INTEGRATED HIV PREVENTION AND CARE PLAN

INCLUDING THE STATEWIDE COORDINATED STATEMENT OF NEED (SCSN)

TAMPA-ST. PETERSBURG ELIGIBLE METROPOLITAN AREA

CY 2022-2026

Section I: Executive Summary of Integrated Plan and SCSN

1. Executive Summary of Integrated Plan and SCSN

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

Local partner agencies have a rich history of collaborating on HIV prevention, surveillance, care, and treatment issues throughout the Tampa-St. Petersburg EMA. This Integrated Prevention and Care Plan was written by the Tampa-St. Petersburg EMA in conjunction with the Part A Recipient, Part B Lead Agency, Part D Recipient, representatives from local Ending the HIV Epidemic (EHE) initiatives, the RWHAP Part A Planning Council, and local health departments.

The 2022-2026 Integrated Plan was written to support the achievement of the National HIV/AIDS Strategy for the United States (NHAS) goals and objectives and includes the four focus areas- Diagnose, Treat, Prevent, and Respond. This document is a city-only prevention and care plan. The Tampa-St. Petersburg EMA's plan will complement the state Integrated Plan, including the Statewide Coordinated Statement of Need (SCSN).

a. Approach

The 2022-2026 Tampa-St. Petersburg EMA Integrated Prevention and Care Plan is a stand-alone document that is relevant and responsive to the needs of the local community. Each of the following sections was written specifically to address the requirements of the 2022-2026 Integrated Plan Guidance. No sections were taken from previously written documents. The four-county Ryan White Part A EMA also includes Ryan White Parts B and D, in addition to two separate EHE jurisdictions, along with several planning bodies covering prevention and care. The EMA's Integrated Plan was written by local experts who reviewed relevant local and national documents to appropriately respond to the requirements of the Guidance.

b. Documents submitted to meet requirements

The Tampa-St. Petersburg Integrated Prevention and Care Plan is a stand-alone document; however, many background materials and other local planning documents were consulted during the writing process.

The following documents were reviewed for the writing of the Integrated Plan:

1. FDOH-Hillsborough EHE 2020 Narrative
2. FDOH-Pinellas EHE Narrative 2021
3. Hillsborough & Pinellas County–HRSA-20-078 Year 2 Workplan
4. Florida Unified EHE Plan
5. US PLHIV Caucus, "Demanding Better: An HIV Federal Policy Agenda by People Living with HIV"
6. FDOH-Hillsborough PS20-2010 Year 2 Work Plan
7. FDOH-Pinellas PS20-2010 Workplan Revised Pillars
8. RWHAP HRSA-22-018 Tampa-St. Petersburg EMA Funding Application
9. 2017-2021 Integrated HIV Prevention and Care Plan for the Tampa-St. Petersburg EMA

Section II: Community Engagement and Planning Process

1. Jurisdiction Planning Process

a. Entities Involved in Planning Process

Collaboration among stakeholders is critical to maximizing resources and efficiencies in serving people at-risk for HIV and People with HIV (PWH). As the Tampa-St. Petersburg EMA strives to coordinate prevention, care, and treatment, collaboration becomes paramount to providing services that fully address each component of the HIV care continuum. Two counties in the EMA, Hillsborough, and Pinellas, are included in the seven counties in Florida as targeted jurisdictions in The Ending the HIV Epidemic: A Plan for America. Entities involved in the planning process, for the 2022–2026 Integrated Plan, include Ryan White Planning Council Support (PCS) Staff, the Ryan White Part A Recipient for the Tampa-St. Petersburg EMA, the Ryan White Part B Lead Agency for Area 5, 6, and 14, the local Ryan White Part D Recipient, local health department staff, and The AIDS Institute. Additional entities involved in the planning process include the Pinellas County's Ending the HIV Epidemic (EHE) Consumer Advisory Council, the Hillsborough EHE Planning Committee, the Pinellas Planning Partnership (PPP), and members of the West Central Florida Ryan White Care Council (RWCC), which is comprised of People with HIV (PWH), healthcare providers, community based organizations serving marginalized populations, AIDS service organizations (ASO), social service and housing and homeless service providers, mental health providers, agencies who provide counseling and treatment for substance misuse, local public health agencies, hospital planning agencies or heath care planning agencies, marginalized communities and historically underserved groups and sub-populations, non-elected community leaders, Medicaid representatives, Ryan White Part D; recipients under federal HIV programs, including Housing Opportunities for People with HIV/AIDS (HOPWA), and individuals who represent formerly incarcerated persons.

The Hillsborough County Ending the HIV Epidemic (EHE) Planning Committee's initial members included representatives from the local universities, social service providers, the health department, hospitals, HIV providers, city and county governments, and pharmaceutical companies. To identify representatives through all community engagement activities, the EHE Planning Committee looked to the social determinants of health most correlated with a high prevalence of People with HIV (PWH) and the opinion leaders who represent them. Engaging populations most impacted by HIV was a priority for the Hillsborough County EHE planning process and based on the epidemiological profile, included residents of zip-codes with high prevalence numbers of HIV/AIDS located in the city of Tampa, those who engage in male-to-male sexual contact (MMSC), and all Black communities. Stakeholder groups were subsequently held for additional engagement activity, with the following representatives: academia; faith communities; Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) youth; local law enforcement; non-HIV medical providers; school board members; farmworkers; homeless persons; pregnant cisgender women; and persons who misuse substances. These communities are represented on the Hillsborough County EHE Planning Committee, which continues to meet monthly to monitor progress on the EHE Plan, review the 2017–2021 Tampa-St. Petersburg Integrated Plan and will continue to monitor and review subsequent plans going forward

The Pinellas County Ending the HIV Epidemic (EHE) initiative's goal is to reduce new cases of HIV by 75% in 2025, and 90% by year 2030. The Pinellas EHE leadership enlisted the help of various community members to address Pinellas County's strengths, opportunities, needs,

perspectives, and experiences of individuals and the community through EHE's four pillars: Diagnose, Treat, Protect, and Respond. Pinellas County formed a community advisory council to create a plan that would address HIV-related issues within high-priority zip codes. The Pinellas County EHE Council meets on a quarterly basis and provides feedback and suggestions to direct the EHE initiative. The EHE initiative has focused its efforts on several initiatives including the social determinants of health, housing instability for PWH, youth education and training services, faith-based community education, and community outreach.

The HRSA-funded EHE project works collaboratively with various community partners to ensure that goals, strategies, and activities for the Ending the HIV Epidemic plans for both Hillsborough and Pinellas counties are on track. These partners include representatives from the Part A Recipient's Office, Florida Department of Health, local AIDS service organizations (ASOs), community-based organizations, the University of South Florida Colleges of Public Health and Medicine, Hillsborough County School Board, the Health Council of West Central Florida, and community stakeholders. Monthly project monitoring calls are held between staff from the Part A Recipient's Office, The AIDS Institute, METRO Inclusive Health, EPIC, University of South Florida Health/Tampa General Hospital, the HIV/AIDS Program Coordinators (HAPCs) for both Pinellas and Hillsborough counties, the project evaluator, and other relevant community members. These partner calls continue to be a means to document successes, lessons learned, and share best practices during implementation. Additional community partners are invited to participate on an as-needed basis.

b. Role of Part A Planning Council

The local Ryan White HIV/AIDS Program Part A planning council is the West Central Florida Ryan White Care Council. The Care Council is a combined Ryan White Part A and Part B planning body and plans for Ryan White HIV care exclusively. It is not a prevention planning body, though providers of prevention services attend meetings and regularly provide updates. The Care Council carefully determines the needs of the HIV community in eight counties: Hillsborough, Pinellas, Pasco, Hernando, Polk, Hardee, Highlands, and Manatee. This includes the four counties that make up the Tampa-St. Petersburg EMA: Hillsborough, Pinellas, Pasco, and Hernando. The Care Council conducts a local HIV needs assessment which includes a client survey, epidemiological data, the HIV care continuum, factors that limit access to care, service gaps, coordination of services and funding streams, and service priorities. This data is collected on an ongoing basis and summarized in a yearly report.

The Tampa-Saint Petersburg EMA administers client surveys every three years, in collaboration with the State of Florida, along with local need assessment activities on an ongoing basis. With this information and the input of community members who participate in workgroups, committee meetings, town halls, listening sessions, focus groups, and other community events, the Care Council decides how and where Ryan White funding is allocated for each service category. The Care Council does not provide direct services but rather service planning and evaluation.

To expand the level of community involvement, the Care Council hosts monthly virtual town halls, or listening sessions, to provide an open forum, for members and the local community, to discuss any issues within the Care Council or the HIV service delivery system. The Care Council hosted an expanded community town hall on March 22, 2022, in a focus group-style structure. This town hall was widely advertised by provider agencies within the EMA with the understanding that the first twenty participants to sign up and attend would be awarded a gift card as an incentive. Major

themes discussed, during the town hall, were focused on low health literacy and the need for prevention education. Strategies noted to overcome these barriers include targeted advertising and increased communication between providers and the community at-large. Information collected from this town hall was then shared with the Florida Comprehensive Planning Network (FCPN) and reported at their spring 2022 statewide meeting. The Care Council is also responsible for electing a community representative and alternate to serve on the Florida Comprehensive Planning Network (FCPN). The FCPN assists with the development and has concurrence responsibilities for Florida's Integrated Plan and the Statewide Coordinated Statement of Need.

Care Council members were directly involved in developing the Integrated Plan, in many ways. Information from the Care Council's needs assessment and the input of community members who participate in meetings, town halls, and other community events, were considered when establishing the priorities, goals, and objectives for the Plan. Several Care Council members volunteered to participate on the writing team and directly contributed to the writing process. As each section of the plan was written, drafts were presented to the Care Council members for review and to collect feedback. The Care Council voted to adopt the 2022-2026 Integrated Plan on October 5, 2022. The Care Council will be involved in the implementation and monitoring of the Plan. Planning Council Support (PCS) staff will share updates to goals and objectives with the Care Council, on an ongoing basis, as the Plan progresses.

c. Role of Planning Bodies and Other Entities

The West Central Florida Ryan White Care Council serves as a combined Part A and Part B planning body. The EMA does not currently have a combined Prevention & Patient Care Planning body. There is, however, a long history of coordination and collaboration between the funding streams and community partners, such as the Pinellas Planning Partnership and the Area 5, 6 & 14 HIV Planning Partnership (HPP) which serves as the prevention planning body for the eight-county region. In January 2022, staff representing all principal grant programs (Ryan White Parts A, B, and D including EHE and CDC/EHE funded prevention grants) held a meeting to lay out the Tampa-St. Petersburg EMA's Integrated Plan (IP) writing schedule and assignments. Timelines were agreed upon and sections were assigned based on areas of expertise. Simultaneously, the Florida Comprehensive Planning Network (FCPN) met and set timelines for the State of Florida's Integrated HIV Prevention and Care Plan.

Stakeholder engagement occurs on a regular basis through the FCPN and assists the Florida Department of Health's HIV/AIDS Section in planning patient care and prevention activities. The Care Council is also responsible for electing a community representative and alternate to serve on the Florida Comprehensive Planning Network (FCPN). The FCPN is composed of representatives from the Department of Health, all parts of the RW Program, Federally Qualified Health Centers (FQHC), academia, service providers, Community-based Organizations (CBO), People with HIV (PWH), and local advocates. The FCPN reviews and delivers feedback on projects the Florida Department of Health's HIV/AIDS Section develops, such as the Needs Assessment, the Statewide Coordinated Statement of Need (SCSN), and the Statewide Integrated Plan. All principal parties involved with the local IP are also a part of the State IP and many local partners serve as members of the FCPN. There is a substantial cross-collaboration among local and State levels which ensures alignment of strategies, goals, and objectives. This is critically important as Florida's HIV rates continue to rank among the highest in the United States.

The Community HIV/AIDS Advisory Group (CHAG) is another statewide advisory group. The primary function of the CHAG is to provide meaningful input into the development of Florida Department of Health (FDOH) policies and programs that impact persons with HIV (PWH). The group is comprised of persons with HIV from each of Florida's 14 service areas including the Tampa-St. Petersburg EMA. CHAG members regularly disseminate information to and solicit input from both the Care Council and HPP.

On November 5, 2021, Tampa Mayor Jane Castor signed an Executive Order for the City of Tampa to be designated a Fast-Track City by the International Association of Providers in AIDS Care (IAPAC). Tampa is the second city in Florida to join a network of more than 350 cities committed to ending the urban HIV epidemic by 2030. Representatives from the Part A Recipient's Office, The AIDS Institute, METRO Inclusive Health, EPIC, USF Health/Tampa General Hospital, the HIV/AIDS Program Coordinators (HAPCs) for both Pinellas and Hillsborough counties, and persons with HIV, and other community members are all members of the Tampa Fast-Track City Taskforce that will lead the efforts of this initiative. The Fast-Track City Taskforce has decided not to create a separate planning body, but to cooperate and coordinate with the existing HIV planning bodies.

All EHE partners including the CDC funding for EHE in Pinellas and Hillsborough County as well as the HRSA EHE funded programs are all involved in the Fast-Track project. A planning meeting was held on March 24, 2022, sponsored by IAPAC and The AIDS Institute to plan and discuss strategies related to further integration of EHE with the Fast-Track project. Plans include the identification of new opportunities to involve the entire community from a grass roots level and ensuring there will be linkage with the new EHE website that is being implemented locally with the Fast-Track dashboard which includes an international group of participating cities and municipalities. A challenge noted is the fact that there are multiple planning groups in the area all working on accomplishing the same goal: Ending the HIV Epidemic and Getting to Zero. Staff are working at capacity already and community volunteers who are already involved are reaching overload and burnout. To avoid duplication of efforts, the EMA will collaborate with existing groups, whenever possible.

d. Collaboration with RWHAP Parts

Three Ryan White Parts are represented in the EMA: Parts A, B, and D. Parts A and B funds are planned concurrently through the Care Council to ensure appropriate allocations, with Part D represented on the Care Council and with a well-established linkage and coordination of services. Collaboration is accomplished through both virtual and face-to-face meetings between the groups listed above on a routine basis. For example, the Florida Comprehensive Planning Network (FCPN) meets semi-annually and includes representatives from all geographic areas and principal grant program of Florida. On the local level, the combined Parts A & B Care Council meets monthly through both virtual and face-to-face meetings, with members from each EMA county and counties served by Ryan White Part B.

The Care Council includes health care providers, including Federally Qualified Health Centers; community based organizations serving marginalized populations and AIDS service organizations; social service providers, including housing services; mental health providers; substance misuse treatment and counseling providers; local public health agencies; hospital planning agencies or heath care planning agencies; people with HIV and historically underserved groups and sub-populations; non-elected community leaders; Medicaid representatives;

representatives for Ryan White Parts B, and D; recipients under federal HIV programs; and individuals who have experienced incarceration; and members of the Care Council's Women, Infants, Children, Youth, and Families (WICY&F) workgroup committee.

The WICY&F workgroup was restructured in September 2021 to ensure the active and meaningful participation of all its members by rotating a different facilitator to conduct each monthly meeting. This structural change ensures the full engagement of every member of the WICY&F workgroup. The workgroup comprises persons with lived HIV experience, voting and non-voting members of the Care Council, who are the voices of the WICY&F community and integral to the implementation of the Integrated Plan. During the planning process, two members of WICY&F were actively engaged with the writing team. In addition, the WICY&F workgroup openly discussed and reviewed revised language, updated goals, objectives, and activities outlined in the Integrated Plan. The WICY&F workgroup is committed to being culturally reflective, inclusive, and affirming in all its collaborative activities. These activities include providing ongoing qualitative and quantitative input to the Care Council. The WICY&F workgroup leads focus group-style meetings within communities being served and hosts meaningfully inclusive town hall events. The primary aim of this workgroup is to identify what is working well, what needs to be improved, barriers to prevention, access, retention in care, emerging and other unmet needs in the Tampa–Saint Petersburg EMA. Furthermore, this workgroup reviews epidemiological data, demographic trends, allocation of resources, needs assessments and related surveys, and the annual Client Satisfaction Survey to form recommendations that will improve overall health outcomes and wellness within all WICY&F communities.

e. Engagement of People with HIV

The Tampa-St. Petersburg EMA holds community input as the core component of providing HIV services and programs. The main sources of community input are local and State HIV client needs assessments and the members of the West Central Florida Ryan White Care Council; 41% of members are People with HIV (36% unaffiliated with funded providers). Activities are guided by the National HIV/AIDS Strategy 2022-2025 and the HIV care continuum. Key partners and stakeholders are actively involved in the HIV planning processes and were intimately involved in the development of the Integrated Plan, from stakeholder identification, to community engagement, to drafting pieces of the Plan (with so many pieces relying on community input for their development) including the goals and objectives, to commenting on said pieces, suggesting revisions, reviewing the revisions, and finally to accepting the Plan through formal voting at the Care Council. The Integrated Plan is designed to be a living document, meaning that future changes, revisions, evaluation, etc. will all rely heavily on collaborations, continued partnerships, and community involvement.

The EMA regularly engages the community for input into the local HIV system. Methods for engaging the general community include HIV/AIDS awareness and testing day events, EHE events and community meetings, health fairs and community-events, targeted interventions, and HIV testing. Clients are regularly surveyed for customer satisfaction by the Part A Recipient and Part B Lead Agency as a part of the EMA's quality management program. In addition to the system-wide customer satisfaction surveys, some sub recipients conduct their own individual surveys for customer satisfaction, to identify gaps in services and needs that may or may not be funded at the current time. These surveys are conducted on an ongoing, as needed, basis to ensure that those living with HIV have a voice in decisions made on their behalf. The community assessment serves

as the basis for identifying populations at risk for acquiring HIV in Florida, the prevention needs of those populations, and the activities/interventions being implemented to address those needs and service gaps. The Care Council regularly reviews and establishes service priority ranks for all Ryan White service categories in the EMA and reviews the HIV care continuum of the United States, Florida, the EMA, along with local special populations. People with HIV (PWH) are involved in the priority setting process in several key ways. The Ryan White Needs Assessment includes the process of establishing priorities and allocating resources based on community input. The Care Council is responsible for overseeing the completion of the annual needs assessment and each element of the EMA's Integrated Plan.

The Care Council considers 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 (PWH). The Care Council utilizes the results of these surveys when setting priorities and allocating funding. In 2019, the service area collected a total of 1,014 HIV Care Needs Surveys from People with HIV. This data was reviewed and utilized by the Care Council's former Planning and Evaluation committee to re-prioritize services. The committee oversaw the design of instruments and developed the final priority rankings for Care Council adoption. PWH were represented on the Care Council, the group ultimately responsible for adopting priorities and allocations. All committee and Care Council meetings were open to the public and included an agenda item for community input. The Care Council continues 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 Care Council and the Recipient, reviews the annual Women, Infants, Children, Youth, and Families (WICY&F) expenditure data to ensure that resource allocations are consistent and in proportion to the percentages of the EMA's reported HIV cases to provide services to these populations.

The Ryan White needs assessment includes the process of establishing priorities and allocating resources based upon community input. The Care Council was responsible for overseeing the completion of the EMA's needs assessment. The needs assessment utilizes client surveys, focus groups, town hall meetings, epidemiological data, service utilization and expenditure data, analysis of public funding streams, and estimates of unmet need. The needs assessment components were presented to the Care Council for adoption. Similarly, members of the Care Council and other interested community members will be actively included in the implementation, monitoring, evaluation, and improvement of the Integrated Plan (IP). Members also volunteered to provide perspective during the IP writing process to ensure meaningful engagement of People with HIV.

f. Priorities

The Integrated Plan addresses the 2022–2025 National HIV/AIDS Strategy's (NHAS) four goals: 1. Prevent new HIV infections; 2. Improve HIV-related health outcomes for people with HIV; 3. Reduce HIV-related disparities and health inequities; and 4. Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders. The EMA's local priorities align with the NHAS, and the four pillars outlined in Ending the HIV Epidemic (EHE): diagnose, treat, prevent, and respond. All goals and objectives, in the EMA's existing three EHE plans for Hillsborough and Pinellas Counties, include various local initiatives with some overlap between several Centers for Disease Control (CDC) and HRSA grants.

