2022-2026

# INTEGRATED HIV PREVENTION AND CARE PLAN

## ORLANDO SERVICE AREA

THE 2022-2026 ORLANDO SERVICE AREA INTEGRATED HIV PREVENTION AND CARE PLAN FOLLOWS THE GUIDANCE SET FORTH BY THE CENTER FOR DISEASE CONTROL (CDC) AND THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) AND WILL ACCELERATE REACHING THE GOALS IN THE NATIONAL HIV/AIDS STRATEGY.

Central Florida HIV PLANNING COUNCIL

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**Figure 1. Table of Acronyms and Definitions**

| Acronym | Definition |
|---|---|
| ACA | Affordable Care Act |
| ACS | American Community Survey |
| ADAP | AIDS Drug Assistance Program |
| AETC | AIDS Education and Training Center |
| AHEC | Area Health Education Center |
| AIDS | Acquired Immunodeficiency Syndrome |
| ART | Antiretroviral Therapy/Treatment |
| ARTAS | Antiretroviral Treatment and Access to Services |
| ARV | Antiretroviral Medication |
| ASO | AIDS Service Organization |
| BNH | Black Non-Hispanic/Latinx Person |
| BPHP | Bureau of Public Health Pharmacy |
| BRTA | Business Responds to AIDS |
| CBO | Community-based Organization |
| CDC | Centers for Disease Control and Prevention |
| CFHPC | Central Florida HIV Planning Council |
| CHAG | Community HIV Advisory Group |
| CHD | County Health Department |
| CHW | Community Health Worker |
| COVID-19 | Coronavirus Disease 2019 |
| CPPA | Collaborative Pharmacy Practice Agreement |
| CPS | Current Population Survey |
| CQM | Continuous Quality Management |
| DCF | Department of Children and Families |
| DIS | Disease Intervention Specialist |
| DOC | Department of Corrections |
| EBI | Evidence-based Interventions |
| ED | Emergency Department |
| EFA | Emergency Financial Assistance |
| EHE | Ending the HIV Epidemic |
| EIIHA | Early Identification of Individuals with HIV/AIDS |
| EMA | Eligible Metropolitan Areas |
| FCPN | FL Comprehensive Planning Network |
| FDC | FL Department of Corrections |
| FDCF | FL Department of Children and Families |
| FDEA | FL Department of Elder Affairs |
| FDOE | FL Department of Education |
| FDOH | FL Department of Health |
| FOCUS | Frontlines of Communities in The United States Initiative |
| FQHC | Federally Qualified Health Centers |
| FRTA | Faith Responds to AIDS |
| HAPC | HIV/AIDS Program Coordinator |
| HAV | Hepatitis A Virus |
| HBCU | Historically Black Colleges and Universities |
| HBV | Hepatitis B Virus |
| HCV | Hepatitis C Virus |
| HIE | Health Information Exchange |
| HIP & CSA | Health Insurance Premium and Cost Sharing Assistance |
| HIP | High-Impact Prevention |

| Acronym | Definition |
|---|---|
| HIV | Human Immunodeficiency Virus |
| HOPWA | Housing Opportunities for People with AIDS |
| HPG | HIV Planning Group |
| HRSA | Health Resources and Services Administration |
| ID | Infectious Disease |
| IDU | Injection Drug Use |
| IPC | Integrated Prevention and Care |
| LAPA | AIDS Pharmacy Assistance Program- Local |
| MAI | Minority AIDS Initiative |
| MIS | Management Information System |
| MMP | Medical Monitoring Project |
| MMSC | Male-to-Male Sexual Contact |
| MSA | Metropolitan Statistical Area |
| ~~MSM~~ | ~~Men who have Sex with Men~~ |
| NHAS | National HIV/AIDS Strategy |
| NIR | No Identified Risk |
| nPEP | Non-Occupational Post-Exposure Prophylaxis |
| OSA | Orlando Service Area |
| PCS | Planning Council Support |
| PE | Provide Enterprise |
| PEP | Post Exposure Prophylaxis |
| PrEP | Pre-Exposure Prophylaxis |
| PWH | Person with HIV |
| PWID | Person Who Inject Drugs |
| PIR | Parity, Inclusion, and Representation |
| RWHAP | Ryan White HIV/AIDS Program |
| SCSN | Statewide Coordinated Statement of Need |
| SDOH | Social Determinants of Health |
| SPNS | Special Projects of National Significance |
| SSP | Syringe Services (Exchange) Program |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| SUD | Substance Use Disorder |
| T&T | Test and Treat |
| TB | Tuberculosis |
| TIC | Trauma-Informed Care |
| TOPWA | Targeted Outreach for Pregnant Women Act |
| UCF | University of Central Florida |
| UM-AETC | University of Miami AIDS Education and Training Center |
| US | United States |
| VA | US Department of Veteran's Administration |
| VL | Viral Load |
| WCBA | Women of Childbearing Age |
| WICY&F | Women, Infants, Children, Youth, and Families |
| WNH | White Non-Hispanic/Latinx Person |

# SECTION I. EXECUTIVE SUMMARY OF THE INTEGRATED HIV PLAN AND STATEWIDE COORDINATED STATEMENT OF NEED

## A. Executive Summary of the Integrated HIV Plan and SCSN

The Orlando Service Area (OSA) is pleased to submit its ***HIV Integrated Prevention and Care Plan, 2022-2026*** to the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The OSA Integrated HIV Plan reflects the culmination of intensive local planning efforts and community engagement. The planning effort was designed to ensure that persons with HIV (PWH), CDC and HRSA-funded prevention and care system, recipients and subrecipients, front-line workers, local government officials, and other stakeholders participated. Community and provider engagement activities included town hall meetings, listening sessions, and surveys.

The OSA Integrated HIV Plan addresses the current and emerging HIV epidemic in the OSA. Central Florida counties included Brevard, Lake, Orange, Osceola, and Seminole. The Central Florida HIV Planning Council (CFHPC) members oversaw the development and contributed to content of the Integrated HIV Plan, as well as conducted extensive community engagement activities to ensure that PWH had input into design of the planning process. CFHPC and committee PWH members helped to design and convene town hall meetings throughout the OSA, listening sessions, and surveys. PWH contributed to questions addressed and moderated the events.

In addition to community engagement activities, PWH also actively served on an ad hoc Integrated HIV Plan committee. Members were briefed RWHAP and CDC-funded prevention, linkage, care, retention, and reengagement activities. Detailed reports were made on HIV epidemiology, biomedical and behavioral prevention strategies, HIV testing methods, HIV housing services, and RWHAP and FDOH-funded services. An extensive funding inventory was completed to identify gaps in resources.

The Integrated HIV Plan ad hoc committee collaborated to develop Integrated Plan goals, objectives, strategies, timeframes, responsible parties, and data indicators. Priority populations were also identified for intensive prevention and care interventions. Those priority population included;

- Hispanic/Latinx PWH with HIV risk related to Male-to-Male Sexual Contact (MMSC),
- Black/African American non-Hispanic/Latinx (BNH) with HIV risk related to MMSC,
- Black/African American non-Hispanic/Latinx with HIV risk related to heterosexual transmission, and
- White non-Hispanic/Latinx with HIV risk related to MMSC.

