HIV/AIDS Needs Assessment Report for the Tampa- St. Petersburg Eligible Metropolitan Area

2020 - 2021

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WHO WE ARE

The health councils were created in 1983 by Florida Statute to identify, address and resolve health care issues of local concern. Each health council is a private, non-profit organization governed by a Board of Directors. The Board members are appointed by County Commissioners to represent the concerns of health care consumers, providers, and purchasers.

The Suncoast Health Council, Inc. (SHC) serves Pasco and Pinellas counties. The Council has extensive experience working with for-profit and non-profit agencies, public health organizations, consumers and professionals. Collaboration and cooperation are critical to the success of our mission.

We have three strategic goals: (1) support the accessibility of health care and social support systems through *comprehensive health planning*; (2) obtain and provide *education* about essential community health challenges and solutions; and (3) participate as collaborative partners to develop and sustain efficient and cost effective *service delivery* systems.

TO LEARN MORE ABOUT THE HEALTH COUNCIL

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WEST CENTRAL FLORIDA RYAN WHITE CARE COUNCIL

Mission Statement

The mission of the West Central Florida Ryan White Care Council is to manage a high quality, cost-effective, easily accessible, culturally responsive, and comprehensive continuum of care that improves the lives of all individuals living with and impacted by HIV.

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INTRODUCTION

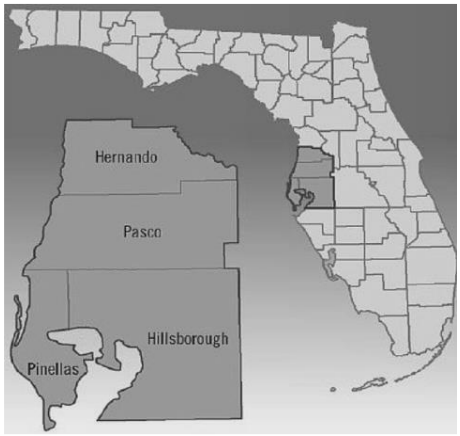
The Tampa-St. Petersburg Eligible Metropolitan Area (EMA), located on the west central coast of Florida, is comprised of Hernando, Hillsborough, Pasco, and Pinellas Counties. The EMA utilizes Ryan White HIV/AIDS Program (RWHAP) Part A grant funds in support of a comprehensive continuum of high-quality care and treatment for People with HIV in the EMA.

The purpose of this needs assessment is to achieve the goals as defined in the National HIV/AIDS Strategy (NHAS) and to facilitate, support, and execute the mission of the West Central Florida Ryan White Care Council: *The mission of the West Central Florida Ryan White Care Council is to manage a high quality, cost-effective, easily accessible, culturally responsive, and comprehensive continuum of care that improves the lives of all individuals living with and impacted by HIV.*

EPIDEMIOLOGIC OVERVIEW

The Tampa-St. Petersburg Eligible Metropolitan Area (EMA)'s total population is approximately 3.1 million, of which 62% are White (non-Latinx), 20% are Latinx, and 12% are Black (non-Latinx). Women[1] represent 51% of the total population. The image below illustrates the geographic layout of the EMA.

Tampa-St. Petersburg EMA
Geographic Layout



The following data provides a description of the sociodemographic, geographic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, persons

[1] This percentage does not include transgender women

living with, and persons vulnerable to acquiring HIV. This information is used by the local area to set priorities, identify interventions and services, and to allocate resources for HIV prevention and care. This epidemiologic overview focuses on the most recent year for which data is available along with three-year trend data as appropriate.

The socioeconomic status of individuals living in the EMA varies throughout the four-county area. In 2018, according to United States Census Bureau, the median household income of residents living in the EMA ranged from $46,030 (Hernando) to $56,137 (Hillsborough), while the median household income of Pinellas is $51,454 and Pasco is $50,417. The percentage of individuals living below the federal poverty level ranges from 13% in Pinellas County to 15.3% in Hillsborough County. The percentage of EMA residents over the age of 25 with a high school diploma ranges from 36.4% of residents in Hernando County to 27.1% in Hillsborough County. The percentage of persons over the age of 25 who possess a bachelor's degree or higher ranges from 17.5% in Hernando County to 32.7% in Hillsborough County. According to Florida's Health Equity Profile in 2018, the percentage of adults in each county who have any type of health insurance ranges from 88.5% in Pinellas to 87% in Hillsborough.

According to the Florida Department of Health's Epidemiological Profile, new HIV cases (incidence[2]) in the EMA rose 3.5% from 2017 to 2018 but decreased overall by 1.1% from 2017 to 2019. New cases of AIDS decreased 11.2% from 2017 to 2019. The most common mode of transmission for HIV in the EMA was cisgender[3] male-to-male sexual contact (MMSC), followed by cisgender male-to-female heterosexual contact, and persons who inject drugs (PWID) among all genders. Changes in the incidence and prevalence[4] for HIV and AIDS, from 2017 to 2019, are shown in **Figure 1**.

Figure 1: Tampa/St. Petersburg EMA Epidemiological Profile

	CY 2017		CY 2018		CY 2019	
	Incidence	**Prevalence**	**Incidence**	**Prevalence**	**Incidence**	**Prevalence**
HIV	543	6,361	562	6,467	537	6,591
AIDS	285	7,409	263	7,354	253	7,360
TOTAL		13,770		13,821		13,951

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2017, 2018, 2019

Attachment 1 describes the demographic data of People with HIV/AIDS in the EMA, which includes race, age, sex, and transmission category.

The most common mode of transmission for individuals diagnosed with HIV/AIDS over the three-year timespan was by way of cisgender male-to-male sexual contact (MMSC),

[2] Incidence is the total number of new diagnoses
[3] Cisgender is the gender descriptor used for all men and women whose current gender aligns with their sex assigned at birth
[4] Prevalence is the total number of all cases, inclusive of new and existing diagnoses

accounting for 415 new cases of AIDS and 1,039 new cases of HIV. Of these, MMSC among white cisgender men has resulted in the greatest number of newly diagnosed cases of HIV, followed by MMSC among Black and Latinx cisgender men, respectively. Transmission among cisgender heterosexuals accounted for 406 new cases of HIV and 239 new cases of AIDS. Black cisgender heterosexuals were the most affected among all other races. Persons who inject drugs (PWID) were the third highest method of transmission with 122 HIV cases and 81 AIDS cases. White injection drug users represented the greatest number of diagnoses among PWID of all other races.

The incidence of HIV among cisgender men in the EMA increased from 431 cases in 2017 to 445 cases in 2019: a 3.2% increase. During the same time frame, new HIV cases among cisgender women decreased by 16.5% from 109 to 91. The incidence of cisgender male AIDS cases decreased 14%, from 222 to 191 cases. The incidence of cisgender female AIDS cases increased 1.6% from 61 to 62 cases.

