SECTION II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan Progress

Goal 1: Reduce New HIV Infections

Objective 1: Increase the percentage of people living with HIV who know their serostatus to at least 90%, from the baseline of 84%.

As of 2019, 86.5% of People with HIV (PWH) know their serostatus.

Strategy 1: Implement routine testing in applicable medical facilities.

Timeframe	Activity	Progress
By the end of September 2017	Distribute the routine testing guidelines developed by the HIV/AIDS Section of the Florida Department of Health headquartered in Tallahassee to applicable medical facilities	**Completed in 2018:** Guideline obtained from FDOH and distributed along with a Dear Colleague letter via the Everbridge system. Provider survey to determine training needs completed and distributed to providers to determine training needs on implementing routine testing. The results indicated no training was required at this time.
By the end of November 2018	Ensure training on implementation of the guidelines is provided to all medical facilities.	**Completed:** No training implemented as a result of the survey (trainings are available)

Strategy 2: Increase outreach and targeted testing.

Timeframe	Activity	Progress
By the end of December 2020	Deliver intensified outreach and testing to MSMs including young MSMs and heterosexuals of color.	**Ongoing:** 28,757 total publicly funded HIV tests performed in 2019. Of which, 4,091 tests were among MSMs of color, 4,316 were among Heterosexuals of color and 5,659 tests were among the 25-29 age group. • 0.97 percent overall HIV positivity rate. A 3 percent positivity rate was seen among MSMs and 0.85 percent positivity among age 25-29-year olds.

		• In 2019, 259 positives were linked to care (92.83%); 115 positive MSM were linked to care (93.50%); 45 individuals between ages 25-29 were linked to care (93.75%). More targeted testing is needed for the identified sub-populations.

Strategy 3: Increase post-test follow-up and coordination with DIS (Disease Intervention Specialists).

Timeframe	Activity	Progress
By the end of March 2018	Designate individuals at testing sites to coordinate daily/weekly follow-up with DIS.	**Completed:** • 244 newly diagnosed confirmed positives referred and linked to DIS for Partner Services. • 168 previously diagnosed confirmed positives referred and linked to DIS for Partner Services. • 223 newly diagnosed confirmed positives linked to Case Management and/or Primary Medical Care (with CD4 cell count and Viral Load testing). • 163 previously diagnosed confirmed positives linked to Case Management and/or Primary Medical Care (with CD4 cell count and Viral Load testing). •
By the end of March 2018	Determine a model to increase collaboration with DIS.	**Completed**: No specific model needs to be identified. • No changes in system needs to occur as greater than 90% of both newly diagnosed and previously positive individuals are referred to DIS.
By the end of December 2020	Develop jurisdiction wide couples' counseling and testing protocols to include partner elicitation and notification.	**Discontinued:** This activity was initially successful during 2016-2017**,** however as the modality was disseminated across the State responses to the very personal sexual history questions generated unsafe conditions for both the clients and the counselor. Utilization decreased from 70 to 7 couples using the services in the 2017-2018 period, therefore dissemination stopped to ensure the safety of both clients and staff.

Objective 2: Reduce the number of new diagnoses by at least 10%, from the baseline of 845 to 760.

As of 2019, the incidence of HIV has been reduced by10.8% from 845 to 754.

Strategy 1: Increase Prevention for Positives Initiatives.

Timeframe	Activity	Progress
By the end of March 2021	Implement Effective Behavioral Interventions (EBIs) for Prevention for Positives/Treatment as Prevention (TaP).	**Ongoing:** 5 organizations responded to provide prevention services of which 4 within the OSA received funding to implement TaP initiatives. In 2019, Let's BeHIVe received monies to implement (TBD; which EBI's and which populations and overall progress update) • A total of $70,338 was received for EHE planning in September 2019.

Strategy 2: Increase knowledge and availability of Pre-Exposure Prophylaxis (PrEP) and Non-Occupational Post Exposure Prophylaxis (nPEP).

Timeframe	Activity	Progress
By the end of June 2019	Identify medical facilities and CBOs predisposed to implementing PrEP and nPEP.	**Ongoing:** All 5 Health Departments (HD) located within the OSA have implemented PrEP and 77 non-HD sites are providing PrEP. There are 11 providers of nPEP services, three of which are within the RWHAP system of care. 82 providers in the OSA are currently providing PrEP.
By the end of September 2020	Provide training on the implementation of PrEP and nPEP.	**Ongoing**: Trainings are implemented within DOH facilities unless contacted by Non-DOH facilities • Trainings have been implemented for PrEP within the DOH's of Area 7, DIS, Family Planning. • More focus will be spent on nPEP trainings in the future.
By the end of March 2021	Implement PrEP and nPEP.	• **Ongoing:** The total number of clients screened for PrEP services within the Health Department facilities grew from 694 in 2018 to 2,726 in 2019, with 145 receiving initial prescriptions and 176 receiving follow-up visits and refills. Within CBOs 6,682 clients were screened for Prep services with 2,272 being eligible for the services with 110 enrolled in services.