A proposed implementation plan was developed that describes the infrastructure, procedures, systems, and tools to support the key phases of integrated HIV planning. We describe the infrastructure, procedures, systems, and tools to support the key phases of integrated HIV planning to accomplish the OSA Integrated HIV Plan's goals and objectives. The key phases include: (1) implementation, (2) monitoring, (3) evaluation, (4) improvement, and (5) reporting and dissemination. The roles of the CFHPC and committees in implementing the Plan were also operationalized.

The CFHPC adopted four goals and related objectives and strategies to be the focus of the Integrated HIV Plan for 2022-2026. A status-neutral approach will be applied to undertaking goals and objectives including:

- Prevent new HIV Infections by (1) increasing HIV awareness among people, communities, and the health workforce, (2) expanding and Improving Implementation of effective prevention Interventions.

- Improve HIV-related health outcomes among PWH by (1) rapidly linking them to care after diagnosis and provide low-barrier access to HIV care and treatment, (2) identifying, engaging, or reengaging PWH not in care or in care but not virally suppressed, and (3) increased retention and adherence to treatment to achieve and maintain long-term viral suppression.
- Addressing HIV-related disparities and health inequities by (1) reducing HIV-related stigma and discrimination; (2) reducing disparities in new HIV infections, awareness of HIV status, and improving the HIV Care Continuum, and (3) addressing social determinants of health and co-occurring conditions that exacerbate HIV-related disparities.
- Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and interested parties: (1) integrate programs to address the Syndemics of HIV, STIs, viral hepatitis, and behavioral health disorders in the context of social and structural/institutional factors and (2) enhancing quality, accessibility, dissemination, and application of aggregate data and analytic analyses, including the HIV prevention and care continuum and social determinants of health data.

### a. Documents Submitted to Meet Requirements

**Figure 2** summarizes all documents used to meet submission requirements, as well as existing and newly development materials applied for each requirement.

**Figure 2: Supporting Documentation Submitted to Meeting Requirements**

| Document | Description | Developed for plan? |
|---|---|---|
| CDC and HRSA Integrated HIV Prevention and Care Planning Guidance, 2022-2026 | Developed to support the submission of the OSA Integrated HIV Plan for states and EMAs for the 2022-2026 cycle | No (Existing) |
| Florida's Unified EHE Plan, 2020 | Unified plan representing FL and counties identified as Phase 1 EHE jurisdictions (including Orange County EMA) | No (Existing) |
| OSA Integrated HIV Plan, 2017-2021 | Developed collaboratively in the OSA among stakeholders to eliminate HIV transmission and reduce HIV-related deaths in 2017-2022 | No (Existing) |
| Orlando EMA Early Identification of Individuals with HIV/AIDS (EIIHA) Plan, October 2021 | Orlando EMA RWHAP Part A integrated prevention and care plan submitted as part of the Part A Supplemental Grant Application | No (Existing) |
| Orlando EMA RWHAP Part A Supplemental Grant Application, FY 2022-2023 | Detailed summary of EMA-wide and county-specific epidemiologic data, unmet need, HIV Continuum of Care, Part A/Minority AIDS Initiative (MAI) service use and outcomes | No (Existing) |
| Orlando EMA EHE Annual Report, September 2022 | Summary of EHE activities, service use, process and outcome measures, successes and challenges, and related program data | No (Existing) |
| Meeting Notes from CFHPC Integrated HIV Plan Ad Hoc Committee meetings | Minutes of the September-November Committee meetings to identify OSA-specific activities to address the Goals, Objectives, and Strategies identified in the CDC/HAB Guidance | Yes (New) |
| Presentations Made to the CFHPC in RWHAP Part A Priority Setting and Resource Allocation (PSRA) Meeting | Presentations summarizing the HIV/AIDS epidemic in the Orlando EMA, Parts A and B FY 2021-2022 use and expenditures, EIIHA service use and process measures, results of Part A process and outcome measures, community engagement events, and RWHAP client satisfaction | No (Existing) |
| OSA Community Engagement | Summaries from local area community engagement | Yes (New) |

| | | |
|---|---|---|
| Discussion Tools and Written Summaries Documenting Results | activities including five Town Hall Meetings, two provider (medical and case management) Listening Sessions, and RWHAP client satisfaction survey | |
| Local Area Resource Inventory and OSA federal, state, and local funding | Resource inventory of HIV prevention and care recipients, subrecipients, and other community resources in the five OSA counties | Yes (New) |
| Local Area Interview Guides and Interviews Summaries | Interview guides applied to gather (1) prevention and care funding data to populate the Resource Inventory, (2) information for OAS Integrated HIV Plan sections, and (3) information from the prevention and Part B HAPC and Area 3/13 Part B staff | Yes (New) |

# SECTION II. COMMUNITY ENGAGEMENT AND PLANNING PROCESS

This section describes how the OSA approached the 2022 Integrated HIV Plan development process through engagement of community members and other stakeholders in the five-county area. The section also describes measures to fulfill legislative requirements including:

- Statewide Coordinated Statement of Need (SCSN),
- RWHAP-funded Parts A and B planning requirements, including those requiring feedback from key stakeholders and PWH; and
- CDC planning requirements.

## I. Jurisdictional Planning Process

OSA includes Brevard, Lake, Orange, Osceola, and Seminole Counties. The OSA has a long history of engaging PWH and other stakeholders in developing and implementing HIV prevention and care. These efforts have been accomplished through PWH representation on the CFHPC and its committees, as well as extensive and ongoing community engagement.

The CFHPC membership consists of about 50% PWH conflicted consumers, and 45% un-conflicted consumers. The CFHPC hosts the PWH Caucus RWHAP-funded Community Meetings, which attracts PWH and front-line workers, including CFHPC members. The Community Meetings serve as an ongoing venue for PWH to provide feedback to RWHAP and CDC recipients and the CFHPC about effective HIV prevention and care services, geographic disparities in accessible services, barriers to care, and other issues.

Priority populations are well represented on the CFHPC. These populations include PWH with the following self-identified characteristics:

- Hispanic/Latinx PWH with HIV risk related to Male-to-Male Sexual Contact (MMSC),
- Black/African American non-Hispanic/Latinx (BNH) with HIV risk related to MMSC,
- Black/African American non-Hispanic/Latinx with HIV risk related to heterosexual transmission, and
- White non-Hispanic/Latinx with HIV risk related to MMSC.

CFHPC different committees meet monthly. Outreach for new CFHPC members is ongoing. Applicants for membership are interviewed by CFHPC consumer members. Skills, lived experience, geographic representation, and ability to meet statutorily required representation from key stakeholders are considered in the application process.

The groups use the principles of parity, inclusion, and representation (PIR). Meetings are held in accessible locations near public transportation systems. Meetings are currently hybrid, offering a virtual meeting platform. Participants were able to attend via computer, smart phone, or telephone, ensuring access to the meetings needed to conduct Integrated HIV Plan efforts.

### a. Entities Involved in the Planning Process

**Figure 1** summaries CFHPC membership, vacancies, and other information about entitles involved in the planning process. Participants in the planning process include the CFHPC and its Integrated HIV Plan Ad Hoc Committee, Orange County Health Services Department Part A Program, Orange County Housing Opportunities for People with AIDS (HOPWA), RWHAP Part B HIV/AIDS Program, Part B Consortium Lead Agency, RWHAP Part C recipients, CDC and RWHAP-funded subrecipients, PWH, organizations directly funded by CDC and/or HRSA, advocates and community leaders, and front-line providers. These entities and individuals have

committed to participate in the OSA Integrated HIV Plan in 2022-2026 to undertake: (1) implementation, (2) monitoring, (3) evaluation, (4) improvement, and (5) reporting and dissemination activities.