Figure 2: Tampa-St. Pete EMA HIV Incidence by Race/Ethnicity

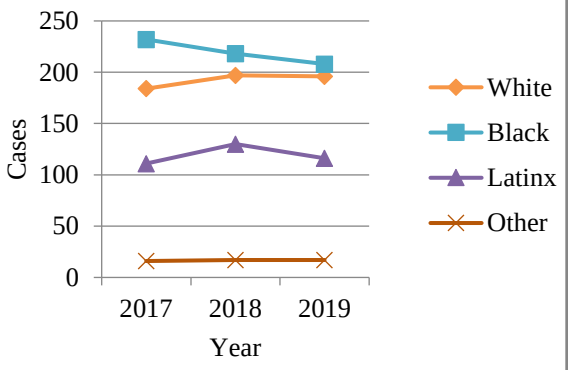
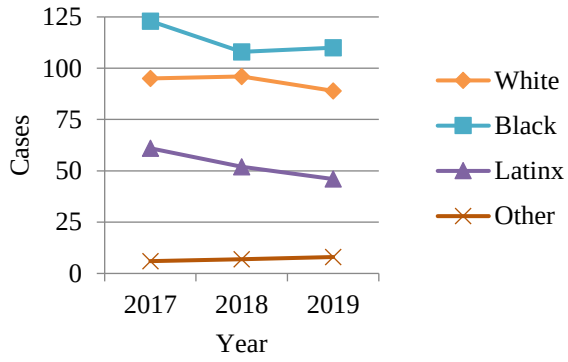


Figure 3: Tampa-St. Pete EMA AIDS Incidence by Race/Ethnicity



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2017, 2018, 2019.

HIV incidence is shown in **Figure 2**. Over the past three years there has been a slight increase in the incidence of HIV in the EMA among White and Latinx populations. From 2017-2019, HIV incidence increased 4.5% for Latinx persons and 6.5% for White persons, while new cases of HIV decreased 10.3% among Black persons.

AIDS incidence is shown in **Figure 3**. There has been a decrease in the incidence of AIDS among Black, White, and Latinx populations, with the most significant decrease among Latinx persons. From 2017-2019, the incidence of AIDS decreased by 6.3% for White persons, 11% for Black persons, and 25% for Latinx persons. The “other” race category is the combined number of cases among Asian, American Indian/Alaska Native (Indigenous), Native Hawaiian/Pacific Islander, and those who identify as multi-race. This racial category experienced a 33% increase in new AIDS cases; however, contextually this was an increase from 6 to 8 cases over the three-year period.

The 2019 calendar year saw minor demographic changes in HIV and AIDS prevalence. White persons in the EMA represented two-thirds of the population and 42% of all HIV cases. Black persons accounted for 37% and Latinx persons represented 19% of all HIV cases. White persons represented the largest prevalence of AIDS cases in the EMA with 44%, followed by Black persons with 36%, and Latinx persons with 17%. Black persons were disproportionately impacted by HIV/AIDS representing 37% of HIV cases and 36% of the AIDS cases, although only 12% of the EMA's total population was Black.

In the EMA, cisgender men comprise approximately 48% of the population but represent a majority of HIV and AIDS cases. In 2019, cisgender men represented 77% and 76% of HIV and AIDS prevalence, cisgender women represented 23% and 23% of HIV and AIDS cases, respectively. For the first time, the Florida Department of Health has provided the EMA with data for transgender women and transgender men; however, it is important to note that due to stigma, many people of transgender experience will not disclose their authentic gender to providers for fear of mistreatment and discrimination. As a result, many transgender women are incorrectly attributed as men and many transgender men are categorized as women. Now that these genders are beginning to be recorded correctly, it would do a disservice to omit HIV and AIDS prevalence data for those who have self-identified themselves to be of transgender experience. Transgender women represent 0.5% and 0.4% of HIV and AIDS prevalence, and transgender men represent 0.05% and 0.01% respectively. As the acceptance and affirmation of transgender populations strengthens, it can be expected that these numbers will increase as individuals feel safer disclosing their authentic selves to their providers. Consideration should also be made for the absence of a third transgender identification option. There are many transgender individuals who do not identify as a binary gender[5], but rather as a gender that is included within the non-binary umbrella[6].

Over the past three years, there have been minimal increases and decreases in HIV/AIDS prevalence among all races. Latinx persons in the EMA saw the greatest increase (6.5%) in HIV/AIDS prevalence from 2,350 cases in 2017 to 2,503 cases in 2019, followed by Black persons (2%) HIV/AIDS prevalence from 5,021 to 5,120 cases over the same three-year period. However, White persons in the EMA experienced a decrease (1.5%) in HIV/AIDS prevalence from 6,065 cases in 2017 to 5,974 cases in 2019. Prevalence of HIV/AIDS among "other" races, combined, increased (6%) from 334 cases to 354 cases. When stratified, changes in HIV/AIDS prevalence among each individual race is negligible.

In 2019, there were 5,120 Black people with HIV/AIDS in the EMA. Approximately 17% of people with HIV/AIDS in this racial group are aware of their status and not in care (unmet need). There were 2,503 Latinx people with HIV/AIDS in the EMA in 2019 and approximately 17% are aware of their HIV/AIDS status and not in care (unmet need). There were 5,974 White people with HIV/AIDS in the EMA in 2019. Approximately 12%

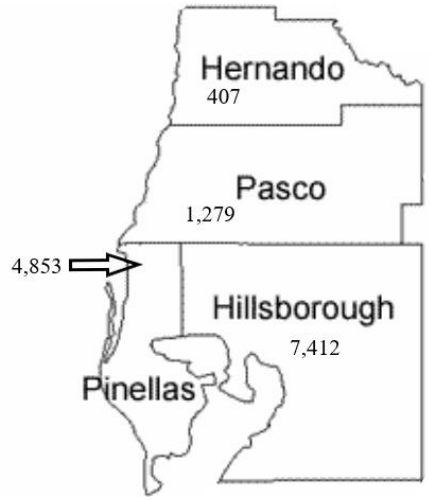
[5] Binary gender is the classification of gender into two distinct, opposite forms of male and female

[6] Non-binary is an umbrella term for all gender identities and expressions outside the gender binary; often referred to as *enby*

of people with HIV/AIDS in this racial group are aware of their status and not in care (unmet need). When compared to the continuum of care in 2017[7], there has been an increase in linking and engaging People with HIV, among all races in the EMA, to care.

The Centers for Disease Control (CDC) estimates that 15.6% of Florida's population is unaware of their HIV status. **Figure 4** shows the total number of diagnosed People with HIV/AIDS in the EMA, by county.

