDS cases. Three Ryan White Parts are represented in the EMA: Parts A, B, and D, and all of them fund services for the WICY populations. Part A and Part B funds are planned concurrently through a combined planning body or Planning Council to ensure appropriate allocations, with Part D being represented on the Council and a well-established linkage and coordination of services.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

a. Resource Inventory Tables

The following tables were developed for this plan with input and information from the Area 5, 6, and 14 HIV Planning Partnership (the local HIV prevention planning body), the West Central Florida Ryan White Care Council (or Planning Council), the Ryan White Part A, B, and D Recipients, and the Florida Department of Health. The first two tables are the Tampa-St. Petersburg EMA Prevention and Patient Care Dashboards. The Dashboard templates were developed by the Florida HIV/AIDS Prevention Planning Group's (PPG) Coordination of Efforts Committee and the Florida HIV/AIDS Patient Care Planning Group's (PCPG) Metrics Workgroup to be used in the integrated HIV plans for the resource inventory. The Dashboards relate to the HIV Continuum of Care in the EMA and list state and federal resources by amount. There is also a community resource section, listing providers and services offered but not specific monetary amounts. The PPG Committee and PCPG Workgroup discussed providers' potential reluctance to share specifics and decided to implement as presented. The PPG's Coordination of Efforts Committee started with the Prevention Dashboards and the stages of the HIV Care Continuum with the goal of individual areas being able to identify gaps in service.

The PCPG's Metrics Committee then developed the Patient Care Dashboard to compliment the Prevention version, with a major focus on the elements of the continuum related to linkage to care, engagement in care, and retention, rather than the HRSA-funded core service.

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*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Figure 31: Tampa-St. Petersburg EMA Prevention Dashboard

Area Profile - Prevention

Tampa - St. Petersburg EMA: Hernando, Hillsborough, Pasco, and Pinellas Counties

Living Cases HIV/AIDS 2014 =	New Cases =	Proportion of State Epidemic =
12,271	803	11.2%

Total EMA Funding: $2,227,946

TAMPA-ST. PETERSBURG EMA PREVENTION DASHBOARD

Local Grantee Resources (Health Department, Parts A, B, C, and D)

Area Counties	Total HIV Funds	Funded PTC (yes or no)	Total Condom Sites	Total Test Sites	HIV-FUNDED DIS (FTE)	Funded Linkage Specialist (FTE)	Funded Peer Program (FTE)	Perinatal Nurse (FTE)
Hernando	$ 83,669	YES	12	4	0	0	0	0
Hillsborough	$1,174,530	YES	96	16	6	0.5	0.125	0.75
Pasco	$ 213,226	YES	18	12	2	0.25	0	0
Pinellas	$ 806,521	NO	96	25	7	0.5	0.125	1
EMA TOTAL	$2,277,946		222	57	15	1.25	0.25	1.75

Agency	Funding Type	Target Population Served	Category of Service
DACCO	SAMHSA	MINORITIES WITH SA ISSUES	HIGH RISK HIV-, HIGH RISK HIV+, LINKAGE/RETENTION, SA PREVENTION
DACCO	TOPWA THRU FDOH	HIGH RISK WOMEN OF CHILDBEARING AGE	HIGH RISK HIV-, HIGH RISK HIV+, LINKAGE/RETENTION
METRO WELLNESS	DIRECT CDC	HIV+/- ;MSM; HIGH RISK HETERO MEN	PrEP, HIGH RISK HIV+/-, P4P, MEDICAL ADHERENCE, LINKAGE/RETENTION
METRO WELLNESS	OFFICE OF MINORITY HEALTH	RE-ENTRY HIV+/-	HIGH RISK HIV+/-, P4P, MEDICAL ADHERENCE, LINKAGE/RETENTION
METRO WELLNESS	SAMHSA	MINORITY YOUTH	HIGH RISK HIV-, HIGH RISK HIV+, LINKAGE/RETENTION, SA PREVENTION
UNIV. OF SOUTH FL - DEPT OF PEDIATRICS	RYAN WHITE PART D	AT RISK YOUTH	HIGH RISK HIV+/-, P4P, MEDICAL ADHERENCE, LINKAGE/RETENTION

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Figure 32: Tampa-St. Petersburg EMA Patient Care Dashboard

Area Profile - Patient Care

Tampa - St. Petersburg EMA: Hernando, Hillsborough, Pasco, and Pinellas Counties

Living Cases HIV/AIDS 2014 = 12,271 **New Cases =** 803 **Proportion of State Epidemic =** 11.2%

Total EMA Funding: $23,728,299

TAMPA-ST. PETERSBURG EMA PATIENT CARE DASHBOARD

Local Grantee Resources (Health Department, Parts A, B, C, and D)

Area Counties	Total HIV Funds	Early Inter-vention Services	ARTAS (or ARTAS Hybrid) FTE	Peer or Near Peer Subset	Outreach FTE	Funded Linkage Specialist (FTE)	Funded Peer Program (FTE)	Other Retention Services
Hernando	$ 753,389	NO	0	0	0	0	0	YES
Hillsborough	$11,405,909	NO	4.25	0	0	0.5	0.125	YES
Pasco	$ 1,400,821	NO	0	0	2	0.25	0	YES
Pinellas	$10,168,180	NO	0	0	0	0.5	0.125	YES
EMA TOTAL	$23,728,299		4.25	0	2	1.25	0.25	

Community Resources

Agency	Funding Type	Target Population Served	Category of Linkage or Retention Service
AIDS HEALTHCARE FOUNDATION	PRIVATE	HIV+	PATIENT CARE, LINKAGE/RETENTION, TREATMENT ADHERENCE
HILLSBOROUGH COUNTY GOVT.	COUNTY HEALTH PLAN	HIV+ <100% FPL	PATIENT CARE, LINKAGE/RETENTION
METRO WELLNESS	GILEAD	HIGH RISK HIV-	PrEP

As mentioned above, the HIV Continuum of Care Dashboards have a major focus on linkage to, engagement in, and retention in care. Therefore, there is the inclusion of two additional tables. These tables help to complete the HIV picture for the area, with more detail as relating to the funding amounts, services delivered, and Ryan White funded full time employees.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Figure 33: Tampa – St. Petersburg EMA Ryan White Funded Human Resources

Tampa – St. Petersburg EMA Ryan White Funded Full Time Employees		
Service	**Position**	**Number of Full Time Employees**
Ambulatory/Outpatient Medical Care	Medical Doctor	12
	Nurse Practitioner	12
	Registered Nurse	10
	Nutritionist	4
	Med Assistant	21
	Lab Technician	2
	Total	**61**
AIDS Pharmaceutical Assistance (local)	Pharmacy Staff	5
	ADAP Staff	8
	Total	**13**
Oral Health Care	Dentist	7
	Hygienist	4
	Dental Assistant	5
	Total	**16**
Mental Health Services	Therapist	7
	Counselor	2
	Total	**9**
Medical Case Management (including Treatment Adherence)	Medical Case Manager	48
	Supervisors	5
	Program Specialist	7
	Educators	8
	Total	**68**
Substance Abuse Services Outpatient	Therapists	6
	Total	**6**
Case Management (non-medical)	Eligibility Specialist	4
	Total	**4**
Administration	Administration Staff	7
	Finance	4
	Management	8
	Total	**19**

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Figure 34: Tampa – St. Petersburg EMA Coordination of Services and Funding Streams

Funding Source	2015 Budget ($)	Anticipated 2016 Budget ($)	**Core Services**	Outpatient/Ambulatory Medical	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	**Supportive Services**	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	**HIV Testing**
Part A	9,114,672	9,573,672		X		X	X		X				X		X	X		X		X													X	
Part B	1,134,216	1,505,605		X					X						X			X																
Part C	0	0																																
Part D	1,267,169	1,305,075		X									X		X							X				X	X	X	X				X	X
Part F	0	0																																
CDC	1,326,217	1,741,217						X														X												X
SAMHSA	595,000	595,000														X																		
HOPWA	3,378,774	3,378,774											X			X		X			X		X			X								
ADAP	11,332,191	11,332,191			X																													
Medicaid/PAC Waiver	38,336,269	38,336,269		X		X	X		X	X	X	X	X		X			X			X	X				X				X				
State	1,988,594	2,052,273				X		X							X							X												X
Local	220,404	220,404		X			X																											
TOTAL	68,693,506	70,040,480																																

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

b. HIV Workforce Capacity

The HIV workforce in the EMA is extremely dedicated, compassionate, and robust. It is also quite diverse in its requirements dependent upon the position. There are licensed providers, community health and social workers, paraprofessionals, and administrators with roles and responsibilities in the local HIV workforce.