**Figure 2** illustrates the extent to which CFHPC members are representative of the demographic characteristics of PWH in the OSA. The CFHPC membership is aligned with HIV prevalence in the OSA by race, ethnicity, age group, and gender.

**Figure 3.** summarizes the roles and responsibilities of CFHPC Committees, their meeting structure, standing committee membership, and the Percent of members that are PWH. The figure illustrates the extent to which PWA are well-represented, with PWAs making up most or all of the members. The figure also underscores the substantial participation of PWAs in HIV prevention and care planning efforts.

**Figure 1. RWHAP Requirements for Planning Council Appointments and Status, November 2022**

| CFHPC Membership Categories | Vacant? | Vacancy duration? | Challenges in filling position (if applicable) |
|---|---|---|---|
| Healthcare Providers, Including FQHCs | No | NA | NA |
| CBOs Serving Affected Populations/ASOs | No | NA | NA |
| Social Service Provider: Housing and Homeless Services | No | NA | NA |
| Social Service Provider – Other | No | NA | NA |
| Mental Health Provider | No | NA | NA |
| Substance Abuse Provider | No | NA | NA |
| Mental Health and Substance Abuse Provider | NA | NA | Filled Separately |
| Local Public Health Agencies | Yes | Oct-21 | Seat vacant for past year. All eligible staff from EMA Local Public Health Agency reached their term limits on CFHPC and must take a one-year break or they already fill other federally mandated seats. CFHPC will continue recruitment and periodic check-ins with FDOH contacts to fill seat. |
| Hospital Planning Agencies or Other Healthcare Planning Agencies | No | NA | NA |
| Affected Communities, including PWH and Historically Underserved Groups | No | NA | NA |
| Non-Elected Community Leaders | No | NA | NA |
| State Medicaid Agency | No | NA | NA |
| State Part B Agency | No | NA | NA |
| State Part B Agency and State Medicaid Agency | NA | NA | Filled Separately |
| Part C Recipient (s) | Yes | Oct-22 | Application received- Waiting for applicant to complete meeting requirements before their interview |
| Part D Recipients | No | NA | NA |
| Other Federal HIV Programs, Including HIV Prevention Programs | No | NA | NA |
| Representatives of/or Formerly Incarcerated PWH | Yes | Apr-21 | Application for this seat was received in June 2022. First application received in over a year. Applicant no longer interested in joining. CFHPC support staff and members collaborating to develop new and better strategies for filling this seat. |

**Figure 2. CFHPC Membership and Comparison of Demographic Characteristics with OSA HIV Prevalence**

| Demographic Characteristics | HIV Prevalence in EMA | | Total CFHPC Membership | | Unaffiliated Part A Clients on CFHPC | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| **Race/Ethnicity** | | | | | | |
| White, not Hispanic | 4,466 | 30% | 6 | 30% | 1 | 20% |
| Black, not Hispanic | 5,806 | 39% | 9 | 45% | 2 | 40% |
| Hispanic | 4,168 | 28% | 5 | 25% | 2 | 40% |
| Asian/Pacific Islander | 0 | 0% | 0 | 0% | 0 | 0% |
| American Indian/Alaska Native | 0 | 0% | 0 | 0% | 0 | 0% |
| Multi-Race | 0 | 0% | 0 | 0% | 0 | 0% |
| Other/Not Specified | 447 | 3% | 0 | 0% | 0 | 0% |
| **Total** | 14,887 | 100% | 20 | 100% | 5 | 100% |
| **Gender Identity** | | | | | | |
| Male | 11,165 | 75% | 10 | 50% | 5 | 100% |
| Female | 3,722 | 25% | 9 | 45% | 0 | 0% |
| Transgender: male-to-female | 0 | 0% | 1 | 5% | 0 | 0% |
| Transgender: female-to-male | 0 | 0% | 0 | 0% | 0 | 0% |
| Additional gender identity | 0 | 0% | 0 | 0% | 0 | 0% |
| **Total** | 14,887 | 100% | 20 | 100% | 5 | 100% |
| **Age (in Years)** | | | | | | |
| 13-19 | 88 | 1% | 0 | 0% | 0 | 0% |
| 20-29 | 1,545 | 10% | 1 | 5% | 0 | 0% |
| 30-39 | 2,779 | 19% | 6 | 30% | 2 | 40% |
| 40-49 | 3,051 | 20% | 5 | 25% | 1 | 20% |
| 50-59 | 4,397 | 30% | 5 | 25% | 1 | 20% |
| 60+ | 3,027 | 20% | 3 | 15% | 1 | 20% |
| **Total** | 14,887 | 100% | 20 | 100% | 5 | 100% |

**Figure 3. CFHPC Committees, Meeting Structure, Standing Committee Membership, and Percent PWH**

| | |
|---|---|
| **Executive Committee** | |
| | Members include the CFHPC's Senior and Junior Co-Chairs, current Committee chairs, Prevention and Patient Consumer Representatives (n=2 PWH) |
| | Oversees all work passed to the CFHPC from the standing committees |
| | Approves work to be reviewed at the next CFHPC Business Meeting |
| **CFHPC Business Meeting** | |
| | Updates presented on all CFHPC business conducted within the current month |
| | CFHPC members review and comment on reports from each standing committee, Community Meeting, Part A Recipient, FDOH prevention and Part B HAPC, HOPWA, and more |
| **Membership, Public Relations, and Marketing Committee (n=6, 100% PWH)** Committees currently combined until March 2023. CFHPC Junior Co-Chair serves as ex-officio member. | |
| | Recruits new CFHPC members and supports retention of current members |
| | Ensures parity, inclusion; and representation |
| | Oversees an open nominations process |
| | Provides member orientation and training |
| | Recommends CFHPC committee assignments |
| | Develops marketing and recruitment strategies including community engagement in developing and implementing the Integrated HIV Plan |
| | Maintains CFHPC social media and website |
| | Disseminates public information and education |
| | Coordinates community events and activities. |
| **Service Systems, Quality, (n=5, 60% PWH) and Needs Assessment Committee (n=5, 605 PWH)** Committees joined until 2023. CFHPC Senior Co-Chair serves as ex-officio member. | |
| | Oversees Recipient and subrecipient activities to improve to the HIV prevention and care continuum |
| | Coordinates implementation and refinement of the Integrated HIV Plan |
| | Oversees and contributes to the design of needs assessments, evaluations and related reports, special studies, town hall meetings, and community engagement events |
| | Reviews aggregate data and manages data presentations |
| | Oversees the PSRA process, monitors Part A and EHE expenditures, and approves reallocations across service categories |
| | Updates Standards of Care, monitors performance of CQM activities, assesses the Efficiency of the Administrative Mechanism per HRSA requirements, and coordinates with federal recipients to ensure responsiveness to requirements and policies |
| **RW Community Meeting** | |
| | Monthly informational and resource-centered meetings for PWH across OSA |
| | While the public is welcomed to the Community Meetings, these meetings are designed as a safe space for local PWH to be informed on the latest CFHPC activities; design and implementation of the Integrated HIV Plan, receives Parts A and B updates, receive monthly life-focused presentations. The Community Meetings participated as an informal focus group to provide feedback about unmet needs, priorities, effective strategies, and methods for community engagement throughout the OSA. |

### b. CFHPC Leadership in Design and Implementation of the Integrated HIV Plan

In 2022, CFHPC formed an Integrated HIV Plan Ad Hoc Committee including CFHPC members as well as volunteering community members. Other participants include PWH, Area 7 HAPC, RWHAP-funded Part A Recipient's Office, RWHAP-funded Parts C and D representative, Housing Opportunities for People with AIDS (HOPWA) representative, mental health and substance abuse providers, and HIV prevention providers. The Integrated HIV Plan Ad Hoc Committee's composition reflects the demographic characteristics of the Central FL HIV epidemic.