Figure 4: Tampa-St. Petersburg EMA
HIV/AIDS Cases per County



Sociodemographic indicators of People with HIV in the EMA were assessed through data reporting and client needs assessment surveys. In 2019, the state conducted the HIV Care Needs Survey, and the EMA collected a total of 1,014 surveys from People with HIV. The state determined that a minimum 10% response rate, from 25% of People with HIV in each county, would be sufficient for generalizable results. The number of survey responses from People with HIV in the Tampa–St. Petersburg EMA exceeded the required minimum for each county.

The preliminary analysis of the data was provided by the state in August 2019 and a final analysis of the data was provided by the state in February 2020. Due to the delay in receiving finalized data, the preliminary data was reviewed and utilized by the Planning and Evaluation Committee to re-prioritize services for the 2020-2021 funding year. According to the final analysis of the 2019 HIV Care Needs Survey, 48% People with HIV in the EMA are unemployed and 15% of People with HIV have no form of insurance.

[7] In 2017: 15% of White persons and 20% of both Black and Latinx persons were not in care

Furthermore, 79% of survey respondents in the EMA reported incomes below the Federal Poverty Level (FPL).

The Planning Council identifies, and monitors populations highly impacted by HIV/AIDS on a continual basis through its committees. From 2017-2019, the EMA observed the most significant increase of new cases of HIV among White cisgender male youth (13-24) and Latinx cisgender male youth, approximately 12% and 36% respectively. However, the EMA has experienced decreases in new cases of HIV among youth of color. The Florida Department of Health's 2019 Epidemiological Profile reports the diagnosis of new cases of HIV among Black cisgender female youth decreased 40%. New cases of HIV among Black cisgender male youth decreased 11% and remained unchanged among Latinx cisgender female youth (0%).

Unique challenges for youth include social, economic, and cultural barriers that limit access to prevention and care. Stigma and misinformation about HIV and AIDS contribute heavily to the disproportionality high rates of HIV among youth. Low rates of condom use, substance misuse, and engaging in sexual contact with older partners are prevention challenges for this emerging population. Youth are more likely to forego needed health care due to lack of access to transportation, fear, lack of insurance, and/or disapproval from family and peers. Service delivery for this emerging population is coordinated through partnerships among EMA community providers, Recipient-funded services, Part B and D funds, as well as Medicaid.

The Florida Department of Health's 2019 Epidemiological Profile reports 22% (n=2,104) of People with HIV in the EMA who were aware of their status were not retained in medical care[8]. Populations in the EMA that are Ryan White eligible and under-represented in care include: White cisgender Women of Childbearing Age (WCBA), Black cisgender WCBA, Latinx cisgender WCBA, and Black cisgender male youth (13-24). Respectively, 34% (n=83) of White cisgender WCBA, 17% (n=108) of Black cisgender WCBA, (n=32), 18% of Latinx cisgender WCBA, and 11% (n=18) of Black cisgender male Youth were not retained in medical care in 2019.

Additionally, Black and Latinx populations were chosen as the Minority AIDS Initiative (MAI) populations of focus due to their under-representation in the Ryan White system of care and their lower-than-expected number of People with HIV retained in medical care. In 2019, 860 (17%) of Black People with HIV and 432 (17%) of Latinx People with HIV in the EMA were not retained in medical care. In contrast, 1,451 (28%) of Black People with HIV and 658 (27%) Latinx People with HIV in the EMA were not retained in medical care, in 2018. This significant increase in retention in medical care, for both populations, indicates that the EMA has improved linkage to care in the span of a single year.

[8] The state of Florida defines retention of People with HIV (PWH) in care by at least one documented Viral Load (VL) or Cluster of Differentiation 4 (CD4) lab, medical visit, or prescription from 1/1/2019 through 3/31/2020, data as of 6/30/2020

It is difficult to determine if the number of People with HIV retained in medical care will continue to increase, over the next year, as the COVID-19 pandemic has forced a substantial shift in the provision of medical care, from face-to-face in-person visits to the delivery of services via telehealth technology. To the EMA's surprise, many clients who had previously fallen out of care have been linked back into care, as reported by providers during the Care Council's Health Services Advisory Committee (HSAC) meetings. Although far too early to tell, the EMA hopes that telehealth technology will continue to be an option indefinitely. In doing so, the EMA may ultimately increase retention in medical care, and ultimately viral load suppression, among consumers with little to no access to reliable transportation.

LIMITS ON ACCESS TO CARE AND SERVICE GAPS

Florida is particularly vulnerable to hurricanes and other weather events which can seriously disrupt an already fragile service delivery system. Hurricane frequency and intensity have increased significantly over the past 3 years, beginning with Hurricane Irma in 2017, when much of the EMA was directly impacted. Statewide, over 7.7 million homes and businesses were left without power during Hurricane Irma, which was approximately 73% of all Florida electrical customers. Heavy rainfall and storm surge caused at least 32 rivers and creeks to overflow, resulting in significant flooding. Many homes and businesses were damaged or destroyed, including over 65,000 structures in west central and southwest Florida alone. Agriculture suffered a $2.5 billion loss. Hurricane Michael, which struck the western Florida panhandle region in October 2018, was the first category 5 hurricane to make landfall in the contiguous United States since Hurricane Andrew in 1992. Hurricane Michael caused an estimated $25.1 billion in damages in the United States and is linked to 59 deaths. In 2019 Hurricane Dorian, another category 5 hurricane, which caused significant damage and loss of life when it directly hit the northern Bahamas and then skirted along the east coast of Florida, left approximately 140,000 Floridians without electrical power. Hillsborough County and City of Tampa officials along with local Emergency Operations/Emergency Management officials have been coordinating preparedness for this 2020 season and the Emergency Operations Center (EOC) has been in partial activation since the beginning of storm season, which becomes even more logistically complicated when factoring in the COVID-19 pandemic and social distancing rules. All the Recipient staff within Hillsborough County participates in annual shelter and preparedness training coordinated by the County Emergency Operations Center. Hillsborough County uses special notification software to alert employees in the event they are going to be deployed for emergency duty. The most recent training session, which was held virtually on August 18, 2020, included new information regarding COVID-19 logistics and how shelters would accommodate residents with more space and an emphasis on hygiene, masks, and all the CDC recommended protocol. More shelters will potentially be opened for a hurricane, since they will be operating at lower capacity in terms of the number of residents, they can accept in one facility.