The licensed providers include the following: MD, DO, DDS, PA, ARNP, RN, LPN, PharmD, LCSW, and RD. The Quality Management provider along with the Health Services Advisory Committee of the Planning Council conducted a recent provider survey, with each of the previously named licensed providers being listed at least once in the responses. The top three were ARNP, MD, and RN with 20, 16, and nine listed respectively in the responses by the eight responding agencies in the EMA. The average amount of total experience was just under 19 years, with 12 ½ years of HIV experience. The licensed providers are primarily involved in the following Ryan White services: outpatient/ambulatory medical care, AIDS pharmaceutical assistance (local), medical case management, and oral health.

Community health and social workers primarily comprise the staff that provides medical and non-medical case management, eligibility determination, mental health, and substance abuse outpatient services through the EMA. The individuals in this category have extensive experience in the field of public health and social services, and the majority also have many years of HIV experience. These providers have at least a Bachelor's degree, with many having Master's degrees (e.g. MSW, MPH) and other certifications such as Certified Health Education Specialist (CHES) and Substance Abuse/Addictions Professionals. All of the case management staff are required to complete the state of Florida's HIV case management training and other HIV-specific trainings upon employment, with annual updates thereafter. Mental health and substance abuse providers complete HIV training and practice-specific continuing education courses annually as well.

Paraprofessional staff are generally those who provide HIV testing, outreach, education, high impact prevention, ADAP and other supportive services throughout the EMA. These staff have completed HIV/AIDS 500/501 (client-centered HIV pre- and post-test counseling) training and specialized training specific to their job duties. The educational requirements are dependent upon the position and the agency, but range from high school diploma/GED to college degrees. Some of these staff are PLWHA themselves and most have diverse and extensive experience working with the populations most affected by HIV.

Finally, administrative staff work to ensure that all providers are operating within CDC, HRSA, and Ryan White regulations. These individuals supervise, monitor, and manage the provision of direct prevention and care services, as well as data entry, fiscal oversight, and support services. The level of experience in administrative staff is based upon the specific role. However, many of these individuals have been working in their fields for more than 10 years, with a majority of them having experience in healthcare, if not in HIV, for most of that time. Educational levels vary from high school/GED (data entry clerks) to MBA (Director of Finance) to MD (Clinical Director) depending on the organization and the services provided.

c. Interaction of Funding Sources

Local partner agencies have a rich history of collaborating on HIV prevention, surveillance, care, and treatment issues throughout the EMA. This tradition continues as the networks implement a plan to incorporate early intervention services with the goal of ensuring 100% of HIV+ clients are linked to services with the local Ryan White programs. Bimonthly meetings of the Part A Recipient, the Part B Lead Agent, and the FDOH HIV/AIDS Program Coordinators (HAPC) occur to ensure optimal service delivery using limited federal, state, and local resources. Included in the agenda are discussing on linking HIV prevention and care services. Meetings focus on coordination between Ryan Part A and Part B (ADAP and Patient Care) programs to maximize funding as well as planning program integration (HIV, STI, TB, and Hepatitis) within the EMA. Collaborative partnerships also exist with local community-based organizations, researchers at the University of South Florida, and local health department officials.

The Planning Council serves as both the Ryan White Part B consortium and the Part A planning body for the EMA. The Planning Council also plans and prioritizes services for the Part A MAI program. Ryan White Parts A, B, and D are represented at the Planning Council and its committees. Membership also includes representatives from other federal, state, and local funding sources including the Veteran's Administration, State Medicaid Program, HOPWA grantees, and county health departments, who keep the Council apprised on related issues. The Area 5, 6, and 14 HIV Planning Partnership (HPP) covers the same eight counties as the Part B consortium, inclusive of the four EMA counties, for prevention planning. The HPP representatives include the Ryan White Part A Recipient, the Part B Lead Agent, the HAPCs, other health department staff, agencies receiving Ryan White Parts A, B, and D, HOPWA providers, Medicaid providers, SAMHSA providers, and consumers. The HPP works primarily on community engagement into the HIV planning process, sharing of best practices, training, and elects the members from this area to the PPG. The PPG in conjunction with FDOH produces a prevention funding analysis by area. FDOH produces the jurisdictional prevention plan, which is subject to concurrence by the PPG. FDOH also produces epidemiological profiles, as well as the annual HIV Continuum of Care documents by area and for the EMA.

For Ryan White, the service continuum in each county is assessed during the needs assessment process. A funding stream analysis is conducted to identify available funding sources to ensure that Ryan White funds are properly utilized as payer of last resort. Further, resources are analyzed to determine where the continuum of care contains gaps. This information is used to set funding priorities. The EMA has a mature planning process that coordinates Ryan White services with those available through other public sources in order to ensure payer of last resort and that there are no duplications of service.

d. Needed Resources and Services

A community assessment serves as the basis for identifying populations at risk for HIV infection in Florida, the prevention needs of those populations, activities/interventions being implemented to address those needs and service gaps. To help assess current needs for HIV prevention services in Florida, the PPG in collaboration with the prevention program conducted an HIV Provider Survey in July 2014. The HIV Provider survey was conducted as part of an ongoing

needs assessment process to identify emerging needs and service gaps related to the delivery of HIV services in Florida. The results of the survey were used to help the FDOH Prevention Program better understand the prevention need for persons living with HIV/AIDS and those at risk for HIV.

The survey was open from July 30, 2014-September 30, 2014. Survey responses were collected electronically utilizing Survey Monkey. In total there were 397 survey respondents. The survey consisted of 33 questions designed to gather information from providers about the types of HIV services provided statewide, access to services, coordination of HIV services, barriers to HIV services, and HIV service needs. Survey responses were summarized through Survey Monkey and subsequently reviewed by the PPG and Prevention Program staff. Analysis of data from the provider survey produced the following key findings related to barriers to HIV/AIDS services, unmet need, and technical assistance and training needs:

- Survey respondents identified the following as the top barriers that their organization faces when providing services to people living with HIV/AIDS or those at risk for acquiring HIV. The top three responses were: 1) inadequate funding resources, 2) stigma, mainly related to HIV status, and 3) inadequate transportation.
- When respondents were asked to identify the top three barriers that their organization faces when trying to find people who are unaware of their HIV status, the following barriers were identified: 1) stigma, mainly related to HIV status, 2) clients not ready to receive HIV test results/address health care, and 3) mistrust of the medical system or providers.
- The top three barriers that were identified as barriers to linking and retaining HIV-positive individuals were: 1) clients are afraid to disclose HIV status, 2) clients not ready to address health care, and 3) transportation.
- Respondents were asked to identify what they felt were the most common barriers that clients face when accessing services. Respondents were given a selection of common barriers from which to choose. The top three barriers that providers strongly agreed with were: 1) our clients are reluctant to seek services due to stigma and/or fear of disclosing HIV status, 2) our clients have difficulties getting transportation to our organization, and 3) our clients are unsure of how to navigate the care system.
- Respondents were asked to identify the three most important unmet needs for HIV prevention in their area. The top three identified unmet needs were: 1) mental health services, 2) substance abuse services, and 3) peer programs.
- Survey respondents were asked to identify training topics or technical assistance areas that would help them to better serve clients. The top three responses for training and technical assistance were: 1) recruiting hard-to-reach populations, 2) linkage to and retention in care, and 3) mental health.

The community also initiated a provider survey in 2016 to gather input on needed community services and human resources as well as funding and program opportunities providers are seeking to address the identified gaps. Identified community service needs are detailed in the Needs, Gaps, and Barriers section.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Identified human resource needs include:

- Spanish and Creole speaking staff
- Additional dentists
- Licensed Clinical Social Workers and mental health providers experienced with HIV/AIDS
- Trained peer educators

Funding and program opportunities that providers are pursuing to address the identified gaps include:

- Staff development
- Funding for Pre Exposure Prophylaxis (PrEP) clinics
- Expansion of oral health services
- Funding for Hepatitis C treatment

The services needed, barriers to prevention and care, and technical assistance and training needs identified through the prevention and care processes are being utilized by the HPP and the Planning Council in current and future planning.

D. Assessing Needs, Gaps, and Barriers

Process to Identify HIV Prevention and Care Service Needs

The Eligible Metropolitan Area (EMA) utilizes a variety of strategies to identify HIV prevention and care service needs of people at higher risk for HIV and people living with HIV/AIDS (PLWHA). These strategies include client and provider surveys, focus groups, and community forums. The surveys referenced in this needs assessment include the 2013 Anonymous Needs Survey, the 2015 Ryan White Client Satisfaction Survey, the 2016 Resource Survey, and the 2016 Linkage to Care Survey.

The 2013 Anonymous Needs Survey was distributed on paper to a total of 17 sites which were selected by Care Council staff across the Total Service Area (TSA) of the West Central Florida Ryan White Care Council to ensure diversity and representativeness in the sample. The TSA is comprised of the EMA in with the addition of Polk, Manatee, Highlands and Hardee Counties. The sites consisted of primary care providers (public and private) and HIV/AIDS case management agencies. A survey link was distributed through the Planning Council e-mail list serve and posted on the Planning Council's website. In addition, the survey link was posted on the Planning Council's Facebook page and on the pages of other providers. A postage paid return envelope was provided with all surveys at sites without a collection box. Key staff at several of the sites collaborated in the distribution by asking clients to complete the survey and by providing assistance with completing the survey as needed. Several agencies also distributed the survey by mailing copies with return envelopes to each client of record. A total of 1,154 surveys were returned.