To prepare for their role, the Integrated HIV Plan Ad Hoc Committee attended a mandatory one-day data presentation prepared by the Part A Recipient's office, Part B Lead Agency (Heart of

Florida United Way, or HFUW), CFHPC staff, and other key programs. Participation in the data presentations was required for Committee members to vote on approving the Integrated HIV Plan for CFHPC review.

The Ad Hoc Committee was responsible for planning and providing input on community engagement activities. They selected the questions for the town hall meetings and assisted with material preparation. They also assisted CFHPC staff to select dates and accessible locations for the Town Hall Meetings. Once the meetings were scheduled, the Committee assisted with outreach in OSA counties. Several members also assisted in conducting presentations at the Town Hall Meetings. The Committee also recommended which groups to participate in PWH and provider surveys, as well as survey content.

The Committee guided development of the Integrated HIV Plan. They also make recommendations to the CFHPC about developing goals, activities, strategies, and process and outcomes measures to be included in the Plan, as well as collaborative methods for implementing the plan.

Standing monthly reports were made by the Chairperson of the Ad Hoc Integrated HIV Plan Committee to the full CFHPC to ensure CFHPC members were involved in the process from inception to submission of the Plan to the CDC and HRSA HAB. The CFHPC also reviewed and commented on the Plan's goals, objectives, strategies, and activities. The writing team reviewed and incorporated CFHPC comments and recommendations as applicable.

The final draft of the Plan was presented to the CFHPC and CFAP during the November meeting for review and approval. Upon CFHPC and CFAP approval, the Letter of Concurrence from the Chairs of those planning bodies wase obtained (see **Appendix A**). The completed OSA Integrated HIV Prevention and Care Plan was then submitted to FDOH in Tallahassee for inclusion into the Statewide Plan. The Plan was also submitted to CDC and HAB/HRSA.

**Methods Used by CFHPC to Conduct Town Hall Meetings**

The CFHPC collaborated with the RWHAP Part A and Part B staff to engage various community members and counties in the OSA in the Integrated HIV Plan assessment and priority setting process. These entities hosted several community engagement activities in the form of Town Hall meetings conducted over a five-month period. The meetings were designed to educate PWH, other community members, providers, and case managers about the purpose of the Integrated HIV Plan and offer an opportunity to offer feedback to be used as qualitative data for the Integrated HIV Plan.

Other than the exception of the provider listening sessions, participants at each Town Hall Meeting were asked a set of seven questions that were recommended by the Florida Comprehensive Planning Network (FCPN). Each Town Hall Meeting lasted between two to three hours. During the meetings, attendees were provided with dinner as well as opportunities to win raffle items. At every event the participants received presentations on the importance of the Integrated HIV Plan, including the impact of HIV on the OSA over the last five years, and a brief presentation from Gilead Sciences who sponsored most of the meetings.

Each Town Hall Meeting was carefully planned to ensure that PWH had free transportation to the meeting sites and the venues were physically accessible. All venues adhered with Americans with Disabilities Act (ADA) accessibility standards. The venues were located on a bus route with a stop nearby, and centrally located within their respective counties. Attendees provided a combination of verbal, written, and online responses collected from Mentimeter, a virtual polling application. Multiple methods for submitting feedback were used to ensure the events were as accessible as possible, specifically for people who might not want speak due to fear of stigma.

**Figure 4. OSA Community Engagement Strategies, Locations, and Presentation Topics at Town Hall Meetings and Listening Sessions by County, 2022**

| Community Engagement Strategies | Location | Presentations Given |
|---|---|---|
| **Orange County Town Hall Meeting: 75 attendees** | | |
| • Marketing campaign with Growth Marketing Company (advertisements on Google, Facebook, Instagram, and Grindr)<br>• Social media pushes from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies<br>• In-person outreach efforts by CFHPC members<br>• Flyers posted in providers' offices<br>• Provide transportation | Holden Heights Community Center | • Introduction to the Integrated HIV Plan by the Recipient or Lead Agency Staff<br>• Gilead Sciences, the Importance of Testing and Care in the EHE |
| **Orange County RWHAP Part A and B Case Managers Listening Session: 43 attendees** | | |
| • Case managers were informed by Recipient and Lead Agency staff of the event through word of mouth, meetings, and email. | Orange County Facilities Building. | • Introduction to the Integrated HIV Plan by the Recipient or Lead Agency Staff<br>• Gilead Sciences presentation: The Importance of Testing and Care in EHE |
| **Orange County Providers' Listening Session: 13 attendees** | | |
| • Collaborated with HAPC and Part B Lead Agency to advertise to providers via social media and email campaigns. | Ruth Chris Steak-house | • Introduction to the Integrated HIV Plan by the Recipient or Lead Agency Staff<br>• Gilead Sciences presentation: The Importance of Testing and Care in EHE |
| **Osceola County Town Hall Meeting: 11 attendees** | | |
| • Social media campaigns from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies<br>• In-person outreach efforts by CFHPC members<br>• Flyers posted in providers' offices<br>• Provide transportation | Hart Memorial Central Library | • Introduction to the Integrated HIV Plan by the Recipient or Lead Agency Staff<br>• Gilead Sciences presentation: The Importance of Testing and Care in EHE |
| **Seminole County Town Hall Meeting: 32 attendees** | | |
| • Social media campaigns from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies<br>• In-person outreach efforts by CFHPC members<br>• Flyers posted in providers' offices<br>• Provide transportation | Seminole County Public Library | • Introduction to the Integrated HIV Plan by the Recipient or Lead Agency Staff |
| **Lake County Town Hall Meeting: 20 attendees** | | |
| • Social media campaigns from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies<br>• In-person outreach efforts by CFHPC members<br>• Flyers posted in providers' offices<br>• Provide transportation | Eustis Service Center | • Introduction to the Integrated HIV Plan by the Recipient or Lead Agency Staff |
| **Brevard County Town Hall Meeting: 31 attendees** | | |
| • Social media pushes from the CFHPC Facebook, Instagram, and digital newsletter and by partner agencies<br>• In-person outreach efforts by CFHPC members<br>• Flyers posted in providers' offices<br>• Collaborated with the Chair of the Integrated HIV Plan Ad Hoc Committee to determine effective outreach strategies for Brevard County residents<br>• Provide transportation | Compre-hensive Healthcare | • Introduction to the Integrated HIV Plan by the Recipient or Lead Agency Staff |

CFHPC staff facilitated the Town Hall Meetings and Listening Sessions. They used a common set of open-ended questions to gather responses from attendees. Separate sets of open-ended questions were used in the online-survey and the Case Management Listing Session. **Figure X** summarizes the questions used.