Due to the disproportionate impact of HIV within Black and Latinx populations, local efforts throughout the Ryan White/EHE patient care and CDC/EHE funded prevention grants have determined to focus on Latinx, Black, and Youth (13-24) populations. Within these populations there is a special emphasis on those who engage in male-to-male sexual contact (MMSC) and Women of Childbearing Age (WCBA).

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

While setting goals and priorities, Demanding Better: An HIV Federal Policy Agenda by People Living with HIV was referenced to ensure the Meaningful Involvement of People with HIV/AIDS (MIPA) in decision-making, at every level of the response. In Demanding Better, The United States People Living with HIV (PLHIV) Caucus outlines five recommendations which must be centered in every aspect of the federal HIV response: 1. Concretely elevating the meaningful involvement of people living with HIV and disproportionately impacted communities in the HIV response; 2. Proactively creating an affirming human rights environment for people living with HIV; 3. Addressing inequities in the federal response by attending to racial and gender disparities; 4. Adding sex workers and immigrants living with HIV as priority populations; and 5. Affirmatively committing to improving quality of life for people living with HIV. MIPA requires dedication, planning and assessment, organizational buy-in, and a champion to help usher its development and continued assessment. Although The HIV National Strategic Plan did not largely address these recommendations in the final version, the EMA's Integrated Plan will do so to the greatest extent possible, as they were created by and for people living with HIV.

g. Updates to Other Strategic Plans Used to Meet Requirements

The jurisdiction did not use portions of other local strategic plans to satisfy this requirement. This section was written solely for the inclusion in the Tampa-St. Petersburg EMA Integrated HIV Prevention and Care Plan, 2022-2026.

Stakeholders and planning bodies will be updated on progress made implementing the Integrated Plan on an annual basis. Reports on plan progress will be presented to the West Central Florida Ryan White Care Council on a quarterly basis, as monitored by Ryan White Planning Council Support (PCS) staff. Planning bodies will utilize regularly collected surveillance and survey data, data collected from local and state needs assessments, focus groups, monthly town halls, and community forum feedback to update the Integrated Plan, on an as needed basis. These pieces will be utilized when ranking service priorities and allocating funding to care services and prioritizing prevention activities in the local area. Plan improvements are contingent on several factors that must be considered over time including changing regulations and requirements, data limitations, shifts in funding, and the ongoing COVID-19 pandemic. As such, goals, objectives, and strategies will be fluid and may be adjusted as needed to respond to programmatic, funding and/or policy changes.

Continual monitoring of plan implementation will assist planning groups, such as Ending the HIV Epidemic (EHE) CDC Initiatives in Pinellas and Hillsborough Counties and the EHE HRSA Initiative for Pinellas and Hillsborough Counties, in making decisions that are data driven. Monitoring and evaluation of the goals, objectives, and strategies will be executed through a collaborative partnership between HIV prevention and care-funded grantees and providers.

The EMA monitors surveillance data provided by the Florida Department of Health and analyzes local program data to assess and improve health outcomes along the HIV Care Continuum. Client level data for Ryan White-funded services in the EMA is reported in CAREWare for Ryan White Part B (patient care), e2Hillsborough for Part A, and tracked by the Clinical Quality Management (CQM) program. The CQM program is a collaborative initiative between the Ryan White Part A Recipient, the local Ryan White Part B Lead Agency, providers within the service area, and the subcontracted CQM provider. The primary purpose of the program is to improve the quality of care and services and improve health outcomes and quality of life for people with HIV. The CQM program reports their findings to community planning bodies to use as a reference tool when setting service priorities, allocating resources, and determining needed updates to their respective workplans.

The EMA strives to actively involve key partners, stakeholders, and People with HIV and, in doing so, incorporates feedback received, for the Integrated Plan and otherwise, on an ongoing basis. The jurisdiction understands that to best serve those most marginalized, their voices must be involved in all aspects of the process. “Nothing about us, without us” is a call to action that informs the need for cultural shifts in programming, provisions of services, and community engagement. Changes have already been made to the planning process, such as within the Care Council, where a greater focus has been placed on creating an environment that is more welcoming to prospective members who represent communities most affected by HIV. Cultural humility workshops are a new addition to Care Council programming and have been successful, thus far, in meeting people where they’re at. With greater representation comes additional perspectives that are pivotal to evaluating and improving all planning processes, including the Integrated Plan (IP). The IP will be reviewed on an ongoing basis and modifications to the IP will be addressed on an as needed basis. For example, on the previous IP the EMA revised outcomes and data points on multiple occasions when it became clear that certain data points, originally proposed, would be unable to be collected or reported. They were then modified based on the data that was confirmed to be accessible at that time.

Section III: Contributing Data Sets and Assessments

1. Data Sharing and Use

Progress has been made recently with the approval of a Data Sharing Agreement (DSA) between the Tampa-St. Petersburg Eligible Metropolitan Area (EMA) and the Florida Department of Health (FL-DOH) which was finalized in September 2022. The document, as originally drafted, is comprised of six sections. The first section outlines the scope of the agreement, which briefly outlines the data sharing agreement. The second section provides definitions for the terms germane to the agreement. To date, there are five terms in this section, being Active Consent, Client Care Data, HIV, Linkage Module, and Linkage Care Activities. The next section cites the Florida Statutes that outline the legal authority of the data sharing agreement. The fourth section discusses the terms of agreement, stating when the agreement begins and terminates. The fifth section

discusses the responsibilities of FL-DOH and Hillsborough County Government. As originally written, FL-DOH would be responsible for matching Hillsborough County's data on a quarterly basis and report the data back to them. Hillsborough County Government would be responsible for providing data to FL-DOH for matching, enter client outcomes data, ensure data is stored and transferred safely, maintain a list of personnel who have access to the data, language stating that the data to be collected and reported will be done so only for official reasons, data storage, and notifying FL-DOH within 24 hours in the event of a data breach. The sixth section is entitled Special Provisions, listing 14 additional items tied to the execution of the agreement. An additional section is under consideration by at least one of the other Florida Part A jurisdictions, which offers language on indemnification and hold harmless.

The Part A Recipient determined that the current version of the client consent form used for e2Hillsborough (the EMA's Part A data system) needed to be revised as it was very restrictive as to who had access to patient level data, and it did not allow any party other than Recipient staff to have access to the Part A data; therefore, DSA's among individual subrecipients in the EMA are needed which are currently being drafted between the EMA subrecipients and the FL-DOH, which will serve as an interim solution until enough time has passed that sufficient data has been accumulated in e2Hillsborough.

Now that the DSA has been formalized, the Recipient and FL-DOH are addressing the logistics involved in the implementation of data sharing across FL-DOH and Hillsborough County Government as Recipient. Hillsborough County Government allocates a portion of its annual Part A administration funding to maintain e2Hillsborough and will potentially need to allocate additional funding for further automation to implement data sharing. Testing and quality checks will be necessary to ensure these changes are made strategically while maintaining all the safeguards for clients, subrecipients, and federal funders to the greatest extent possible. The revised consent form is being implemented to coincide with the DSA.

Prior to the formal DSA, historically the Ryan White Part A office and its providers have had local agreements with FL-DOH to ensure data can move between care providers to coordinate efficient and timely manner. The Part A EMA and FL-DOH utilize separate databases for patient care client-level data. Part A utilizes e2Hillsborough, developed by RDE Systems. FL-DOH utilizes CAREWare for most of its patient care data and uses Provide Enterprise for its AIDS Drug Assistance Program (ADAP) client-level data. As currently configured, there are no built-in mechanisms for data transfer between databases. Local Part B leadership at the Department of Health in Pinellas County has been accommodating in the facilitation of data exchange, particularly as it pertains to prevention activities within the service area, providing value to the work being done through Early Intervention Service (EIS) programs.

Regarding *informal* existing data sharing agreements that are *still in place* through the network, almost all the HIV service providers with one exception receive funding through Part A and Part B. Since these providers access both Part A and FL-DOH client databases to store client-level data, this has served as a work-around to formal data sharing agreements since these providers access both Part A and FL-DOH client databases to store client-level data. As of the writing of this document, existing data sharing agreements amongst the west central Florida Ryan White providers are local and informal between leadership at Part B, Florida Department of Health in Pinellas County, the local county health departments, and Part A. In most instances these agreements are in place between Part A providers and certain databases for reporting and tracking.

For example, one of the currently funded Ending the HIV Epidemic (EHE) initiative providers, through an agreement with the local Department of Health Part B program, accesses prevention data through CAREWare to assist them in their Early Intervention Services (EIS) efforts. Collaborative efforts began in earnest approximately two years ago to develop and implement formalized parameters in a meeting held in Palm Beach County with the HIV/AIDS Program Coordinators (HAPCs) and Florida Department of Health leadership. These meetings were held to identify the essential elements to be established to execute a workable data sharing agreement. Those meetings resulted in the Florida Department of Health drafting a data sharing and use document designed to achieve a more formalized agreement between itself and each of the Ryan White Part A jurisdictions.

One of the primary concerns noted by area leadership is potentially losing people to care, whether they are newly diagnosed individuals or those who have been seen by a medical professional within the last 12 months. The lack of a formal mechanism up until recently for data sharing may result in unnecessary delays in successfully engaging and retaining people in medical care. Currently, the Ryan White funded providers must make multiple phone calls to obtain consents and clearances to contact individuals. The new DSA's will facilitate the flow of information to ensure people are contacted quickly and linked seamlessly into the necessary care.

2. Epidemiologic Snapshot

Geographic Region

The Tampa-St. Petersburg Eligible Metropolitan Area (EMA) consists of four counties: Hernando, Hillsborough, Pasco, and Pinellas. The total population is approximately 3.2 million, of which 62% are White (non-Latinx), 21% are Latinx, 12% are Black (non-Latinx), and 6% are other racial and ethnic categories. Women represent 51% of the total population. The image below illustrates the geographic layout of the EMA.

Tampa-St. Petersburg EMA
Geographic Layout

Socio-demographic Characteristics of Region

The following data provides a description of the demographic, geographic, socioeconomic, behavioral, and clinical characteristics of persons newly diagnosed with HIV, persons with HIV, 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 snapshot focuses on the most recent year for which data is available, along with five-year trend data as appropriate.

The socioeconomic status of individuals living in the EMA varies throughout the four-county area. Selected characteristics are displayed in **Figure 1**.

Figure 1: Tampa-St. Petersburg EMA Socioeconomic Profile, 2016-2020

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 (%)	No health insurance coverage (%)	Civilian labor force unemployed (%)
Hillsborough	1,451,358	60,566	14.0	88.9	34.5	12.2	5.2
Hernando	190,700	50,280	14.4	88.4	19.1	12.5	6.9
Pasco	539,885	53,431	12.3	89.9	24.6	11.5	6.0
Pinellas	970,985	56,419	11.6	91.6	32.5	10.7	5.2

Source: United States Census Bureau, American Community Survey (ACS) 5-year estimates, 2016-2020.

According to the Florida Department of Health's Epidemiological Profile, new HIV cases (incidence) in the EMA increased 6.2% from 2016 to 2018 and decreased 17.9% from 2018 to 2020, for an overall decrease of 12.8% from 2016 to 2020. New cases of AIDS increased 2.5% from 2016 to 2017 and decreased 22.7% from 2017 to 2020, for an overall decrease of 17.2% from 2016 to 2020. The decrease in new HIV/AIDS cases in 2020 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 of HIV and AIDS, from 2016 to 2020, are shown in **Figure 2**.

Figure 2: Tampa-St. Petersburg EMA Epidemiological Profile, 2016-2020

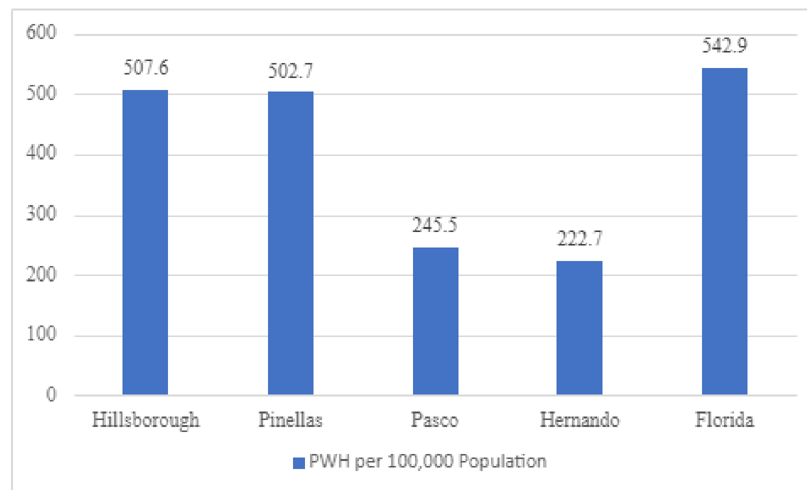
	CY 2016		CY 2017		CY 2018		CY 2019		CY 2020	
	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence	Incidence	Prevalence
HIV	530	6,357	544	5,599	563	6,603	538	6,707	462	6,816
AIDS	279	7,455	286	7,466	264	7,410	255	7,395	231	7,414
TOTAL		13,812		13,065		14,013		14,102		14,230

Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2016, 2017, 2018, 2019, 2020. Note: HIV diagnoses cannot be added with AIDS diagnoses to get combined totals, since these categories are not mutually exclusive.

Characteristics of People with HIV

Within the four EMA counties of Hernando, Hillsborough, Pasco, and Pinellas, Hillsborough County has the largest population and the largest prevalence of HIV and AIDS, followed by Pinellas, Pasco, and Hernando respectively. Prevalence is defined by the National Institutes of Health as the proportion of a population who have a specific characteristic in a given time period. In this instance, prevalence is the number of people living in the EMA who have ever been diagnosed with HIV or AIDS. In calendar year (CY) 2020, there were 7,518 People with HIV (PWH) in Hillsborough County, 4,959 PWH in Pinellas County, 1,325 PWH in Pasco County, and 428 PWH in Hernando County. **Figure 3** shows prevalence rates per 100,000 population for each county, compared to Florida as a whole. In CY 2020, Hillsborough County had 507.6 PWH per 100,000 population, Pinellas County had 502.7 PWH per 100,000 population, Pasco County had 245.5 PWH per 100,000 population, and Hernando County had 222.7 PWH per 100,000. The prevalence of HIV for the State of Florida is 542.9 PWH per 100,000. According to the Centers for Disease Control and Prevention (CDC), approximately 13% of PWH in Florida are unaware of their status.

Figure 3: Tampa-St. Petersburg EMA
People with HIV (PWH) Per 100,000 Population, 2020

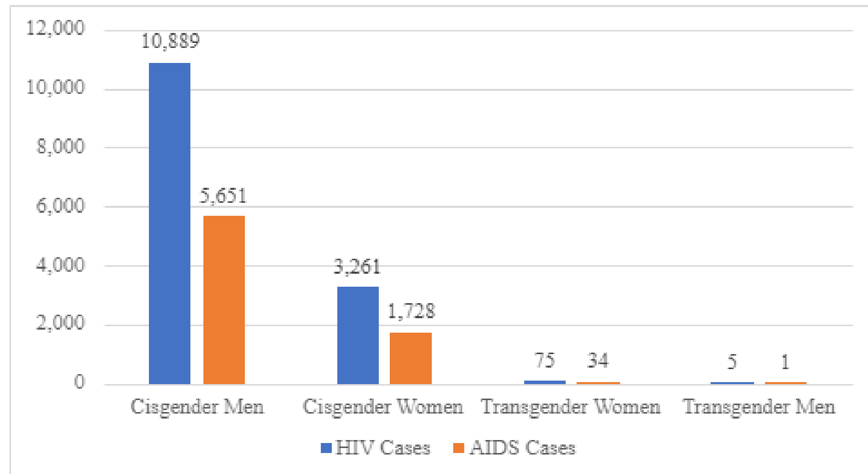


Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2020.

In the EMA, cisgender (a person whose gender corresponds with their birth sex) men comprise approximately 49% of the population but represent a majority of HIV and AIDS cases. In 2020, cisgender men represented 76.5% of HIV prevalence (10,889 cases) and 76.2% of AIDS prevalence (5,651 cases); cisgender women represented 22.9% of HIV prevalence (3,261 cases) and 23.3% of AIDS prevalence (1,728 cases). Starting in 2020, 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 are incorrectly attributed as men and many transgender men are categorized as women. Transgender women represent 0.5% of both HIV (75 cases) and AIDS prevalence (34 cases), and transgender men represent 0% of HIV (5 cases) and AIDS prevalence (1 case). 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 4** shows the prevalence of HIV and AIDS by gender.

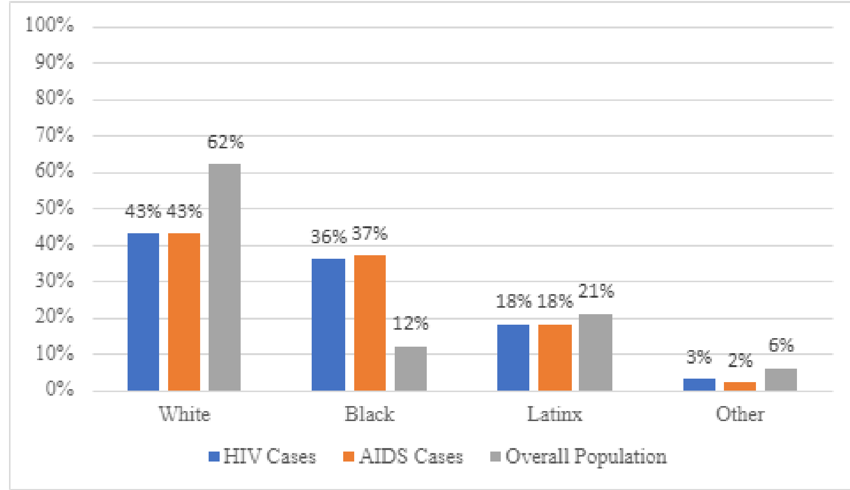
Figure 4: Tampa-St. Petersburg EMA
HIV/AIDS Prevalence by Gender, 2020



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

In CY 2020, White individuals in the EMA represented 62% of the population and 43% of all HIV cases. Black individuals accounted for 36% of all HIV cases and Latinx individuals accounted for 18% of all HIV cases. White individuals represented the largest prevalence of AIDS cases in the EMA with 43%, followed by Black individuals with 37%, and Latinx individuals with 18%. Black individuals were disproportionately impacted by HIV/AIDS representing 36% of HIV cases and 37% of AIDS cases, although only 12% of the EMA's total population was Black. **Figure 5** shows 2020 HIV and AIDS prevalence by race, compared to population totals.

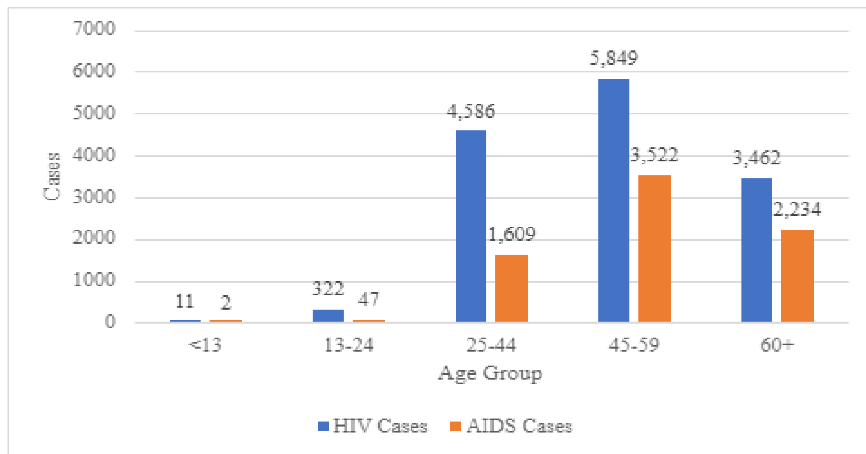
Figure 5: Tampa-St. Petersburg EMA
HIV/AIDS Prevalence by Race, Compared to Overall Population, 2020



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

Over the past five years, there have been increases and minimal decreases in HIV/AIDS prevalence among all races. Latinx individuals in the EMA saw the greatest increase (12.1%) in HIV/AIDS prevalence from 2,308 cases in 2016 to 2,587 cases in 2020, followed by Black individuals (3.7%) HIV/AIDS prevalence from 4,995 to 5,182 cases over the same five-year period. White individuals in the EMA experienced a 1.3% decrease in HIV/AIDS prevalence from 6,172 cases in 2016 to 6,090 cases in 2020. Prevalence of HIV/AIDS among "Other" races, combined, increased (10.1%) from 337 cases to 371 cases. Within the "Other" racial category, the most significant change was in Asian individuals who saw an increase (34.9%) of cases from 106 in 2016 to 143 in 2020. When stratified, changes in HIV/AIDS prevalence among the other individual races within this category were negligible.