Strategy 3: Increase knowledge and availability of interventions for high-risk populations.

Timeframe	Activity	Progress

By the end of March 2017	Identify and apply for alternative funding sources for EBIs for target populations.	**Completed in 2018**: Identified and applied for a total of seven grant opportunities, including the prevention RFA 18-001. Five applications received funding an increase of 2 agencies receiving funding.
By the end of June 2017	Implement training to CBOs, ASOs, medical facilities, etc. on EBIs for target population.	**Completed in 2018:** Six EBIs were identified and will be implemented in January of 2019 to include CONNECT, ARTAS, VOICES, Peer Program, Sister-to-Sister, and Healthy Love.
By the end of December 2017	Implement appropriate EBIs.	**Completed in 2019:** 7 distinct EBIs were implemented in 2019 due to the timing of the Prevention RFA award.

Goal 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV

Objective 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 80%.

As of 2019, 80.6% of individuals that were newly diagnosed were linked to care within 30-days.

Strategy 1: Increase peer support services, linkage to care and case management services.

Timeframe	Activity	Progress
By the end of September 2020	Identify funding resources to support expansion of: Early Intervention Services (EIS), linkage, peer support and case management services.	**Completed:** One RWHAP sub-recipient received new SAMSHA funding for $500,000 per year for at least 4 years to identify and link individuals with HIV who are also misusing substances. Additionally, EHE funding in the amount of $1 million has been provided to expand EIS, linkage, peer support and case management services. • PCS to care providers and prevention providers, are any of the 340B funds being used to provide HIV services?
By the end of December	Expand the aforementioned services.	**Ongoing**: Services for EIS, linkage, peer support and case management services were expanded in 2019.

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Strategy 2: Increase uniformity in peer support, linkage to care and case management services.

Timeframe	Activity	Progress
By the end of September 2018	Identify/develop standardized training for the provision of the aforementioned services.	**Completed**: Trainings were implemented with medical case management, referral for healthcare/support, and early intervention specialist staff on HIV basics and labs, linkage and retention, medication adherence, medication resistance, HIV & aging, mental health and substance abuse, and navigating payor systems.
By the end of February 2019	Implement the standardized training to CBOs, ASOs, etc.	**Completed:** The Peer Support online training offered through the CDC Every Dose Every Day Toolkit has become the standardized training for Peers in the service area. To date four organizations have had their staff trained, 7 individuals have participated. A standardized training for all linkage staff was developed and the first training session completed on 5/29/2019, 12 individuals participated. New linkage staff will be required to access this training. A Manual on providing MCM services was developed and disseminated in August of 2019 to enhance the training information included in the Service Standards that will increase the uniformity of the delivery of this service.

Strategy 3: Increase presence of peer support, linkage to care and case management services in the private sector.

Timeframe	Activity	Progress
By the end of December 2018	Identify the models/best practices of aforementioned services that work in the private sector.	**Completed in 2019:** Two to three RWHAP funded providers established collaborations with private providers to provide the Ryan White of linkage, case management and peer support services. Additionally, 2-3 private providers have adopted the RWHAP model of care for individuals with HIV by hiring case managers and or peers.
By the end of March 2021	Implement identified models/best practices.	**Completed:** In 2019, three private providers implemented the Ryan White model of care by offering Peer and Case Management Services to clients with HIV. In 2020, two of those providers came into the Ryan White HIV/AIDS Program system of care.

Objective 6: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 65% from the baseline of 59%.

As of 2019, the percent of persons diagnosed with HIV infection who have been virally suppressed has increased to 69.5%.

Strategy 1: Increase the number and percentage of individuals on ARV (antiretroviral therapy).