The 2015 Ryan White Client Satisfaction Survey was originally developed to gather Ryan White client feedback regarding the quality of services rendered. The survey tool was developed

by referencing The AIDS Institute's *Patient Satisfaction Survey for HIV Ambulatory Care*. The ongoing administration of the survey allows for continuous monitoring of satisfaction among clients at the provider level as well as across the EMA. Surveys are distributed to each of the Ryan White providers in the EMA and are provided in English and Spanish. Clients are asked to provide feedback for each service category they have utilized through the Ryan White funded provider network. Client satisfaction results and suggestions for calendar year 2015 were reviewed by the Care Council's Community Advisory Committee (CAC) in January 2016 to identify service gaps and suggestions for improvement. Survey results are also reviewed by the Ryan White Quality Management Technical Workgroup along with Part A Recipient and Part B Lead Agency. A total of 1,309 surveys were returned and reviewed.

The 2016 Resource Survey was initiated by the Planning and Evaluation (P&E) committee of the West Central Florida Ryan White Care Council to gather input from providers on needed community services as well as needed human resources. The survey contained 3 questions and was distributed to providers via SurveyMonkey. A total of 11 providers responded. All counties were represented in the sample.

The 2016 Linkage to Care Survey was initiated by the Planning and Evaluation (P&E) committee of the West Central Florida Ryan White Care Council. A community group was convened to create a short survey specifically targeted at collecting information about retention and re-engagement in care and opinions about Pre-exposure Prophylaxis (PrEP) as these issues are highlighted in the National HIV/AIDS Strategy for 2020. The survey, containing three questions about retention/re-engagement in care, one question about taking HIV medications, and two questions about PrEP, was reviewed by P&E committee members, key stakeholders, and consumers prior to implementation on January 4, 2016. The survey was administered via Ryan White providers, key partners, and county health departments throughout the month of January 2016. It was available in both English and Spanish and was completed on paper (through a color-coded system by provider to avoid duplication). A SurveyMonkey link was available for clients to complete the survey online, but this option was not utilized. A total of 1,124 surveys were completed at 12 provider sites throughout the EMA. All counties were represented in the sample.

Focus group data was collected from the Care Council's Community Advisory Committee (CAC) and the Women, Infants, Children, Youth, and Families (WICY&F) Committee. Both committees hosted town-hall meetings in January, February, and March 2016 to identify community needs, gaps, and barriers to accessing HIV care. These meetings were advertised on the Care Council's website as well as their Facebook page. The focus groups consisted of PLWHA, HIV care and prevention service providers, community members, as well as Ryan White Part A, Part B, and Part D representatives. These committees will host town-hall meetings bi-annually to assess the continued needs, gaps and barriers to assessing HIV care as the Integrated HIV Prevention and Care Plan is implemented.

Community input was collected from The AIDS Institute, the Florida Consortium of HIV/AIDS Research, and Connect to Protect Tampa Bay's Research and Practicum Symposium on March 3, 2016. Symposium participants were recruited through social media, e-mail notifications, and through announcements at various community events. The event featured a community round table discussion on strategies for HIV testing, community access to Post-exposure prophylaxis (PEP) and PrEP. The round table consisted of PLWHA, HIV care and prevention providers,

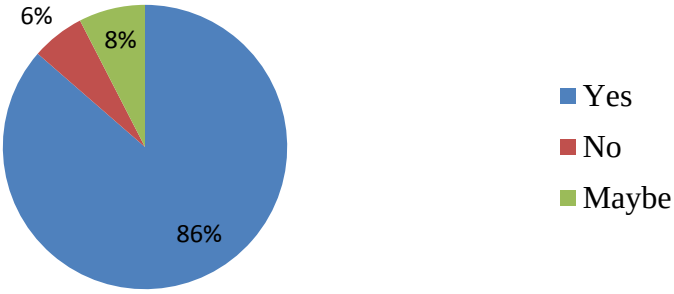
*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

community members, and researchers. Information about community needs, gaps, and barriers to accessing HIV prevention services was also collected at The Area 5, 6, and 14 HIV Planning Partnership (HPP)'s March 28, 2016 meeting. The meeting consisted of PLWHA, Community Based Organizations (CBOs), healthcare providers, community members, as well as representatives from the Department of Health and the Department of Education. The HPP will host an annual meeting to assess the continued needs, gaps and barriers to assessing HIV prevention as the Integrated HIV Prevention and Care Plan is implemented.

Service Needs

Access to PrEP and education about the medication were identified as HIV prevention service needs in community forums. The community round table discussion at the Research and Practice Symposium emphasized the need for more community providers who are willing to prescribe PrEP and monitor long-term adherence. Participants also discussed the need for community education about PrEP for both clients and providers. The 2016 Linkage to Care Survey also highlighted the need for PrEP access. Figure 35 shows the percentage of survey respondents who would encourage their partner(s) to take PrEP if the service was available.

Figure 35:
If medication (also known as PrEP) was available that would decrease the risk of HIV transmission, would you encourage your partner(s) to take it/ask the doctor for it?



Tampa-St. Petersburg EMA Linkage to Care Survey, 2016.

HIV testing service needs were discussed at the Research and Practice Symposium. The group cited community testing and street outreach in high risk areas as an effective strategy. Additional peer to peer programs and continued testing of men who have sex with men (MSM) were also identified as needed services in the local area. The WICY&F focus group identified HIV testing and education targeted to heterosexual women as a community need as well as HIV prevention education in schools. The HPP community forum noted the need for HIV testing in Emergency Rooms, mobile testing units, and routine testing for all populations.

Figure 36 highlights the perceived service needs for PLWHA as identified in the 2013 Anonymous Needs Survey. Respondents were asked to rank the five services they felt were most important. Responses are listed in order of how frequently they were selected. Brief

definitions for each service were provided. "Other" services specified were housing assistance (n=55), emergency financial assistance (n=9), support groups (n=7), and acupuncture/massage (n=7).

Figure 36: Most Important Services to provide for people with HIV/AIDS in the TSA

Which five services do you think are most important for people living with HIV/AIDS to be able to access throughout the state?		
Answer Options	Response Percent	Response Count (#) n= 1076
Outpatient Medical Care	74%	797
Payment for Medications	68%	729
Dental/Oral Health Services	56%	606
Assistance receiving and accessing services	45%	480
Food Bank/Food Voucher	39%	417
Mental Health Services	32%	348
Private Health Insurance co-payment or premium assistance	30%	318
Transportation to and from HIV related care services	24%	256
Linking newly diagnosed HIV patients to care	17%	182
Outreach to HIV patients who have fallen out of care to get them back into care	17%	187
Legal services	16%	175
Nutritional Counseling for healthy eating habits	15%	161
Health education about risk reduction	11%	123
Substance Abuse Treatment	10%	106
Home Health Care	8%	85
Treatment adherence counseling	8%	87
Other (please specify)	7%	80
Rehabilitation services	6%	68
Hospice Services	5%	51
Early Intervention Services	2%	19

Care service needs mentioned in the 2015 Ryan White Client Satisfaction Survey included outpatient medical care, transportation assistance, shorter wait times for dental services, medication payment assistance, support groups, access to a food pantry, medical case management, and substance abuse services. The needs of PLWHA identified in the CAC and WICY&F focus groups included transportation assistance, access to dental providers, outpatient medical care, help navigating services among various agencies, medication payment assistance, medical providers that have flexible office hours and convenient locations, health literacy,

support groups for females, support groups for youth, as well as reliable and affordable health insurance.

Service Gaps

Prevention service gaps identified in the 2016 Resource Survey included funding for PrEP/PEP for uninsured patients and prevention materials in Spanish/Creole. The HPP community forum identified the following HIV prevention service gaps:

- Transportation to/from testing sites
- Lack of PrEP clinics and funding for the labs required to prescribe the medication
- Provider training for PrEP
- Testing in non-clinical settings, specifically in Hernando and Pasco Counties
- Community resource guide for the local area that details services available at each agency
- Health information available in various languages as well as for various reading levels

Figure 37 showcases the care service gaps for PLWH as identified in the 2013 Anonymous Needs Survey. Service gaps combines respondents who selected "needed service, but could not get service" and "needed service, but did not know about service." The services are ranked in order from highest service gap percentage to lowest service gap percentage.

