**HIV/AIDS Needs Assessment Report for the**

**Tampa- St. Petersburg Eligible Metropolitan Area**

**2023 - 2024**

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Rob Marlowe, Board Chair

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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.

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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**

Eligible Metropolitan Area Overview:

The Tampa-St. Petersburg Eligible Metropolitan Area (EMA)’s total population is approximately 3.3 million, of which 61% are White (non-Hispanic/Latinx), 21% are Hispanic/Latinx, and 12% are Black (non-Hispanic/Latinx). Women represent 52% of the total population. The geographic layout of the EMA is shown in the image below:

**Figure 1: Geographic Layout of the Tampa-St. Petersburg EMA**

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The socioeconomic status of individuals living in the EMA varies throughout the four-county area. Selected characteristics are displayed in **Figure 2**.

**Figure 2: Tampa-St. Petersburg EMA Socioeconomic Profile, 2021**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **County** | **Total Population (n)** | **Median Household Income ($)** | **Individuals Below the Poverty Level (%)** | **Residents over 25 w/a high school diploma (%)** | **Residents over 25 w/a bachelor’s degree or higher (%)** | **Population w/Health Insurance (%)** | **Civilian labor force unemployed (%)** |
| Hillsborough | 1,515,107 | 64,164 | 14.0 | 89.2 | 35.5 | 87.9 | 4.3 |
| Hernando | 196,419 | 53,301 | 13.2 | 89.0 | 19.4 | 87.1 | 5.1 |
| Pasco | 558,627 | 58,084 | 12.2 | 90.4 | 26.1 | 88.6 | 4.4 |
| Pinellas | 990,077 | 60,451 | 11.5 | 92.1 | 34.1 | 89.0 | 4.0 |

Source: Florida Department of Health, Division of Public Health Statistics and Performance Management, FLHealthCHARTS.org

Overview of the HIV Epidemic within the EMA:

According to the Florida Department of Health’s Epidemiological Profile, new HIV cases (incidence) in the EMA decreased 16.0% from 2019 to 2020 and increased 15.5% from 2020 to 2021, for an overall decrease of 3.0% from 2018 to 2020. New cases of AIDS decreased 9.1% from 2019 to 2020 and increased by 14.7% from 2020 to 2021, for an overall increase of 4.3%. The decrease in new HIV and AIDS cases in 2020, and subsequent increase in 2021, should be interpreted with caution due to the impact of the COVID-19 pandemic on access to HIV testing. Changes in the incidence and prevalence for HIV and AIDS, from 2019 to 2021, are shown in **Figure 3**.

**Figure 3: Tampa-St. Petersburg EMA Epidemiological Profile**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **CY 2019** | **CY 2020** | **CY 2021** |
| **Incidence** | **Prevalence** | **Incidence** | **Prevalence** | **Incidence** | **Prevalence** |
| **HIV** | 537 | 6,874 | 451 | 6,981 | 521 | 7,129 |
| **AIDS** | 254 | 7,485 | 231 | 7,499 | 265 | 7,538 |
| **TOTAL** |  | 14,359 |  | 14,480 |  | 14,667 |

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2019, 2020, 2021. Note: HIV diagnoses cannot be added with AIDS diagnoses to get combined totals, as these categories are not mutually exclusive.

**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 cisgender[[1]](#footnote-1) male-to-male sexual contact (MMSC), accounting for 958 new cases of HIV and 386 new cases of AIDS between 2019 and 2021. Of these, MMSC among Black cisgender men has resulted in the greatest number of newly diagnosed cases of HIV, followed by MMSC among White and Hispanic/Latinx cisgender men, respectively. Transmission among cisgender heterosexual individuals accounted for 371 new cases of HIV and 242 new cases of AIDS during the three-year period. Black cisgender heterosexual individuals were the most affected among all other races. Injection Drug Use (IDU) was the third highest mode of transmission with 113 new HIV cases and 68 new AIDS cases in the three-year period. White people who inject drugs (PWID) represented the greatest number of diagnoses among PWIDs of all other races. HIV Incidence by mode of transmission is shown in **Figure 4**.

**Figure 4: Tampa-St. Petersburg EMA HIV Incidence by mode of transmission, 2019-2021**

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2019, 2020, 2021.