Figure 6: Tampa-St. Petersburg EMA
HIV/AIDS Prevalence by Age, 2020



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

Figure 6 shows HIV and AIDS prevalence by age group. In CY 2020, the age group with the largest number of HIV and AIDS cases was 45-59-year-olds, with 5,849 cases of HIV and 3,522 cases of AIDS. People in the 25-44 age group had the second highest number of HIV cases (4,586) and the third highest number of AIDS cases (1,609). People in the 60 and up age group had 3,462 cases of HIV and 2,234 cases of AIDS. People in the 13-24 age group had 322 cases of HIV and 47 cases of AIDS and people under age 13 had 11 cases of HIV and 2 cases of AIDS.

Figure 7 shows conditions co-occurring with HIV within the Tampa-St. Petersburg EMA during calendar year (CY) 2020. There were 432 co-occurring cases of gonorrhea among PWH in 2020, 414 cases of chlamydia, and 388 cases of early syphilis. 3,768 PWH within the EMA report history of substance use and 1,184 report history of mental illness.

Figure 7: Conditions Co-Occurring with HIV within the Tampa-St. Petersburg EMA, 2020

Co-occurring condition	Number	Rate per 1,000 PWH
Hepatitis B	36	2.5
Hepatitis C	67	4.7
Tuberculosis	5	0.4
Early Syphilis	388	27.3
Gonorrhea	432	30.4
Chlamydia	414	29.1
History of mental illness	1,184	83.2
History of substance use	3,768	264.8
Homeless at year-end	52	3.7
Inmates living with HIV released in 2020	84	5.9

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

Sociodemographic indicators of PWH 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 PWH. According to the final analysis of the 2019 HIV Care Needs Survey, 48% of PWH in the EMA are unemployed and 15% of PWH have no form of insurance. Furthermore, 79% of EMA survey respondents reported incomes below the Federal Poverty Level (FPL). **Figure 8** shows healthcare coverage and poverty levels of people receiving Ryan White services within the EMA. These numbers do not represent all PWH within the EMA, just those receiving Ryan White services.

Figure 8: Tampa-St. Petersburg EMA
Healthcare Coverage and Poverty Levels of Ryan White Clients, 2020-2021

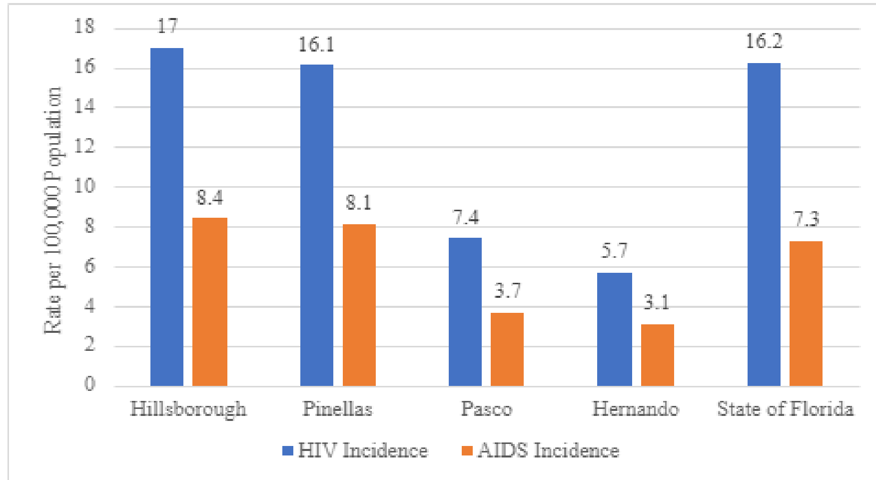
Tampa-St. Petersburg EMA Ryan White Clients	Number	Percentage
Enrolled in Medicaid	1,763	27.26
Enrolled in Medicare	1,600	24.74
Enrolled in Private Insurance (Employer)	662	10.24
Enrolled in Private Insurance (Individual)	801	10.75
No insurance	2,068	12.38
Living at or below 138% FPL	4,216	65.18
Living at or below 400% FPL*	6,435	99.49

Source: e2Hillsborough, September 17,2020-September 17, 2021
*Percentage of Federal Poverty Level (FPL) used to determine Ryan White eligibility.

Characteristics of New Diagnoses/Incidence

Within the four EMA counties of Hernando, Hillsborough, Pasco, and Pinellas, Hillsborough County has the largest population and the largest number of new HIV and AIDS cases (incidence), followed by Pinellas, Pasco, and Hernando. HIV/AIDS incidence is defined as the number of new cases of HIV or AIDS that develop in a given time frame. Between 2016 and 2020, there were 1,462 new cases of HIV and 714 new cases of AIDS in Hillsborough County, with a rate of 17.0 new HIV diagnoses per 100,000 population and 8.4 new AIDS diagnoses per 100,000 population in 2020. Over the same five-year period, there were 875 new cases of HIV and 448 new cases of AIDS in Pinellas County, with a rate of 16.1 new HIV diagnoses per 100,000 population and 8.1 new AIDS diagnoses per 100,000 population in 2020. From 2016 to 2020, Pasco County had 227 new cases of HIV and 108 new cases of AIDS, with a rate of 7.4 new HIV diagnoses per 100,000 population and 3.7 new AIDS diagnosis per 100,000 in 2020. Over the same five-year period, Hernando County had 73 new cases of HIV and 45 new cases of AIDS, with a rate of 5.7 new HIV diagnoses per 100,000 population and 3.1 new AIDS diagnosis per 100,000 in 2020. **Figure 9** shows the incidence rates for HIV and AIDS in each county in 2020, compared to the State of Florida as a whole.

Figure 9: Tampa-St. Petersburg EMA
HIV/AIDS Incidence Per 100,000 Population, 2020



Source: Florida Department of Health, FLHealthCharts.gov, 2020.

New cases of HIV by county are shown in **Figure 10** and new cases of AIDS are shown in **Figure 11.** All counties have seen decreases in HIV and AIDS cases between 2016 and 2020, except for Pasco which had a slight increase in AIDS cases. As stated above, decreases in HIV incidence between 2019 and 2020 should be interpreted with caution, due to the impact of the COVID-19 pandemic on access to HIV testing. New cases of HIV in Hillsborough County increased by 4% between 2016 and 2018 and decreased 20% between 2018 and 2020, for an overall decrease of 16.8% over the five-year period. New cases of AIDS in Hillsborough County increased by 2% between 2016 and 2017 and decreased 18.8% from 2017 to 2020, for an overall decrease of 17.2% over the five-year period. New cases of HIV in Pinellas County increased by 17.7% between 2016 and 2019 and decreased 17.6% between 2019 and 2020, for an overall decrease of 3%. New cases of AIDS in Pinellas County decreased by 20.8% over the five-year period, with just a small increase of 4.7% between 2018 and 2019. New cases of HIV in Pasco County increased by 13% between 2016 and 2018 and decreased by 23% between 2018 and 2020, for an overall decrease of 13% over the five-year period. New cases of AIDS in Pasco County increased by 64.7% between 2016 and 2017 and decreased by 28.6% from 2017 to 2020, for an overall increase of 17.6% over the five-year period. (Contextually, this change was an increase from 17 cases in 2016 to 20 cases in 2020.) New cases of HIV in Hernando County have decreased by 35.3% over the five-year period, from 17 cases in 2016 to 11 cases in 2020. New cases of AIDS in Hernando County increased slightly between 2016 and 2018, from 10 cases in 2016 to 13 cases in 2018, and decreased 53.8% from 2018 to 2020, from 13 cases to 6 cases.

Figure 10: Tampa-St. Petersburg EMA
HIV Incidence by County, 2016-2020

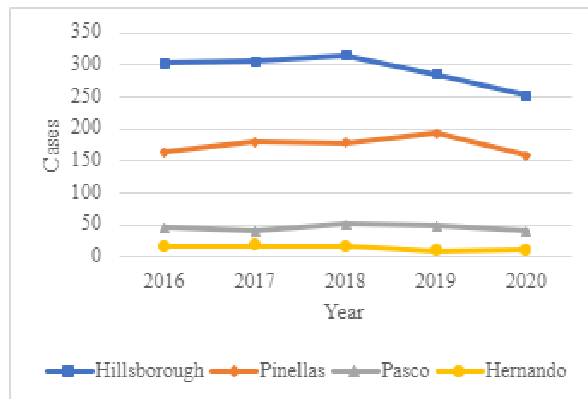
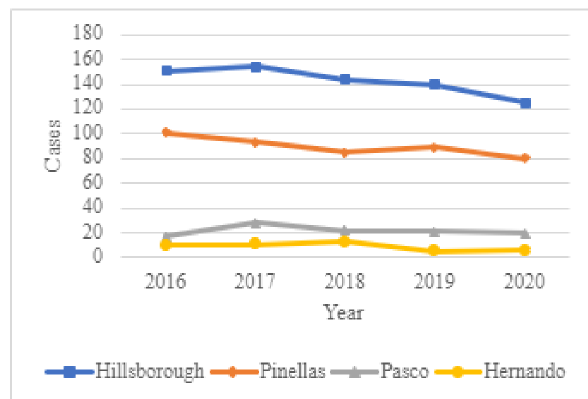


Figure 11: Tampa-St. Petersburg EMA
AIDS Incidence by County, 2016-2020



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2016, 2017, 2018, 2019, 2020.

The incidence of HIV among cisgender men in the EMA increased from 416 cases in 2016 to 465 cases in 2018 and decreased from 465 in 2018 to 365 in 2020, an overall decrease of 12.3% over the five-year period. During the same time frame, new HIV cases among cisgender women decreased from 108 cases in 2016 to 92 cases in 2020, a 14.8% decrease. The incidence of AIDS in cisgender men decreased 24.4%, from 221 in 2016 to 167 cases in 2020. The incidence of cisgender female AIDS cases increased 16.7%, from 54 cases in 2016 to 63 cases in 2020.
Among transgender individuals, there was a small decrease in HIV incidence among transgender women with 6 cases in 2016 and 5 cases in 2020. There was one case of HIV in a transgender man in 2017 and no other cases reported in 2016, 2018, 2019, or 2020. The incidence of AIDS in transgender women decreased slightly with 4 cases in 2016 and 1 case in 2020. There were no cases of AIDS reported in transgender men over the five-year period. New cases of HIV by gender are shown in **Figure 12** and new cases of AIDS by gender are shown in **Figure 13**. As stated above, these number may be underestimated, as many transgender women may be incorrectly categorized as men and transgender men may be incorrectly categorized as women. Due to stigma, many people of transgender experience will not disclose their authentic gender to providers for fear of mistreatment and discrimination. Consideration should also be made for the absence of a

third transgender identification option, as 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 12: Tampa-St. Petersburg EMA HIV Incidence by Gender, 2016-2020

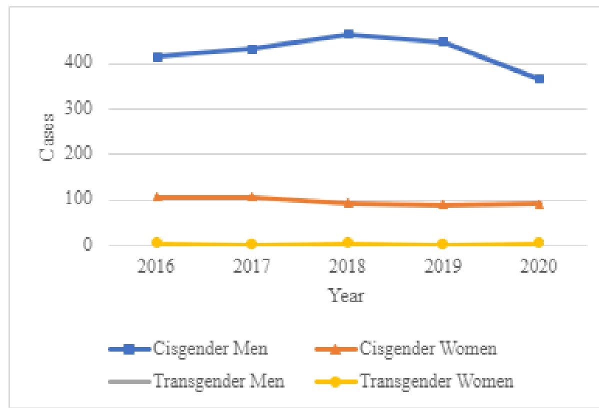
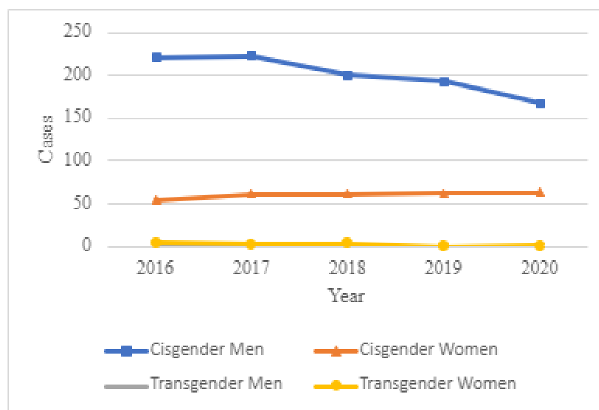


Figure 13: Tampa-St. Petersburg EMA AIDS Incidence by Gender, 2016-2020



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2016, 2017, 2018, 2019, 2020.

In the EMA from 2016-2020, the highest number of new cases of HIV and AIDS have been in Black individuals with 1,038 new cases of HIV and 552 new cases of AIDS, followed by 934 new cases of HIV and 456 new cases of AIDS in White individuals, and 581 cases of HIV and 266 cases of AIDS in Latinx individuals. While Black persons make up just 12% of the overall population of the EMA, 39% of new HIV cases and 42% of new AIDS cases between 2016 and 2020 were in Black persons. Latinx persons make up 21% of the population and 22% of new HIV cases and 20% of new AIDS cases. White persons make up 62% of the population, but just 35% of new HIV cases and 35% of new AIDS cases. New cases of HIV by race are shown in **Figure 14** and new cases of AIDS by race are shown in **Figure 15.**

Figure 14: Tampa-St. Petersburg EMA HIV Incidence by Race, 2016-2020

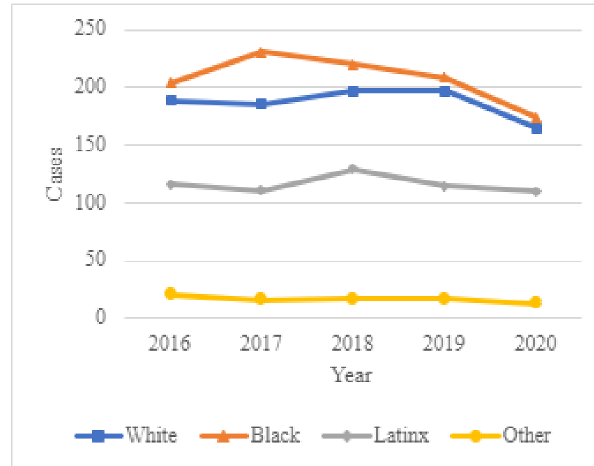
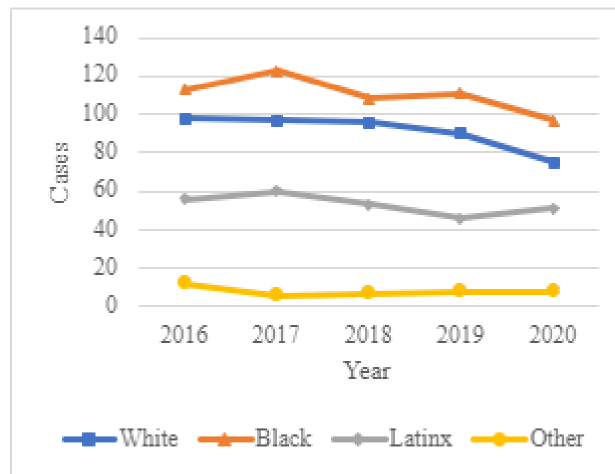


Figure 15: Tampa-St. Petersburg EMA AIDS Incidence by Race, 2016-2020



Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2016, 2017, 2018, 2019, 2020.

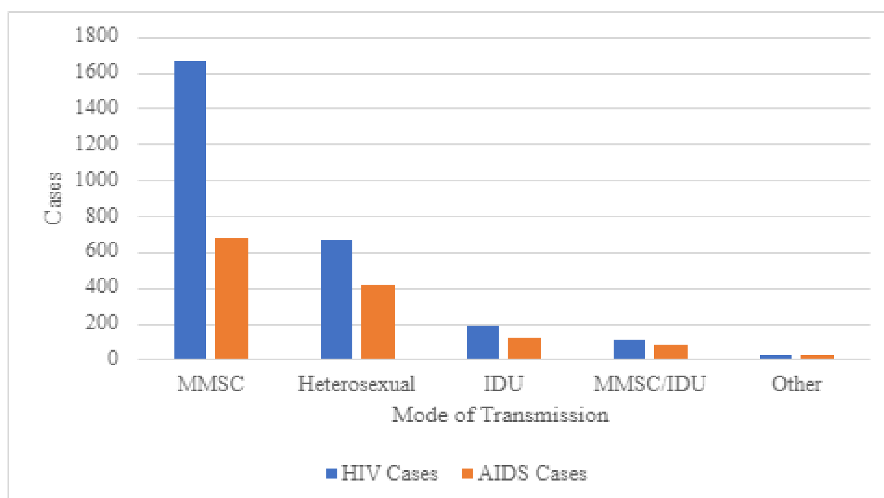
Between 2016 and 2020, HIV incidence decreased 14.7% among Black persons, decreased 12.7% among White persons, and decreased 5.2% among Latinx persons. As stated above, the decrease in HIV incidence between 2019 and 2020 should be interpreted with caution, due to the impact of the COVID-19 pandemic on access to HIV testing. 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 38% decrease in new HIV cases, from 21 cases in 2016 to 13 cases in 2020.

From 2016 to 2020, there was a decrease in AIDS incidence in White, Black, and Latinx populations, with the most significant decrease in White persons. From 2018-2020, the incidence of AIDS decreased 23.5% for White persons, 14.2% for Black persons, and 8.9% for Latinx

persons. The "Other" race category experienced a 33.3% decrease in new AIDS cases, from 12 cases in 2016 to 8 cases in 2020.

The most common mode of transmission for individuals diagnosed with HIV/AIDS in the EMA between 2016 and 2020 was cisgender male-to-male sexual contact (MMSC), accounting for 1,660 new cases of HIV and 678 new cases of AIDS. The second most common mode of transmission between 2016 and 2020 was heterosexual sexual contact, accounting for 662 new cases of HIV and 415 cases of AIDS. Injection drug use (IDU) accounted for 188 new cases of HIV and 123 new cases of AIDS. The transmission category of MMSC/IDU accounted for 106 new cases of HIV and 81 new cases of AIDS. Among transgender populations, sexual contact accounted for 18 new cases of HIV and 10 new cases of AIDS. Perinatal exposure accounted for 4 new cases of HIV over the five-year period and 0 new cases of AIDS. New cases of HIV and AIDS from 2016 to 2020 by mode of transmission are summarized in **Figure 16**.

Figure 16: Tampa-St. Petersburg EMA
HIV/AIDS Incidence by Mode of Transmission, 2016-2020

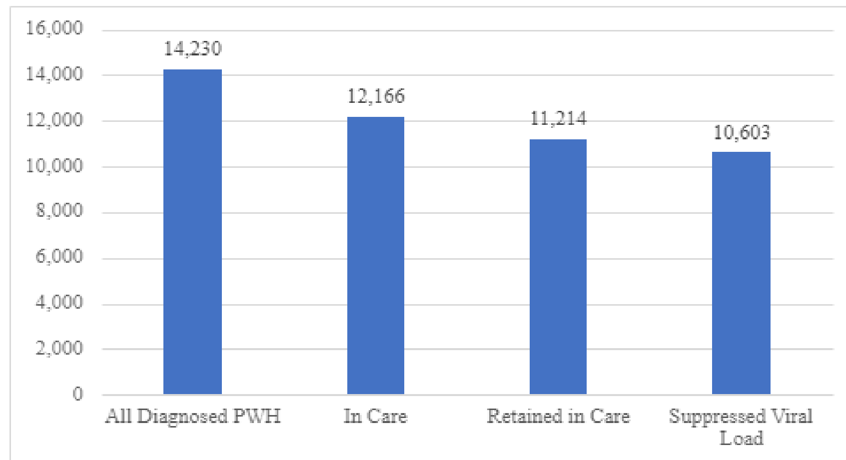


Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2016, 2017, 2018, 2019, 2020.