Timeframe	Activity	Progress
Annually, by end of December	Educate clinical providers on the most current Public Health Service (PHS) Guidelines annually (within 90 days of update).	**Ongoing:** 2 webinar sessions have been offered to date – One session was completed with __ participants. The second session had to be cancelled due to lack of registrants. PCS will be exploring with AETC if pre-recorded webinars could be made available and providers contractually required to complete a certain number of sessions within a pre-determined timeframe. ASK YASMIN • 94% of clients receiving HIV-related medical care in the RWHAP Part A system were prescribed ARV in FY 2019; this represents a 7% increase from FY 2018. In Brevard, 92% of clients were prescribed ARV in FY 2019 which represents a 7% increase from FY 2018.
Annually, by end of December	Provide treatment updates in a Continued Medical Education/Continued Educational Units (CME/CEU) setting for clinical providers.	**Ongoing:** Number of sessions receiving CME/CEUs. - Need to get information from AETC • 94% of clients receiving HIV-related medical care in the RWHAP Part A system were prescribed ARV in FY 2019; this represents a 7% increase from FY 2018. In Brevard, 92% of clients were prescribed ARV in FY 2019 which represents a 7% increase from FY 2018.
By the end of August 2017	Identify and strengthen partnerships with key points of entry.	**Ongoing:** In 2017 MOA/MOU with Emergency Rooms (ER) were identified as a gap and the area has begun collaboration with Gilead and Advent Health (one of the largest Hospital Systems in the area) to implement FOCUS.

Strategy 2: Increase adherence to treatment by promoting a consumer centered system focused on acceptance, trust and caring.

Timeframe	Activity	Progress
By the end of May 2017	Provide system-wide standardized customer service training.	**Completed in 2019:** Three (4) completed across the EMA and Brevard County *(October 26, 2017, July 26, 2018 and July 27, 2018, July 2019)* • Number of staff trained: 209 • Referral Specialists, EIS, front desk staff, Medical Case Managers and Peers • 6 individual completed a TOT to provide ongoing training for the area. • Training is provided per request
By the end of August 2018	Provide comprehensive cultural competency training reflective of consumers served.	**Completed in 2019:** Three (4) completed across the EMA and Brevard County *(October 26, 2017, July 26, 2018 and July 27, 2018, July 2019)* • Number of staff trained: 144 • Referral Specialists, EIS, front desk staff, Medical Case Managers and Peers • 6 individuals completed a TOT to provide ongoing training for the area. • Training is provided per request
By the end of October 2018	Provide activities to decrease compassion fatigue across agencies and providers.	**Ongoing:** The Lead Agency is exploring adding this to the Cultural Humility Training of Trainers session with AETC to increase the availability and frequency of the training. Ask Yasmin

Strategy 3: Increase the awareness and the use of EBIs that address treatment adherence.

Timeframe	Activity	Progress
By the end of February 2019	Provide information, resources and technical assistance to strengthen and increase delivery of EBIs that address treatment adherence.	**Completed:** The QM Technical Workgroup has piloted 2 interventions (Peer Support and Partnership for Health) earmarked to increase the viral suppression rates of clients receiving care through the RWHAP system of care. Ongoing training is provided as

Goal 3: Reduce HIV-Related Disparities and Health Inequities

Objective 7: Reduce the percentage of persons in HIV medical care who are homeless (as defined by the HAB SPNS Initiative) to no more than 5%.

Met: In 2019, 5% of clients enrolled in HIV medical care within the RWHAP Part A system of care are unstably (homeless) housed.

Strategy 1: Increase collaboration with organizations serving the homeless population.

Timeframe	Activity	Progress
By the end of November 2017	Establish relationships/ partnerships with Homeless Service Network (HSN), Housing Opportunities for Persons with AIDS (HOPWA) and other homeless service providers.	**Completed in 2018:** The Ryan White Part A office has representation on the HSN and provides liaison activities between the two systems. Cross training of HOPWA Case Managers and Ryan White Case Managers was completed in July 2018. A total of 53 individuals participated in the training – HOPWA Case Managers, Ryan White Medical Case Managers, Referral Specialists, Executive Directors and Supervisors. The HOPWA Program Manager attends the HSN meetings on a monthly basis, to date 5 meetings have been attended, and informs the RWHAP service system about changes and challenges within the housing arena. She also attends the Permanent Supportive Housing Chronic Registry meetings on a weekly basis, during which chronically homeless individuals and individuals in critical situations (regardless of HIV status) are discussed regarding placement in permanent housing. Due to the lack of affordable housing in the area, this meeting has decreased to approximately twice per month.

Strategy 2: Align with the "Housing First" initiative.

Timeframe	Activity	Progress
By the end of May 2018	Educate the Ryan White system of care on the "Housing First" initiative.	**Completed:** This information was provided to the Ryan White Case Managers during the cross-training sessions.