Figure 37: Service Gaps

Service	Service Gap Percentage (%)
Dental/Oral Health	30%
Food Bank or Food Vouchers	27%
Legal Support	24%
Housing	24%
Health Insurance	22%
Transportation	20%
Nutritional Counseling	15%
Mental Health Services	13%
Peer Mentoring	13%
Rehabilitation	12%
Other: A service not listed	12%
Outreach	10%
Case Management	8%
Home Health Care	7%
Early Intervention Services	6%
Health Education/Risk Reduction	6%
Hospice Services	4%
Treatment Adherence	4%
Outpatient Medical Care	3%
Medications	3%
Substance Abuse Treatment	3%

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Additional care service needs that were mentioned in the previous section, but are not currently funded through Ryan White include support groups, acupuncture, and health literacy. Care service gaps identified in the 2016 Resource Survey included food banks, housing for HIV positive men, peer education programs, transportation, funding for Hepatitis C/HIV co-infection, expanded insurance premium/medication co-pay assistance, additional funding for dental services, and youth case management services in Pinellas County.

Barriers

A variety of barriers exist within the EMA that hinder access to prevention services. The HPP community forum discussed the following barriers:

- Need to change policies that hinder data sharing between service providers
- Accessible child care
- Limited testing services available in fast-growing areas in the EMA (i.e., Brandon, Wesley Chapel, New Port Richey)
- Limited collaboration among providers
- Absence of services available at night and on the weekends
- Stigma about HIV among the medical community in rural areas
- Funding is limited to testing specific populations rather than for routine testing of all populations

Barriers can limit or prevent PLWH from receiving available services that are essential to improving or maintaining their health and well-being. Barriers to care were identified by clients in the 2013 Anonymous Needs Survey. Respondents were asked to describe the reasons they did not receive a service they needed. A list of responses is detailed below (listed in order from most responses to least) (N= 1,154).

- I did not know where to get services (n=141).
- I could not pay for services (n=114).
- I could not get transportation (n=111).
- I was depressed (n=95).
- Other (n=85).
- I did not qualify for services (n=67).
- I did not want people to know that I have HIV (n=43).
- I could not get an appointment (n=35).
- I had a bad experience with the staff (n=35).
- I could not get time off work (n=15).
- I could not get childcare (n=4).
- Services were not in my language. (n=2).

"Other" reasons cited included length of time they had been on a waiting list and various complications of getting through the process to receive assistance. Several respondents listed jail or prison as a barrier. Other respondents listed the need for a service that was unavailable to them or lacks funding such as vision care, specialty dentistry, and legal services.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

The 2016 Linkage to Care Survey identified reasons clients fell out of care. A total of 1,124 surveys were completed. Respondents were asked what prompted them to stop coming in to care (listed in order from most responses to least).

- Had transportation issues (n=113).
- Change in financial/insurance status (n=97).
- Confidentiality concerns (n=67).
- Other (n=67).
- Did not feel sick (n=66).
- Did not feel ready to engage in care (n=43).
- Provider issue, not comfortable/not respected (n=42).
- Family/child care issues (n=30).
- Relocation (moved) (n=10).
- Substance abuse (n=7).
- Incarceration (n=3).

"Other" reasons cited included: mental health issues (denial/depression/anxiety), medication side effects, missed medical appointments, fear that their family would find out their HIV status, difficulty scheduling an appointment to see a doctor at a time convenient for the client, incarceration, treatment fatigue, fear of losing their job if they had to explain frequent doctor's visits, client was not comfortable with their healthcare provider.

WICY&F facilitated a specific focus group to identify barriers to accessing care for youth. HIV-positive youth (18-24) identified the following barriers: insurance does not cover all needed medications, the location of services in not convenient, difficulty understanding the directions being given by their healthcare providers and/or case managers, difficulty communicating with service providers, fear their HIV status will be disclosed to others, dependence on parents/not wanting to disclose their status to their parents, and difficulty balancing the stress of school/work/health appointments. One member of the group noted that she was not adherent to her medications until she was hospitalized. Another member mentioned treatment fatigue as a barrier to accessing care. Obstacles to accessing care identified at the general WICY&F and CAC focus groups are: strict provider policies that don't allow for missed appointments, feeling stigmatized because there is a separate waiting areas for PLWH at one of the Health Departments, inconvenient provider hours for lab work, stigma, and difficulty navigating the system of care.

Barriers to care that were identified by community service providers included lack of data sharing among healthcare providers and difficulty sharing data among HIV prevention and care service providers. Service providers also identified the lack of resources for general HIV prevention programs for all communities as a barrier. Current funding is specified for target populations (i.e., men who have sex with men (MSM), Hispanic outreach). There is also a lack of funding for non-core HIV care services as all Ryan White funding is allocated to core services such as outpatient ambulatory medical care (OAMC), medication assistance, oral health, and medical case management.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

E. Data: Access, Sources and Systems

Primary Data Sources: Data for the needs assessment and developing the HIV continuum of care is obtained from multiple sources, managed predominately by the Florida Department of Health, (surveillance and epidemiological data), as well as all Part B patient care data which includes the AIDS Drug Assistance Program (ADAP). Surveillance data is derived by the Florida Department of Health from eHARS (enhanced HIV/AIDS Reporting System), a browser-based, CDC-developed application that assists the Department with reporting, data management, analysis and transfer of non-confidential data. The care continuum is developed based on data collected by CAREWare, as well as the other sources, all managed currently by the Department of Health.

Multiple systems are used for prevention and patient care programs locally, which are not linked for data sharing purposes. These include CAREWare for Parts A, B and D; a separate ADAP database; the Counseling, Testing, and Linkage (CTL) database; the AIDS Information Management System (AIMS) for patient care services and financials; the Medical Monitoring Project (MMP) database, a surveillance special project used to collect comprehensive clinical and behavioral information about PLWHA; Evaluation Web, used by contracted HIP (High Impact Prevention) providers; and PRISM (Patient Reporting Investigating Surveillance Manager), used by linkage to care coordinators. Effective 2016, a new system is being implemented by Part A named e2Hillsborough for patient care data, program reporting, and claims reimbursement.

Data Policies: The Florida Department of Health's data which is provided routinely for planning and analysis purposes is dependent on the accuracy and complete reporting in eHARS, maintaining timely reporting of deaths, maintaining accurate addresses, and accommodating for in and out migration, which is a significant issue in Florida due to the transient nature of the population. Adjustments also are made to the data profiles to account for the populations within the Department of Corrections (DOC). The most significant challenge to the HIV Care Continuum for the EMA in the coming year will be maintaining and expanding quality data collection. Due to the transition in 2016 from CAREWare to the new e2Hillsborough database, it will be difficult to analyze any trends in utilization and potential unmet need in the initial stages of implementation as there will not be enough consistent mature data collected to be analyzed for trends such as service gaps, utilization, and outcomes.

Unavailable Data: There are pieces of HIV prevention data that are not available at the local level. For example, there is not a centralized database tracking the number and type of educational and outreach activities conducted. Counseling and testing data are available at the local level through DOH's database. Other prevention information is entered into the CDC's Evaluation Web but that information is not easily accessible for community planning purposes.

In addition, data on co-morbidities for PLWHA such as cancers, heart disease, diabetes, and other chronic health conditions is not currently tracked or available but would be useful for planning especially as the population ages.

Due to the Quality Management program being reliant upon multiple data systems, some of the HRSA indicators (viral load, prescription of HAART, HIV test results, linkage to care, CD4 counts, etc.) that would be available for planning purposes are currently difficult to obtain since

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Part A moved from a previously utilized data system in 2014 to CAREWare, and now another data migration/transfer will occur in 2016. Optimally, the EMA wants to have the ability to analyze the local Part A and B data in these categories with a uniform baseline, but this has not been achieved yet. The current data is limited because it is all sourced from the Department of Health and includes the entire area profiles, with no specific data limited strictly to Ryan White clients.

SECTION II: HIV PREVENTION AND CARE PLAN

A. Integrated HIV Prevention and Care Plan

The Tampa-St. Petersburg EMA collaboratively established its prevention and care plan for 2017-2021 to achieve a more coordinated response to addressing HIV in the local area. The plan aligns with the National HIV/AIDS Strategy (NHAS)'s primary goals of reducing new infections, increasing access to care, and reducing HIV-related disparities. The plan was developed as a response to the needs detailed in the preceding section.

Tampa-St. Petersburg EMA Objectives, Strategies, and Activities

I. NHAS Goal 1: Reducing New Infections

A. Tampa-St. Petersburg EMA Objective 1: By January 2019, increase the number of providers offering PrEP in the EMA by 50%.