Of these transmission categories, MMSC among White cisgender men accounted for 596 new cases of HIV and 250 new cases of AIDS from 2016 to 2020. While Black individuals comprise just 12% of the overall population of the EMA, MMSC among Black cisgender men accounted for similar numbers of new HIV and AIDS cases as their White counterparts with 591 new cases of HIV and 252 cases of AIDS from 2016 to 2020. Among cisgender women, heterosexual contact mode of transmission category, Black women accounted for 241 new cases of HIV and 148 new cases of AIDS from 2016 to 2020, while their White counterparts accounted for 78 new cases of HIV and 44 new cases of AIDS. Latinx women in this transmission category accounted for 73 new cases of HIV and 48 new cases of AIDS over the five-year period. Within the IDU mode of transmission category, White persons had the highest numbers of new HIV and AIDS cases from 2016 to 2020 with 122 new cases of HIV and 58 new cases of AIDS, followed by Black persons with 37 new cases of HIV and 37 new cases of AIDS and Latinx persons with 25 new cases of HIV and 25 new cases of AIDS.

Care Continuum

Figure 17: Tampa-St. Petersburg EMA
Number of PWH Engaged in Selected Stages of the Diagnosis-Based Continuum of HIV Care, 2020



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

Figure 17 depicts the EMA's diagnosis-based HIV Care Continuum. Definitions and data sources for the diagnosis-based Care Continuum are:

All Diagnosed PWH: the number of persons living with an HIV diagnosis in this area at the end of each respective calendar year, data as of 6/30/2021.

In Care: PWH with at least one documented viral load (VL) or CD4 lab, medical visit, or prescription from 1/1/2020 through 3/31/2021, data as of 6/30/2021.

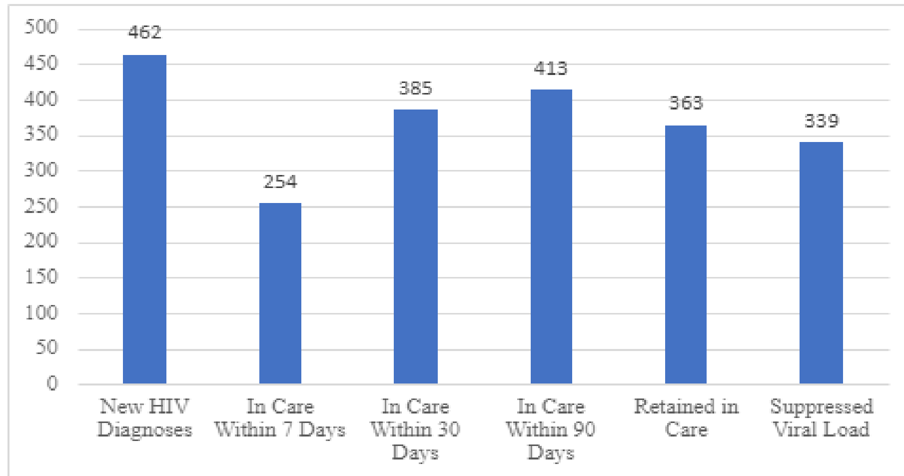
Retained in Care: PWH with two or more documented VL or CD4 labs, medical visits, or prescriptions at least three months apart from 1/1/2020 through 6/30/2021, data as of 6/30/2021.

Suppressed Viral Load: PWH with a suppressed VL (<200 copies/mL) on the last VL from 1/1/2020 through 3/31/2021, data as of 6/30/2021.

In CY 2020, 85.5% of PWH in the EMA were in care, 78.8% were retained in care, and 74.5% had a suppressed viral load. Of those retained in care, 89.9% had a suppressed viral load.

Figure 18 depicts the EMA's diagnosis-based HIV Care Continuum for new diagnoses. Of the 462 new diagnoses in CY 2020, 55% were in care within 7 days (254), 83.3% were in care within 30 days (385), 89.4% were in care within 90 days (413), 78.6% were retained in care (363), and 73.4% had a suppressed viral load (339).

**Figure 18: Tampa-St. Petersburg EMA
Number of New Diagnoses Engaged in Selected Stages of the Diagnosis-Based Continuum of HIV Care, 2020**



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

From 2016-2020, there have been significant increases in linking and engaging People with HIV to care within the EMA. In 2016, 81.1% of PWH were in care (compared to 85.5% in 2020), 72.2% were retained in care (compared to 78.8% in 2020), 63.9% had a suppressed viral load (compared to 74.5% in 2020), and 68.1% of new diagnoses were in care within 30 days (compared to 83.3% in 2020). Between 2019 and 2020, there were some slight decreases in linking and engaging PWH in care, likely due to the impact of the COVID-19 pandemic on access to care. Between 2019 and 2020, the percentage of PWH in care decreased slightly from 85.6% in 2019 to 85.5% in 2020 and the percentage of new diagnoses in care within 30 days decreased from 84.4% in 2019 to 83.3% in 2020. Encouragingly, between 2019 and 2020, the percentage of PWH retained in care increased from 78.2% in 2019 to 78.8% in 2020, and the percentage of PWH with a suppressed viral load increased from 73.6% in 2019 to 74.5% in 2020. These increases in retention in care and viral load suppression may be due to the expanded use of telehealth within the EMA during the COVID-19 pandemic.

Priority Populations

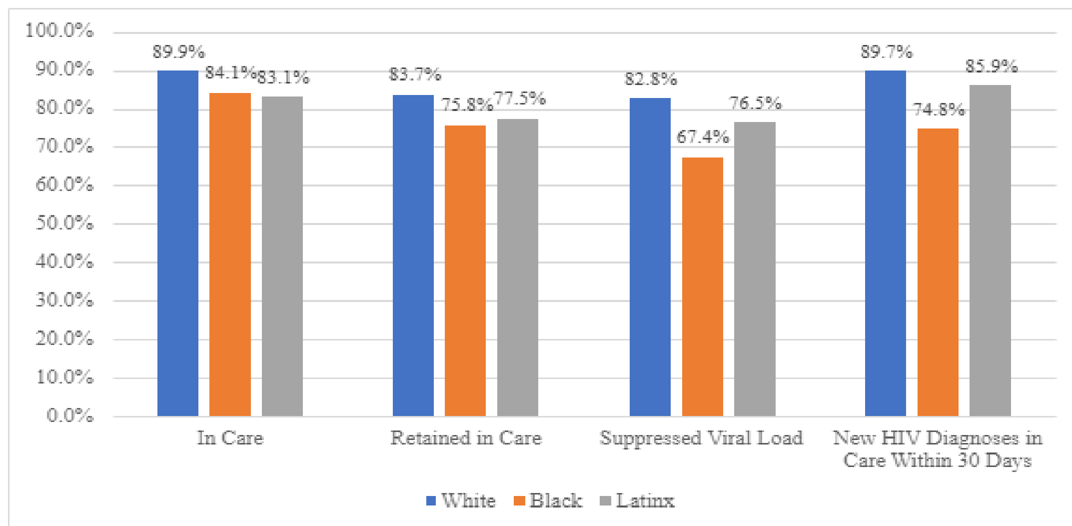
The 2021 HIV National Strategic Plan identified five priority populations for HIV prevention and care. These populations were chosen based on the disproportionate impact that HIV has on these groups. The five priority populations are the following: gay, bisexual, and other men who have sex with men, in particular Black, Latinx, and American Indian/Alaska Native men; Black women; transgender women; youth aged 12-24 years; and people who inject drugs.

Data on gay, bisexual, and other men who have sex with men is assessed through the mode of transmission category of male-to-male sexual contact (MMSC). In 2020, there were 8,199 PWH in the EMA whose mode of transmission was MMSC. Of these, 87% were in care (7,132), 80.3% were retained in care (6,580), and 77.4% had a suppressed viral load (6,350). Of the 2,160 Black cisgender men whose mode of transmission was MMSC, 84.1% were in care (1,817), 75.8% were retained in care (1,638), and 67.4% had a suppressed viral load (1,456). Of the 1,448 Latinx

cisgender men whose mode of transmission was MMSC, 83.1% were in case (1,204), 77.5% were retained in care (1,122), and 76.5% had a suppressed viral load (1,107).

There were 284 new diagnoses in CY 2020 whose mode of transmission was MMSC. Of these, 56% were in care within 7 days (159), 83.5% were in case within 30 days (237), 89.1% were in care within 90 days (253), and 77.1% had a suppressed viral load (219). Of the 107 new diagnoses among Black cisgender men with MMSC as the mode of transmission, 55.1% were in case within 7 days (59), 74.8% were in care within 30 days (80), 81.3% were in case within 90 days (87) and 69.2% had a suppressed viral load (74). Of the 71 new diagnoses among Latinx cisgender men with MMSC as the mode of transmission, 50.7% were in care within 7 days (36), 85.9% were in case within 30 days (61), 91.5% were in care within 90 days (65), and 81.7% had a suppressed viral load (58). **Figure 19** shows the percentages of PWH with MMSC as mode of transmission at selected stages of the care continuum in 2020, by race.

Figure 19: Tampa-St. Petersburg EMA
Percentage of PWH with MMSC as Mode of Transmission Engaged in Selected Stages of the Diagnosis-Based Continuum of HIV Care, 2020



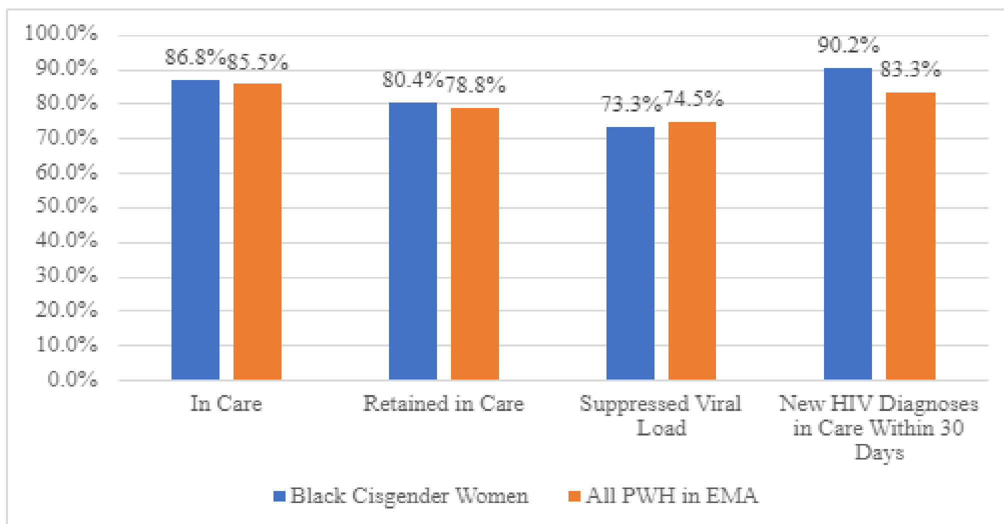
Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2020.

Unfortunately, the state of Florida does not provide the EMA with specific data on American Indian/Alaska Native gay, bisexual, and other men who have sex with men, as the overall population of American Indian/Alaska Native PWH made up just 0.1% of all PWH (17 cases) in the EMA in CY 2020. Within this racial group, across all genders and modes of transmission, 88.2% were in care (15), 70.6% were retained in care (12), and 76.5% had a suppressed viral load (13). There were 2 new diagnoses in 2020, both of which were in care within 7 days.

There were 1,795 Black cisgender women with HIV in the EMA in CY 2020. Of these, 86.8% were in care (1,558), 80.4% were retained in care (1,444), and 73.3% had a suppressed viral load (1,316). Of the 41 new diagnoses of HIV in Black cisgender women in 2020, 51.2% were in care within 7 days (21), 90.2% were in care within 30 days (37), 92.7% were in care within 90 days

(38), and 65.9% had a suppressed viral load (27). The 2020 care continuum data for Black women with HIV within the EMA is shown in **Figure 20**.

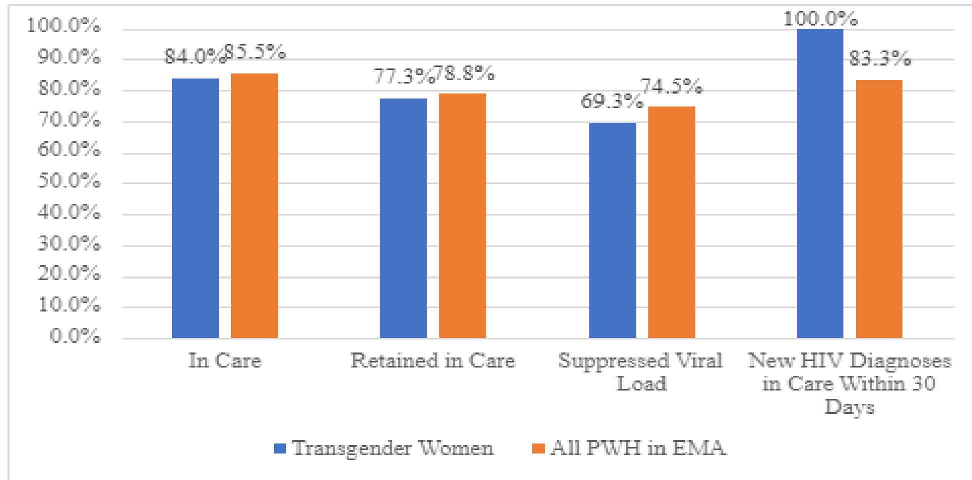
Figure 20: Tampa-St. Petersburg EMA
Percentage of Black Cisgender Women with HIV in Selected Stages of the Diagnosis-Based Continuum of HIV Care, 2020



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

According to the Florida Department of Health's Epidemiological Profile for the EMA, there were 75 transgender women with HIV in the EMA in CY 2020. As previously stated, this number is likely an underestimate, as many transgender women may be incorrectly categorized as men. Due to stigma, many people of transgender experience will not disclose their authentic gender to providers for fear of mistreatment and discrimination. Of these 75 transgender women, 84% (n=63) were in care, 77.3% (n=58) were retained in care, and 69.3% (n=52) had a suppressed viral load. There were five new HIV diagnoses among transgender women in 2020. Of these, zero were in care within seven days, and 100% (n=5) were in care within 30 days. The CY 2020 care continuum data for transgender women is shown in **Figure 21.**

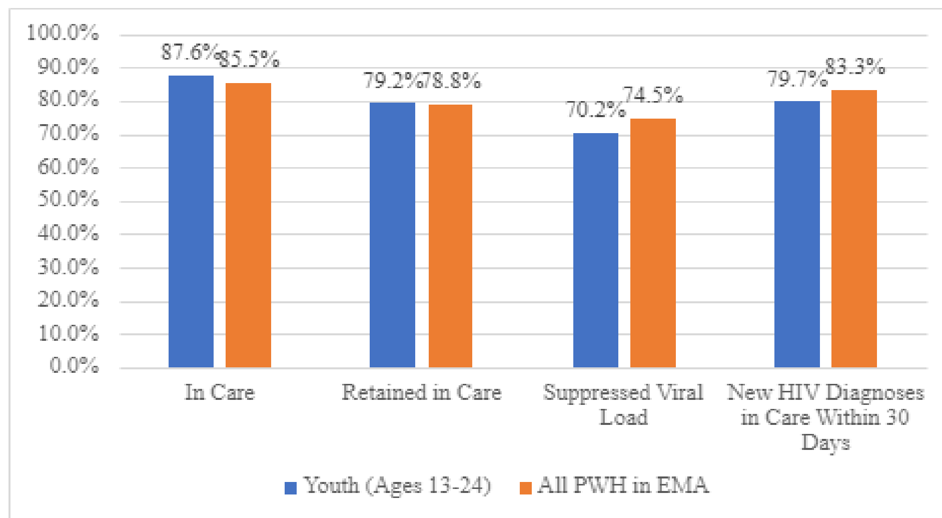
Figure 21: Tampa-St. Petersburg EMA
Percentage of Transgender Women with HIV in Selected Stages of the Diagnosis-Based Continuum of HIV Care, 2020



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

In 2020, there were 322 youth (ages 13-24) with HIV in the EMA. Of these, 87.6% (n=282) were in care, 79.2% (n=255) were retained in care, and 70.2% (n=226) had a suppressed viral load. There were 69 new diagnoses among youth in CY 2020. Of these, 53.6% (n=37) were in care within seven days, 79.7% (n=55) were in care within 30 days, and 87% (n=56) were in care within 90 days. The CY 2020 care continuum data for youth is shown in **Figure 22.**

Figure 22: Tampa-St. Petersburg EMA
Percentage of Youth (Ages 13-24) with HIV in Selected Stages of the Diagnosis-Based Continuum of HIV Care, 2020

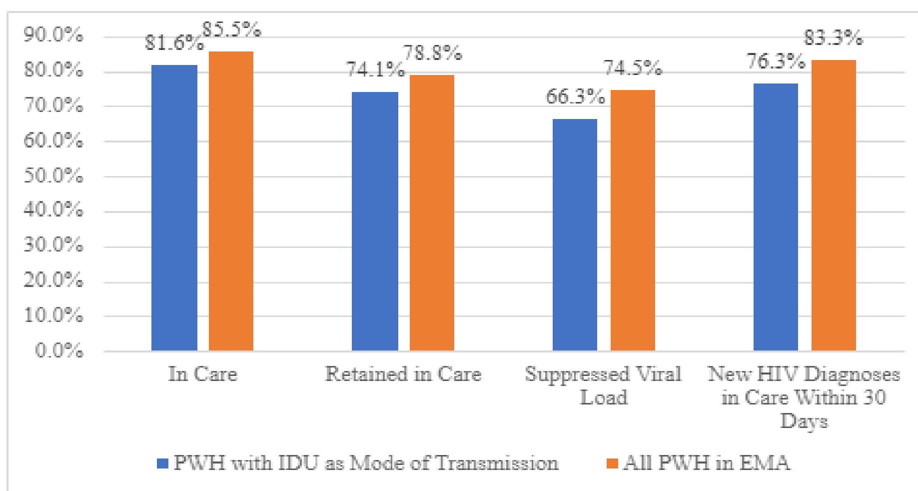


Source: Florida Department of Health, Tampa-St. Petersburg EMA Epidemiological Profiles CY 2020.

There were 1,136 PWH in the EMA with IDU as their mode of transmission in 2020. Of these, 81.6% (n=927) were in care, 74.1% (n=842) were retained in care, and 66.3% (n=753) had a

suppressed viral load. There were 38 new diagnoses in the EMA among people who inject drugs. Of these, 52.6% (n=20) were in care within seven days, 76.3% (n=29) were in care within 30 days, 86.8% (n=33) were in care within 90 days, and 55.2% had a suppressed viral load. The CY 2020 care continuum data for people who inject drugs is shown in **Figure 23.**

Figure 23: Tampa-St. Petersburg EMA
Percentage of PWH with Injection Drug Use (IDU) as Mode of Transmission in Selected Stages of the Diagnosis-Based Continuum of HIV Care, 2020



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

HIV Clusters

The Florida Department of Health, Bureau of Communicable Diseases, monitors clusters that have added five or more reported cases within a 12-month period. CDC publications indicate that persons associated with rapidly growing molecular clusters have transmission rates 8-11 times greater than the average HIV case.