**Figure 5** and **Figure 6** show incidence of HIV and AIDS by gender.The incidence of HIV among cisgender men in the EMA decreased from 444 cases in 2019 to 416 cases in 2021: a 6.3% decrease. During the same time frame, new HIV cases among cisgender women increased from 91 cases in 2019 to 105 cases in 2021: a 15.4% increase. The incidence of cisgender male AIDS cases increased 2.6%, from 191 in 2019 to 195 cases in 2021. The incidence of cisgender female AIDS cases increased 9.5%, from 63 cases to 69 cases. Among transgender women, there were 2 cases of HIV and 0 cases of AIDS reported in 2019, 5 cases of HIV and 2 cases of AIDS in 2020, and 0 cases of HIV and 1 case of AIDS in 2021. There were no cases reported in transgender men. The Florida Department of Health does not give a third transgender identification option to capture individuals who may identify under the non-binary[[2]](#footnote-2) umbrella. It is possible that HIV incidence in the transgender population is underrepresented due inaccurate classification or individuals not feeling safe disclosing their authentic gender identity.

**Figure 5: Tampa-St. Petersburg EMA 2021 HIV Incidence by Gender**

**Figure 6: Tampa-St. Petersburg EMA 2021 AIDS Incidence by Gender**

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2019, 2020, 2021.

HIV incidence is shown in **Figure 7**. HIV incidence increased among all races between 2020 and 2021, however, this increase was likely due in part to the decrease in testing in 2020 during the beginning of the COVID-19 pandemic. From 2019-2021, HIV incidence decreased 10.5% among Black people and 13.7% among White people but increased 34.2% among Hispanic/Latinx people. 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 35.3% decrease in new HIV cases, from 17 cases in 2019 to 11 cases in 2021.

AIDS incidence is shown in **Figure 8**. AIDS incidence increased among all races between 2020 and 2021, likely due to a decrease in testing in 2020. Overall between 2019-2021, there were only slight changes in the incidence of AIDS in Black and White people with 89 cases in White people in 2019 and 90 cases in 2021 and 111 cases in Black people in 2019 and 110 cases in 2021. Over the same period, AIDS cases in Hispanic/Latinx individuals increased by 30.4% from 46 cases in 2019 to 60 cases in 2021.The “Other” race category experienced a 37.5% decrease in new AIDS cases, from 8 cases in 2019 to five cases in 2021.

**Figure 7: Tampa-St. Petersburg EMA HIV Incidence by Race/Ethnicity**

**Figure 8: Tampa-St. Petersburg EMA AIDS Incidence by Race/Ethnicity**

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2019, 2020, 2021.

The 2021 calendar year saw minor demographic changes in the overall numbers of people with HIV and AIDS (prevalence). White people in the EMA represented 61% of the population and 42% of all HIV cases. Black people accounted for 36% of HIV cases and Non-Black Hispanic/Latinx people accounted for 19%. White people represented the largest prevalence of AIDS cases in the EMA with 43%, followed by Black people with 36%, and Hispanic/Latinx people with 18%. Black people were disproportionately impacted by HIV/AIDS representing 36% of both HIV cases and AIDS cases, although only 12% of the EMA’s total population was Black. **Figure 9** shows HIV and AIDS prevalence by race/ethnicity in 2021, compared to the overall population.

**Figure 9: Tampa-St. Petersburg EMA 2021 HIV/AIDS Prevalence by Race/Ethnicity, Compared to Overall Population**

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2019, 2020, 2021.

In the EMA, cisgender men comprise approximately 49% of the population but represent a majority of HIV and AIDS cases. In 2021, cisgender men represented 76.8% of HIV prevalence and 76.4% of AIDS prevalence; cisgender women represented 22.9% of HIV prevalence and 22.6% of AIDS prevalence. Starting in 2019, the Florida Department of Health began providing 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 may be incorrectly attributed as men and many transgender men may be categorized as women. Transgender women represent 0.6% of HIV prevalence and 0.5% of AIDS prevalence, and transgender men represent 0.0% of HIV and AIDS prevalence. As the acceptance and affirmation of transgender populations strengthen, 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, but rather as a gender that is included within the non-binary umbrella. **Figure 10** shows HIV and AIDS prevalence by gender in 2021.

**Figure 10: Tampa-St. Petersburg EMA 2021 HIV/AIDS Prevalence by Gender**

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2019, 2020, 2021.

Over the past three years, there have been minimal increases and decreases in HIV/AIDS prevalence among all races. Notably, the number of Hispanic/Latinx people with HIV in the EMA increased by 6.9%, from 2,587 cases in 2019 to 2,765 cases in 2021. Over the same period, HIV prevalence increased by just 0.6% in White people and 1.4% in Black people. Among other races, the most significant change was in Asian people who saw an increase (7.6%) of cases from 144 in 2019 to 155 in 2021.