**Figure 5. Questions Addressed in OSA Community Engagement Activities, 2022**

| Community Engagement Activity | Questions Addressed |
|---|---|
| **CFHPC Town Hall Meetings (Brevard, Lake, Orange, Osceola, Seminole)** | From your observations and experiences, what are the two or three major problems in the system of care as it related to HIV prevention and care? |
| | What are the barriers to engaging the community? |
| | What are barriers to starting and staying in care? |
| | What are some solutions to consider in reducing barriers? |
| | What do you think is the most important factor in addressing the HIV epidemic in your community? |
| | Do you believe the community has a role or any responsibility in HIV prevention and care? |
| | • If YES, what do you consider to be the role of the community in HIV prevention/care? |
| | • If NO, why don't you think the community has a responsibility in HIV prevention/care? |
| | What are some activities from the last Integrated HIV Plan that we should consider including in the new plan? |
| **Townhall Online Campaign** | From your observations and experiences, what are the two or three major problems in the system of care as it is related to HIV prevention and care? |
| | What are the barriers to engaging the community? |
| | What are barriers to starting and staying in care? |
| | What are some solutions to consider in reducing barriers? |
| | What do you think is the most important factor in addressing the HIV epidemic in your community? |
| | Do you believe the community has a role or any responsibility in HIV prevention and care? |
| | If YES, what do you consider to be the role of the community in HIV prevention/care? |
| | If NO, why don't you think the community has a responsibility in HIV prevention/care? |
| | What are some activities from the last Integrated HIV Plan that we should consider including in the new plan? |
| **Case Manager Listening Session** | What are the barriers to reaching/contacting clients? |
| | What resources and training, such as communication tools or technology, do you feel that you need to contact and provide quality care to clients? |
| | What solutions would you have to prevent compassion fatigue, burnout, or secondary trauma? |
| | What solutions would you have to some of the issues raised in the March 15th Orange County Town Hall Meeting? (In response to summary hand-out) |
| | What solutions do you have to issues within the RWHAP system in general? |
| | To what services are you having difficulty linking clients? |
| | What are your barriers to efficiently and effectively providing care? |
| | If funding was no object, how would you design the case management system? |

Qualitative methods were used to identify key themes identified in summaries of each of the community engagement activities. Qualitative analytic software was not used to summarize the data due to the need to summarize the data quickly for inclusion in the OSA Integrated HIV Plan. Rather, a consultant to the CFHPC applied qualitative coding methods to assign responses to overarching themes and domains. These data were used to identify barriers and facilitators (e.g., physical, personal, financial, structural, and policy) and recommended actions. Results of the community engagement activities are summarized in **Section III. Contributing Data Sets and Assessments** summarize key themes identified in the qualitative analysis.

### c. Role of Planning Bodies and Other Entities

The FDOH plays a major role in HIV planning, organization, funding, and service delivery. FLDOH uses a centralized public health delivery model in which it directly funds and operates County Health Departments throughout FL. FDOH also is the RWHAP Part B Program Recipient in which it directly funds care services in counties outside Part A EMAs. FLDOH also operates the

statewide AIDS Drug Assistance Program (ADAP) and Health Insurance Premium and Cost Sharing Assistance.

FDOH has organized FL counties into 14 HIV Partnership Areas, each with an HIV/AIDS Program Coordinator (HAPC) to oversee prevention and care program operations in each HIV partnership area. HAPCs ensure that program activities are planned in an inclusive and collaborative manner to assure other local resources and specific client needs are considered and addressed. Two HAPCs are assigned from Partnership Areas 7 and 3/13, respectively, due to inclusion of Lake County in the OSA.

FDOH RWHAP Part B consortia operating in FL further complicate planning, services delivery, and outcomes measurement. Consortia are community-based regional planning entities established by RWHAP Part B recipients. The consortia plan and prioritize RWHAP Part B funds allocated to their area, promote service coordination, and serve as a community forum. Representatives of local public and non-profit health and support service providers serve as consortium members. Lead agencies are member agencies within the consortium designated by FDOH to perform contract administration as a fiscal agent. clinical quality management (CQM), and core medical and support services. Upon receiving RWHAP Part B funds from FDOH, each lead agency is required to provide administrative assistance to the planning body (consortium) in the program area. The planning bodies serve as the entities that meet the RWHAP planning requirements for the program area and advise the lead agencies in the PSRA process. Lead agencies facilitate the provider selection process through a network of local partners (CBOs, CHDs, consumers, planning bodies, etc.).

The FDOH HIV Prevention Program collaborates with the Patient Care, Medical, and Surveillance programs to deliver comprehensive HIP strategies and services with overarching goals of reducing the number of new HIV transmissions, increasing the proportion of persons living with HIV who know their status, linking PWH to care and support services, and reducing risk behaviors that may lead to HIV and STD diagnoses. Florida's HIP program is multi-faceted and includes HIV testing, linkage to care, peer navigation programs, comprehensive prevention interventions for PWH, partner services, PrEP/PEP, perinatal HIV prevention, corrections initiatives, condom distribution, community outreach (traditional and Internet-based) and engagement, and other services. The Prevention Program also collaborates with the RW Part A programs, FQHCs, CBOs, academia, PWH, and other stakeholders to implement many HIP interventions and strategies. These essential partnerships help to ensure individuals are receiving comprehensive HIV prevention services along the HIV care continuum, leading to improved health outcomes for those living with HIV/AIDS.

### d. Collaboration with RWHAP-Funded Parts- SCSN Requirement

The Part A Recipient and CFHPC aligned its integrated planning activities with the FDOH statewide Integrated HIV Plan. The aims of that alignment was to avoid duplication and gaps and optimize funding and other resources.

### e. Engagement of PWH- SCSN Requirement

Not applicable.

### f. Priorities

Key priorities are summarized in Section V.

### g. Updates to Other Strategic Plans Used to Meet Requirements

Not applicable.

# SECTION III. CONTRIBUTING DATA SETS AND ASSESSMENTS

In this section, we summarize the findings of qualitative and quantitative analyses to describe how HIV impacts the OSA to identify: (1) services that OSA residents need to access and maintain HIV prevention, care, and treatment services; (2) barriers encountered by clients accessing those services; and gaps in the HIV prevention and care service delivery system.

This section fulfills several legislative requirements including: (1) SCSN, (2) Part A and B planning requirements including those necessitating feedback from people with HIV (PWH) and other key stakeholders, and (3) CDC planning requirements.

## I. Data Sharing and Use

Data sharing agreements (DSAs) were executed between RWHAP Parts A, B, and C recipients and subrecipients for participation in Provide Enterprise (PE), a client and provider-level relational database. PE modules include client demographics, HIV epidemiologic, financial, and health insurance enrollment data. PE uses unique client identifiers to link client-level data with detailed client assessments, service utilization data, lab orders and results, and expenditures, and other programmatic information. Groupware Technologies, Inc. (GTI), the PE developer, has DUA with Transunion, a third-party data vendor that queries FL Medicaid enrollment files to complete HIPAA 270/270 transactions. GTI also has a DSA with FL ADAP. In turn, FL ADAP has DSAs with each Part A recipient, including the Orlando EMA.

Similarly, DUAs were established between the FDOH and Part B subrecipients for use of CAREWare, a client-level relational database. Similarly, FDOH ADAP and the health insurance premium and cost sharing program have DSAs with Part B subrecipients and FDOH local health departments (LHDs).