As of March 9, 2022, a rapidly growing molecular cluster has been identified in Hillsborough County. The Hillsborough cluster includes 34 molecularly linked cases, with 11 of those cases having been added in the last 12 months. The cluster includes 32 males[1] (94.12%) and two females (5.88%), with 23 persons identifying as Black (67.65%), five as Hispanic/Latinx (14.71%), five as White (14.71%), and one as multi-race (2.94%). The age breakdown is as follows: 13-19: one (2.94%); 20-29: 14 (41.18%); 30-39: 14 (41.18%); 40-49: four (11.76%); and 60+: one (2.94%). Of the cluster members, 27 (79.41%) report MMSC as mode of exposure; three (8.82%) report heterosexual sexual contact; and four (11.76%) have no identified risk. Between 2019 and 2021, 15 Pinellas County residents and two Pasco County residents were identified as members of 13 different rapidly growing molecular clusters. During this time, no rapidly growing molecular clusters occurred primarily within Pinellas or Pasco Counties.

[1] The Florida Department of Health did not specify whether male and female categories were inclusive or exclusive of transgender identities.

Cluster driven interventions include engagement of community-based organizations (CBOs), enhanced linkage to care, retesting risk network partners, interviewing/re-interviewing cluster members and partners, and PrEP linkage for partners.

3. HIV Prevention, Care, and Treatment Resource Inventory

Resource Inventory Table

Funding Source	FY 2021 Funding Amount		Number of Agencies	Prevention Services	HIV Testing & Policy Alignment Efforts	PLWH/Partner Prevention Services	Condom Distribution	Core Medical-related Services	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 Adherence	Substance Abuse Outpatient Care	Supportive Services	Non-Medical Case Management Services	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
	Dollar Amount	%																																				
Part A	$9,093,530	35.3%	8						x		x	x		x				x		x	x				x		x											
Part B	$3,520,398	13.7%	11						x	x	x	x	x	x						x			x		x							x						
Part C	$0	0.0%	0																																			
Part D	$1,465,105	5.7%	1		x				x									x		x			x				x			x		x	x	x				x
Part F	$0	0.0%	0																																			
CDC	$1,050,000	4.1%	4		x	x	x						x														x					x						
SAMHSA	$679,000	2.6%	1			x							x							x	x																	
HOPWA	$4,378,068	17.0%	7																				x					x										
State	$1,865,583	7.2%	7		x		x		x		x	x	x							x			x		x		x					x						x
CARES Act	$740,849	2.9%	7						x			x		x						x						x												
End HIV Epidemic	$2,806,083	10.9%	11		x								x					x			x						x	x	x			x						
Local	$190,404	0.7%	1						x																													
Total	$25,789,020	100%																																				

a. Strengths and Gaps

The EMA has a strong history of collaboration between all patient care and prevention funded programs and actively promotes cross-collaboration. The Care Council includes prevention updates as a standing agenda item during meetings and the Florida Community Planning Network (FCPN) has a strong level of community involvement between patient care representatives and prevention, as well as the existing prevention planning groups that function locally. The Ending the HIV Epidemic (EHE) grants also have planning groups that meet monthly 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 prevention and care resources, 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 (and the local EMA) 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.

There are 187 public and private testing sites throughout the EMA, including a project at the regional teaching hospital, Tampa General Hospital (TGH), which is also a Level I trauma center. TGH tests all patients who enter the hospital through the emergency room for HIV and is one of several testing projects like this across the state of Florida.

The Kaiser Family Foundation reports (January 2021) that if Florida had not rejected federal dollars for Medicaid expansion, an estimated 833,000 more residents would have health insurance because all who earn up to 138% of the Federal Poverty Level would be covered. Floridians in the Medicaid gap are adults who earn too little to qualify for Affordable Care Act (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 statistics from Medicaid.Gov and the Kaiser Family Foundation, Florida Medicaid covers 3.6 million low-income children, pregnant people, adults, seniors, and people with disabilities. Based on Florida's population of approximately 21.4 million people in 2020, 19% of the population are covered by some form of Medicaid or the State Children's Health Insurance Program (SCHIP), and 31% of the population is defined as low income, which is anyone living below 200% of the Federal Poverty Level. The latest efforts to expand Medicaid in Florida involve a ballot initiative going to voters in late 2022.

In addition to these options, 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 more densely populated areas to serve clients who will travel from their 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. We have not seen a surge in utilization yet, but LAI's are available throughout the EMA for any patient who meets the medical protocol.

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 but despite some patient hesitancy is now increasing again. Access to substance misuse and mental health services is another area of focus since substance misuse services are not available in the two outlying counties and the allocation for mental health services is very minimal in those same areas. During the pandemic these two services increased utilization significantly using telehealth and smart phone technology, which allowed those patients that had access to a mobile device the opportunity to continue to receive counseling services (both individual and group). This had a positive impact on patients who were vulnerable and living in isolation.

Utilizing e2Hillsborough, the EMA has been able to rapidly identify new HIV clusters. The Part A Recipient's Office will collaborate with community partners and provide input on county-wide media/marketing campaigns that focus on prevention, youth education and training services, and stigma reduction.

The AIDS Institute, which serves as the coordinating entity for the EHE HRSA cooperative agreement, is also involved in two statewide Molecular Surveillance (HIV Transmission Networks) initiatives. These initiatives include focus groups, community surveys, and webinars

aimed to address community concerns and help reduce stigma. Information and lessons learned will be utilized to help inform community education efforts.

Florida is particularly vulnerable to hurricanes and other weather events, which can seriously disrupt the service delivery system. Recipient and Ryan White Planning Council staff monitor and plan for severe weather each year throughout the Atlantic hurricane season (June 1st through November 30th), to ensure that services continue to be delivered as efficiently as possible during any extreme weather event.

b. Approaches and partnerships

The jurisdiction has worked collaboratively with various community partners to complete the HIV prevention, care, and treatment inventory. These partners include representatives from the Part A Recipient's Office, Florida Department of Health, local AIDS service organizations (ASOs), the West Central Florida Ryan White Care Council, community-based organizations, the University of South Florida Colleges of Public Health and Medicine, the Part D Recipient, Hillsborough County School Board, Suncoast Health Council, and community stakeholders.

4. Needs Assessment

The Eligible Metropolitan Area (EMA) utilizes a variety of strategies to identify the HIV prevention and care service needs of people with HIV and those vulnerable to HIV. These strategies include reviewing epidemiologic data, care continuum data, resource inventories, service priorities, conducting client and provider surveys, focus groups, and community forums. Items referenced in this needs assessment include the state of Florida's 2019 HIV Care Needs Survey, the EMA's 2021 Ryan White Services Needs Assessment Survey, West Central Florida Ryan White Care Council Town Hall meetings, Ending the HIV Epidemic (EHE) initiatives, as well as other needs assessments completed by community partners. All needs assessment activities are used to inform the goals, objectives, strategies, and activities in this submission.

a. Priorities

Testing and Status-Neutral Services

Access to HIV testing is needed, so that people are informed of their status and those who are HIV positive are rapidly linked into care services. Priorities for testing are those most vulnerable to HIV transmission, including individuals who engage in male-to-male sexual contact (MMSC), cisgender women of childbearing age (WCBA), and youth. Black and Latinx populations face disproportionate impact from HIV and should be prioritized for testing outreach. Increased testing is needed in correctional facilities, among persons experiencing homelessness, and among those who misuse drugs. As of October 2022, there were 187 test sites listed by the Florida Department of Health within the EMA: 59 in Pinellas County, 86 in Hillsborough County, 26 in Pasco County, and 16 in Hernando County. For those who test negative, access to PrEP is needed, as well as culturally and linguistically competent PrEP education. As of June 2022, there were 11 PrEP providers and six nPEP providers listed by the Florida Department of Health within the EMA.

Syringe exchange services are needed to prevent new cases of HIV in people who inject drugs and to link those who are HIV positive into care services. For more than 10 years, the steady increase of opioid misuse and addiction has contributed to rising rates of injection drug use in the United States. Sharing needles, syringes, or other drug-injection equipment puts people at risk for

contracting or transmitting infections and viruses. Studies show that syringe exchange programs significantly reduce overdose-related deaths and prevent HIV and hepatitis B and C, thus reducing risk for community outbreaks.

On June 27, 2019, Governor Ron DeSantis signed into law the Infectious Disease Elimination Act (IDEA) that allows county commissions to authorize sterile needle and syringe exchange programs for people who inject drugs. Disease prevention should be the goal of every exchange program. Per section 381.0038(4)[1], Florida Statutes, county commissions must authorize syringe exchange programs by way of a county ordinance and must enter into a letter of agreement with the Florida Department of Health prior to contracting with an entity to operate the program. Syringe exchange programs in Florida cannot use state, county, or municipal funds to operate. The law requires that exchange programs be funded through grants and donations from private resources and funds. Hillsborough County has an operational syringe exchange program through IDEA Exchange Tampa. Pinellas and Manatee Counties have an executed letter of agreement with the Florida Department of Health for syringe exchange programs but are not yet operational.

Services Needed to Stay in HIV Care and Achieve Viral Suppression

Figure 24 highlights 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 24: 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.

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

Mental health and substance misuse treatment resources are needed to keep clients retained in care. Feelings of anger, fear, guilt, denial, and sadness can overwhelm a newly diagnosed person. Pressure regarding who to disclose one's HIV status to, as well as the impact of HIV on establishing or maintaining close relationships, can contribute to the need for these services. Linkage to Care Coordinators (LTC) throughout the EMA work to re-engage those clients who have fallen out of care through supported referrals and multi-session follow-up counseling for PWH.

HIV care services that are not currently funded by Ryan White were assessed in the 2021 Ryan White Services Needs Assessment Survey. The following services were identified to be among the top priorities among non-funded service categories: short-term emergency housing assistance; transportation to HIV-related appointments; food and/or nutritional supplement assistance; and legal services for HIV-related issues (wills, living wills, social security, and disability).

Barriers to Accessing Existing HIV Testing, Prevention, and Care and Treatment Service

Legal barriers still exist in Florida concerning HIV. One such barrier is a Florida law that makes it a third-degree felony for an individual who knows that they have HIV to have sexual intercourse with another person unless they have informed the person of their status and the person has consented to sex. This criminalization of HIV causes people to avoid testing for fear of prosecution. For other sexually transmitted infections, non-disclosure is a first-degree misdemeanor. Care Council partners have continued to advocate for HIV criminalization reform to reduce the stigma and discrimination associated with HIV. A bill was introduced in the 2020 Florida Legislative Session that would update HIV criminalization laws to reduce the charges for non-disclosure of HIV status to a first-degree misdemeanor. The bill did not pass the Florida House; however, the Florida HIV Justice Coalition introduced the bill to the United States House

of Representatives on February 24, 2021: *(H.R.1305) Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act of 2021 or the REPEAL HIV Discrimination Act of 2021.* On April 28, 2021, this bill was referred to the Subcommittee on Crime, Terrorism, and Homeland Security where it remains.

The COVID-19 pandemic has created disruptions in access to HIV testing, prevention, care, and treatment services. Decreased outreach efforts in 2020 and 2021, due to social distancing efforts to slow the spread of COVID-19, contributed to an overall decrease in the number of HIV tests, potentially increasing the number of persons who are HIV-positive but unaware of their status. The EMA experienced decreases in the percentages of clients who were classified as retained in medical care and virally suppressed in calendar years 2020 and 2021, likely due to decreased visits to provider offices to avoid exposure to COVID-19. Providers and clients also reported longer wait times for lab appointments and delays in receiving results, due to the inundation of COVID-19 testing at many labs, particularly during the early months of the pandemic and during periods of high viral spread within the community.

Geographic variation within the Tampa-St. Petersburg EMA can be a barrier in accessing HIV care services. The more densely populated counties of Hillsborough and Pinellas experience higher prevalence rates compared to the less densely populated counties of Pasco and Hernando. The Ryan White Part A Recipient and Part B Lead Agency work to ensure that access to core medical services is equally available across all four counties within the EMA. Travel times and access to transportation, however, can present barriers for some populations in the less densely populated counties, particularly regarding specialty care and support services.

HIV stigma is still a significant barrier, both for people seeking HIV testing and PWH needing care and treatment services. PWH who reside in less densely populated areas tend to be more isolated and face increased stigma, coupled with fears of disclosure to family or friends. It is still routine for service providers in the more densely populated areas/larger cities to serve clients who will travel from a more isolated 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. In addition to stigma and lack of social support, barriers to care identified during the West Central Florida Ryan White Care Council Town Hall meetings included low health literacy and lack of awareness of available services.

b. Actions Taken

The following activities were undertaken by the Tampa-St. Petersburg EMA to address identified needs and barriers:

- The West Central Florida Ryan White Care Council updated the Minimum Standards of Care for the Total Service Area in September 2020 to include provisions for telehealth services, so that these services could continue to be implemented to minimize service disruptions during the COVID-19 pandemic and to support clients facing difficulties with transportation, childcare, or other barriers to traveling for in-person appointments.
- A Health Education and Risk Reduction (HERR) program and Early Intervention Services (EIS) were expanded in Pinellas and Hillsborough counties in 2020 using Ending the HIV Epidemic (EHE) funding.

- EHE funding was used to expand mental health, substance misuse, and supportive housing services in Pinellas County in 2021. The Part A program is considering allocating additional funding to housing services within the EMA, once the budget for the 2022-2023 fiscal year is finalized.
- Allocations to oral health services were increased in the Part A budget in fiscal year 2021-2022 to support expanded access for clients needing these services. Oral health was identified as an area of unmet need in the 2019 HIV Care Needs Survey.
- Two new oral health providers were funded in Pinellas County in 2021 to expand access to these services.
- A large area hospital, Tampa General Hospital, began implementing HIV testing and linkage to care through its Emergency Department. This initiative has been able to reach populations who otherwise may not have regular contact with the healthcare system.
- The EMA has adopted the State of Florida's Test & Treat strategy, whereby all individuals who test positive for HIV can access treatment immediately. The Test & Treat program helps newly diagnosed people or those returning to care by providing immediate linkage to a clinician who can provide access to antiretroviral medications, medical assessments, education on HIV and HIV management and linkage to medical and non-medical case management to help navigate the HIV system of care and access community resources.
- A five-part cultural competency training series was offered between October 2021 and March 2022 to all Care Council members, leadership, and the community at-large to increase knowledge of the importance of diversity, equity, and inclusion in the decision-making process and to help make the planning council more inclusive of persons with marginalized identities.
- In 2022, the EMA began collaborating with the State of Florida to update the eligibility process for Ryan White clients so that eligibility may be recertified annually, rather than every six months. The Part A program is updating this policy in tandem with Part B, so that the process is streamlined across both programs. The new policy will be less burdensome for clients and will remove barriers to receiving care, improving engagement and retention.

c. Approach

The EMA assesses HIV prevention and care needs on an ongoing basis through the review of epidemiologic data, care continuum data, resource inventories, service priorities, and conducting client and provider surveys, focus groups, and community forums. Epidemiology and Care Continuum reports are generated on a yearly basis and presented to the Care Council, for consideration when establishing services priorities and determining gaps in services. A listing of area HIV resources is maintained on the Care Council's website and updated at least once per year.

Service gaps were identified 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 widely distributed, both on paper and through a virtual link. The EMA had a total of 1,023 surveys returned, representing a statistically valid sampling rate which is >10% of the 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.

In 2021, Care Council planning and support staff distributed an additional needs assessment survey to people living with HIV and HIV service providers in the EMA to assess top priorities within the service categories that are currently unfunded by the local Ryan White program. Results of the survey were used to determine additional service categories that may be funded by Ryan White Parts A and B in future fiscal years. Based on the results of the 2019 HIV Care Needs Survey, Care Council planning and support staff determined eight unfunded service categories that survey respondents indicated as inaccessible resources. These eight categories included transportation to HIV-related appointments; legal services for HIV-related issues (will, living will, social security, disability); short-term emergency housing assistance; food and/or nutritional supplement assistance; professional nutrition counseling; bereavement (grief) support groups or counseling; childcare assistance for HIV-related appointments groups and/or training; and physical therapy, occupational therapy, speech therapy, and/or vision assistance. The survey asked respondents to rank the eight service categories by need, with 1 as most needed and 8 as least needed.

In addition to the two client need surveys, the West Central Florida Ryan White Care Council hosts monthly virtual town halls to provide an open forum for members and the local community to discuss any issues within the Care Council or the HIV service delivery system. The Care Council hosted an expanded community town hall on March 22, 2022, in a focus group-style structure, and provided $50 Amazon gift cards to participants as incentives. More information on town hall meetings is available in **Section II: Community Engagement and Planning Process** of this plan. Needs identified during this town hall included housing services, transportation in rural areas, and expanded psychosocial support services. Other themes discussed included stigma, lack of awareness in the community of the availability of services, and low health literacy. Possible solutions discussed included increasing messaging and advertising, increasing peer navigator services, and advocating for pharmacists to have prescribing authority for PrEP and nPEP.

Community partners, Empath Partners in Care (EPIC) and Metro Inclusive Health, have completed separate needs assessments that were referenced during the writing of this plan. Between January 2021 and June 2021, EPIC conducted a Community Health Needs Assessment (CHNA) to better understand the needs of individuals and families facing chronic, advanced, and terminal illness in Pinellas County, including HIV/AIDS. The intent of this assessment was to identify issues, community assets and barriers that can enable the improvement of programs, services, and partnerships to better meet the needs of marginalized populations and create shared solutions to long-term challenges. This CHNA was based on publicly available quantitative data and thematic analysis of newly gathered qualitative information regarding chronic, advanced, and terminal illness in Pinellas County, Florida. Equity-related issues and barriers to care arose organically in 10% of responses. Some respondents highlighted insufficient attention to diversity, equity, and inclusion within organizations, and/or a lack of will to address health equity. People with chronic, advanced, and terminal illness face various issues and barriers to care stemming from systemic disparities and demographic factors that impact equitable access to care. Barriers mentioned include a lack of culturally/linguistically informed services, immigration status, ageism, and, notably, race-based disparities with respect to both access to quality care and social determinants of health. Multiple respondents mentioned the impact that disparities have on Black individuals' access to adequate care, including early diagnosis of health issues. Responses also note the impacts of implicit bias within the healthcare system and chronic stressors (such as racism) on individual

health. Respondents noted specific health disparities experienced by people of color and by individuals who are LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer).

Another community partner, Metro Inclusive Health, is a resource and asset to high-risk pregnant cisgender women in Hillsborough and Pinellas Counties. Through the Targeted Outreach for Pregnant Women Act (TOPWA), Metro engages pregnant cisgender women in services that assist under-served cisgender female populations with accessing medical and essential support services and reducing their risk factors for transmission of HIV and substance misuse with the goal of increasing positive perinatal outcomes. Additionally, TOPWA participants may experience factors that place them at risk of contracting HIV, such as inadequate education about the virus and how it is transmitted. During navigation sessions, TOPWA program staff provide clients with a safe space to discuss any questions or concerns regarding their sexual health, encompassing physical, emotional, mental, and social well-being. TOPWA program staff educate clients on risk reduction methods to assist with creating strategies that are tailored to each client including: condom use and condom varieties, PrEP/nPEP, routine sexually transmitted infection (STI) screening & testing, HIV testing, and addressing challenges with substance use/misuse.

Finally, all available local Ending the HIV Epidemic (EHE) plans were reviewed in the process of conducting this needs assessment. The Health Council of West Central Florida, Inc. (HCWCF) completed the Hillsborough County EHE Plan in October 2020. To inform the plan, HCWCF identified existing community stakeholders and resources, formed a planning committee that met monthly, conducted key informant interviews, held a series of focus groups, and distributed an online survey. Identified needs were organized under each EHE pillar: Diagnose, Treat, Prevent, and Respond and were considered when informing the goals, objectives, and strategies of this plan.

Section IV: Situational Analysis

The CDC defines the social determinants of health as the conditions in the places where people live, learn, work, and play that affect a wide range of risks and outcomes. Tampa-St. Petersburg EMA is a diverse community and evaluation of the social determinants of health allows for tailored strategies that best meet the needs of those most vulnerable and affected by HIV/AIDS. **Figure 25** shows selected demographic characteristics of the counties in the EMA.