In 2021, there were 5,288 Black people with HIV/AIDS in the EMA (36% of the total population with HIV). Approximately 17% of people with HIV/AIDS in this racial group were aware of their status and not in care. There were 2,765 Hispanic/Latinx people with HIV/AIDS in the EMA in 2021 (18% of the total population) and approximately 18.4% were aware of their HIV/AIDS status and not in care. There were 6,215 White people with HIV/AIDS in the EMA in 2021 and approximately 13.6% were aware of their status and not in care. Additional care continuum data from this time period is available in the 2022-2023 HIV/AIDS Care Continuum Report for the Tampa-St. Petersburg Eligible Metropolitan Area.

**Figure 11** shows the total number of People with HIV/AIDS in the EMA in 2021 by county.

**Figure 11: Tampa-St. Petersburg EMA HIV/AIDS Cases per County in 2021**



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2021.

New and Emerging Populations:

The Florida Department of Health’s 2021 Epidemiological Profile reports that while new HIV cases in cisgender male youth (13-24) decreased overall from 2019 to 2021, there was a 16.1% increase in cases in this population between 2020 and 2021. Cases in White cisgender male youth decreased 47.4% from 2019-2021, while cases in Black cisgender male youth decreased just 4.3% in the same period. Among Hispanic/Latino cisgender male youth, new cases remained the same with 12 cases in 2019 and 12 cases in 2021. While there are low numbers of HIV cases in cisgender female youth overall, the number of cases in Black cisgender female youth doubled between 2019 and 2021, from three cases in 2019 to six cases in 2021. Over the same period, cases in Hispanic/Latina cisgender female youth increased slightly from three cases in 2019 to four cases in 2021 and cases in White cisgender female youth dropped from four cases in 2019 to zero cases in 2021.

Unique challenges for youth include social, economic, and cultural barriers that limit access to prevention and care. Stigma and misinformation about HIV contribute heavily to new cases of HIV among youth. Low rates of condom use, substance misuse, and partner age differences (and the potential for coercion in these relationships) are prevention challenges for this emerging population. Youth are more likely to forego needed health care due to lack of access to transportation, lack of time off from work and school, fear, lack of insurance, disapproval from family and peers, and not feeling sick. 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 2021 Epidemiological Profile reports 22.1% (n=3,236) of People with HIV in the EMA who were aware of their status were not retained in medical care.Populations in the EMA that are under-represented in care include: unhoused people[[3]](#footnote-3) of all races/ethnicities, PWID of all races/ethnicities, and Black transgender people. Among these groups, the percentages of people not retained in medical care in 2021 are as follows: 80% (n=8) of Hispanic/Latino unhoused cisgender men, 75% (n=15) of Black unhoused cisgender men, 63.6% (n=7) of White unhoused cisgender women, 61.9% (n=13) of White unhoused cisgender men, 50% (n=3) of Black unhoused cisgender women, 50% (n=2) of Hispanic/Latina unhoused cisgender women, 35.2% (n=81) Black cisgender male PWID, 34.4% (n=67) White cisgender male PWID, and 32.6% (n=14) Black transgender people.

Black and Hispanic/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 2021, 24.1% (n=1,277) of Black People with HIV and 23.3% (n=645) of Hispanic/Latinx people with HIV in the EMA were not retained in medical care. In contrast, in 2017, 29.2% (n=1,494) of Black People with HIV and 28.3% (n=690) Hispanic/Latinx People with HIV in the EMA were not retained in medical care. While rates of retention in care in these populations have improved significantly over the past five years, this progress has stalled within recent years, with only marginal changes in retention in care between 2019 and 2021. **Figure 12** shows the percentages Black and Hispanic/Latinx populations not retained in care, compared to White people, from 2017-2021.

**Figure 12: Tampa-St. Petersburg EMA Percentages of PWH Not Retained in Care, 2017-2021**

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2017, 2018, 2019, 2020, 2021.

**THE EPIDEMIC IN THE TOTAL SERVICE AREA**

The State of Florida is comprised of numbered areas. The West Central Florida Ryan White Care Council covers three areas: Area 5, Area 6, and Area 14. To provide information regarding all the areas covered by the Care Council and not just the EMA, **Figures 13 – 19** represent the three geographic areas that make up the Total Service Area (TSA).