## 2. Epidemiologic Snapshot

*Data presented in this snapshot were obtained for the period through Calendar Year (CY) 2020. Updated OSA epidemiologic and related data from FDOH for the five county OSA was unavailable until late in the Integrated HIV Plan preparation process. Analyses had to be recomputed to align with the OSA definition, rather than the jurisdictional definitions used for the Part A EMA or Part B Area. The snapshot will be updated early in 2023 to include analyses through 2022.*

**Incidence:** The FDOH Bureau of Communicable Diseases, reports that there were 518 new (incident) HIV cases in the OSA in 2020- a decrease by 139 cases from 657 cases in 2019. Over the past five years, the number of new AIDS cases decreased by 62 for a total of 200 cases in 2020. The decline in HIV testing during the COVID pandemic likely contributed to the decline in new HIV and AIDS case reporting.

Over the past three years, the number of PWH increased by 132 cases for a total of 13,389 PWH. In all three groups, the Black non-Hispanic (BNH) population was overrepresented in the percent of new HIV cases and new AIDS cases. BNHs accounting for 40.5% and 49.0%, respectively. The Hispanic/Latinx population accounted for 37.1% of new HIV cases and 31.0% of new AIDS cases. The BNH population increased to 39.4% of PWH while consistently representing around 15.8% of the OSA population.

Cisgender men were disproportionately represented among new AIDS cases, ranging from 73.5% of new AIDS cases to 82.0% of new HIV cases in the last three years. The ratio of females to males was the same from 2019 to 2020; 51:49, respectively. Youth ages 13-24 years accounted for 20.7% of new HIV cases, 5.0% of new AIDS cases, and 5.0% of PWH.

Older adults 50 years of age or older accounted for 17.6% of new HIV cases, 32.0% of new AIDS cases, and 49.6% of PWH. The MMSC exposure category accounted for 81.5% of all new Cisgender male HIV cases, 74.1% of new Cisgender male AIDS cases and 75.3% of male PWH. Heterosexual contact was reported as the mode of exposure for 92.2% of new Cisgender female HIV cases, 96.2% of new Cisgender female AIDS cases, and 83.5% of Cisgender female PWH. Perinatal exposure accounted for 100.0% of new HIV cases for children ages 0-12 years and 100.0% of PWH for the same age range.

**Trends in New Incident HIV Cases:** The number of PWH newly diagnosed with HIV decreased by 19.5% from 619 cases to 518 cases between 2016-2020). Among racial and ethnic groups, 19.7% identified as WNH, 40.5% as BNH, and 37.1% as Hispanic. Both BNHs and Hispanics were overrepresented when compared to the racial/ethnic distribution in the OSA population.

Over the past five years, the percentage of Hispanics newly diagnosed with HIV remained stable- from 34.1% in 2016 to 37.1% in 2020. Cisgender males were also overrepresented. accounting for 82.0% of new HIV cases. People who identified as transgender represented 0.6% of newly diagnosed with HIV in 2020.

Among age groups, the greatest increases in the last five years were noted among PWH 60 years or older and PWH 40-44 years of age. The number of new HIV cases increased 19.4% and 8.7%, respectively. For people 35-39 years of age, new cases increased 3.1% over the past five years. MMSC exposure accounted for 81.5% of new HIV cases among Cisgender males in 2020.

Trends in HIV exposure categories over the last five years were identified. MMSC/IDU decreased by 18.2% and PWH exposed via IDU decreased by 33.3%. Among race and ethnic groups, IDU exposure increased 200.0% among BNH Cisgender males, as well as Hispanic/Latino MMSC/IDU by 33.3%. IDU exposure among WNH PWH decreased over the past five years. Heterosexual contact accounted for 14.9% of HIV cases among Cisgender males and 92.4% of new HIV cases among Cisgender females. New HIV cases increased by 166.7% for Hispanic/Latina women of child bearing age (WCBA) as defined by the 15-44 age group. In contrast, 21.1% for Hispanic/Latina Cisgender women accounted for 21.1% of WCBY. In the past five years. Hispanic/Latina Cisgender females with IDU exposure increased from zero cases in 2016 to three cases in 2020. Newly diagnosed people with AIDS decreased 19.4% from 248 cases in 2016 to 200 cases in 2020.

Racial and ethnic diversity as found in the OSA general population, with 17.0% identifying as WNH, 49.0% as BNH, and 31.0% as Hispanic. BNHs were overrepresented when compared to the OSA population, with only 15.8% of OSA residents identifying as BNH. Over the last five years, new AIDS cases among WNHs decreased 22.7%, BNHs decreased 7.5%, and Hispanics decreased 20.5%. Among Asian/Native Hawaiian/Pacific Islanders, the number of new AIDS cases decreased from five cases in 2016 to two cases in 2020- a 60.0% decrease over the past five years. Males were overrepresented, accounting for 73.5% of all new HIV cases. People who identify as transgender male increased from no cases in 2016 to one case in 2020. New AIDS cases increased among adults ages 40-44 years and 60 years or older. Among people with new AIDS cases between 30-34 years, new AIDS cases increased 21.4% from 2016 to 2020. Increases in AIDS cases were also noted in the 13-19 age group, with two cases in 2016 versus four cases in 2020. MMSC exposure accounted for 74.1% of all new AIDS cases among Cisgender men. Decreases were noted for all exposure categories except Cisgender females with heterosexual contact who had a 2.0% increase between 2016-2020.

**Prevalence:** Living PWH increased from 12,583 in 2016 to 13,389 in 2020- a 6.4% increase. Racial/ethnic disparities exists, as BNHs accounted for 15.8% of the OSA population but 39.4% of PWH. The percentage of Hispanic PWH were similar to the OSA population- 29.9% versus

32.0%, respectively. Asian/ Pacific Islander, American Indian/Alaska Native, and Others accounted for 2.5% of PWH.

Cisgender males were overrepresented among PWH (75.7%) versus Cisgender females (24.3%). Less than 1% of PWH identified as Transgender. Increases over the last five years were noted among PWH 60 years of age or older (47.0%), PWH 0-34 years (24.7%), and 55-59 years (23.9%). PWH ages 13-19 decreased by 25.3%, while youth 13-24 decreased by 13.7% from 2016-2020. MMSC accounted for 75.3% of all Cisgender male PWH, an increase of 9.7% over the past five years. Cisgender males with IDU exposure decreased 10.2% from 2016-2020. Heterosexual contact accounted for 83.5% of Cisgender female PWH and 13.0% of Cisgender male PWH. An increase was also noted among Transgender PWH adult sexual contact, with cases in 2016 versus 53 cases in 2020. PWH increased 50.0% among Hispanic/Latino Transgender IDU, Hispanic MMSC exposure a 32.2%, Hispanic Transgender at 27.8% and 27.1% among Hispanic/Latino Cisgender males

PE data were used to assess the socioeconomic characteristic of OSA PWH. Over two-thirds of (68.9%) RWHAP clients had a 12th grade education or less. Over 75% of clients spoke English versus 16.9% who spoke Spanish and 5% who spoke Haitian Creole. In 2020, 23.8% of clients had health insurances/benefits other than the RWHAP. The percentage of clients without insurance or other benefits increased slightly over the past four years; from 74% in 2018 to about 78% in 2021. Median annual household declined from $1,235 in 2019 to $1,213 in 2020/2021. On average, most clients were slightly below 100.0% of the federal poverty level (FPL) for the past three grant years.