Strategy 1: Increase PrEP awareness and support within the Tampa/St. Petersburg EMA.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Community-Based Organizations (CBOs), Department of Health, Healthcare Providers	Educate high-risk populations and communities about PrEP	Communities where HIV is most heavily concentrated	Number of PrEP education sessions
Ongoing	AIDS Education and Training Center	Educate healthcare providers about PrEP	Healthcare providers	Number of PrEP education sessions
Ongoing	CBOs, Department of Health, Healthcare Providers	Facilitate community PrEP education seminars	Communities where HIV is most heavily concentrated	Number of education seminars
By December 2017, updated by December 2019	CBOs, Department of Health	Develop a community PrEP resource guide	Persons at risk for HIV infection	Creation of the resource guide

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Strategy 2: Develop a system for PrEP delivery within the Tampa/St. Petersburg EMA.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2016	Department of Health	Identify potential PrEP providers	Healthcare providers	Number of identified providers
Ongoing	AIDS Education and Training Center	Identify resources available for clinical consultation and education	Healthcare providers	• Number of trainings offered/consultations in the EMA • Number of healthcare providers attending each training
Ongoing	Department of Health, Healthcare Providers	Identify best practices to finance PrEP	Persons at risk for HIV infection	Discussion of best practices with the HIV Planning Partnership

Strategy 3: Increase PrEP marketing within the Tampa/ St. Petersburg EMA.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	CBOs, Department of Health	Advertise PrEP through direct marketing (face-to-face and mail)	Persons at risk for HIV infection	Creation and distribution of the direct marketing messages
Ongoing	CBOs, Department of Health	Advertise PrEP through social media	Persons at risk for HIV infection	Creation and distribution of the advertisement
Ongoing	CBOs, Department of Health	Advertise PrEP at community events	Persons at risk for HIV infection	Creation and distribution of the advertisement

B. Tampa-St. Petersburg EMA Objective #2: By December 2021, increase to 90% the number of persons living with HIV in the EMA who know their status.

Strategy 1: Test high risk communities in non-conventional venues.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health	Increase testing and education in correctional facilities	Incarcerated persons	Number of persons tested
Ongoing	Department of	Increase testing,	Persons	Number of

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	Health, CBOs	education, and follow-up with persons experiencing homelessness	experiencing homelessness in rural communities	persons tested
Ongoing	Emergency Room Staff	Increase testing, education, and linkage to care at Emergency Rooms in the EMA	Patients who visit the Emergency Room	Number of persons tested

Strategy 2: Use peers and partners to help identify persons at high risk for HIV in their social network.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health, CBOs	Use of Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies)	Persons at risk for HIV	Number of persons training in Community PROMISE
Ongoing	Department of Health, CBOs	Train peer educators to disseminate accurate and relevant HIV information in their communities	Persons living with HIV	Number of persons trained
Ongoing	Department of Health	Continue HIV partner counseling and referral services	Partners of persons diagnosed with HIV	Number of partners who are tested and referred to services
Ongoing	Department of Health, CBOs	Testing for persons at risk for HIV as identified by persons living with HIV in their social network	Persons at risk for HIV	Number of persons trained

Strategy 3: Encourage routine HIV testing.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health, CBOs	Utilize social media to advertise information about HIV testing	Persons at risk for HIV	Number of posts on the Department of Health's social media pages about HIV testing
Ongoing	AIDS Education and Training Center	Inform healthcare providers about routine testing	Healthcare providers	Number of healthcare providers trained

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

		strategies		
Ongoing	Department of Health, CBOs	Incentivize testing	Persons at risk for HIV	Number of persons tested

C. Tampa-St. Petersburg EMA Objective #3: By December 2021, reduce the number of new HIV diagnoses in the EMA by 10%.

Strategy 1: Intensify HIV prevention efforts funded through the Department of Health in communities where HIV is most heavily concentrated.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health, Department of Health funded CBOs	Increase HIV education in local schools using age-appropriate HIV prevention materials	Youth	Number of outreach activities conducted
Ongoing	Department of Health funded CBOs	Collaborate with faith-based organizations to provide HIV education	Persons at risk for HIV	Number of outreach activities conducted
Ongoing	Department of Health, Department of Health funded CBOs	Continue distributing condoms in the community through outreach	Persons at risk for HIV	Number of condoms distributed
Ongoing	Department of Health, Department of Health funded CBOs	Continue safer sex kit distributions in the community through outreach	Persons at risk for HIV	Number of safer sex kit distributed

Strategy 2: Provide clear, specific, consistent, and scientifically up-to-date messages about HIV risks and prevention strategies.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health, Department of Health funded CBOs	Use YouTube videos approved by the Department of Health to disseminate prevention strategies to youth	Youth	Number of times YouTube videos are shared or viewed
Ongoing	Department of Health, Department of Health funded CBOs	Disseminate education materials approved by the Department of Health	Persons at risk for HIV	Number of education materials handed out

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Strategy 3: Disseminate HIV prevention messages through social media.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Department of Health funded CBOs	Use Facebook, Twitter, and Instagram to disseminate HIV prevention education	Youth	Number of posts about HIV prevention education
Ongoing	Department of Health funded CBOs	Use pop-ups on dating websites to disseminate HIV prevention education	Persons at risk for HIV	Number of HIV prevention education pop-ups

II. NHAS Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV

The following objectives, strategies, and activities are all aimed at addressing gaps along the HIV Care Continuum.

A. Tampa-St. Petersburg EMA Objective 1: By December 2021, increase the percentage of difficult to reach persons newly diagnosed with HIV* who are linked to Ryan White-funded medical care.

*Difficult to reach persons newly diagnosed with HIV is defined as individuals who have tested positive for HIV, but do not have any evidence of engagement in care (CD4 count, Viral Load or HIV medical visit).

Strategy 1: Identify the process for tracking difficult to reach persons newly diagnosed with HIV who are Ryan White eligible and linked to medical care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of January 2017	Department of Health Surveillance, Disease Intervention Specialists (DIS), and Linkage Coordinators	Identify the process of how newly diagnosed individuals are linked to care in the EMA	Difficult to reach persons newly diagnosed with HIV	Establishment of a written process
Annually, by the end of January for the previous calendar year	DOH-funded Linkage Coordinators	Track the number of individuals who are referred to Ryan White care	Difficult to reach persons newly diagnosed with HIV	Number of persons referred to care
Annually, by the end of	Re-entry providers, DOH-funded	Track the number of individuals	Difficult to reach persons	Number of persons

January for the previous calendar year	Linkage Coordinators	who are referred to Ryan White care	newly diagnosed with HIV	referred to care

Strategy 2: Establish a baseline of persons eligible for Ryan White funding in the EMA who are linked to Part A, Part B, and Part D-funded medical care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Annually, by the end of January for the previous calendar year	Part A, Part B, and Part D	Compare the names of newly diagnosed individuals referred to care with those in the Ryan White care database	Difficult to reach persons newly diagnosed with HIV	Number of persons referred to care vs. number of persons in care
Annually, by the end of January for the previous calendar year	Linkage Coordinators, Part A, Part B, and Part D.	Meet to review baseline data and discuss strategies to enhance linkage and engagement in care	Difficult to reach persons newly diagnosed with HIV	Meeting attendance

Strategy 3: Strengthen relationships and referral systems among providers in the EMA to ensure persons newly diagnosed with HIV are engaged in care.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	ARTAS funded providers	Continue the use of Anti-Retroviral Treatment and Access to Services (ARTAS)	Persons newly diagnosed with HIV	Number of persons receiving ARTAS services
By December 2021	CBOs	Create a community resource guide detailing available services at community providers utilizing the What's Next resource guide as a baseline	Persons living with HIV Case managers	Creation of a community resource guide

B. Tampa-St. Petersburg EMA Objective 2: By December 2021, increase the percentage of persons with diagnosed HIV infection, who are accessing Ryan White outpatient ambulatory medical care (OAMC), and who are retained in care, from 81% to 86%.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Strategy 1: Offer ongoing support services and health education for persons living with HIV.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	CBOs	Increase support groups offered in the EMA	Women Youth Heterosexual men Persons who have fallen out of care	Number of support groups offered in the EMA as reported to the Care Council and HIV Planning Partnership
Ongoing	CBOs, Healthcare Providers	Provide supportive education materials and resources for individuals through each step of the HIV Care Continuum	Persons living with HIV	Number of providers offering education and resources in the EMA as reported to the Care Council and HIV Planning Partnership

Strategy 2: Increase the availability of medical case management services.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Annually, beginning in 2017	Ryan White grant administrators	Facilitate a capacity-building training for case managers	Ryan White funded case managers	Number of trainings offered
Bi-annually in June and December	Quality Management Technical Workgroup	Monitor case management utilization	Persons living with HIV who are accessing Ryan White services	Number of persons who have a Medical Case Management Plan

Strategy 3: Increase the capacity of peer intervention programs.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	CBOs	Identify funding sources available for peer intervention programs	Persons living with HIV	Number of peer programs available in the EMA
Ongoing	CBOs	Replicate successful evidenced-based program	Persons living with HIV	Number of peer programs available

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

		from other communities		in the EMA

C. Tampa-St. Petersburg EMA Objective 3: By December 2021, increase the percentage of persons with diagnosed HIV infection, who are accessing Ryan White outpatient ambulatory medical care (OAMC), who are virally suppressed from 78% to at least 83%.

Strategy 1: Increase the number of people who are prescribed and adherent to Anti-Retroviral Therapy (ART).