Figure 25: Tampa-St. Petersburg EMA Demographic Profile

County	Asian Population (%)	Black Population (%)	White Population (%)	Hispanic Population (%) (any race)	Total Population (n)
Hernando	1.2	5.2	86.6	14.1	190,700
Hillsborough	4.2	16.7	67.1	29.1	1,451,358
Pasco	2.7	5.8	84.2	15.9	539,885
Pinellas	3.5	10.3	80.0	9.9	970,985

Source: United States Census Bureau, American Community Survey (ACS) 5-year estimates, 2016-2020.

Figures 26-29 demonstrate the disparities between measures relating to the social determinants of health among racial and ethnic groups. These disparities create barriers for people with and at risk for HIV in accessing prevention, testing, and treatment services.

Figure 26: Median Household Income by Race and Ethnicity 2016-2020

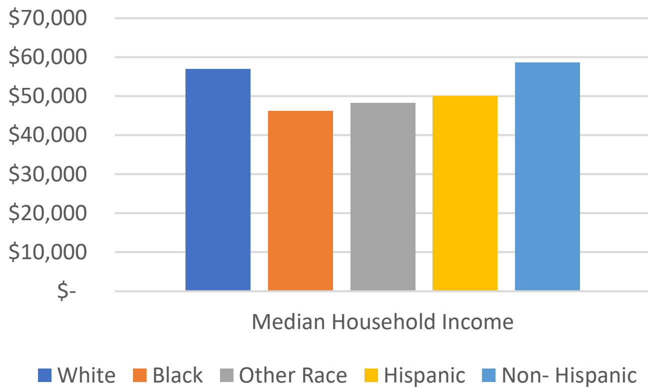
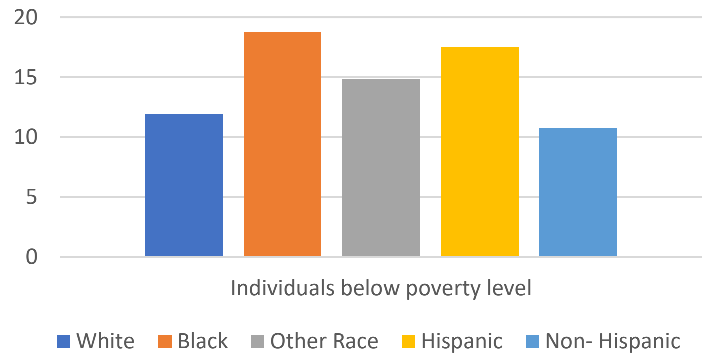


Figure 27: Percent of Individuals Living Below Poverty Level by Race and Ethnicity 2016-2020



Source: Florida Department of Health, Health Equity Profile, 2020.

Figure 28: % of Individuals 25 Years and Older with No High School Diploma 2016-2020

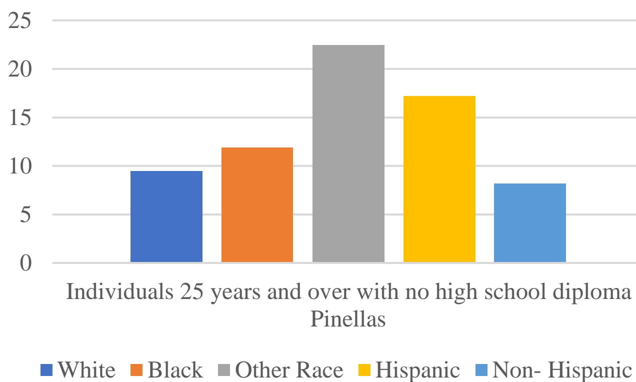
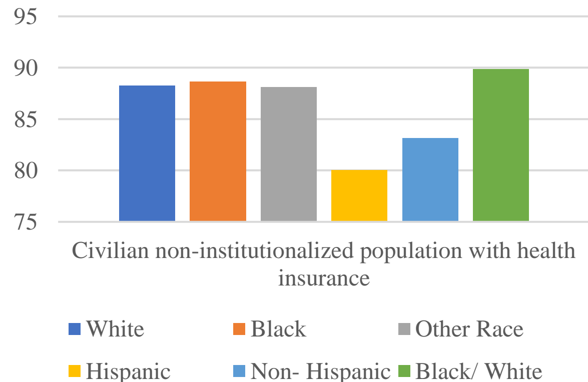


Figure 29: % of Civilian Non-institutionalized Population with Health Insurance 2016-2020



Source: Florida Department of Health, Health Equity Profile, 2020.

According to the Florida Department of Health's Epidemiological Profile, new HIV cases (incidence) in the EMA decreased 4.4% from 2018 to 2019 and 14.1% from 2019 to 2020, for an overall decrease of 17.9% from 2018 to 2020. New cases of AIDS decreased 12.5% from 2018 to 2020. The decrease in new HIV cases in 2020 should be interpreted with caution, due to the impact of the COVID-19 pandemic on access to HIV testing.

Access to Care

Beginning in March 2020, the COVID-19 pandemic imposed far reaching consequences across the nation, with the most vulnerable populations bearing the greatest burdens. The effect of social distancing measures that helped prevent the spread of COVID-19 has been detrimental to the social determinants of health. Jobs were lost resulting in the loss of health insurance, incomes have

decreased, many are facing impending eviction, routine and preventative medical care has been delayed, food insecurity has increased, public transportation volumes have decreased creating budget shortfalls that may result in reductions in service, mental health has been impacted, and an overall sense of insecurity has increased. At this time, the impact of COVID-19 cannot be measured as it continues to evolve and pose a threat. According to the CDC, while there is limited data, it appears that PWH on effective treatment regimens are at the same risk for COVID-19 as people who do not have HIV. PWH who are not on effective HIV treatment (antiretroviral therapy) and/or with a low CD4 cell count, are at a greater risk for getting very sick from COVID-19 due to their suppressed immune system (Content source: Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention).

Geographic variation within the EMA can present a challenge for providing equal access to care. In the more densely populated areas with large cities, prevalence rates are higher compared to the less densely populated neighboring counties. Travel times and lack of access to transportation can present barriers for some populations in less densely populated areas of the county, particularly regarding specialty care and support services. The existing bus routes are not enough to support the size of the county, making it difficult for residents to get from one place to another. Traveling by public transit regularly includes transfers resulting in longer commute times than what occurs with personal vehicles. Public transportation is not a good option for a person that might also be feeling ill and needs to attend medical appointments.

HIV stigma is still a barrier especially for PWH who reside in less densely populated areas where they tend to be more isolated and fears of disclosure to family or friends may be greater. Service providers in larger cities routinely care for patients traveling from isolated communities. In addition to limited resources in less densely populated areas, PWH often seek care outside of their community to maintain privacy and avoid the stigma of HIV. Cultural and language barriers also inhibit access to care, due to increasing diversity. To increase access to care, all Ryan White services are delivered by providers who employ bilingual staff, utilize language interpretation services, and 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.

Environmental Impact

Florida is particularly vulnerable to hurricanes and other weather events which can seriously disrupt an already fragile service delivery system. As a result of COVID-19, state and local officials need to consider social distancing measures and the impact on shelter space and how to provide transportation to shelters that limit the risk of exposure. A shortage of space may leave low-income populations with very few options if large scale evacuations are needed.

The Tampa-St. Petersburg EMA was directly impacted in 2017 by Hurricane Irma. Over 230,868 customers were left without power, approximately 36% of the county. Heavy rainfall resulted in flooding along the Alafia, Hillsborough, and Little Manatee Rivers. Forty-one businesses and homes were demolished, and 130 suffered extensive damage. Hurricane Irma cost the county almost $20 million in damages, with an additional loss of $28.5 million in citrus plants.

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 impact 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 environmental challenges the EMA is faced with increases the burden associated with the social determinants of health.

1. Situational Analysis

a. Diagnose

A targeted approach to diagnosing HIV is a critical component of ending the epidemic. One of the first steps is to look at the most common modes of HIV transmission in the EMA to identify target populations. The table below demonstrates HIV and AIDS prevalence by demographic group and exposure category for the EMA. While the higher numbers indicate the greatest immediate need for treatment and where to deploy prevention efforts, it is crucial to consider the exposure categories with few or no new positive tests. For example, perinatal rates of HIV have dropped significantly due to a focus on prevention, which must continue for these rates to remain low.

FIGURE 30: HIV* PREVALENCE AND AIDS PREVALENCE DATA BY DEMOGRAPHIC GROUP AND EXPOSURE CATEGORY

Demographic Group/ Exposure Category	2018 PREVALENCE		2019 PREVALENCE		2020 PREVALENCE	
Race/Ethnicity	**HIV**	**AIDS**	**HIV**	**AIDS**	**HIV**	**AIDS**
White, not Latinx	2,791	3,296	2,813	3,239	2,869	3,221
Black, not Latinx	2,424	2,667	2,461	2,688	2,476	2,706
Latinx	1,219	1,266	1,251	1,285	1,291	1,296
Other / Unknown	169	181	182	183	180	191
Total	6,603	7,410	6,707	7,395	6,816	7,414
Gender	**HIV**	**AIDS**	**HIV**	**AIDS**	**HIV**	**AIDS**
Cisgender Men	5,042	5,634	5,155	5,630	5,238	5,651
Cisgender Women	1,517	1,736	1,511	1,730	1,533	1,728
Transgender Women	39	38	37	34	41	34
Transgender Men	5	2	4	1	4	1
Total	6,603	7,410	6,707	7,395	6,816	7,414

Current Age as of Reporting Year	HIV	AIDS	HIV	AIDS	HIV	AIDS
<13 years	12	3	8	3	9	2
13 - 24 years	338	78	309	56	275	47
25 - 44 years	2,873	1,672	2,944	1,656	2,977	1,609
45 - 59 years	2,373	3,819	2,336	3,661	2,327	3,522
60+ years	1,007	1,838	1,110	2,019	1,228	2,234
Total	6,603	7,410	6,707	7,395	6,816	7,414
Exposure Category	**HIV**	**AIDS**	**HIV**	**AIDS**	**HIV**	**AIDS**
Cisgender Male-to-male sexual contact (MMSC)	4,064	3,919	4,156	3,944	4,230	3,969
Injection drug users (IDU)[2]	423	735	429	703	439	697
MMSC/IDU	290	439	286	442	280	421
Cisgender Heterosexual Contact[3]	1,708	2,159	1,726	2,158	1,756	2,176
Transgender Sexual Contact[4]	39	32	35	30	38	30
Perinatal Exposure	12	3	8	3	9	2
Other/Unknown	65	123	66	116	63	119
Total	6,601**	7,410**	6,706**	7,396**	6,815**	7,414**

Source: Florida Department of Health EMA Epidemiological Profiles CY 2018; CY 2019; CY 2020 as of August 11, 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.

The HIV epidemic will not end unless we are able to identify every case transmitted. As testing of the population increases, the probability of identifying HIV cases that are not yet symptomatic

[2] Includes IDU of ALL genders, excluding MMSC/IDU

[3] 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)

[4] “Transgender 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

increases, which can help prevent or reduce death and disability from the virus. Identifying these cases will allow for earlier treatment, reduction of viral loads and education so that transmission is less likely to occur.

While the CDC and the United States (US) Preventive Services Task Force recommend HIV testing as part of routine healthcare, HIV testing does not typically take place at the recommendation of a physician or other healthcare provider. Community engagement activities yielded great support for the inclusion of HIV testing in routine healthcare. This includes all different types of providers from family physicians, emergency room staff, to gynecologists, urologists, mental health providers, and more. Patients without health insurance and/or individuals who live in poverty are not likely to see a regular provider. Their source of healthcare is frequently emergency health providers, so it was recommended that HIV testing be incorporated into standard emergency room protocols. Cultural and linguistic competency training was also recommended for providers to eliminate bias and for providers to gain trust with vulnerable communities. Providers need to understand the reasons why a vulnerable patient may lack trust, and resist testing or treatment. By implementing these strategies, community members will be more likely to get tested, allowing for earlier treatment and effective prevention.

Strengths

- Testing and treatment model in one hospital emergency department in Hillsborough County.
- Home testing capacity and providers mobilized to dispense testing kits.
- Universal support for incorporating HIV testing into routine healthcare.
- Community Promise Intervention.
- Mobile testing units.
- Funding to support Health Education Risk Reduction Specialist.
- Social networks for peer outreach.

Weaknesses

- People don’t prioritize HIV as a health issue, particularly when other basic needs aren’t being met or are unstable.
- Fear of testing and fear of what a positive test would mean. Lack of understanding that treatment and preventative methods are available at free/reduced cost.
- Limited capacity for some populations to access internet services for telehealth and to receive prevention messaging.
- Lack of messaging using novel technologies such as smart phone applications, social media, etc.

Identified Needs

- Prioritize strategies around incorporating HIV prevention, testing and treatment in routine health and wellness, including emergency healthcare.
- Messaging that includes education about what it means to be HIV positive and what it means if a test comes back negative. Need to dispel misconceptions about the availability and cost of testing. Need to promote messaging that HIV, while a life-altering diagnosis, is a manageable condition and high quality of life is not only possible, but attainable.

- Meeting people “where they are” in a variety of venues for the purposes of testing. Examples include healthcare facilities, childcare centers and schools that serve vulnerable populations, meal distribution sites, shelters, restaurants, convenience stores, liquor stores, vape shops, Walmart, and Target.
- Continued use and expansion of 4th generation rapid testing.
- Ad hoc committee to identify barriers and make recommendations for implementing routine testing.
- Collaboration between Federally Qualified Health Center’s (FQHCs), DOH/CHD, and local health and medical associations to support routine testing.
- Funding and strategy to support routine testing in healthcare and community settings.
- Workgroup to explore contact tracing, service linking and health education technologies (ex: phone apps/social media).

b.Treat

The HIV Care Continuum has seen incremental improvement in several outcomes between 2017 and 2019. Annual retention in medical care, viral load suppression for those retained in medical care, and the overall percentage of people considered virally suppressed has seen a gradual increase in this timespan. Between 2017 and 2019, the overall percentage of individuals with HIV considered to be medically retained in care (two medical visits at least three months apart over a twelve-month period) increased from 74.1% to 77.6%. When examining viral load suppression in this timeframe, the percentage moved from 66.1% to 73.8%. The percentage of individuals considered to be virally suppressed while also being considered retained in care showed improvements as well, going from 85.1% to 90.1%.

While looking at specific demographic variables such as gender identity, race/ethnicity, and age, the Tampa-St. Petersburg EMA continued to see improvements between 2017 and 2019. Many of these gains were due to the area’s Ryan White provider’s dedication to tracking, reporting, and acting on readily available data to successfully link and retain people into care and keeping them engaged in medical care.

The EMA’s continuing focus on performance measure outcomes at the provider and network level, in part via the clinical quality improvement program, has resulted in favorable outcomes across each of the indicators. The providers have continued to dedicate more attention to ensuring that data is properly entered, appointments are kept, and clients are continuously engaged. Utilizing HRSA’s outcome measures and standards as its focal point, in combination with the HIV Care Continuum, a more accurate sense of the epidemic throughout the EMA is provided.

The EMA evaluates outcome measures on a quarterly basis through the Quality Management consultant in collaboration with the Recipient, the West Central Florida Ryan White Care Council and its committees, and local prevention representatives. In addition, the area engages in system-wide continuous quality improvement efforts as well as provider-initiated efforts.

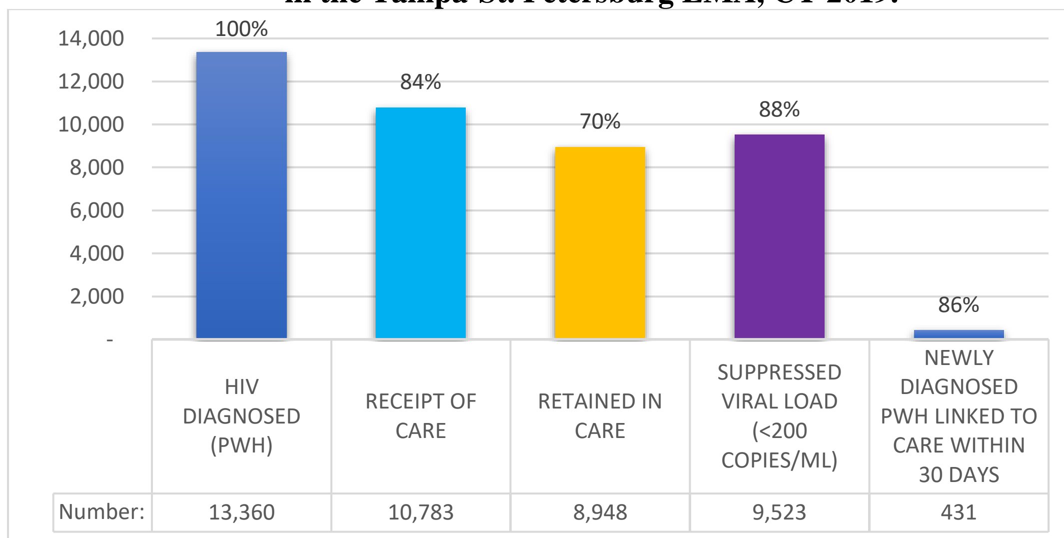
Those continuous quality improvement efforts have resulted in fewer instances of no shows for medical appointments, a higher percentage of people who have received a syphilis screening, and a more rigorous effort to ensure individuals with HIV have received HIV risk counseling. More recently, efforts have focused on improving several key indicators (prescription of antiretroviral

drugs, retention in medical care, and viral load suppression) among individuals 29 years of age and younger.

In addition, care disparities based on race and ethnicity have seen an incremental decline over time, specifically as it pertains to retention in medical care and viral load suppression. A disparity in care is defined as a medical outcome for one group being higher or lower by at least five percentage points than another comparable group. By 2019, the percentage of Black individuals with HIV considered to be retained in medical care stood at 75.2%. White individuals with HIV, when looking at retention in medical care along this same time frame, came in 80.4% in 2019, where the disparity decreased between 2017 and 2019 in these two groups by nearly 0.5%. Retention in medical care for Latinx individuals with HIV in 2019 was measured at 76%, effectively erasing the retention in care disparity between this group and White individuals with HIV.
A similar pattern emerges when examining viral load suppression. Between 2017 and 2019 the percentage of White individuals with HIV considered virally suppressed moved from 71.8% to 78.8%. In that same timespan, the rates for Black individuals with HIV rose from 59.5% to 68.2%. and for Latinx individuals, increased from 66% to 73.6%. While there is still considerable work to go regarding the elimination of disparities as it pertains to viral load suppression outcome, the gaps are narrowing across the board as of 2019.

The clinical quality management program, when calculating and presenting initial performance measure breakouts by demographics, showed where the EMA and service providers were coming up short in caring for all individuals with HIV. This data was, and continues to be, shared among the provider network and the Recipient, culminating in paying closer attention to engagement strategies. Over the past few years, the area continues to aggressively pursue eliminating care disparities and achieving parity across key medical outcomes across all demographics.

Figure 31: Number and Percentage of PWH Engaged in Selected Stages of the Diagnosis-Based Continuum of HIV Care in the Tampa-St. Petersburg EMA, CY 2019.



Source: CDC Division of HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; data (as of 12/31/2020) has been formatted by HAB DMHAP Data Team.

Strengths

- There is a decrease in the number of new cases of AIDS which may indicate that more of cases of HIV are being managed so they do not progress to AIDS.
- Florida's Test and Treat protocol.
- Services like food pantry, mental health support, peer community, healthcare etc., are co-located to increase access and encourage compliance with treatment.
- 94% of all People with HIV in the EMA, retained in care, had a suppressed viral load in 2019.
- 86% of the 502 newly diagnosed PWH in the EMA had at least one documented HIV-related care visit within 30 days of diagnosis in calendar year 2019.
- Because this measure is limited to people with HIV diagnosed in a single year, it cannot be directly compared to other steps in the continuum. An individual who enters care more than 30 days after diagnosis may still be included in subsequent steps of the continuum but would not be counted as linked to care.
- Getting to Zero Tampa Bay to support efforts to address unmet needs.
- Funding to support the mobilization of early intervention specialist to insure PWH are engaged efficiently and adhere to effective treatment.