**Figure 13** shows the number of People with HIV (PWH) per 100,000 population for all eight TSA counties.

**Figure 13: People with HIV (PWH) per 100,000 Population in 2021**

Source: Florida Department of Health, HIV/AIDS Section, 2021

**Figures 14-19** show new cases (incidence) of HIV and AIDS in each area, broken down by county of residence at diagnosis.

**AREA 5: PASCO & PINELLAS COUNTIES**

**Figure 14: HIV by Year of Diagnosis in Area 5**

**by County of Residence at Diagnosis, 2019-2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **County***HIV Incidence* | **2019**(#) | **2020**(#) | **2021**(#) | **2019-2021***% Change* |
| **Pasco** | 48 | 38 | 48 | 0% |
| **Pinellas** | 192 | 155 | 130 | -32.3% |

Source: Florida Department of Health, HIV/AIDS Section, 2021

**Figure 15: AIDS by Year of Diagnosis in Area 5**

**by County of Residence at Diagnosis, 2019-2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **County***AIDS Incidence* | **2019**(#) | **2020**(#) | **2021**(#) | **2019-2021***% Change* |
| **Pasco** | 21 | 21 | 20 | -4.8% |
| **Pinellas** | 87 | 80 | 72 | -17.2% |

Source: Florida Department of Health, HIV/AIDS Section, 2021

**AREA 6: HERNANDO, HILLSBOROUGH, & MANATEE COUNTIES**

**Figure 16: HIV by Year of Diagnosis in Area 6**

**by County of Residence at Diagnosis, 2019-2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **County***HIV Incidence* | **2019**(#) | **2020**(#) | **2021**(#) | **2019-2021***% Change* |
| **Hernando** | 9 | 9 | 20 | 122.2% |
| **Hillsborough** | 288 | 249 | 323 | 12.2% |
| **Manatee** | 35 | 41 | 56 | 60% |

Source: Florida Department of Health, HIV/AIDS Section, 2021

**Figure 17: AIDS by Year of Diagnosis in Area 6**

**by County of Residence at Diagnosis, 2019-2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **County***AIDS Incidence* | **2019**(#) | **2020**(#) | **2021**(#) | **2019-2021***% Change* |
| **Hernando** | 5 | 6 | 8 | 60% |
| **Hillsborough** | 141 | 124 | 165 | 17% |
| **Manatee** | 17 | 30 | 25 | 47.1% |

Source: Florida Department of Health, HIV/AIDS Section, 2021

**AREA 14: HARDEE, HIGHLANDS, & POLK COUNTIES**

**Figure 18: HIV by Year of Diagnosis in Area 14**

**by County of Residence at Diagnosis, 2019-2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **County***HIV Incidence* | **2019**(#) | **2020**(#) | **2021**(#) | **2019-2021***% Change* |
| **Hardee** | 0 | 0 | 3 | 100% |
| **Highlands** | 13 | 10 | 4 | -69.2% |
| **Polk** | 131 | 77 | 129 | -1.5% |

Source: Florida Department of Health, HIV/AIDS Section, 2021

**Figure 19: AIDS by Year of Diagnosis in Area 14**

**by County of Residence at Diagnosis, 2019-2021**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **County***AIDS Incidence* | **2019**(#) | **2020**(#) | **2021**(#) | **2019-2021***% Change* |
| **Hardee** | 1 | 1 | 0 | -100% |
| **Highlands** | 8 | 5 | 1 | -87.5% |
| **Polk** | 56 | 41 | 57 | 1.8% |

Source: Florida Department of Health, HIV/AIDS Section, 2021

**ACCESS TO CARE AND SERVICE GAPS**

The EMA has a strong history of collaboration between all patient care and prevention funded programs and actively promotes cross-collaboration. In addition to the Care Council, the Ending the HIV Epidemic (EHE) grants also have planning groups that meet regularly which include the two CDC funded grants for Hillsborough and Pinellas County as well as the HRSA funded EHE grant which covers both jurisdictions. Each grant has a separate planning group. Due to the recent expansion in the number of planning groups, the EMA needs to consider consolidation of the local patient care and prevention planning to achieve a higher level of community involvement as there tend to be competing interests for time, especially with community volunteers who have interest but may be limited on their time due to work or other obligations.