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Ryan White grant recipients	Continue funding for OAMC	Persons living with HIV	Number of OAMC providers funded by Ryan White in the EMA
Annually in December	Quality Management Technical Workgroup	Monitor prescription of ART among persons living with HIV who are accessing Ryan White funded OAMC services	Persons living with HIV who are accessing Ryan White funded OAMC services	Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.

Strategy 2: Support screening for and referral to substance use and mental health services for people living with HIV.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Healthcare Providers, Department of Health, CBOs	Increase community collaboration to ensure identification of and treatment for substance abuse and mental health problems	Persons living with HIV experiencing substance abuse and/or mental health problems	Number of providers offering substance abuse and mental health services in the EMA as reported to the Care Council and HIV Planning Partnership
Ongoing	Healthcare Providers, Department of Health	Increase the use of brief screening tools for substance abuse and mental health problems	Persons living with HIV experiencing substance abuse and/or mental health problems	Number of providers using the brief screening tool in the EMA as reported to the Care Council and HIV Planning Partnership

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Strategy 3: Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-infections.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
Ongoing	Healthcare Providers, Department of Health	Increase the number of providers offering HIV/Hepatitis C (HCV) treatment	Persons living with HIV who are co-infected with HCV	Number of providers offering HIV/HCV treatment in the EMA as reported to the Care Council and HIV Planning Partnership
Ongoing	Healthcare Providers, CBOs, Department of Health	Encourage providers to refer persons living with HIV to other community services (i.e., housing, child care, etc.)	Persons living with HIV	Creation of a community resource guide

III. NHAS Goal 3: Reducing HIV-Related Disparities and Health Inequities

A. Tampa-St. Petersburg EMA Objective 1: By December 2021, increase culturally and linguistically competent outreach efforts, funded through the Department of Health and Ryan White, targeting Hispanic persons in the EMA by 25% in order to engage the community in the continuum of care.

Strategy 1: Establish a baseline of the number of outreach activities conducted by CDC-funded organizations and Ryan White Part A Minority AIDS Initiative (MAI)-funded organizations targeting Hispanic persons. Outreach is defined as face-to-face health information and education, linkage to care, testing, health system navigation, social marketing, and adherence support.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of CY 2017	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC, Ryan White Part A Recipient	Compile the number of outreach activities that were conducted targeting Hispanic persons and Hispanic clients served in CY 2017	Hispanic persons in the EMA	Number of clients served Number of outreach activities conducted
January 2018	Care Council Planning Staff	Compile the number of outreach activities that were conducted targeting	Hispanic persons in the EMA	Number of clients served

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

		Hispanic persons and Hispanic clients served in CY 2017 based on information provided by the previously referenced responsible parties		Number of outreach activities conducted

Strategy 2: Monitor and track progress on the number of outreach activities conducted and Hispanic clients served.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
February 2018 – March 2018	Care Council Planning Staff	Present results of the collected baseline data to community stakeholders	Community groups Care Council HIV Planning Partnership	Number of clients served Number of outreach activities conducted
Annually	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC, Ryan White Part A Recipient	Compile the number of outreach activities conducted and clients served in CY 2018, CY 2019, CY 2020, and CY 2021	Hispanic persons in the EMA	Number of clients served Number of outreach activities conducted
Annually	Care Council Planning Staff	Update community stakeholders on the area's progress towards increasing outreach efforts by 25%	Community groups Care Council HIV Planning Partnership	Number of clients served Number of outreach activities conducted

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Strategy 3: Identify and prioritize effective outreach strategies targeting Hispanic persons based on feedback from PLWH and community providers.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2018, updated December 2020	HIV Planning Partnership	Host a focus group to assess strategies for engaging Hispanic persons in HIV prevention and care activities	Hispanic persons at high risk of HIV Hispanic persons living with HIV/AIDS Community providers	Meeting minutes
By December 2018, updated December 2020	Care Council	Host a focus group to assess strategies for engaging Hispanic persons in HIV prevention and care activities	Hispanic persons at high risk of HIV Hispanic persons living with HIV/AIDS Community providers	Meeting minutes

B. Tampa-St. Petersburg EMA Objective 2: By December 2021, increase culturally and linguistically competent outreach efforts, funded through the Department of Health and Ryan White, targeting Black persons in the EMA by 25% in order to engage the community in the continuum of care.

Strategy 1: Establish a baseline of the number of outreach activities conducted by CDC-funded organizations and Ryan White Part A Minority AIDS Initiative (MAI)-funded organizations targeting Black persons. Outreach is defined as face-to-face health information and education, linkage to care, testing, health system navigation, social marketing, and adherence support.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of CY 2017	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC,	Compile the number of outreach activities that were conducted targeting Black persons and Black clients served in CY 2017	Black persons in the EMA	Number of clients served Number of outreach activities conducted

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

	Ryan White Part A Recipient			
January 2018	Care Council Planning Staff	Compile the number of outreach activities that were conducted targeting Black persons and Black clients served in CY 2017 based on information provided by the previously referenced responsible parties	Black persons in the EMA	Number of clients served Number of outreach activities conducted

Strategy 2: Monitor and track progress on the number of outreach activities conducted and Black clients served.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
February 2018 – March 2018	Care Council Planning Staff	Present results of the collected baseline data to community stakeholders	Community groups Care Council HIV Planning Partnership	Number of clients served Number of outreach activities conducted
Annually	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC, Ryan White Part A Recipient	Compile the number of outreach activities conducted and clients served in CY 2018, CY 2019, CY 2020, and CY 2021	Black persons in the EMA	Number of clients served Number of outreach activities conducted
Annually	Care Council Planning Staff	Update community stakeholders on the area's progress towards increasing outreach efforts by 25%	Community groups Care Council HIV Planning Partnership	Number of clients served Number of outreach activities conducted

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Strategy 3: Identify and prioritize effective outreach strategies targeting Black persons based on feedback from PLWH and community providers.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2018, updated December 2020	HIV Planning Partnership	Host a focus group to assess strategies for engaging Black persons in HIV prevention and care activities	Black persons at high risk of HIV Black persons living with HIV/AIDS Community providers	Meeting minutes
By December 2018, updated December 2020	Care Council	Host a focus group to assess strategies for engaging Black persons in HIV prevention and care activities	Black persons at high risk of HIV Black persons living with HIV/AIDS Community providers	Meeting minutes

C. Tampa-St. Petersburg EMA Objective 3: By December 2021, increase culturally and linguistically competent outreach efforts, funded through the Department of Health and Ryan White, targeting youth in the EMA by 25% in order to engage the community in the continuum of care.

Strategy 1: Establish a baseline of the number of outreach activities conducted by CDC-funded organizations and Ryan White funded organizations targeting youth. Outreach is defined as face-to-face health information and education, linkage to care, testing, health system navigation, social marketing, and adherence support.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By the end of CY 2017	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC,	Compile the number of outreach activities conducted and clients served in CY 2017	Youth (age 13-24) in the EMA	Number of youth served Number of outreach activities conducted targeting youth

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

	Ryan White funded grant recipients			
January 2018	Care Council Planning Staff	Compile the number of outreach activities conducted and clients served in CY 2017 based on information provided by the previously referenced responsible parties	Youth (age 13-24) in the EMA	Number of youth served Number of outreach activities conducted targeting youth

Strategy 2: Monitor and track progress on the number of outreach activities conducted and youth served.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
February 2018 – March 2018	Care Council Planning Staff	Present results of the collected baseline data to community stakeholders	Community groups Care Council HIV Planning Partnership	Number of youth served Number of outreach activities conducted targeting youth
Annually	Area 6 Florida Department of Health HIV/AIDS Program Coordinator (HAPC), Area 5 Florida Department of Health HAPC, Ryan White funded grant recipients	Compile the number of outreach activities conducted and clients served in CY 2018, CY 2019, CY 2020, and CY 2021	Youth (age 13-24) in the EMA	Number of youth served Number of outreach activities conducted targeting youth
Annually	Care Council Planning Staff	Update community stakeholders on the area's progress towards increasing outreach efforts by 25%	Community groups Care Council HIV Planning Partnership	Number of youth served Number of outreach activities conducted targeting youth

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Strategy 3: Identify and prioritize effective outreach strategies targeting youth based on feedback from PLWH and community providers.

Timeframe	Responsible Parties	Activity	Target Population	Data Indicators
By December 2018, updated December 2020	HIV Planning Partnership	Host a focus group to assess strategies for engaging youth in HIV prevention and care activities	Youth at high risk for HIV Youth living with HIV/AIDS Community providers	Meeting minutes
By December 2018, updated December 2020	Care Council	Host a focus group to assess strategies for engaging youth in HIV prevention and care activities	Youth at high risk of HIV Youth living with HIV/AIDS Community providers	Meeting minutes

Challenges and Barriers

The Integrated HIV Prevention and Care Plan encourages a streamlined approach to HIV planning. Unfortunately, data and funding limitations can impede the ability to achieve all identified objectives. Some of the anticipated barriers to plan implementation include difficulty sharing data between the various databases utilized for prevention and care services in the EMA, additional capacity needed to accommodate new positives, limited funding available for HIV support services (i.e., peer programs, support groups), and additional staff support needed to monitor plan progress.