Weaknesses

- Turnover of case managers, social workers, outreach workers. Consistency in personnel is critical in establishment of trust; when turnover occurs, the individual must start from the beginning, telling their story and building trust again. When there are breaks in the system, stability is challenged, and the system of care can easily fall apart.
- Insufficient housing options for people with HIV impacting their ability to maintain treatment protocols.
- Some individuals are not able to reach viral suppression even with adherence to treatment.
- Need to improve cultural and linguistic competency, and purposeful inclusion practices that establish trust and comfort for PWH with health and medical providers, case workers, etc.

Identified needs

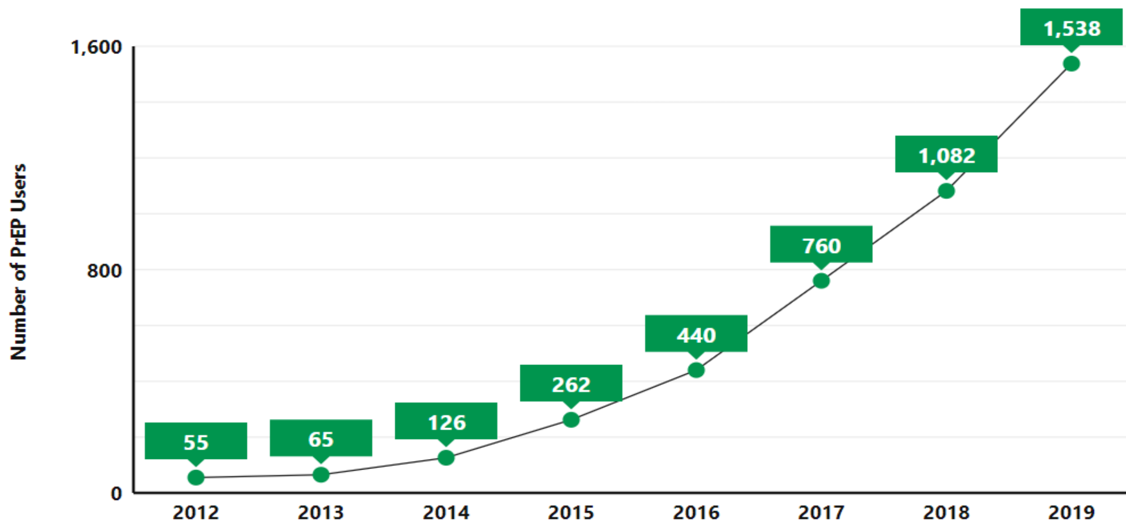
- Develop additional cultural and linguistic competency and implicit bias training for all providers and outreach workers to best understand vulnerable communities and promote health equity. It is important for providers to understand the stigmas around HIV and how they are interpreted by each group. Trainings need to identify the fears and misconceptions that are present and address how these fears, assumptions, and misinformation impact engagement in prevention, testing, and treatment of HIV.
- Take advantage of machine learning technology to address the PWH's unmet needs and minimize the likelihood they will fall out of care.
- Support for telehealth to establish initial visit and on-going treatment.
- Protocols for home HIV testing and linking to appropriate care (treatment and/or prevention like PrEP/nPEP).

c. Prevent

Pre-Exposure Prophylaxis (PrEP) is a comprehensive HIV prevention strategy involving the daily use of antiretroviral medications to reduce the risk of HIV infection in HIV-negative individuals who have a sexual partner who is HIV+ or who is at high-risk for HIV exposure. PrEP should be used in conjunction with other prevention methods to reduce the risk of infection. Post Exposure Prophylaxis (nPEP) involves taking antiretroviral medications as soon as possible after a potential exposure to HIV to reduce the likelihood of HIV transmission.

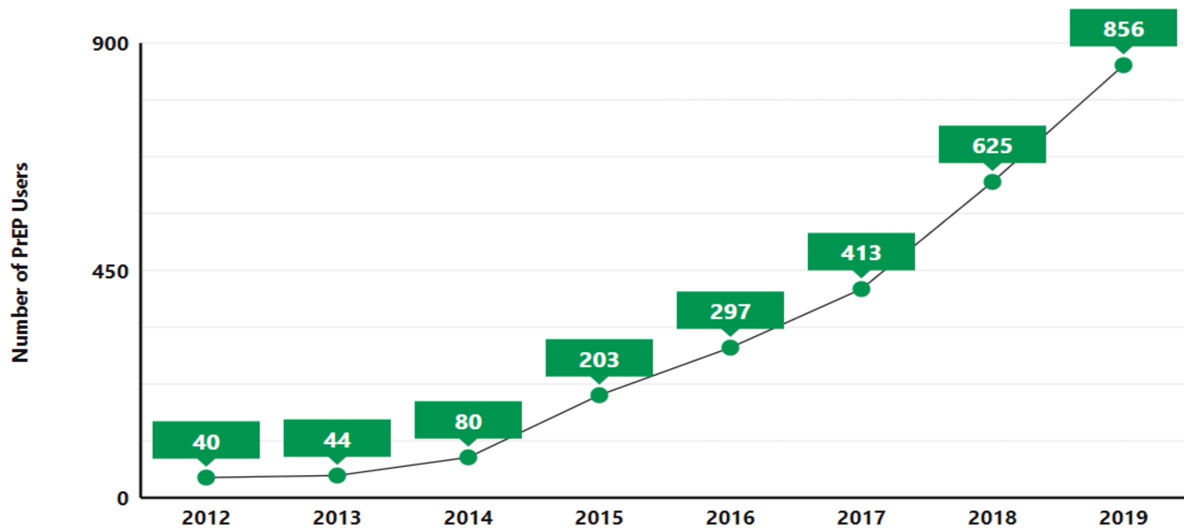
Figures 32 and 33 illustrate PrEP usage and the growth of uptake between 2012 and 2019. Data are only available for the EHE prioritized jurisdictions within the EMA: Hillsborough and Pinellas County. Several factors begin to explain the rates of usage over the period displayed. PrEP was first approved in 2012 and between 2015-2016, Gilead, the pharmaceutical company that distributes PrEP, initiated a marketing campaign demonstrating an increase in usage. A generic form of PrEP is expected to expand access to the treatment and subsequently increase uptake.

Figure 32: Number of PrEP Users, Hillsborough County 2012-2019



Source: AIDSVu, Local Data: Hillsborough County, 2012-2019.

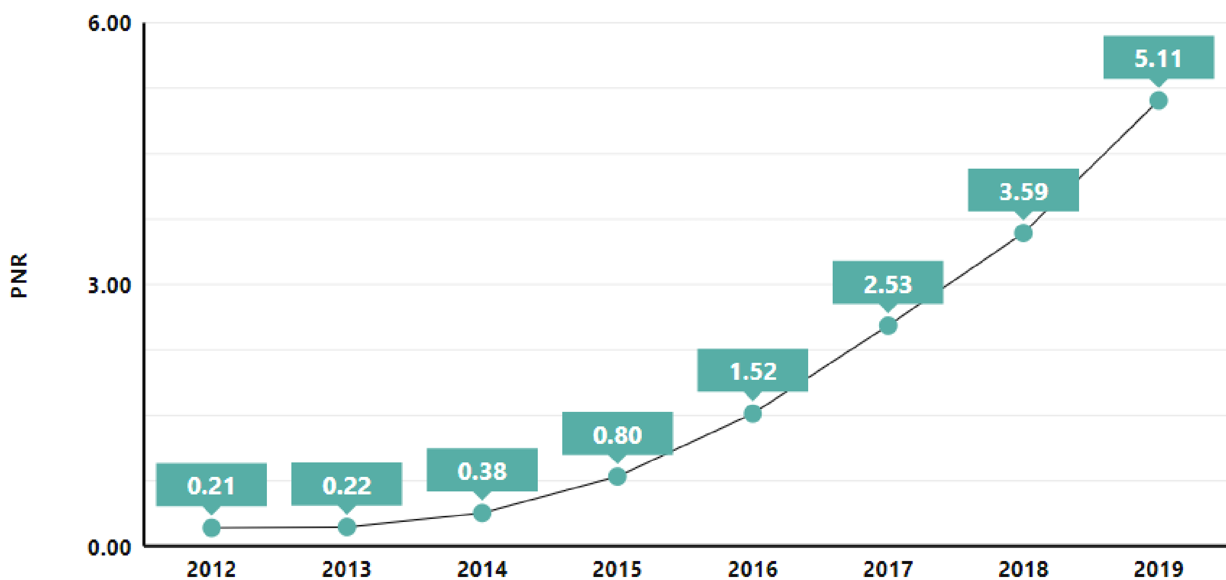
Figure 33: Number of PrEP Users, Pinellas County 2012-2019



Source: AIDSVu, Local Data: Pinellas County, 2012-2019

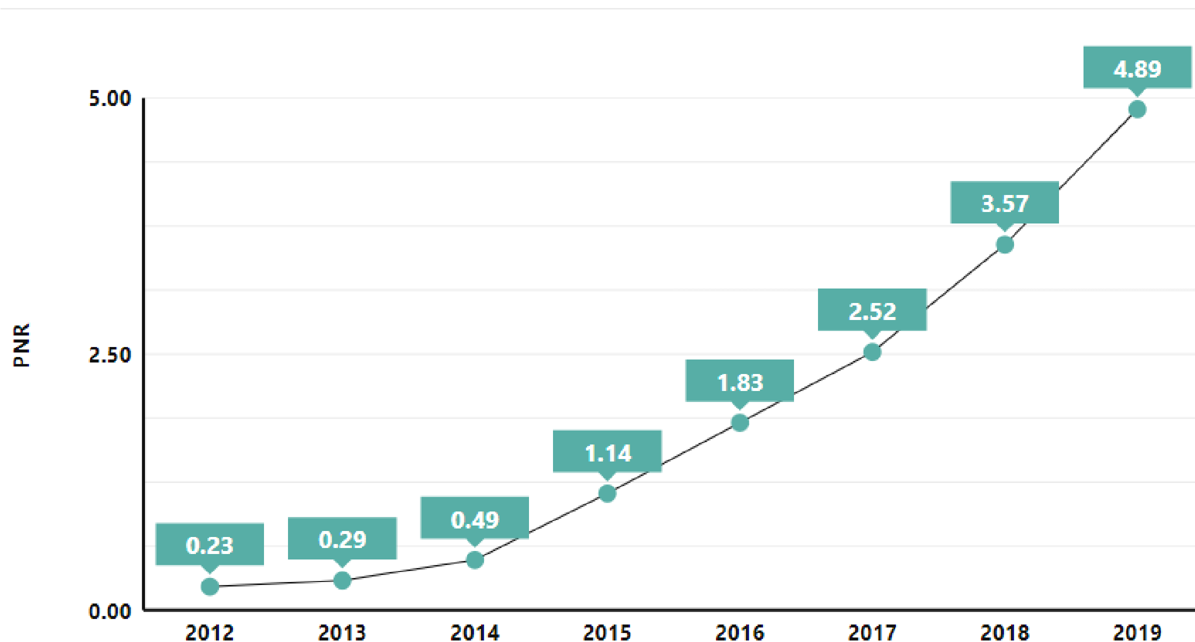
Figures 34-35 display the PrEP-to-need ratio (PNR) reflecting the number of PrEP users from 2012-2019 over the number of people newly diagnosed with HIV in each respective year. The ratio is used to describe the distribution of prescriptions relative to the epidemic need. The lower the PNR, the more unmet need.

Figure 34: PrEP-to-Need Ratio (PNR), Hillsborough County 2012-2019



Source: AIDSVu, Local Data: Hillsborough County, 2012-2019.

Figure 35: PrEP-to-Need Ratio (PNR), Pinellas 2012-2019



Source: AIDSVu, Local Data: Pinellas County, 2012-2019.

Strengths

- A growing number of PrEP access sites in the EMA.
- From 2016-2019, there was nearly a 250% increase in PrEP usage and in the PNR increased from 1.52 to 5.11 for Hillsborough County. Similarly, In Pinellas County, PrEP usage increased 188% and PNR increased from 1.83 to 4.89. The increase in PNR indicates that more people who need PrEP are getting it.
- Ready, Set, PrEP initiative to support free PrEP to eligible clients, and marketing to increase PrEP awareness.
- The Hillsborough County Public School District received a CDC grant to improve their sexual health programing. The grant provided the school district with the capacity to define a specific curriculum for sexual health education where the existing program provided instructors with topics to teach in their own way.
- Hillsborough County approval for Syringe Exchange Program.

Weaknesses

- Lack of awareness of PrEP and nPEP by physicians and community members, especially those at higher risk.
- The stigma around HIV, including a notion of promiscuity, sexuality that is not accepted in some communities, and frailty. This inhibits the capacity of sexual health education to be inclusive and medically accurate.
- Some populations find it difficult to trust people and systems of authority, including medical professionals. The experiences that caused distrust may be varied and need to be understood to overcome the impacts.

- People in low socioeconomic groups must juggle competing priorities and need to meet basic human needs like food, shelter, clothing, and education.
- Individuals cannot access PrEP without a prescription, and ongoing HIV testing is required.
- Youth cannot access PrEP without parental agreement, youth are often resistant to inform parents of the behaviors they engage in that put them at risk for HIV.

Identified needs

- Training and education for physicians, nurses, healthcare professions students and support staff to collect sexual health history and prescribe or refer PrEP/nPEP.
- Identify existing health education programs and strategies and incorporate HIV into the experience. Need to expand sexual health education to be both comprehensive and inclusive. This will not only educate individuals but begin to eliminate stigma and create a culture where HIV is part of general healthcare.
- Expand messaging and materials in all environments, especially where target populations are likely to receive them. Messaging should occur in multiple formats and represent all populations for individuals to identify their risks and mitigate existing stigmas.
- Attention to the basic needs such as food, shelter, and clothing is essential to economic and physical wellbeing and a person's ability to take care of their health.
- Legislation to support individuals to access to PrEP without a prescription.
- Advocacy to support access to PrEP for adolescents 13-17 years without parental consent.
- Expansion of nPEP awareness and access points throughout the county.
- Database/referral source to connect individuals with PrEP/nPEP.
- Build collaborations with private pharmacies, sexual assault teams, clinical social workers, nurses, and rape crisis centers.
- Social media campaigns designed to change attitudes that prevent people from seeking testing and or care fir HIV/AIDS.
- Maintenance of standard HIV testing and treatment in prenatal care.

d. Respond

To eradicate HIV from the EMA, it is best to tailor efforts to high PWH density zip codes. The figure below reflects the top 5 zip codes with the highest concentration of PWH for each county within the EMA. More rural areas of the EMA should also be assessed for additional testing and treatment sites to assist those with transportation challenges and to be able to respond more effectively to clusters that may develop.

Figure 36: Number of PWH by County and Zip Code

Hernando		Hillsborough	
Zip Code	# of Cases	Zip Code	# of Cases
34609	86	33612	511
34608	84	33610	489
34606	74	33604	472
34613	56	33619	447
34601	52	33605	368
Pasco		**Pinellas**	
Zip Code	# of Cases	Zip Code	# of Cases
34668	146	33713	433
34653	105	33712	401
34652	99	33705	388
34667	96	33701	268
34691	83	33711	227

Source: Florida Department of Health, PWH By Zip code, with 3 or more cases Ages 13+, Living in Hillsborough County, as of June 30, 2021.

Strengths

- Capacity to utilize DOH surveillance data and e2Hillsborough to identify and to improve response to HIV transmission networks.
- Stakeholder support in connecting vulnerable populations to testing, treatment and prevention, especially as transmission networks are identified.
- Zero new cases of perinatally acquired HIV due to standard testing and treatment of women during pregnancy.
- Homeless point-in-time count data is available to overlay with HIV zip code level data to identify common hotspots to tailor efforts.
- Funding to support Early Intervention Specialists and Health Education Risk Reduction Specialists to support the needs of transmission networks.

Weaknesses

- Increased need for data related to the social determinants of health and risk factors specific to people living with or at risk for HIV, including sex workers, children aging out of foster care and victims of human trafficking.
- Limited resources for prevention, testing, and treatment of individuals in rural locations
- Lack of a countywide strategy to identify and respond to HIV transmission network.

Identified Needs

- Work with stakeholders to gather social, economic and HIV data for local underserved populations. For example, the average income for migrant workers with HIV or the prevalence of HIV among sex workers.

- Incorporate members of target populations into the development and implementation of strategies and compensate them appropriately.
- Use GIS data to identify where vulnerable populations reside and overlay this with HIV data. Identify areas with no access to testing and develop strategies to test in these areas to assess unknown prevalence of HIV.
- Deploy Early Intervention Specialists (EIS) and Health Education Risk Reduction Specialists (HERR) to locate those who were recently diagnosed to gather additional data.
- Establish MOAs with homeless/migrant/immigrant serving agencies to be better able to respond to networks.

a. Priority Populations

The Community Engagement and Planning Process is outlined in Section II and the contributing data sets and assessments are detailed in Section III. Using information gathered, specific objectives, strategies, and activities were developed to address the needs of the identified priority populations of Latinx, Black, and Youth (13-24) populations. Within these populations there is a special emphasis on Men who have Sex with Men (MSM) and Women of Childbearing Age (WCBA) for the EMA.

Strategies and activities such as addressing stigma, developing cultural and linguistic competency and implicit bias training, expanding messaging and materials to include representation from priority populations, and working with "gatekeepers" to priority communities are intended to decrease the health disparities found in and among our identified priority populations.

Section V: 2022-2026 Goals and Objectives

1. Goals and Objectives Description

The Tampa-St. Petersburg EMA collaboratively established its prevention and care plan for 2022-2026 to achieve a more coordinated response to addressing HIV in the local area. The plan's objectives and outcomes align with the Four Pillars of the Ending the HIV Epidemic (EHE), Diagnose, Treat, Prevent, and Respond. This section was developed as a response to the needs detailed in the preceding section. The Baseline Data presented under each Strategy is current as of June 2022.

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

***I. Diagnose* all people with HIV as early as possible**

Goal 1: Expand routine HIV testing by 25% in 5 years.
Key Activities and Strategies:

1. Increase the number of publicly funded test events from 25,039 to 32,000
2. Monitor total testing annually

Key Partners: DOH Pinellas, Testing and Prevention funded agencies
Potential Funding Sources: CDC HIV Prevention and Surveillance Programs, State and/or Local Funding, Medicaid, Medicare, Private Insurance
Estimated Funding Allocation: To Be Tracked
Outcomes (reported annually, locally monitored more frequently): Number of people newly diagnosed with HIV

Monitoring Data Source: DOH
Expected Impact on the HIV Care Continuum: Decrease the number of people with HIV in the EMA who receive a late HIV diagnosis (AIDS diagnosis within 3 months of HIV diagnosis) from 23% to 19%.

Goal 2: Expand HIV testing in non-traditional venues throughout the EMA by 20% in 5 years.
Key Activities and Strategies:

1. Obtain baseline testing data in jails, emergency rooms, and non-housed people by March 2023
2. Monitor testing in non-traditional venues annually
3. Increase testing in jails by 20%
4. Increase testing in emergency rooms by 20%
5. Increase testing in people experiencing homelessness by 20%

Key Partners: DOH Pinellas, Testing and Prevention funded agencies
Potential Funding Sources: CDC HIV Prevention and Surveillance Programs, State and/or Local Funding, Medicaid, Medicare, Private Insurance
Estimated Funding Allocation: To Be Tracked
Outcomes (reported annually, locally monitored more frequently): Number of people receiving HIV tests in non-traditional venues
Monitoring Data Source: DOH
Expected Impact on the HIV Care Continuum: Increase the number of people tested in non-traditional settings by 20%.

Goal 3: Increase partner testing for HIV by 50% in 5 years.
Key Activities and Strategies:

1. Increase new diagnosed clients interviewed for partner testing from 151 to 250.
2. Increase previously diagnosed clients interview for partner testing from 185 to 275.
3. Monitor partner testing annually.

Key Partners: DOH Pinellas, Testing and Prevention funded agencies
Potential Funding Sources: CDC HIV Prevention and Surveillance Programs, State and/or Local Funding, Medicaid, Medicare, Private Insurance
Estimated Funding Allocation: To Be Tracked
Outcomes (reported annually, locally monitored more frequently): Number of partners being tested for HIV and number of people living HIV
Monitoring Data Source: DOH
Expected Impact on the HIV Care Continuum: The percentage of newly diagnosed individuals successfully linked into medical care will reach 90%.