**Mortality:** FDOH reports the deaths among PWH. In 2020, there were 75 deaths of PWH in the OSA, an increase from 67 deaths in 2019. In 2019, there were 46 deaths (67.7%) in Orange County, 10 deaths (15.1%) in Seminole County, seven deaths (10.6%) in Osceola County, and three deaths (4.55%) in Lake County. In 2020, deaths among racial/ethnic groups were highest among the BNH population, with 41 deaths (54.7%). There were 23 deaths (30.7%) among White Non-Hispanics (WNHs). Hispanics accounted for 10.7% of PWH deaths in 2020. Among gender groups, Cisgender males accounted for 69.3% of deaths, while Cisgender females represented 30.7%.

**HIV and Comorbid Conditions:** FDOH provided population-adjusted rates of co-morbid conditions per 100,000 population. Persons at disproportionate risk for HIV infections included those diagnosed with infectious syphilis, chlamydia, and gonorrhea. Generally, the BNH population had higher rates of sexually transmitted infections (STIs) infection for both males and females, compared to their WNH and Hispanic counterparts. Rates among WNHs were generally lower compared to BNHs but higher when compared to Hispanics. PWH aged 13-24 years had the highest rates of HIV infection. It is noteworthy that socioeconomic data were unavailable for persons at higher risk for HIV infection.

Population-adjusted rates of infectious syphilis in 1999 ranged from 7.1 in Lake County to 22.5 in Orange County. Rates in Osceola and Seminole Counties were 7.3 and 9.5, respectively. In Orange County, the rate among BNH males (54.2), was almost double the rate of 16.3 among WNH males (16.3). BNH males in Seminole County had a rate (43.4), almost five times the rate of 8.8 among WNH males. There was less disparity among Hispanic males in Osceola and Lake Counties. Among females in the OSA, the syphilis rate was highest (8.2) among BNH females in Orange County followed by 7.0 in Seminole County and 5.2 in Lake County. By age, rates were highest among PWH ages 30-34 years- ranging from 57.0 in Orange County to 15.7 in Lake County. The rate in Seminole County (41.40, was highest among those aged 20-24 years. County rates of chlamydia in 2019 were lower than the FL rate (525.5) except in Orange and Osceola Counties, with rates of 752.4 and 553.1, respectively. Cisgender females had higher rates when

compared to Cisgender- ranging from 482.1 in Lake County to 916.6 in Orange County. Rates among females in Osceola and Seminole Counties were 743.8 and 534.0, respectively. Among BNH females, rates were highest in Orange County (1,023.9), over five times the rate among WNH females (194.3) and more than double the rate among Hispanic females (444.6). Similar disparities were noted among females in Lake, Osceola and, Seminole Counties. The highest County rates were among those ages 20-24 years and ranged from 2718.9 in Seminole to 3787.9 in Orange County. In Lake, Orange, Osceola, and Seminole Counties rates among those ages 13-19 years were higher than for those ages 25-29 years. Youth rates ranged from 1381.0 in Lake to 1743.2 in Orange County. In 2019, rates of Gonorrhea ranged from 109.2 in Lake County to 235.7 in Orange County, with Osceola and Seminole County rates at 129.1 and 132.0, respectively. Rates among BNH males and females were higher when than their WNH and Hispanic counterparts. In Orange County, the rate among BNH males (575.9) was over five times the rate of WNH males (110.8). Among BNH females, the rate of 287.6 was seven times that of 40.8 among WNH females. In Lake County, the rate among BNH males was over 13 times that of WNH males. Rates of gonorrhea among Non-Hispanics were generally twice the rates among Hispanics for males and females. Among age groups, rates were highest among PWH ages 20-24 years- ranging from 566.8 in Lake County to 804.6 in Orange County. Rates for Osceola and Seminole Counties were 607.1 and 678.9, respectively.

Data from Florida's web-based reportable surveillance system revealed chronic HBV rates in the OSA decreased from 26.17 in 2018 to 21.04 in 2019. Lake was the only county that had a slight increase over the last three years (from 17.4 in 2017 to 20.0 in 2019). Decreased rates were noted in Orange County, which fell from 31.3 in 2017 to 24.6 in 2019, in Osceola County where the rates decreased from 17.7 to 15.7, and Seminole County with rates decreasing slightly from 16.2 in 2017 to 15.4 in 2019. The 2019 rates were highest in Orange County (24.6) and lowest in Seminole County (15.4).

Rates for chronic hepatitis C virus (HCV) decreased marginally in all OSA counties from 2017 to 2019. The rate decreased overall from 106.3 in 2017 to 96.62 in 2019- or a 9.1% decrease in the number of reported cases. The 2019 rate was highest in Orange County (110.1) and the lowest among those living in Seminole County (63.0). The greatest change was in Osceola County where the rate in 2017 (118.4) dropped to 81.6 in 2019- a 31.1% decrease.

The FDOH Division of Disease Control and Prevention, Tuberculosis (TB), reported that TB rates generally decreased from 2016-2020 among all residents in the OSA except for Seminole County. In Seminole, there were three cases in 2016 versus seven cases in 2020. The 2020 rates ranged from 0.5 in Lake to 3.2 in Orange County. The number of cases in Osceola County decreased from nine cases in 2016 to five in 2020. Lake County had the greatest decrease- from five cases in 2016 to two cases in 2020- a 60.0% decline.

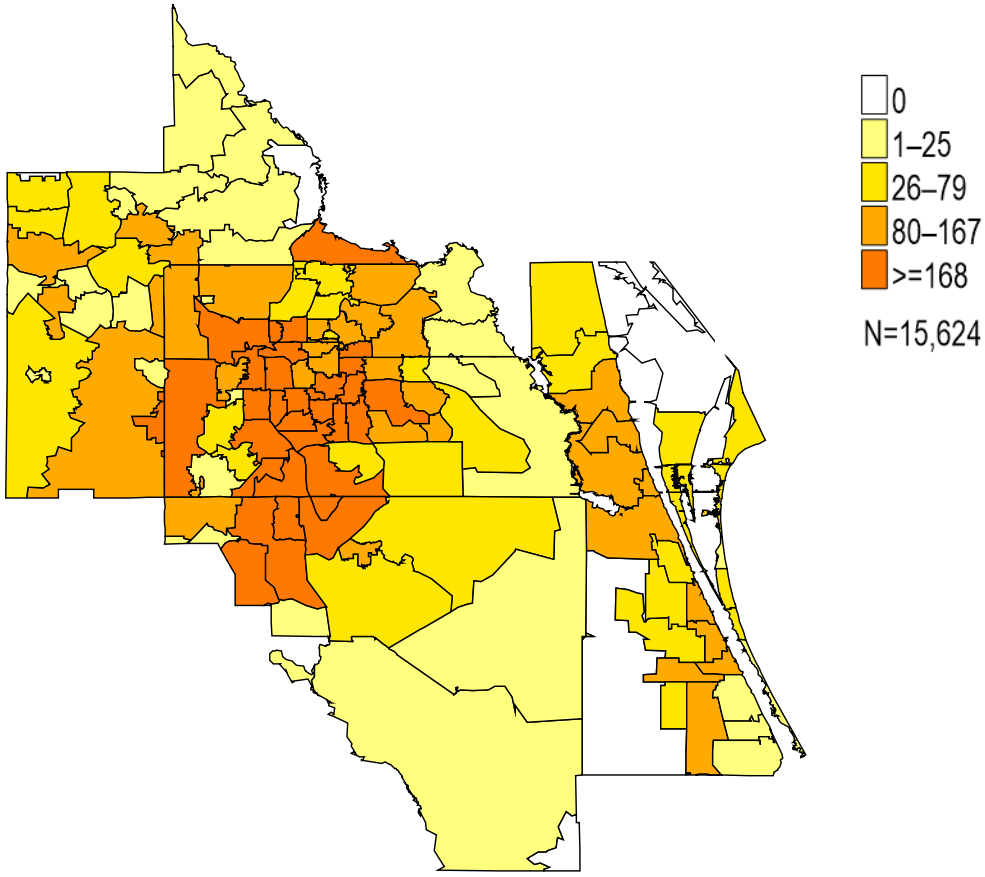
Behavioral risk factors can increase the risk for HIV infection. Although the Youth Risk Behavioral Surveillance (YRBS) survey is only administered in Orange County, it can provide useful data for interventions to promote healthy activities across the OSA. Among high school students, 37.7% of males and 29.1% of females had engaged in sexual intercourse in 2019. More than 10% of males and almost 7% of females had sexual intercourse with four or more persons. Among those sexually active, 40.3% did not use a condom and 22.9% drank alcohol or used drugs before their last sexual encounter. Adult (ages 18-64 years) behaviors as reported by the 2016 Behavioral Risk Factor Surveillance System (BRFSS), revealed percentage of adults less than 65 years of age who have ever been tested for HIV in the past 12 months ranged from 13.8% in Lake County to 19.4% in Orange County.