B. Collaborations, Partnerships, and Stakeholder Involvement

Collaboration among stakeholders is critical to maximizing resources and efficiencies in serving people at-risk for HIV-infection and PLWHA. As the Tampa-St. Petersburg EMA strives to coordinate prevention, care, and treatment, collaboration becomes paramount to providing services that fully address each component of the HIV care continuum. This section describes the contributions of stakeholders and key partners to the development of the plan; describes stakeholders and partners not involved in the planning process, but who are needed to improve outcomes along the HIV care continuum; and includes letters of concurrence to the goals and objectives of the Integrated HIV Prevention and Care Plan from the Area 5, 6, and 14 HIV Planning Partnership and the West Central Florida Ryan White Care Council.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Contributions of Stakeholders and Key Partners

Collaborative partnerships exist with local AIDS service organizations, community-based organizations, faith-based organizations, mental health providers, substance abuse agencies, housing providers, community health centers, hospitals, clinics, research institutions, the University of South Florida, and other representatives from state and local governments and agencies. All of these individuals/groups were actively involved in the drafting, reviewing, revising, disseminating, and soliciting input processes that went into the Integrated Plan, with the local HIV prevention and care planning bodies completing and providing concurrence on the Tampa-St. Petersburg Integrated HIV Plan. The Part A Recipient submitted the Tampa-St. Petersburg Plan to the HIV/AIDS Section of the Florida Department of Health, to be included as a chapter in Florida's Integrated HIV Plan. The Part A Recipient plans to submit the entire Plan to the Part A project officer. The HIV/AIDS Section will submit the entire Integrated Plan to both the CDC and Part B project officers.

The local HIV prevention planning body is the Area 5, 6, and 14 HIV Planning Partnership (HPP) covering the EMA and four additional counties. The HPP is co-chaired by a community representative and someone from the Florida Department of Health. The HPP is also responsible for electing a community representative and alternate to serve on the Florida HIV/AIDS Prevention Planning Group (PPG). The PPG assists with the development and has concurrence responsibilities for Florida's Statewide Integrated Plan. The current DOH co-chair of the HPP is also the DOH co-chair of the PPG.

The overall goal of the HPP is, "to improve local HIV prevention programs by strengthening the 1) scientific basis, 2) community relevance, 3) key stakeholder involvement, 4) risk-based focus of HIV prevention interventions, and 5) communication and coordination of services across the continuum of HIV prevention, care, and treatment, including social determinants of health associated with HIV/AIDS, STDs, infectious diseases, substance abuse, and mental health." With regard to stakeholders, the HPP defines a stakeholder as, "a person or representative who has personal or professional experience, skills, resources, or expertise in HIV." The HPP continually works on strategies to recruit and retain members, targeting participants who represent the diversity of HIV-infected populations, HIV service providers, and other individuals who are able to assist with the coordination and collaboration of prevention, care, and treatment services. The HPP also works to ensure the planning process aligns with the National HIV/AIDS Strategy and High Impact Prevention. The HPP identifies the top six priority populations for primary and secondary prevention based on persons living with HIV disease. The priority populations include 1) White MSM, 2) Black Heterosexuals, 3) Black MSM, 4) Hispanic MSM, 5) White Heterosexuals, and 6) Hispanic Heterosexuals.

The local HIV patient care planning body is the West Central Florida Ryan White Care Council. The Care Council carefully determines the needs of the HIV community in eight counties, including the Tampa-St. Petersburg EMA, by conducting a needs assessment. With this information and the input of community members who participate in committee meetings, town halls, and other community events, the Care Council decides how much Ryan White funding is allocated to each service category. The Care Council does not provide direct services, rather planning for and evaluating them. The Care Council is also responsible for electing a community representative and alternate to serve on the Florida HIV/AIDS Patient Care Planning Group

(PCPG). The PCPG assists with the development and has concurrence responsibilities for Florida's Integrated Plan, particularly the Statewide Coordinated Statement of Need.

Per the bylaws, the Care Council shall include representatives of health care providers, including Federally Qualified Health Centers; community based organizations serving affected populations and AIDS service organizations; social service providers, including housing and homeless services; mental health providers; substance abuse providers; local public health agencies; hospital planning agencies or heath care planning agencies; affected communities, including PLWHA and historically underserved groups and sub-populations; non-elected community leaders; Medicaid representatives; Ryan White Parts B, C, and D; recipients under federal HIV programs; and formerly incarcerated individuals.

The Tampa-St. Petersburg EMA holds community input as the core component of providing HIV services and programs. The main sources of community input are the prevention and Ryan White needs assessments, the HPP and its committees, and the Care Council and its committees. The HPP has three committees, broken down by the Florida Department of Health's HIV/AIDS Program geographical areas. Areas 5 and 6 cover the Tampa-St. Petersburg EMA plus Manatee County. The Care Council Committees include the following: Planning and Evaluation; Membership; Standards, Issues, and Operations; Resource Prioritization and Allocation Recommendations; Health Services Advisory; Women, Infants, Children, Youth, and Families; and Consumer Advisory. Planning activities are guided by the Updated National HIV/AIDS Strategy and the HIV care continuum.

The community assessment serves as the basis for identifying populations at risk for HIV infection in Florida, the prevention needs of those populations, activities/interventions being implemented to address those needs and service gaps. The Ryan White needs assessment includes the process of establishing priorities and allocating resources based upon community input. The Care Council Planning and Evaluation Committee was responsible for overseeing the completion of the needs assessment elements. The needs assessment utilizes client surveys, focus groups, town hall meetings, epidemiological data, service utilization and expenditure data, analysis of public funding streams, and estimates of unmet need. The needs assessment components were presented to the Care Council by the Planning and Evaluation Committee for adoption. All Care Council meetings are open to the public and include an agenda item for community input.

This section highlights the collaborative spirit in the Tampa-St. Petersburg EMA for HIV programming and services. Key partners and stakeholders are actively involved in the HIV planning processes and were intimately involved in the development of the Integrated Plan, from stakeholder identification, to community engagement, to drafting pieces of the Plan (with so many pieces relying on community input for their development) including the goals and objectives, to commenting on said pieces, suggesting revisions, reviewing the revisions, and finally to accepting the Plan through formal voting at the HPP and at the Care Council. The Integrated Plan is designed to be a living document, meaning that future changes, revisions, evaluation, etc. will all rely heavily on collaborations, continued partnerships, and community involvement.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Stakeholders and Partners Not Involved in the Planning Process

As stated above, local planning activities are guided by the Updated National HIV/AIDS Strategy and the HIV care continuum. The Updated National HIV/AIDS Strategy states the following: "HIV does not impact all Americans equally." Looking at this statement from the local level, it still holds true. While anyone can become infected with HIV, the epidemic is concentrated in key populations. Of the groups where HIV is most concentrated, there are three who are not currently actively involved in HIV planning in the Tampa-St. Petersburg EMA. These stakeholders include youth aged 13 to 24 years, with a special emphasis on young gay and bisexual men of color; transgender women, with a special emphasis on Black transgender women; and people who inject drugs.

Unique challenges for these three populations include social, economic, and cultural barriers that limit access to prevention and care. Stigma, misinformation about HIV and AIDS, low rates of condom usage, survival sex, and low rates of PrEP utilization are also contributing factors for their disproportionately higher rates of HIV infection. Additionally, state-prohibited syringe access programs continue to place injection drug users at increased risk of transmission. In recent years, there has been a drop-off of healthcare providers serving as members of the HPP, the Care Council, and their respective committees. As mentioned earlier, healthcare providers are still surveyed on a regular basis for emerging needs and identification of gaps and barriers.

The Area 5, 6, and 14 HIV Planning Partnership and the West Central Florida Ryan White Care Council will develop strategies to recruit and maintain members from all of these populations in order to develop strategies and interventions that will help improve the outcomes along the HIV care continuum.

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

The Tampa-St. Petersburg Integrated Plan follows the strategies supported by CDC and HRSA for development by including at-risk groups and representation of people living with HIV/AIDS (PLWHA).This section describes how the people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the Tampa-St. Petersburg epidemic. It includes a description of how PLWHA contributed to the Plan's development. The section describes the methods used to engage communities, PLWHA, and those at substantial risk of acquiring HIV, as well as other impacted populations. Lastly, this section details how impacted communities are engaged in the planning process.

How Plan Developers are Reflective of the Epidemic

The people involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction since the Plan is developed jointly between the West Central Florida Ryan White Care Council and the Area 5, 6, and 14 HIV Planning Partnership (HPP).