***II. Treat* people with HIV rapidly and effectively to reach sustained viral suppression.**

Goal 1: Increase the percentage of people newly diagnosed with HIV linked into medical care within 30 days from 85% to 90%.
Key Activities and Strategies:

1. Utilize test and treat services to link 90% of newly diagnosed individuals into medical care.

2. Monitor number of people newly diagnosed with HIV linked into medical care annually
3. Monitor number of people previously diagnosed with HIV re-engaged into medical care annually

Key Partners: Part A funded providers, Part B funded providers, DOH Pinellas, Hillsborough County Government
Potential Funding Sources: HRSA, CDC State/Local Funding, Medicaid, etc.
Estimated Funding Allocation: $3,174,487 (OAHS Part A)
Outcomes (reported annually, locally monitored more frequently): Number of people newly diagnosed with HIV linked into medical care; number of people previously diagnosed with HIV re-engaged into medical care
Monitoring Data Source: CAREWare, e2Hillsborough, EMRS
Expected Impact on the HIV Care Continuum: The percentage of newly diagnosed individuals successfully linked into medical care will reach 90%.

Goal 2: Increase the percentage of people with HIV considered to be retained in medical care from 75% to 85%.
Key Activities and Strategies:

1. Monitor the number of clients accessing medical case management services annually.
2. Monitor the number of clients accessing Health Education and Risk Reduction services annually.
3. Facilitate two capacity trainings for medical case management providers by December 2024

Key Partners: Part A funded providers, Part B funded providers, DOH Pinellas, Hillsborough County Government
Potential Funding Sources: HRSA, CDC State/Local Funding, Medicaid, etc.
Estimated Funding Allocation: $3,174,487 (OAHS Part A)
Outcomes (reported annually, locally monitored more frequently): Percentage of people with two medical visits at least three months apart.
Monitoring Data Source: CAREWare, e2Hillsborough, EMRS
Expected Impact on the HIV Care Continuum: The percentage of individuals with HIV considered retained in medical care will increase from 81% to 87%.

Goal 3: Increase the use of telemedicine to reach 450 clients throughout the EMA.
Key Activities and Strategies:

1. Facilitate a training for telemedicine providers on properly entering telemedicine services into the e2-Hillsborough database by December 2023.
2. Monitor telemedicine usage quarterly.
3. Increase the use of telemedicine services to 100 clients accessing substance misuse services, 100 access mental health services, 100 accessing Health Education and Risk Reduction, and 250 access Outpatient Ambulatory Medical Care.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services Department, Medical Case Management agencies
Potential Funding Sources: HRSA, State and/or Local Funding, Medicaid, Medicare, Private Insurance
Estimated Funding Allocation: $2,122,543 (MCM Part A)

Outcomes (reported annually, locally monitored more frequently): Number of people utilizing medical case management services.
Monitoring Data Source: CAREWare, e2Hillsborough
Expected Impact on the HIV Care Continuum: Increase the percentage of people considered to be virally suppressed from 87% to 90%.

Goal 4: Increase the use of screenings for mental health and substance misuse to reach 4,000 clients per year throughout the EMA by 2025.
Key Activities and Strategies:

1. Facilitate a capacity training for medical and mental health/substance abuse providers by December 2023.
2. Facilitate two community training courses, for the Ryan White Care Council or other community groups, on mental health and/or substance misuse topics by December 2024.
3. Monitor number of screenings quarterly.
4. Increase substance misuse screenings from 3,016 to 4,000 yearly by 2025
5. Increase mental health screenings from 2,668 to 4,000 yearly by 2025.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services Department, Medical providers, Mental Health/Substance Abuse providers
Potential Funding Sources: HRSA, State and/or Local Funding, Medicaid, Medicare, Private Insurance
Estimated Funding Allocation: $704,519 (MH&SU Part A)
Outcomes (reported annually, locally monitored more frequently): Number of people receiving screenings for mental health and substance misuse.
Monitoring Data Source: CAREWare, e2Hillsborough
Expected Impact on the HIV Care Continuum: Increase the number of people receiving mental health and substance misuse services from 550 people to 700 people.

***III. Prevent* new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and syringe services programs**

Goal 1: Increase the number of providers offering PrEP throughout the EMA from 11 to 20
Key Activities and Strategies:

1. Monitor the number of PrEP providers in the EMA annually.
2. Facilitate two capacity trainings for medical providers on the use of PrEP by December 2025.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services Department, Medical providers, pharmacies
Potential Funding Sources: HRSA, State and/or Local Funding, Medicaid, Medicare, Private Insurance
Estimated Funding Allocation: To Be Tracked
Outcomes (reported annually, locally monitored more frequently): Number of PrEP providers in the EMA.
Monitoring Data Source: DOH, CAREWare, e2Hillsborough
Expected Impact on the HIV Care Continuum: Increase the number of individuals prescribed PrEP, thereby decreasing the number of new transmissions from 462 to 350.

Goal 2: Increase the number of providers offering nPEP throughout the EMA from 6 to 12.
Key Activities and Strategies:

1. Monitor the number of nPEP providers in the EMA annually.
2. Facilitate two capacity trainings for medical providers on the use of nPEP by December 2025.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services Department, Medical providers, pharmacies
Potential Funding Sources: HRSA, State and/or Local Funding, Medicaid, Medicare, Private Insurance
Estimated Funding Allocation: To Be Tracked
Outcomes (reported annually, locally monitored more frequently): Number of nPEP providers in the EMA.
Monitoring Data Source: DOH, CAREWare, e2Hillsborough
Expected Impact on the HIV Care Continuum: Increase the number of individuals prescribed nPEP, thereby decreasing the number of new transmissions from 462 to 350.

Goal 3: Increase access to syringe exchange programs in the EMA to reach 800 participants by 2026.
Key Activities and Strategies:

1. Increase awareness of syringe exchange programs in the EMA by facilitating a community training by December 2024
2. Increase the number of education sessions conducted yearly from 20 to 40.
3. Increase the number of participants receiving syringe exchange services from 538 to 800.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services Department, IDEA Exchange Tampa
Potential Funding Sources: Private funding sources (state, federal, and local/municipal funds do not support local syringe service programs)
Estimated Funding Allocation: $115,000 (IDEA Exchange Tampa)
Outcomes (reported annually, locally monitored more frequently): Number of people utilizing syringe exchange program and monitor medical outcomes.
Monitoring Data Source: DOH, CAREWare, e2Hillsborough, IDEA Exchange Tampa
Expected Impact on the HIV Care Continuum: Increase the availability of syringe exchange providers, increasing the number of providers from one to three, as well as decreasing the number of new HIV transmissions through drug injection from 20 to five.

<u>IV. Respond</u> quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

Goal 1: Increase overall outreach efforts for persons living with HIV throughout the EMA.
Key Activities and Strategies:

1. Facilitate two trainings for service providers to encourage culturally and linguistically competent care.
2. Ensure provider staff are reflective of service population.
3. Develop and deploy effective messaging strategies.
4. Conduct focus groups and town halls regarding access to care and retention strategies.

5. Utilize programs such as ARTAS to identify and bring back individuals considered to be lost to medical care.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services
Potential Funding Sources: HRSA, State and/or Local Funding
Estimated Funding Allocation: To Be Tracked
Outcomes (reported annually, locally monitored more frequently): Number of individuals retained in medical care and virally suppressed.
Monitoring Data Source: DOH, CAREWare, e2Hillsborough.
Expected Impact on the HIV Care Continuum: Expand the number of individuals accessing medical care through Ryan White funding from 5,981 to 6,500 as well as increase the percentage of individuals retained in medical care from 81% to 87%.

Goal 2: Increase culturally and linguistically competent outreach efforts for Black and non-Black persons of color throughout the EMA.
Key Activities and Strategies:

1. Increase the number of people accessing Health Education and Risk Reduction services through Minority AIDS Initiative from 845 to 1,050.
2. Ensure provider staff are reflective of service population.
3. Develop and deploy effective messaging strategies.
4. Conduct focus groups and town halls regarding access to care and retention strategies.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services
Potential Funding Sources: HRSA, State and/or Local Funding
Estimated Funding Allocation: $643,761 (MAI)
Outcomes (reported annually, locally monitored more frequently): Number of Black and non-Black individuals retained in medical care and virally suppressed.
Monitoring Data Source: DOH, CAREWare, e2Hillsborough.
Expected Impact on the HIV Care Continuum: Increase the number of Black and non-Black persons of color retained in medical care from 3,780 to 4,500, as well as increasing the percentage of those retained in care from 81% to 85% and increasing the percentage of viral load suppression from 87% to 90%.

Goal 3: Increase culturally and linguistically competent outreach efforts for youth between 13 and 24 years of age throughout the EMA.
Key Activities and Strategies:

1. Increase the number of young people tested through outreach efforts from 1,307 to 1,550.
2. Track current social media usage.
3. Develop effective messaging strategies.
4. Place messaging on high usage social media platforms.
5. Conduct focus groups and town halls with young people regarding access to care and retention strategies.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services
Potential Funding Sources: HRSA, CDC HIV Prevention and Surveillance Programs, State and/or Local Funding
Estimated Funding Allocation: To Be Tracked
Outcomes (reported annually, locally monitored more frequently): Number of young people accessing and being retained in medical care.

Monitoring Data Source: DOH, CAREWare, e2Hillsborough.
Expected Impact on the HIV Care Continuum: Increase the number of young people engaging and being retained in care from 85% to 92% and increasing the percentage of viral suppression from 88% to 95%.

Goal 4: Decrease the number of unhoused people living with HIV in the EMA.
Key Activities and Strategies:

1. Monitor the number of unhoused people living with HIV in the EMA annually.
2. Increase funding available for HOPWA and other housing programs in the EMA.
3. Increase the number of providers offering housing services through Ryan White and HOPWA.
4. Expand Ryan White housing services to Pasco and Hernando counties.

Key Partners: DOH Pinellas, Hillsborough County Health Care Services, HOPWA
Potential Funding Sources: HRSA, EHE, HOPWA
Estimated Funding Allocation: $4,727,081 (HOPWA, Part A)
Outcomes (reported annually, locally monitored more frequently): Number of PWH being retained in medical care and virally suppressed.
Monitoring Data Source: CAREWare, e2Hillsborough, HOPWA
Expected Impact on the HIV Care Continuum: The percentage of individuals with HIV considered retained in medical care will increase from 81% to 87%. Increase the percentage of people considered to be virally suppressed from 87% to 90%.

a. Updates to Other Strategic Plans Used to Meet Requirements

The Tampa-St. Petersburg EMA is not using portions of another local strategic plan to satisfy this requirement. The Goals and Objectives listed were developed for the 2022-2026 Integrated Prevention and Care Plan after reviewing local data and priorities.

Section VI: 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up

1. 2022-2026 Integrated Planning Implementation Approach

The Tampa-St. Petersburg Eligible Metropolitan Area (EMA) Administration is accountable, responsible, and answerable for planning, directing, coordinating, and improving healthcare services in the EMA. The overall responsibility and leadership for the Integrated Plan lies with the Recipient (Part A) and the Lead Agency (Part B). They oversee the overall planning, assessing, measuring, and implementation of the Plan. EMA Administration leadership has identified the professional planning staff of the Ryan White Care Council to assist with monitoring, implementation, and evaluation. The goals and objectives section of the Plan outlines the responsible parties for each of the activities to be undertaken over the life of the Plan.

The West Central Florida Ryan White Care Council will convene quarterly meetings of the Planning and Evaluation committee to discuss, review, and revise the Plan. Provider representatives, quality management staff, planning council staff, and consumers will provide updates to the group on Plan-related activities, share successes and challenges, as well as determine

the nature of reporting findings to community stakeholders in a timely and continuous manner. The process will be data driven and team focused, adhering to the Plan-Do-Study-Act (PDSA) method.

a. Implementation

The Plan-Do-Study-Act (PDSA) method serves as the foundation for the overall implementation of the Integrated Plan. It is a deliberate approach that allows for a potential change to be tested and evaluated. Going through the prescribed four steps guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again. The first step, Plan, emphasizes operationalizing objectives in clear language, developing benchmarks based on available data, and institute and engage a plan to implement changes. The second step is Do, where the actual plan is executed. In this phase all issues are identified as well as any unexpected observations. Early analysis of the data occurs at this stage as well. The third phase of PDSA is Study. A full analysis of the data is made and compared against the benchmarks stated in the first stage. A summary is developed and then presented to the interested parties. The fourth stage is Act, where the findings determine the changes that need to be made. The fourth stage feeds back into the first stage, and the loop begins again.

Successful implementation of the plan requires collaboration across all the identified parties throughout this document as well as sufficient funding and staffing. Part A and Part B leadership will distribute the plan to the provider network, focusing primarily on the activities for which they will be responsible. Once the plan has been distributed to the providers, the Recipient Office and Lead Agency will begin engaging in the activities.

Funding must be commensurate of the plan's intended outcomes, and to that end the data used to justify the proposed activities in this document will be part of the annual prioritization and resource allocation process. The data will be presented to the Planning and Evaluation Committee and the Care Council to assist in determining the best ways to meet the community's needs.

Providers must be positioned to succeed. To that end, once funding has been allocated according to services, Part A and Part B leadership will work with service providers on an ongoing basis to ensure staffing levels and resources are appropriate to properly implement the goals and objectives. In addition to funding, education will be essential to ensure successful plan implementation. Training needs will be identified on an ongoing basis to implement the most effective treatments and coordinated by Part A and Part B leadership.

On top of having buy-in across the board and appropriate funding, the plan will require accurate data for review and analysis. A concerted and collaborative effort must be in place to ensure data is collected and entered in a timely manner, and erase gaps in clinical outcome data. Based on clinical outcome data in CAREWare and e2Hillsborough, there are gaps in clinical data with respect to individuals who are insured through Medicare, Medicaid, and the private sector. Lead Agency and Recipient Office leadership will work with provider staff to obtain permission from individuals to gather viral load and proof of the prescription of anti-retroviral medication. This is due to gaps found in CAREWare and e2Hillsborough. Should the EMA succeed in obtaining viral load and medication info, that would be of great help to achieving the Plan's goals and objectives

through a better understanding of the landscape of HIV throughout the community, and not just for those who access HIV care through Ryan White funded entities.

Once the plan is set in place throughout the EMA, the plan will begin immediate implementation. Providers, with the assistance of Quality Management staff, will track outcomes associated with the objectives tied into their respective service(s).

b. Monitoring

The professional planning staff of the Ryan White Care Council will oversee the monitoring process. They will work in conjunction with the Planning and Evaluation committee to ensure that data is being consistently tracked, reported, and examined for areas of actionable improvement. Monitoring reports will be presented quarterly to the Planning and Evaluation Committee as data is updated on Plan goals and objectives. The Care Council will review Integrated Plan progress twice a year, or as necessary. Additional HIV prevention and care planning groups in the EMA can request monitoring updates at any time. The Planning and Evaluation (P&E) Committee will include Part A and Part B leadership, provider representatives, Quality Management staff, community members, and People with HIV. Clinical outcome data will be pulled from CAREWare and e2Hillsborough and reported quarterly, as available. P&E will review the data and discuss strategies to either maintain the findings or develop and implement strategies to improve on the reported data.

In addition to the data from CAREWare and e2Hillsborough, providers and Part A and Part B leadership will present data and updates pertaining to the goals and objectives focused on administrative and policy-related activities.

Annual monitoring visits, as contractually required by Part A and Part B, will also include the review of administrative, policy, and outcome data outlined in the goals and objectives. This will be reported back to Part A and Part B leadership, providers, as well as the monitoring group.

c. Evaluation

Part A and Part B leadership will spearhead all evaluation activities, with staff assigned to conduct monthly reviews of outcome data. This will ensure quick turnaround so that providers can make changes on the fly to improve overall service delivery. Part A and Part B Quality Management staff will be tasked with collecting clinical performance measure data and will use CAREWare and e2Hillsborough as data sources. Part A and Part B leadership, in collaboration with the provider network, will oversee and collect all pertinent data related to administrative and policy changes. Evaluation data will be shared with the Planning and Evaluation Committee on a quarterly basis or as requested.

d. Improvement

Grounded in the Plan Do Study Act methodology, data will serve as the foundation for service improvement. Data will be collected quarterly and reported back to the Planning and Evaluation Committee for review and discussion. To make meaningful changes that result in service

improvement, and most importantly, the lives of those living with HIV, the necessary resources must be in place and the commitment to seeing the plan through must also be strong.

e. Reporting and Dissemination

Reporting will be led by the professional planning staff of the Care Council, with input from Part A and Part B leadership and the members of the Planning and Evaluation Committee. Quarterly status reports will be developed and shared at the West Central Florida Ryan White Care Council meetings, local prevention planning body meetings, Florida Department of Health leadership, Hillsborough County Government leadership, and will also be posted online for wider distribution. Annual reports will be shared to the groups as well.

Additionally, once a PDSA cycle has been successfully implemented multiple times and is proven to be successful, it is adopted as a Best Practice. This will also be shared amongst the provider network for wider implementation if not already being done so.

f. Updates to Other Strategic Plans Used to Meet Requirements

The jurisdiction consulted existing plans during the writing of the Integrated Plan, but each section has been written specifically for this document. Each of the plans throughout the Tampa-St. Petersburg EMA rely upon quality data and team-based decision making to ensure an optimal system of care for persons living with HIV. The community is an integral part in ensuring the area's successes.

The annual Ryan White Needs Assessment includes the process of establishing priorities and allocating resources based on community input with the assistance of Ryan White Planning Council Support. Since the West Central Florida Ryan White Care Council is a community-driven structure, it is ultimately responsible for overseeing the completion of the Needs Assessment and Integrated Plan elements. 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 Care Council when setting priorities. Each element is reviewed in conjunction with the HIV Care Continuum, Unmet Need estimates, and Emerging Issues in the EMA and is reviewed and approved by Care Council with input from people living with HIV as well as the community. If service needs change from one year to another, they are documented and presented to Care Council for consideration when determining priorities and funding decisions.

Multiple methods are already in place to obtain feedback from people living with HIV and community stakeholders. One is through direct participation during Care Council and Planning and Evaluation meetings. Regular meetings provide everyone with ample opportunities to comment on reporting that impacts funding and the overall system of care for the Tampa-St. Petersburg EMA. Part A and Part B leadership produce reports and discuss programmatic and fiscal updates monthly and solicit feedback from all of those in attendance, ensuring a constant feedback loop between leadership and the community. For the purposes of the Integrated Plan, quarterly updates will be provided to the Planning and Evaluation Committee and updates at least twice a year to the Care Council to provide an ongoing venue for feedback and critiques of the Plan.

In addition, the Tampa-St. Petersburg area regularly implements Client Satisfaction Surveys to obtain feedback from individuals accessing Ryan White services. Findings from these surveys will also be presented to West Central Florida Ryan White Care Council as well as any consumer advisory boards interested in learning about the perception of the quality of care received.

The Tampa-St. Petersburg EMA utilizes the Plan-Do-Study-Act (PDSA) methodology to assess the course of an initiative and determine if changes should be made based on the data available to the area. The process will serve as the foundation for reviewing and analyzing findings pertaining to the goals and objectives. Should new evidence present cause for service or structural improvements, it will be discussed, and the Integrated Plan working group will make needed changes to incorporate those changes based on the new data.

One of the advantages of the PDSA model is that it also serves as a vehicle for examining processes. Process and outcome review will operate under parallel processes. Should issues arise within the work group, all discussions will be led by Part A and Part B leadership. The area(s) of concern will be brought to light and a decision on how to best move forward will be decided based on the good of the Plan and the community which it serves.

Section VII: Letters of Concurrence

1. RWHAP Part A Planning Council: The West Central Florida Ryan White Care Council
2. Hillsborough County Ending the HIV Epidemic (EHE) Planning Body
3. Pinellas County EHE Planning Body
4. Area 5/6/14 HIV Planning Partnership: Prevention Planning Body
5. Pinellas Planning Partnership