Geographic variation within the Tampa-St. Petersburg EMA can present a challenge for providing equal access to care. The more urban counties of Hillsborough and Pinellas experience higher prevalence rates compared to the more rural counties of Pasco and Hernando. The Recipient works to ensure that access to core medical services are equally available across all four counties within the EMA. Travel times and access to transportation, however, can present barriers for some populations in more rural counties, particularly regarding specialty care and support services. The EMA is considered by HRSA to be a medically underserved area (MUA) which has only been exacerbated by the COVID-19 pandemic. A MUA is defined as a population area which has too few primary care providers, high infant mortality rates, high poverty or a high elderly population. Especially troubling are recent statistics which show a significant disproportionate impact to African American/Black populations where COVID-19 spread has been high which mirrors the disproportionate number of HIV cases in these same population groups. An excellent illustration of this disparity comes from a recent article published in the Tampa Bay Times on August 7, 2020. In Pinellas County (one of the two urban counties) African American/Black residents are 2.5 times as likely to test positive for the novel coronavirus. That is one of the largest disparities in Florida. Among the 12 counties with over 500,000 people, only Duval County (Jacksonville) has a similar gap. The infections are centered in a handful of neighborhoods in south St. Petersburg, where most of the city's African American/Black residents live, which historically also has had disproportionately high HIV infection rates. There is not one clear reason why the virus has spread so quickly among Pinellas' African American/Black residents. But experts and community leaders point to a history of systemic neglect and failure on the part of state and local government that has left residents in jobs that expose them to the virus, in dense housing that spreads the infection and with preexisting conditions that make getting an infection more dangerous.

HIV stigma is still a significant barrier especially for People with HIV who reside in less urban areas where they tend to be more isolated coupled with fears of disclosure to family or friends. It is still routine for service providers in the urban areas to serve clients who will travel from a more isolated rural community in the EMA for care rather than risk being seen or having to disclose their HIV status to the local health department provider, which might be the sole HIV service provider in that County.

Cultural and language barriers may also inhibit access to care in the EMA, due to the cultural diversity of the area. To increase access to care, all Ryan White services are delivered by providers who employ bilingual staff, language interpretation services, and who strive for cultural competence. Agencies place importance on hiring employees who culturally reflect the HIV population that they serve. In addition to Spanish speaking staff, some agencies also have Haitian Creole speaking staff members. These factors, as well as additional accessibility factors including locations along bus routes and after-hours appointments, are standards that are assessed during the application process for each provider.

The EMA identified service gaps as a component of the most recent 2019 HIV Care Needs Survey, which was completed 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 with the addition of Polk, Manatee, Highlands, and Hardee counties. The 2019 HIV Care Needs Survey was distributed on paper to a total of 30 sites, selected by Planning Council Support staff. The sites consisted of primary care providers (public and private), HIV/AIDS case management agencies, and other AIDS service organizations (ASOs). A survey link was distributed through the Planning Council e-mail listserv and posted on the Planning Council's website. The survey link was posted on the Planning Council's Facebook page and on the Facebook pages of other providers as well. A postage-paid return envelope was provided with all surveys at sites without a collection box. The EMA also received support from other integral organizations with a wide reach in the community, such as St. Petersburg, Pasco, and Tampa Pride organizations. Key staff at several of the survey sites collaborated in the distribution by asking clients to complete the survey and helped with completing the survey as needed. The EMA had a total of 618 surveys returned, representing a statistically valid sampling rate which is >10% of our unduplicated population being served. With the use of online data collection software, all surveys were examined for each individual question answered and preliminary analysis of the data was distributed to all areas.

Figure 5 showcases the service gaps for People with HIV in the EMA as identified in the 2019 HIV Care Needs Survey. The services are ranked in order from highest service gap percentage to lowest service gap percentage.

Figure 5: 2019 HIV Care Needs Survey Service Gaps

Service	Service Gap Percentage (%)		Total % (% is rounded)
	Needed service, but could not get service	Needed service, but did not know about service	
Dental/Oral Health	11.1%	9.2%	20%
Food Bank of Food Vouchers	3.5%	11.5%	15%
Legal Support	4.2%	8.8%	13%
Mental Health Services	4.7%	7.0%	12%
Housing	5.4%	5.7%	11%
Health Insurance	6.1%	3.4%	10%
Transportation	4.0%	6.1%	10%
Outreach	2.7%	6.7%	9%
Peer Mentoring	3.9%	3.9%	8%
Home Health Care	2.7%	4.1%	7%
Medical Case Management	3.1%	2.8%	6%
Health Education / Risk Reduction	2.1%	3.2%	5%
Substance Misuse Treatment	2.5%	1.7%	4%
Hospice Services	1.2%	2.5%	4%
Treatment Adherence	2.8%	1.2%	4%
Outpatient Ambulatory Health Services	1.5%	1.0%	3%
Medications	2.1%	1.0%	3%

Source: Florida Department of Health Statewide HIV Care Needs Survey, 2019.

Figure 6 showcases the prioritized services for People with HIV in the EMA as identified in the 2019 HIV Care Needs Survey. Ryan White services are ranked in order from highest service priority to lowest service priority.

Figure 6: 2019 HIV Care Needs Survey Service Priorities

Service	% of Survey Responses
Medications	80%
Health Insurance	62%
Medical Case Management	60%
Dental/Oral Health	57%
Outpatient Ambulatory Health Services	45%
Housing	34%
Mental Health	33%
Food Bank or Food Vouchers	21%
Emergency Financial Assistance	21%
Health Education / Risk Reduction	11%
Substance Misuse Treatment	10%
Nutritional Counseling	9%
Legal Services	8%
Peer Support	7%
Home Health Care	7%
Outreach	7%
Referral for Health Care	7%
Early Intervention Services	6%
Hospice Services	4%
Substance Misuse Residential Treatment	4%
Child Care	3%
Rehabilitation Services	3%
Linguistic Services	2%

Source: Florida Department of Health Statewide HIV Care Needs Survey, 2019.

The Planning Council prioritizes and allocates funding based on a grid which divides core and non-core (support) services. The EMA has focused on allocating funds to core services for the past several years, primarily due to the unmet need which continues to exist in core services, such as substance abuse, health insurance, mental health, oral health, and medical case management. Due to the Florida Legislature opting not to accept the Medicaid expansion funding made available by the Affordable Care Act (ACA), the EMA is unable to fund all the above service gaps identified since the area continues to

focus attention on core services. All but three of the top ten ranked service gaps (oral health, mental health, and health insurance) in Figure 10 are defined as non-core services. The Planning Council, in the prioritization and allocation process, reviews all service categories, including those which are not funded, and considers other funding streams. The Planning Council considers these categories, in the event additional funds are made available or utilization trends change for core services due to the impact of the ACA.