Cultural and language barriers in the EMA may hinder access to care, due to the cultural and linguistic diversity of the area. To increase access to care, all Ryan White direct services are delivered by providers who employ bilingual staff, provide language interpretation services, and who strive to provide culturally sensitive care. Agencies prioritize hiring employees who culturally reflect the HIV population that they serve. In addition to Spanish speaking staff, some agencies within the EMA have staff who speak Haitian Creole. To ensure that services are as accessible as possible, the Recipient evaluates accessibility standards during the application process for each provider to ensure quality of care and services. In addition to having bilingual staff, providers are expected to have locations along bus routes and offer after-hours appointments. Florida has an inconsistent patchwork of health care options, depending on what area of the state one resides in. Urban areas with locally funded programs generally offer more choice and access compared to rural areas.

Florida is a non-Medicaid expansion state, meaning that the state has rejected federal funds under the Affordable Care Act (ACA) to expand its Medicaid program. Many low-income Floridians fall in the Medicaid gap, meaning they earn too little to qualify for ACA subsidies and are ineligible for Medicaid unless they fall into a special category, such as pregnant people, parents of children under 19, seniors, and people with certain disabilities. According to the Florida Department of Children and Families, Florida Medicaid covered 5.5 million low-income children, pregnant people, adults, seniors, and people with disabilities in 2022. Based on Florida’s population of approximately 21.8 million people in 2021, approximately 25% of the population were covered by some form of Medicaid or the State Children’s Health Insurance Program (SCHIP). The number of Floridians covered by Medicaid grew from 3.8 million in March 2020, as a result of the continuous enrollment provision in the Families First Coronavirus Response Act (FFCRA). Starting in April 2023, with the ending of the Public Health Emergency, Floridians who were able to maintain their Medicaid coverage during this period have started to be disenrolled. As of August 23, 2023, more than 182,000 Floridians have received termination notices, with hundreds of thousands more expected to lose coverage over the next year. The Medicaid provider Clear Health Alliance has worked to identify individuals with HIV who are at risk of losing coverage to help them renew their Medicaid plans or transition to other forms of coverage. The EMA anticipates that many of these individuals with HIV may need to be transitioned into Ryan White care and there may be an influx of new clients over the next year. In particular, the EMA noticed a decrease in the utilization of Ryan White outpatient ambulatory health services (OAHS) in the 2022-2023 funding year, which may have been a result of an increase in clients receiving their medical care through Medicaid. The EMA will pay close attention to the utilization of OAHS through the 2023-2024 funding year to assess whether utilization increases from the previous year.

In addition to Medicaid, the EMA has two locally funded health care plans for low-income residents, the Hillsborough Health Care Plan (HCHCP) and the Pinellas County Health Plan (PCHP), that offer primary care and other core medical services to qualifying residents. The HCHCP is more robust in the fact that it covers individuals without other health options up to 175% of the Federal Poverty Level (FPL). The PCHP covers individuals up to 100% of the FPL. Both require documentation of county residency, proof of income, identification, etc. for eligibility purposes. Eligible clients are then enrolled and are assigned to a clinic medical home for primary care, which focuses on prevention and management of chronic diseases. The HCHCP offers limited dental services as well as other ancillary services, including three wellness centers which offer HCHCP members access to nutrition counseling, and fully equipped fitness centers with staff who can provide a customized fitness plan based on individual needs and personal training, as well as fitness classes.

Services in Pasco and Hernando counties, which are less densely populated, are not as accessible due to there being less provider locations and very limited public transportation. Stigma is still a significant barrier, especially for People with HIV who reside in less densely populated areas, as they tend to be more isolated and may fear disclosing their HIV status to family or friends. It is still routine for service providers in Pinellas and Hillsborough to serve clients who will travel from less densely populated communities for care rather than risk being seen by people they know or disclosing their HIV status to the local health department provider, who may be the sole HIV service provider in their county of residence.

Mental health and pain management services are severely limited and therefore difficult to access in the EMA. The opioid epidemic has contributed to additional controls and restrictions, which took effect with Florida legislation on July 1, 2018. Specialty care services were traditionally enhanced and/or supplemented by state general revenue funds and in-kind contributions since the pool of specialists who accept the cost-based reimbursement price is limited, especially in the less densely populated areas. Most specialist care is provided in the more densely populated areas/large cities necessitating travel over long distances for many where transportation is already a barrier. Coordination of all these services and the significant wait times for specialist appointments can be frustrating for clients and may cause them to fall out of care or not seek the specialist care needed.

Long Acting Injectables (LAI’s) were successfully added to the local HIV continuum of care in 2021, with the Florida Department of Health AIDS Drug Assistance Program (ADAP) paying for the cost of the medications and Ryan White Part A covering the cost of the office visit. Despite LAI’s being available throughout the EMA for any patient who meets the medical protocol, providers have not seen a surge in usage, perhaps due to medical hesitancy or difficulty committing to the regular in-office appointments needed to receive injections.