The Tampa-St. Petersburg Eligible Metropolitan Area (EMA) engages the local communities through the West Central Florida Ryan White Care Council. As of February 2016, the Council is comprised of 24 members and is reflective of the epidemic in the EMA in most demographic areas. Overall, 39% of the Council are Persons Living with HIV/AIDS (PLWHA); 26% of the total Care Council members are Black, 22% Hispanic, 43% White and 9% are other races. The

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Council is actively recruiting more Black members so the Council is more reflective of the epidemic. Overall, 48% of the Council members are 50-59 years of age, 13% are 40-49 years of age, 26% are 30-39 years of age and 13% are 20-29 years of age. The Council is currently recruiting members in the 20-29 year old age group and the 40-49 years of age group.

Of the nine self-identified PLWHA members, seven are men, and two are women. Three of the PLWHA members are Black, one is Hispanic and five are White. Seven of the PLWHA members are ages 50-59, one is 40-49 and one is 30-39 years of age.

The members of the Ryan White Care Council come from very diverse backgrounds--some are People Living with HIV/AIDS, some are community service providers (such as healthcare providers, case managers, mental health providers and housing providers), while others are family or friends of PLWHA.

The Care Council and its seven associated committees, comprised of Care Council members and additional committee members meet regularly and bring action items to the Council on a monthly basis. Members are responsible for disseminating information from the Council back to their respective areas of representation, as well as bringing concerns from those same areas to such meetings, thus ensuring that the voice of PLWHA in the EMA are included in the process.

As of December 2015, there were 68 members of the HPP. The top priority populations are represented on the HPP, whose members self-identify by race/ethnicity as 45.6% Black, 33.8% White, 19.1% Hispanic, and 1.5% Asian Pacific Islander. With respect to gender, the membership is 61.8% female and 38.2% male. Overall, 83.8% of the members self-identify as heterosexual and 16.2% as LGBTQ. Of the males, 38.5% self-identify as gay. Overall, 20.6% of HPP members self-identify as clients.

Inclusion of Persons Living With HIV/AIDS to the Plan Development

PLWHA are well represented in the development of this Integrated HIV Prevention and Care Plan, as 20.6% of the HPP members and 39% of the Care Council members self-identify as PLWHA, with Care Council committees having additional self-identified PLWHA representatives. The clients on the local HIV planning bodies were crucial in the review process of the plan. The Planning and Evaluation Committee of the Care Council was responsible for overseeing the completion of the Integrated Plan elements. Each element was reviewed, in conjunction with the comprehensive plan, unmet need estimates, and emerging issues in the EMA. The limitations and strengths of each element were discussed. The HPP, including client members, were surveyed about the goals, objectives, and strategies, as well as how to monitor and evaluate these. The Integrated Plan is designed to be a living document, meaning that future changes, revisions, evaluation, etc. will all rely heavily on at-risk groups, PLWHA, and those affected by HIV/AIDS through various community engagement processes.

Methods of Engaging Communities

The Tampa-St. Petersburg EMA regularly engages the community for input into the local HIV system. Methods for engaging the general community include HIV/AIDS awareness and testing day events; health fairs and community-events; targeted interventions and HIV testing; presentations on HIV such as National Public Radio's *HIV in the Community* held at the

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University of South Florida (USF); the annual research symposium held at USF; and the *Faces of HIV* mobile art exhibit. For clients, they are regularly surveyed for customer satisfaction. The Florida Department of Health conducts an HIV testing customer satisfaction survey every two years, with the latest version being held in March 2016.

The Planning and Evaluation Committee regularly reviews and establishes service priority ranks for needed services in the EMA and reviews the HIV care continuum of the United States, Florida, the EMA and special populations. PLWHA are involved in the priority setting process in several key ways. First, a total of 1,154 clients completed an anonymous needs assessment survey designed to assess needs and identify service gaps. This resulted in 1,127 viable surveys for analysis. Second, there is PLWHA representation on the Planning and Evaluation Committee. The committee oversaw the design of instruments and developed the final priority rankings for Care Council adoption. Third, PLWHA were also represented on the RPARC, as well as the full council, the group ultimately responsible for adopting priorities and allocations. Fourth, all committee and council meetings were open to the public and included an agenda item for community input.

Unmet need estimates are used to concentrate efforts to areas and target populations and continue to build capacity in our care system. According to the Florida Department of Health in 2014, 3,708 PLWHA (30%) were aware of their status yet were not retained in care.

These estimates are used to focus efforts and activities of the local Early Identification of Individuals Living with HIV/AIDS (EIIHA) plan. EIIHA efforts focus on pre/post-test counseling, referrals and linkage into appropriate services. The overall goal is to identify people who are HIV+ and bring them into and/or retain them in care. The EMA's community based AIDS service organizations work to identify and engage HIV positive clients and get them into care. Major testing efforts continue in the area.

How Impacted Communities are Involved in the Planning Process

The Community Advisory and WICY&F Committees completed focus group style meetings within their committee meetings to ensure the voices of the community were heard and part of this Integrated HIV Prevention and Care Plan. Through these meetings, the committees were able to identify what is working well, what could be improved, barriers to accessing prevention and care services, and emerging and other unmet needs in the EMA. In addition, the Community Advisory Committee reviews the Client Satisfaction Survey to identify areas that have room for improvement, service needs and the areas that the EMA is reaching successfully.

To help assess current needs for HIV prevention services in Florida, the PPG in collaboration with the Florida Department of Health's Prevention Program conducted a HIV Provider Survey in July 2014. The Area 5, 6, and 14 HPP was charged with getting the word out locally about the Survey. The HIV Provider Survey was conducted as part of an ongoing needs assessment process to identify needs and service gaps related to the delivery of HIV services in Florida. The results of the survey, from just under 400 individuals, were used to help the FDOH Prevention Program better understand the prevention need for persons living with HIV/AIDS and those at-risk for HIV. They were also used in determining both Florida's and the EMA's Integrated Goals and Objectives.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

To integrate prevention and care planning the EMA has done several things. The Care Council has multiple representatives from prevention who serve as members, in addition the Council elected members to participate on the statewide Patient Care Planning Group (PCPG). Members and Planning Council staff attend the Prevention Planning Group (PPG) and PCPG meetings and report back. The local HIV/AIDS Program Coordinators (HAPCs) attend Care Council meetings on a regular basis and work closely with the Part A Recipient. The Care Council agenda also includes a monthly prevention update.

III. MONITORING AND IMPROVEMENT

Monitoring the Integrated HIV Prevention and Care Plan will assist the EMA in providing high quality HIV prevention and care services. The local area has developed the following strategies to measure progress toward the goals, objectives, and strategies established in Section II.

Plan Updates

Stakeholders and planning bodies will be updated on the progress of plan implementation on an annual basis. A report on plan progress will be presented to the West Central Florida Ryan White Care Council and the HIV Planning Partnership in the first quarter of each calendar year. The planning bodies will utilize regularly collected surveillance and survey data, focus group, and community forum feedback to update the Epidemiologic Overview, Care Continuum, and Financial and Human Resources Inventory pieces of the plan on an as needed basis. These pieces will be utilized when ranking service priorities and allocating funding to care services and prioritizing prevention activities in the local area.

Plan improvements are contingent on a number of factors that must be considered over time including changing regulations and requirements, data limitations, and shifts in funding. As such, goals, objectives and strategies should be seen as fluid. They may adjust as needed to respond to funding and policy changes.

Monitoring and Evaluating Goals and Objectives

Ongoing monitoring of the Integrated Plan is undertaken by the Planning and Evaluation Committee of the Care Council, the Ryan White Quality Management Technical Workgroup, as well as the HIV Planning Partnership. Continual monitoring of plan implementation will assist planning groups in making decisions that are data driven. Monitoring and evaluation of the goals, objectives, and strategies will be executed through a collaborative partnership between HIV prevention and care-funded grantees and providers.

The first goal of the plan, reducing new infections, will be tracked by the Department of Health HIV/AIDS Program Coordinators (HAPCs) and monitored by the HIV Planning Partnership. The second goal, increasing access to care and improving health outcomes will be tracked by the Department of Health as well as Ryan White grant administrators and monitored by the Ryan White Quality Management Technical Workgroup. The third goal, reducing HIV-related disparities and health inequities, will be tracked by the Department of Health HAPCs as well as Ryan White grant recipients and monitored by the Planning and Evaluation Committee.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.

Community planning groups will monitor each goal as needed to enhance access to HIV prevention, care, and treatment services in the EMA.

Surveillance and Program Data

The EMA monitors surveillance data provided by the Florida Department of Health and analyzes local program data to assess and improve health outcomes along the HIV Care Continuum. Client level data for Ryan White-funded services in the EMA is reported in CAREWare and tracked by the Clinical Quality Management (CQM) program. The CQM program is a collaborative initiative between the Ryan White Part A Recipient, the local Ryan White Part B Lead Agency, providers within the service area and the subcontracted CQM provider. The primary purpose of the program is to improve the quality of care and services and improve health outcomes and quality of life for people living with HIV and AIDS. The CQM program reports their findings to community planning bodies to use as a reference tool when setting service priorities and allocating resources.

*NOTE: Statewide and local epidemiology data was measurably adjusted subsequent to the writing of this plan.