Expanding access to oral health remains a priority but is a difficult challenge due to level funding and a lack of dental providers. Health Insurance is another priority category identified through the survey which continues to be closely monitored for expansion by the Planning Council. In October 2017, the Planning Council voted to accept recommendations to increase the base allocation for Health Insurance Premium and Cost Sharing Assistance from $695,566 in FY 2017 to $782,830 in FY 2018 to meet increased need. The base allocation for Medical Case Management also increased during this same period from $1,931,524 to $2,122,543, a total recurring increase of $191,019. These allocations have remained stable as the EMA has continued to receive essentially level funding without any decreases. The contracted subrecipient for health insurance services tracks data that relates to how many clients being served in the local health insurance program would be eligible under the AIDS Drug Assistance Program (ADAP) for premium payments if additional ADAP funding were to become available. The Recipient, in collaboration with the Planning Council, will continue to monitor service gaps in FY 2021. The Planning and Evaluation Committee will review service priorities for FY 2021 based on updated epidemiological and needs assessment data.

COORDINATION OF SERVICES AND FUNDING STREAMS

Attachment 2 presents the funding available in the EMA. The table was developed with input and information from the Area 5, 6, and 14 HIV Planning Partnership (the local HIV prevention planning body), the Planning Council, the Ryan White Part A, B, and D Recipients, and the Florida Department of Health. The table includes each Part of Ryan White HIV/AIDS Program funding and other known federal, state, and local funding streams. This information is from the EMA's Integrated Plan, adopted by the Planning Council in July 2016 and submitted to HRSA in September 2016. Items were updated for 2021, as available.

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 the counties have basic services provided, including outpatient ambulatory health services, AIDS pharmaceutical assistance (local), emergency financial assistance, medical case management, oral health, mental health, substance abuse-outpatient, and health insurance premium and cost-sharing assistance.

There are five core services that are not funded with Ryan White Part A HIV/AIDS Program funds, including medical nutrition therapy, early intervention services, home health, hospice services, and home/community-based health services. These services are all prioritized by the Planning Council, with no allocations because all the services have other payer sources. Due to the unmet need in the top priority categories such as outpatient ambulatory health services, the Planning Council cannot, with limited funding, expand beyond the top eight funding priorities. It has not funded other supportive services such as legal assistance, food banks, and housing for many years.

The EMA, including the Planning Council and the Recipient, reviews 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 the Planning Council to ensure appropriate allocations, with Part D being represented on the Planning Council and with a well-established linkage and coordination of services.

The area does not currently receive Ryan White Part C or Part F funds. The EMA does have providers who are funded to provide HIV/AIDS prevention and treatment by the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The area also has a Housing Opportunities for Persons with AIDS (HOPWA) program that provides housing services. Two counties in the EMA (Hillsborough and Pinellas) receive direct Ending the HIV Epidemic funding. The State of Florida and Hillsborough County Government also contribute to the EMA's funding streams for HIV prevention and care.

In FY 2020, the EMA received Coronavirus Aid, Relief, and Economic Security (CARES) Act funding in the amount of $558,041. The statewide Part B program received $1,500,000 to cover the State of Florida and the local Part D program received an additional $96,542. These funds were allocated to help Ryan White recipients respond to the COVID-19 pandemic.

EARLY IDENTIFICATION OF INDIVIDUALS WITH HIV/AIDS (EIIHA)

Currently, no Part A funds are allocated to Early Intervention Services (EIS) in the Eligible Metropolitan Area (EMA); however, there are Part B funds allocated to EIS and Linkage to Care services in Pasco County. The State of Florida, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA) allocate approximately $35 million dollars to support the HIV prevention efforts of Florida's CBOs (community-based organizations), ASOs (AIDS service organizations), CHDs (county health departments), and the FDOH (Florida Department of Health). The EMA was also awarded an additional $1,000,000 in Ending the HIV Epidemic (EHE) funds

through HRSA for funding year 2020, part of which is being allocated to EIS. To maximize the efficiency, effectiveness, and allocation of limited HIV prevention resources throughout the state, the FDOH has taken the lead in prevention and early intervention.

In 2021, the Tampa-St. Petersburg EMA will continue to implement its 2017-2021 Integrated Prevention and Care Plan goals, objectives, and strategies for addressing the Early Identification of Individuals with HIV/AIDS (EIIHA). The EMA's Integrated Plan will work in concert with the Statewide Integrated Plan and strategies to ensure a coordinated effort in addressing the EIIHA through HIV prevention and care across Florida.

The primary activities of the EIIHA plan include the following elements of High Impact Prevention (HIP): HIV testing (rapid testing, targeted testing in correctional facilities and faith-based settings, etc.), outreach, condom distribution, comprehensive prevention with positives, and prevention interventions for high-risk individuals with unknown or negative statuses in high prevalence areas. Testing in non-healthcare settings, behavioral interventions, biomedical interventions such as PrEP (Pre-Exposure Prophylaxis) and nPEP (non-occupational Post Exposure Prophylaxis), social marketing and media, and partnerships with linkage-to-care programs are also direct and indirect activities of the 2021 EIIHA plan. Several activities are targeted to work specifically with one, or more, of the target populations, while others have a broader range of targets. This multi-pronged approach encourages the identification of individuals who do not know their status and encourages those that do to get into care.

The Tampa-St. Petersburg EMA collaboratively established its 2017-2021 Integrated Prevention and Care Plan to achieve a coordinated response to 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. In June 2019, the Integrated Plan was converted to a living document so that it could be revised and updated on an ongoing basis to reflect changes in the local HIV care system and the availability of measurable data. The current Integrated Plan will begin its final year in 2021. With the addition of EHE funding to the EMA, and the multiple planning groups that have formed in response to this funding, there is now increased collaboration between prevention and care and new opportunities for innovative strategies. The EIIHA plan was developed to address the needs detailed in the previous sections and in the Integrated Plan. Detailed timelines, responsible parties, and data indicators are included in the EMA's Integrated Plan but are not included in this section for the purpose of brevity. The following objectives, strategies, and activities are aimed at addressing gaps along the HIV Care Continuum.

<u>NHAS Goal 1: Reducing New Infections</u>

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

1. Strategy: Increase PrEP awareness and support within the Tampa-St. Petersburg EMA.
   Activities: Educate high-risk populations about PrEP; Educate healthcare providers about PrEP; Facilitate community education seminars; Develop a PrEP resource guide.

2. Strategy: Develop a system for PrEP delivery within the Tampa-St. Petersburg EMA.
   Activities: Identify potential PrEP providers; Identify resources available for clinical providers; Monitor sources of funding for PrEP.

3. Strategy: Increase PrEP marketing within the Tampa-St. Petersburg EMA.
   Activities: Advertise PrEP through direct marketing, social media, and at community events.