By the end of December 2021	Identify the number of homeless HIV positive individuals in medical care.	**Ongoing:** For the FY 2018-2019 period, 8% of clients receiving RWHAP Part A-funded medical care were in a temporary housing situation and 13% were unstably housed. In the RWHAP Part B-funded medical care for the same period, 4% of clients were in a temporary housing situation and 2% were unstably housed. For the FY 2019-2020 period, 7% of clients receiving RWHAP Part A-funded medical care were in a temporary housing situation and 6% were unstably housed. In the RWHAP Part B-funded medical care for the same period, 4% of clients were in a temporary housing situation and 2% were unstably housed.
By the end of December 2021	Link homeless HIV positive individuals to housing.	• Not started

Strategy 3: Establish "out-call" (non-traditional) services to provide medical care in a non-clinical setting.

Timeframe	Activity	Progress
By the end of October 2019	Identify current and potential providers of needed services.	**In Progress:** The Mobile Unit operated by a RWHAP Part A-funded provider has increased the number of locations, additionally more providers are offering telehealth services and one is exploring providing telehealth services on 6 Mobile Units.
By the end of December 2021	Implement "out-call"/non-traditional services.	**In Progress:** • No. of tests • No. of positives • No. of individuals linked to care

Objective 9: Reduce disparities in the rate of new diagnoses by at least 10% in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females.

Strategy 1: Expand available services to the aforementioned populations.

Timeframe	Activity	Progress
By the end of March 2017	Identify and strengthen relationships with key stakeholders in the aforementioned populations.	**Discontinued:** A number of providers (both prevention and care) are currently providing services to these subpopulations therefore; the current activity should be replaced with the activity immediately below.
By the end of December 2019	Work with providers to ensure culturally appropriate services are provided to increase and retain these subpopulations in all services.	**Measure:** • Encouraging Prevention Providers & Public Testing Providers to seek out cultural humility trainings • Number of priority population participants enrolled in various interventions offered Percentage of priority populations retained in various interventions offered
By the end of November 2019	Increase mobile testing to address disproportionately affected populations as identified in epidemiological profile.	**Ongoing:** The number of mobile testing units from 2 in 2017 to 5 in 2019 – will receive data quarterly from Area 7. Ask Dean, number of tests per mobile unit In CY 2018 6,804 MSMs 1,176 young MSM of color and 4,062 Black heterosexual individuals were tested. In CY 2019: (Alelia)

Strategy 2: Promote a consumer-centered system focused on acceptance, trust, and caring.

Timeframe	Activity	Progress
By the end of September 2018	Continue and improve education among clinical providers regarding current and updated modalities of treatment for the aforementioned populations.	**Completed:** Three (4) completed across the EMA and Brevard County *(October 26, 2017, July 26, 2018 and July 27, 2018, July 2019)* • Number of staff trained: 144 • Referral Specialists, EIS, front desk staff, Medical Case Managers and Peers • 6 individual completed a TOT to provide ongoing training for the area.
By the end of July of each year	Continue and improve cultural competency training for Provider staff.	**Ongoing:** 6 individuals successfully completed the TOT to provide the training on an ongoing basis in 2019.

		• Two (2) training sessions were completed in 2019 with 61 participants. One was completed in 2020 with 20 participants prior to the corona virus pandemic.

Strategy 3: Increase the availability of EBIs that target these populations.

Timeframe	Activity	Progress
By the end of March 2017	Identify best practices and successful techniques in existing EBIs.	**Completed in 2019:** The number of funded providers implementing EBIs increased from three to five in December of 2018.
By the end of March 2019	Standardize implementation of identified best practices and successful techniques for all EBIs.	**Completed** in 2019: All funded prevention provider staff received standardized training on implementation of the chosen EBIs.

Goal 4: Achieving a More Coordinated Local Response to the HIV Epidemic

Objective 1: Determine and develop mechanisms to improve coordination across all planning bodies.

Achieved! We have one planning body in the OSA providing planning & coordination for the area.

Strategy 1: Investigate the feasibility of combining planning bodies.

Timeframe	Activity	Progress
By the end of June 2019	Improve education regarding coordination of effort and system of care.	**Completed:** Discussed merger with Planning Bodies. Decision to merge prior to the timeframe in the Plan.
By the end of December 2019	Convene with all planning body stakeholders.	**Completed:** Hired a consultant to facilitate the process in May and began developing a merged body via processes and bylaws.
By the end of June 2020	Update 2005 feasibility study.	**Discontinued**

Strategy 2: Identify best practices for coordinating planning bodies based on the results of the investigation.

Timeframe	Activity	Progress
By the end of December 2020	Develop and implement communication protocols between the planning bodies.	**Completed:** Meeting of both bodies held in August 2017 to vote on new Bylaws and to name the merged body. All recommendations adopted by both bodies.
By the end of December 2021	Implement the results of the feasibility study.	**Completed:** Membership of new merged body began with members of each body requesting to remain as members of merged body. Merged body began meeting with 20 members in October 2017.