Due to the Florida Legislature opting not to accept the Medicaid expansion funding made available by the Affordable Care Act (ACA), the EMA has continued to focus Ryan White patient care funds only on provision of core services. The Care Council, in the prioritization and allocation process, reviews all service categories, including those which are not funded, and considers other funding streams. The Care 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 or other initiatives.

Expanding access to oral health remains a priority but is a difficult challenge due to level Ryan White Part A funding and a lack of dental providers. Utilization dropped during the height of the COVID-19 pandemic and has still not returned to pre-pandemic levels. Access to substance misuse and mental health services is another area of focus since substance misuse services were not available until recently in Pasco and Hernando Counties and mental health services were very limited. New contracts supporting mental health and substance misuse services began in the 2023-2024 funding year.

Florida is particularly vulnerable to hurricanes and other weather events which can seriously disrupt an already fragile service delivery system. On September 28, 2022, Hurricane Ian hit southwest Florida and traveled through the EMA impacting residents and services. Many residents lost power and experienced damages due to wind and flooding. Many businesses closed in preparation for the storm and remained closed for several days to a week or more. A hurricane may last a day or two but the impacts that it leaves on the community are detrimental to many of the systems needed to support a person’s ability to access the things that keep them healthy. For example, a person may not be able to go to work, access their medications or attend medical appointments.

The EMA identified service gaps as a component of the most recent 2022 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 2022 HIV Care Needs Survey was open from October 2022 to April 2023 and was distributed to an email list of 19 provider agencies across 24 different locations (33 unique email addresses), with reminders sent every 2-4 weeks. The survey was also sent to the West Central Florida Ryan White Care Council’s community email list (244 unique email addresses) every two weeks for the duration of the survey period. The survey was shared on the Care Council Facebook page a total of nine times. Provider agencies were also encouraged to share the survey on their social media pages. 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. Paper copies of the survey were distributed to six providers in Hillsborough, Pasco, Pinellas, and Polk Counties. Responses were received from 516 individuals with 480 completed in English, 35 in Spanish, and one in Haitian Creole. The 516 responses reflect a 95% confidence level with a +/-4% margin of error.

**Figure 20** showcases the service gaps for People with HIV in the EMA as identified in the 2022 HIV Care Needs Survey. The services are ranked in order from highest service gap percentage to lowest service gap percentage.

**Figure 20: 2022 HIV Care Needs Survey Service Gaps**

|  |  |
| --- | --- |
| **Service Category** | **Needed Service But Could Not Get** |
| # | % |
| Dental/Oral Health | 66 | 14.0% |
| Emergency Financial Assistance | 62 | 13.3% |
| Housing | 61 | 13.0% |
| Food Bank, Food Vouchers, or Home Delivered Meals | 53 | 11.4% |
| Health Insurance | 52 | 11.2% |
| Legal Services | 36 | 7.6 |
| Mental Health Services  | 35 | 7.5% |
| Nutritional Counseling | 29 | 7.5% |
| Transportation | 26 | 5.6% |
| Psychosocial Support Services | 24 | 5.1% |
| Eligibility Services (Non-Medical Case Management) | 22 | 4.6% |
| Substance Misuse Services - Outpatient | 20 | 4.3% |
| Referral Services | 18 | 3.9% |
| Rehabilitation Services  | 17 | 3.63% |
| Medical Case Management | 13 | 2.7% |
| Substance Misuse Services - Residential | 13 | 2.7% |
| Outpatient/Ambulatory Health Services | 11 | 2.3% |
| Health Education/Risk Reduction | 11 | 2.3% |
| Medications | 10 | 2.1% |
| Home Health Care | 10 | 2.1% |
| Outreach Services | 10 | 2.1% |
| Hospice Services | 5 | 1.1% |
| Linguistic Services (Interpretation/Translation) | 2 | 0.4% |

Source: Florida Department of Health Statewide HIV Care Needs Survey, Results from Areas 5-6-14, 2022-2023

**Figure 21** showcases the prioritized services for People with HIV in the EMA as identified in the 2022 HIV Care Needs Survey. Ryan White services are ranked in order from highest service priority to lowest service priority.