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

1. Strategy: Test high risk communities in non-conventional venues.
   Activities: Increase testing and education in correctional facilities; Increase testing, education, and follow-up with persons experiencing homelessness; Increase testing, education and linkage to care at Emergency Rooms in the EMA.

2. Strategy: Use peers and partners to help identify persons at high risk for HIV in their social network.
   Activities: Use of Community PROMISE (Peers Reaching Out and Modeling Intervention Strategies); Train Peer Educators to disseminate accurate and relevant HIV information in their communities; Continue HIV partner counseling and referral services; Peer and Partner training model used to educate communities about the importance of HIV testing.

3. Strategy: Encourage routine HIV testing.
   Activities: Utilize social media to advertise information about HIV testing; Incentivize testing.

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

1. Strategy: Intensify HIV prevention efforts funded through the Department of Health in communities where HIV is most heavily concentrated.
   Activities: Increase education in local schools using age-appropriate HIV prevention materials; Collaborate with faith-based organizations to provide HIV

education; Continue distributing condoms through outreach; Continue safer sex kit distributions in the community through outreach.

2. Strategy: Provide clear, specific, consistent, and scientifically up-to-date messages about HIV risks and prevention strategies.
   Activities: Use YouTube videos approved by the Department of Health to disseminate prevention strategies to youth; Disseminate education materials approved by the Department of Health.

3. Strategy: Disseminate HIV prevention messages through social media.
   Activities: Use Facebook, Twitter, and Instagram to disseminate HIV prevention education; Use pop-ups on dating websites to disseminate HIV prevention education.

<u>NHAS Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV</u>

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 test, or HIV medical visit).

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1. Strategy: Identify the process for tracking difficult to reach persons newly diagnosed with HIV who are Ryan White eligible and linked to medical care.
   Activities: Identify the process of how newly diagnosed individuals are linked to care in the EMA; Track the number of individuals who are referred to Ryan White care by DOH Linkage to Care Coordinators; Track the number of individuals who are referred to inmate Ryan White.

2. Strategy: Strengthen relationships and referral systems among providers in the EMA to ensure persons newly diagnosed with HIV are engaged in care.
   Activities: Continue the use of Anti-Retroviral Treatment and Access to Services (ARTAS); Encourage providers to consistently contribute to Tampa Bay Health Resources and promote use of resource guide.

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 health services (OAHS), and who are retained in care, from 81% to 86%.

1. Strategy: Offer ongoing support services and health education for People with HIV.
   Activities: Survey number of support groups offered in the EMA; Provide

supportive education materials and resources for individuals through each step of the HIV Care Continuum.

2. Strategy: Increase the availability of medical case management services.
   Activities: Facilitate a capacity-building training for case managers; Monitor case management utilization.

3. Strategy: Increase the capacity of peer intervention programs.
   Activities: Identify funding sources available for peer intervention programs; Provide support training and resources for peer intervention programs.

Tampa-St. Petersburg EMA Objective 3: By December 2021, increase the percentage of People with HIV, who are accessing Ryan White outpatient ambulatory health services (OAHS), who are virally suppressed from 78% to at least 83%.

1. Strategy: Increase the number of people who are prescribed and adherent to Anti-Retroviral Therapy (ART).
   Activities: Continue funding OAHS; Monitor prescription of ART among persons living with HIV who are accessing Ryan White funded OAHS services.

2. Strategy: Support screening for and referral to substance use and mental health services for People with HIV.
   Activities: Increase community collaboration to ensure identification of and treatment for substance abuse and mental health problems; Increase the use of brief screening tools for substance abuse and mental health problems.

3. Strategy: Support comprehensive, coordinated patient-centered care for People with HIV, including addressing HIV-related co-infections Hepatitis C (HCV). Increase the number of providers offering HIV/Hepatitis C (HCV) treatment; Encourage providers to refer People with HIV to other community services (I.e., housing, child care, etc.).

<u>NHAS Goal 3: Reducing HIV-Related Disparities and Health Inequities</u>

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 Latinx persons in the EMA by 25% in order to engage the community in the continuum of care.

1. Strategy: Monitor and track progress on the number of outreach activities conducted and Latinx clients served.
   Activities: Present results of the collected baseline data to community stakeholders; Compile the number of outreach activities conducted and clients

served in CY 2019, CY 2020, and CY 2021; Update community stakeholders on the area's progress towards increasing outreach efforts by 25%.

2. Strategy: Identify and prioritize effective outreach strategies targeting Latinx persons based on feedback from People with HIV and community providers.
   Activities: Host a focus group to assess strategies for engaging Latinx persons in HIV prevention and care activities.

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.

1. Strategy: Monitor and track progress on the number of outreach activities conducted and Black clients served.
   Activities: Present results of the collected baseline data to community stakeholders; Compile the number of outreach activities conducted and clients served in, CY 2019, CY 2020, and CY 2021; Update community stakeholders on the area's progress towards increasing outreach efforts by 25%.

2. Strategy: Identify and prioritize effective outreach strategies targeting Black persons based on feedback from People with HIV and community providers.
   Activities: Host a focus group to assess strategies for engaging Black persons in HIV prevention and care activities; Host a focus group to assess strategies for engaging Black persons in HIV prevention and care activities.

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.

1. Strategy: Monitor and track progress on the number of outreach activities conducted and youth served.
   Activities: Present results of the collected baseline data to community stakeholders; Compile the number of outreach activities conducted and clients served in CY 2019, CY 2020, and CY 2021; Update community stakeholders on the area's progress towards increasing outreach efforts by 25%.

2. Strategy: Identify and prioritize effective outreach strategies targeting youth based on feedback from People with HIV and community providers.
   Activities: Host a focus group to assess strategies for engaging youth in HIV prevention and care activities; Host a focus group to assess strategies for engaging youth in HIV prevention and care activities.

PLANNING AND RESOURCE ALLOCATION

The EMA holds community input as a core component of providing Ryan White services. The main sources of community input are the Ryan White Needs Assessment, the Integrated Plan, the Planning Council, and the Planning Council's committees. The Planning Council committees include: Planning and Evaluation; Membership, Nominations, Recruitment and Training Committee; Standards, Issues and Operations (SIOC); Resource Prioritization and Allocation Recommendations (RPARC); Women, Infant, Children, Youth and Families (WICY&F); Health Services Advisory; and the Community Advisory Committee. Planning activities are influenced by the updated National HIV/AIDS Strategy and the HIV Care Continuum. The Care Continuum is utilized by Planning and Evaluation, RPARC, and WICY&F, as well as at Planning Council meetings to analyze gaps in service and determine how to best allocate Part A funding. The planning process highlights the need to fund categories, such as medical case management, that help navigate clients in the EMA along the HIV Care Continuum.

The Ryan White Needs Assessment includes the process of establishing priorities and allocating resources based on community input. Since the Planning Council is a committee-driven structure, the Planning and Evaluation Committee was responsible for overseeing the completion of the Needs Assessment and Integrated Plan elements. Each element was reviewed in conjunction with the HIV Care Continuum, Unmet Need estimates, and Emerging Issues in the EMA. The limitations and strengths of each element were discussed.

A matrix is developed listing each HRSA service category in the previous year's ranking, the service utilization from surveys, expenditures, and allocations to each service category across public funding streams and estimates of unmet need. The committee then discusses the implications of the service rankings, availability of other funding sources for support services, finalizes the priority rankings, and forwards the rankings to the Planning Council for adoption where the priorities can be further revised or accepted as presented. Once the priorities are adopted, RPARC's process of allocating dollar amounts to specific categories begins. The process includes a review of the Integrated Plan: Financial and Human Resources Inventory, along with current and historical expenditures by category. RPARC then presents these recommendations to the Planning Council for adoption.

People with HIV were involved in the priority setting process in several keyways. First, a total of 1,014 clients, in the service area, completed the 2019 HIV Care Needs Survey. This survey was designed to assess needs and identify service gaps. Second, there was representation of People with HIV on the Planning and Evaluation Committee. This committee oversaw the design of instruments and developed the final service priority rankings for the adoption by the Planning Council. Third, People with HIV were also

represented on the RPARC and the Planning Council, which was ultimately responsible for adopting service priorities and resource allocations. Forty seven percent (53%) of the Planning Council members are People with HIV (8 out of 15 members). Fourth, all committee and Planning Council meetings were open to the public and included an agenda item for community input to allow for public comments and discussion of emerging issues.

Unmet need data, data related to persons unaware of their HIV status (EIIHA), and historically underserved populations were prevailing factors in giving priority and additional funding to services such as outpatient ambulatory health services, oral health care, health insurance premium and cost sharing assistance, and medical case management, as these were the services most necessary to engage and retain individuals within the system of care. Priority and allocation/reallocation decisions were made to maximize capacity at these entry points into care and minimize wait lists so as not to lose individuals trying to enter care.

Epidemiological data is updated and reviewed annually as part of the needs assessment process. Changes in the data as well as trends are considered by the Planning and Evaluation Committee when setting priorities. Due to the increases and disproportionate impact among the historically underserved populations of Latinx and Black persons in the EMA, targeted efforts within the Minority AIDS Initiative (MAI) Projects were developed. HIV incidence increased 5% among Latinx persons from calendar year 2017 to calendar year 2019 but decreased 10% among Black persons over the same time span. From calendar year 2017 to calendar year 2019, the incidence of AIDS decreased among all races: 6% for White persons, 11% for Black persons, and most significantly for Latinx persons with a 25% decrease in new AIDS diagnoses. The EMA's MAI continues to fund the Health Education and Risk Reduction (HERR) service category to continue to address barriers to care and improve retention within the Ryan White systems of care.

The following are examples of the use of cost data in making funding and allocation decisions: cost data was assessed, by the Recipient, as one of the factors in determining awards; expenditure reports by service category and county are used to determine allocations and reallocations in addition to setting service caps and limits, based on utilization reviews; expenditure reports are reviewed quarterly by the RPARC and Planning Council.

On several occasions the Planning Council faced allocation adjustments, after a Request for Applications (RFA) was issued, because of changes in available funding. In the case of an increase in funding, RPARC considered restoring funding to services that had been cut during previous fiscal years and allocating additional funding to meet a growing demand for core services. In the instance of a reduction in funding, RPARC carefully reviewed expenditure history and client utilization. The priority ranking of each service was considered, as well as other elements of the needs assessment process, in order to make data-based decisions. The committee determined that cuts would be made to

services to align with actual expenditures, based on historical spending. In each case, the Planning Council received public comment prior to making funding decisions.

Funding from other federal sources is reviewed when developing priorities and allocating funds. The Integrated Plan's Financial and Human Resources Inventory describes State funds, local funds, Centers for Disease Control and Prevention (CDC), Substance Abuse Mental Health Services Administration (SAMSHA), AIDS Drugs Assistance Program (ADAP), Housing Opportunities for Persons with AIDS (HOPWA), Part B, Part C, and Part D funds utilized by clients, in each of the counties, in the EMA. The Financial and Human Resources Inventory was utilized by the Resource Prioritization and Allocation Recommendations Committee, Planning and Evaluation Committee, and the Planning Council. The Inventory is included as **Attachment 2** with updates for 2021.

The Planning Council and associated committees closely follow the Affordable Care Act (ACA) and its impact on the local Ryan White system of care. The EMA has observed a shift in demand and funding from Outpatient Ambulatory Health Services to Health Insurance Premium and Cost Sharing Assistance. This shift caused the Planning Council to reexamine its priorities and led to the development of a brief priority setting survey, distributed in 2016, to People with HIV in the EMA. The results of this survey were then reviewed by the Planning and Evaluation committee.

The Planning and Evaluation and RPARC committees consider the impact of the changing health care landscape when setting priorities and making funding recommendations. Every three years the State of Florida conducts a statewide anonymous needs assessment survey for People with HIV. The Planning and Evaluation committee utilizes the results of these surveys when setting priorities and allocating funding. The service area collected a total of 1,014 HIV Care Needs Surveys from People with HIV. The state determined that a minimum 10% response rate, from 25% of People with HIV in each county, would be sufficient for generalizable results. The number of survey responses from People with HIV in the Tampa–St. Petersburg EMA exceeded the required minimum for each county. This data was reviewed and utilized by the Planning and Evaluation committee to re-prioritize services for the 2020-2021 Funding Year. No significant changes were made in the prioritization and allocation process for the 2020-2021 project periods. The Planning and Evaluation committee will continue to review priorities on an annual basis, based on requirements set by Health Resources and Services Administration (HRSA), as well as the anticipated needs of People with HIV in the EMA.

The EMA, including the Planning Council and the Recipient, reviews 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. All three Parts fund services for the WICY populations to reduce disparities in access to HIV care in the EMA. Parts A and B funds are planned

concurrently through the Planning Council to ensure appropriate allocations, with Part D represented on the Planning Council and RPARC with a well-established linkage and coordination of services.

In FY 2019-2020, the Planning Council trained members on pertinent social issues such as compassion fatigue and updating the Council's Mission and Vision Statements. Along with further training, the Council will actively recruit members who are knowledgeable on service issues related to the prevention of intimate partner violence, opioid and other drug use, and trauma informed care.