**Figure 21: 2022 HIV Care Needs Survey Service Priorities**

|  |  |  |
| --- | --- | --- |
|  | **Service Category** | **% of Survey Responses** |
| 1. | Medical Case Management | 77% |
| 2. | Medications | 63% |
| 3. | Dental/Oral Health | 55% |
| 4. | Health Insurance | 54% |
| 5. | Housing | 47% |
| 6. | Emergency Financial Assistance | 33% |
| 7. | Food Bank/Food Voucher | 33% |
| 8. | Mental Health Services | 30% |
| 9. | Transportation | 21% |
| 10. | Outpatient Medical Care | 18% |
| 11. | Health Education/Risk Reduction | 13% |
| 12. | Early Intervention Services | 11% |
| 13. | Peer Support | 10% |
| 14. | Referral for Health Care | 7% |
| 15. | Legal Services | 5% |
| 16. | Outreach | 4% |
| 17. | Substance Use Services - Outpatient | 4% |
| 18. | Home Health Care | 4% |
| 19. | Nutritional Counseling | 4% |
| 20. | Substance Misuse Services -Residential | 4% |
| 21. | Child Care | 3% |
| 22. | Hospice Services | 3% |
| 23. | Linguistic Services | 2% |
| 24. | Rehabilitation | 2% |

Source: Florida Department of Health Statewide HIV Care Needs Survey, Results from Areas 5-6-14, 2022-2023

The Care 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 use, 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 20 are defined as non-core services. The Care Council, in the prioritization and allocation process, reviews all service categories, including those which are not funded, and considers other funding streams. The Care 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.

**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 Care Council, the Ryan White Part A, B, and D Recipients, the local HOPWA Recipient, 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.

Due to the diverse nature of the Tampa-St. Petersburg EMA (two of the counties are more densely populated), the Care 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 use-outpatient, and health insurance premium and cost-sharing assistance. In October 2022, the Care Council voted to allocate additional funding for mental health and substance use services in Pasco and Hernando counties, in order to increase parity across the four-county area. The Care Council also voted to allocate funding for a housing program in these two counties, as Pinellas and Hillsborough counties have housing funded under EHE grants.

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 Care 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 Care Council cannot, with limited funding, expand beyond the top ten funding priorities. It has not funded other supportive services, such as legal assistance and food banks, in many years.

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

The EMA does not currently receive Ryan White Part C or Part F funds (though there are Part C funds in the Total Service Area, in Polk and Manatee Counties). 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.

**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 needs assessment surveys, the Integrated Plan, the Care Council, and the Care Council’s committees. The Care Council committees include: Planning and Evaluation; Membership and Community Outreach; Standards, Issues and Operations (SIOC); Resource Prioritization and Allocation Recommendations (RPARC); Women, Infant, Children, Youth and Families (WICY&F); and Health Services Advisory Committee. Due to difficulty meeting quorum during the COVID-19 pandemic, the Care Council suspended all committees except for WICY&F from a period of October 2021 through February 2023. During this same period, the Care Council held a series of virtual town hall meetings for members and the local community to discuss any issues within the Care Council or the HIV service delivery system. Committee meetings resumed in March 2023. Planning activities are influenced by the updated National HIV/AIDS Strategy and the HIV Care Continuum. The Care Continuum is used by the Planning and Evaluation Committee and the Care Council 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.

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 Care Council when setting priorities. Due to the increases and disproportionate impact among the historically underserved populations of Hispanic/Latinx and Black persons in the EMA, targeted efforts within the Minority AIDS Initiative (MAI) Project were developed. HIV incidence increased 34% among Hispanic/Latinx persons from calendar year 2019 to calendar year 2021 but decreased 11% among Black persons over the same time span. From calendar year 2019 to calendar year 2021, the incidence of AIDS increased by 30% in Hispanic/Latinx persons and decreased by less than 1% in Black persons.  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.

To allocate resources, the Planning and Evaluation Committee considers service utilization, expenditures, and allocations to each service category across public funding streams and estimates of unmet need. The committee forwards the recommended priorities to the Council, where members then discuss the implications of the service rankings and finalizes the priority rankings before adoption. Funding is allocated according to the service priorities, with consideration for other available funding sources for support services within the community.

**SERVICE PRIORITIES**

The Care Council sets service priorities based on information from HIV Care Needs Surveys, service utilization, and feedback from the community. The FY 2023-2024 Service Priorities are listed in **Figure 22**.

**Figure 22: Care Council Service Priorities**

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

\*The Emergency Financial Assistance (EFA) category will cover ADAP medications only, for those eligible clients who have been approved for ADAP and are still in the waiting period, which will serve as a “bridge” program in the manner it has historically.