To integrate prevention and care planning, the Planning Council has multiple representatives from prevention who serve as voting members. In addition, the Planning Council elected members to participate on the statewide Florida Comprehensive Planning Network (FCPN), formerly known as the Patient Care Prevention Planning Group (PCPPG). The HIV Planning Partnership recently elected members to serve on the FCPN and one member to serve as an alternate, all three of whom are members of the Planning Council. Planning Council members and staff attend the FCPN meetings and report back to the Council. The local HIV/AIDS Program Coordinators (HAPCs) attend Planning Council meetings on a regular basis and work closely with the Part A Recipient to provide the highest quality care and treatment and to help prevent new cases of HIV.

SERVICE PRIORITIES

The Planning and Evaluation Committee sets service priorities based on information from the 2019 Statewide Consumer Needs Assessment as seen in **Figure 7**.

Figure 7: Service Priorities

1. Outpatient/Ambulatory Health Services 2. AIDS Pharmaceutical Assistance (local) 3. Emergency Financial Assistance* 4. Medical Case Management 5. Oral Health (dental) Care 6. Health Insurance Premium and Cost Sharing Assistance 7. Mental Health Services 8. Substance Abuse Services - outpatient 9. Health Education/Risk Reduction 10. Case Management (non-medical) 11. Housing Services 12. Treatment Adherence Counseling 13. Early Intervention Services 14. Medical Transportation Services 15. Legal Services 16. Outreach Services	17. Child Care Services 18. Food Bank/Home Delivered Meals 19. Medical Nutrition Therapy 20. Psychosocial Support Services 21. Substance Abuse Services-residential 22. Home Health Care 23. Home and Community Based Health Services 24. Rehabilitation Services 25. Linguistic Services (interpretation & translation) 26. Hospice Services 27. Respite Care 28. Referral Services

Source: Florida Department of Health Statewide HIV Care Needs Survey, 2019.

ATTACHMENT 1

EMA AIDS PREVALENCE AND HIV* PREVALENCE DATA BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY

Demographic Group/ Exposure Category	2017-PREVALENCE		2018-PREVALENCE		2019-PREVALENCE	
Race/Ethnicity	**HIV**	**AIDS**	**HIV**	**AIDS**	**HIV**	**AIDS**
White, not Latinx	2,736	3,329	2,725	3,264	2,756	3,218
Black, not Latinx	2,351	2,670	2,391	2,659	2,434	2,686
Latinx	1,118	1,232	1,186	1,254	1,226	1,277
Other / Unknown	156	178	165	177	175	179
Total	**6,361**	**7,409**	**6,467**	**7,354**	**6,591**	**7,360**
Gender	**HIV**	**AIDS**	**HIV**	**AIDS**	**HIV**	**AIDS**
Male	4,787	5,608	4,918	5,585	5,043	5,598
Female	1,535	1,760	1,510	1,731	1,512	1,729
Transgender Women	34	40	35	36	33	32
Transgender Men	5	1	4	2	3	1
Total	**6,361**	**7,409**	**6,467**	**7,354**	**6,591**	**7,360**
Current Age as of Reporting Year	**HIV**	**AIDS**	**HIV**	**AIDS**	**HIV**	**AIDS**
<13 years	15	3	12	3	8	3
13 - 24 years	371	91	330	78	299	55
25 - 44 years	2,729	1,749	2,794	1,670	2,873	1,659
45 - 59 years	2,363	3,897	2,338	3,788	2,310	3,644
60+ years	883	1,669	993	1,815	1,101	1,999
Total	**6,361**	**7,409**	**6,467**	**7,354**	**6,591**	**7,360**

Exposure Category	HIV	AIDS	HIV	AIDS	HIV	AIDS
Cisgender Male-to-male sexual contact (MMSC)	3,815	3,905	3,948	3,889	4,055	3,920
Persons Who Inject Drugs (PWID)[9]	427	757	425	730	428	701
MMSC/PWID	296	444	282	430	278	437
Cisgender Heterosexual Contact[10]	1,707	2,139	1,706	2,148	1,728	2,154
Sexual Contact[11]	33	33	34	33	30	28
Other/Unknown	66	129	64	123	65	117
Total	**6,344****	**7,407****	**6,459****	**7,353****	**6,584****	**7,357****

Source: Florida Department of Health EMA Epidemiological Profiles CY 2017; CY 2018; CY 2019 as of June 30, 2020

*People without an AIDS diagnosis; solely HIV prevalence

**Risk data are calculated values from a weighted database to redistribute the NIRs into known vulnerabilities. Therefore, some vulnerability data was off from the total due to rounding issues, according to the Florida Department of Health

[9] Includes IDU of ALL genders, excluding MMSC/PWID

[10] Includes specifically cisgender male and cisgender female heterosexual contact. Cisgender is defined as men and women who identify with the gender they were assigned at birth (not of transgender experience)

[11] "Sexual Contact" is specific to all persons of transgender experience and is an aggregate of all sexual contact among all transgender populations, as categorized and reported by the Florida Department of Health

ATTACHMENT 2

Coordination of Services and Funding Streams Table

Funding Source	FY 2020 Funding Amount		Number of Agencies	Prevention Services				Core Medical-related Services													Supportive Services																				
	Dollar Amount	%			HIV Testing & Policy Alignment	PLWH/Partner Prevention Services	Condom Distribution		Outpatient/Ambulatory Health Services	AIDS Drug Assistance Program	AIDS Pharmaceutical Assistance	Oral Health Care	Early Intervention Services	Health Insurance Premium &Cost-	Home Health Care	Home & Community-based Health	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Mgmt, incl. Tx	Substance Abuse Outpatient Care		Non-Medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Linguistic Services	Medical Transportation	Other Professional Services: Legal	Outreach Services	Psychosocial Support Services	Referral for Health Care & Support	Rehabilitation Services	Respite Care	Substance Abuse Services (residential)	Treatment Adherence Counseling
Part A	$9,268,312	31.0%	8						x		x	x		x				x		x	x			x		x													
Part B (+ADAP)	$9,583,083	32.0%	9						x	x	x	x	x	x						x			x	x						x								
Part C	$0	0.0%	0																																				
Part D	$1,462,702	4.9%	1		x				x									x		x			x			x			x		x	x	x				x
Part F	$0	0.0%	0																																				
CDC	$1,695,259	5.7%	5		x	x	x						x													x					x							
SAMHSA	$844,512	2.8%	5		x								x					x			x		x			x						x	x				
HOPWA	$3,865,945	12.9%	7																								x											
State	$1,080,383	3.6%	6		x				x		x	x	x						x	x				x		x					x							
End Epidemic-Hills	$1,154,419	3.9%	2		x	x	x						x																										
End Epidemic-Pinellas	$777,986	2.6%	1										x																										
Local	$190,404	0.6%	1						x																														
Total	$29,923,005	100%																																					