**EMA AIDS Prevalence and HIV\* Prevalence Data by Demographic Group and Exposure Category**

Attachment 1

| **Demographic Group/****Exposure Category** | **2019-PREVALENCE** | **2020-PREVALENCE** | **2021-PREVALENCE** |
| --- | --- | --- | --- |
| ***Race/Ethnicity*** | **HIV** | **AIDS** | **HIV** | **AIDS** | **HIV** | **AIDS** |
| White, non-Hispanic/Latinx | 2,896 | 3,283 | 2,949 | 3,266 | 2,983 | 3,232 |
| Black, non-Hispanic/Latinx | 2,507 | 2,706 | 2,519 | 2,722 | 2,541 | 2,747 |
| Hispanic/Latinx | 1,278 | 1,309 | 1,322 | 1,315 | 1,411 | 1,354 |
| Other / Unknown | 193 | 187 | 191 | 196 | 194 | 205 |
| **Total** | 6,874 | 7,485 | 6,981 | 7,499 | 7,129 | 7,538 |
| ***Gender*** | **HIV** | **AIDS** | **HIV** | **AIDS** | **HIV** | **AIDS** |
| Cisgender Men | 5,294 | 5,704 | 5,376 | 5,720 | 5,504 | 5,760 |
| Cisgender Women | 1,533 | 1,745 | 1,554 | 1,741 | 1,573 | 1,741 |
| Transgender Women | 43 | 35 | 47 | 37 | 48 | 36 |
| Transgender Men | 4 | 1 | 4 | 1 | 4 | 1 |
| **Total** | 6,874 | 7,485 | 6,981 | 7,499 | 7,129 | 7,538 |
| ***Current Age as of Reporting Year*** | **HIV** | **AIDS** | **HIV** | **AIDS** | **HIV** | **AIDS** |
| <13 years | 8 | 3 | 9 | 2 | 8 | 3 |
| 13 - 24 years | 318 | 56 | 282 | 47 | 277 | 44 |
| 25 - 44 years | 3,038 | 1,680 | 3,071 | 1,630 | 3,127 | 1,625 |
| 45 - 59 years | 2,381 | 3,698 | 2,372 | 3,553 | 2,329 | 3,392 |
| 60+ years | 1,129 | 2,048 | 1,247 | 2,267 | 1,388 | 2,474 |
| **Total** | 6,874 | 7,485 | 6,981 | 7,499 | 7,129 | 7,538 |
| ***Exposure Category*** | **HIV** | **AIDS** | **HIV** | **AIDS** | **HIV** | **AIDS** |
| Cisgender Male-to-male sexual contact (MMSC) | 4,276 | 3,999 | 4,353 | 4,020 | 4,475 | 4,082 |
| Injection drug users (IDU)[[4]](#footnote-4) | 440 | 710 | 447 | 705 | 445 | 675 |
| MMSC/IDU | 298 | 448 | 294 | 429 | 287 | 433 |
| Cisgender Heterosexual Contact[[5]](#footnote-5) | 1,743 | 2,178 | 1,771 | 2,190 | 1,807 | 2,203 |
| Transgender Sexual Contact[[6]](#footnote-6) | 41 | 31 | 43 | 33 | 45 | 32 |
| Perinatal Exposure | 8 | 3 | 9 | 2 | 8 | 3 |
| Other/Unknown | 66 | 117 | 63 | 120 | 61 | 110 |
| **Total** | 6,872\*\* | 7,486\*\* | 6,980\*\* | 7,499 | 7,128\*\* | 7,538 |

*Source: Florida Department of Health EMA Epidemiological Profiles CY 2019; CY 2020; CY 2021*

\*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.

Attachment 2



1. Cisgender is the gender descriptor used for all men and women whose current gender aligns with their sex assigned at birth. [↑](#footnote-ref-1)
2. Non-binary is an umbrella term for all gender identities and expressions outside the gender binary. [↑](#footnote-ref-2)
3. According to the Florida Department of Health’s Epidemiology Profile, the designation of unhoused, or homeless, is based on the current address at the end of the calendar year and includes addresses labeled as Homeless, Shelter, Temporary, or with a zip code of 99999. [↑](#footnote-ref-3)
4. Includes IDU of ALL genders, excluding MMSC/IDU [↑](#footnote-ref-4)
5. 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) [↑](#footnote-ref-5)
6. “Transgender Sexual Contact” is specific to all people 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 [↑](#footnote-ref-6)