Relative rate of increased HIV diagnosed cases within new and emerging population: An analysis of FDOH data revealed increases in new HIV cases among Black MMSC and Hispanic/Latina

WCBA (age 15-44). Among BNH MMSC, cases increased 12.9% from 2016 to 2020. Among Hispanic/Latina WCBA ages 15-44, new HIV cases increased 166.7% in the past five years. Among adults ages 60+ years, there were a total of 43 cases in 2020: an increase of 19.4% from 2016. Additionally, Hispanic/Latina Cisgender Women cases increased 21.1% from 19 cases in 2016 to 23 cases in 2020. New AIDS incidence among White WCBA (age 15-44) increased 200.0% from one case in 2016 to three cases in 2020. Among Hispanic/Latina Cisgender women, cases increased 116.7%, from six cases in 2016 to 13 cases in 2020.

**Figure 6** illustrates the strong association between HIV prevalence and residential location among PWH. The brighter the yellow-orange tone, the higher the number of PWH residents.

**Figure 6: PWH by ZIP Code for Orlando Service Area, Year-End 2021**




## 3. Needs Assessment

This section summarizes needs assessment activities and data to inform the goals and objections of the OSA Integrated HIV Plan. We specifically summarize needs assessment activities and data about the services that:

- People need to access HIV testing;
- People at-risk for HIV need to stay HIV negative
- People need to link rapidly link to HIV medical care and treatment after receiving an HIV positive diagnosis

**Figure 7: Barriers to HIV Prevention – Service Gaps**

| Barriers to Prevention | Social and Structural | Legislative | LHD | Program | Provider | Client |
|---|---|---|---|---|---|---|
| Inadequate funding | | X | X | X | | |
| Federal guidelines restricting bridging of programs | | X | X | X | | |
| Federal, State, and local policies not aligned with community needs | | X | X | X | X | |
| Agency turnover and lack of staff continuity | | | X | | X | |
| Varied needs in among residents in the OSA counties | | X | X | X | | |
| Weak or nonexistent partnership and/or communication between agencies | | | X | X | X | |
| Community members unaware of available programs | X | | | | X | X |
| Lack of community education leading to HIV stigma | | | X | X | X | X |
| Inability to educate the public due to local and state policies | X | X | | | | |
| Lack of staff training to understand and address cultural barriers and norms | | | X | X | X | |
| Inadequate public transportation | X | X | | | | |

**Figure 8: Barriers to HIV Care and Treatment**

| Barriers to Care | Social and Structural | Legislative | Health Department | Program | Service Provider | Client |
|---|---|---|---|---|---|---|
| Policy implementation (e.g., Medicaid expansion, SSPs, abstinence-based curriculum, etc.) | X | X | | X | X | X |
| Federal, State, and County contracting and procurement processes | | X | X | X | X | X |
| Inadequate coordination between FDOH and Medicaid managed care program and MCOs | | | | | | |
| Insufficient health insurer payments | X | X | | X | X | |
| Delay in FDOH epidemiologic data impeding unmet need and planning process | | X | | X | X | X |
| Insufficient communication between prevention and care providers | X | X | X | X | X | |
| Inadequate local public transportation | X | X | | | | |
| Insufficient dental providers | X | | | X | | X |
| Insufficient primary and specialty care providers | X | X | | | | X |
| Insufficient staff to client ratios | | | | | X | X |
| Lack of community partnerships and linkages | | X | X | X | X | X |
| Lack of affordable housing | X | X | | X | | X |
| Lack of knowledge of the RWHAP-funded services | X | | X | X | X | X |
| Lack of affordable health insurance | X | X | | | | |
| Linguistic and cultural barriers | X | | | | X | X |

### a. Priorities

Figure 9 summaries key priorities arising from the needs assessment.

**Figure 9. Key Priorities Arising From OSA Needs Assessment**

| |
|---|
| **Priority 1. Prevent New Infections** |
| Increase HIV awareness |
| Increase knowledge of HIV status |
| Expand and Improve Implementation of effective prevention Interventions |
| **Priority 2: Improve HIV-Related Health Outcomes Among PWH** |
| Rapidly link PWH to care after diagnosis and provide low-barrier access to HIV care and treatment |
| Identify, engage, or reengage PWH not in care or in care but not virally suppressed |
| Increase retention and adherence to treatment to achieve and maintain long-term viral suppression |
| **Priority 3: Reduce HIV-Related Disparities and Health Inequities** |
| Reduce HIV-related stigma and discrimination |
| Reduce disparities in new HIV infections, awareness of HIV status, and along the HIV Care Continuum |
| Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities |
| **Priority 4: Integrated and Coordinated Efforts Addressing the HIV Epidemic Among Partners and Interested Parties** |
| Integrate programs to address the Syndemics of HIV, STIs, viral hepatitis and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence. |
| Enhance the quality, accessibility, dissemination, and application of aggregate data and analytic analyses, including HIV prevention and care continuum and social determinants of health data |

### b. Actions Taken

Not applicable

### c. Approach

## 4. Financial and Human Resources Inventory

**Figure 10** summarizes the inventory of financial and human resources for the five counties in the OSA.

- Organizations and agencies providing HIV care and prevention services in the jurisdiction.
- HRSA (must include all RWHAP-funded parts) and CDC funding sources.
- Leveraged public and private funding sources including the HRSA's Community Health Center Program, HUD HOPWA Program, Indian Health Service (IHS) HIV/AIDS Program, Substance Abuse and Mental Health Services Administration (SAMHSA) programs, and foundation funding.

It is noteworthy that expenditure data were unavailable to the OSA Part A Recipient for key funders including FL AHCA (Medicaid), Medicare, Department of Veteran's Affairs, FDOH ADAP for OSA residents, FDOH Health Insurance Premiums and Cost Sharing.

**Table 11. CY 2021 OSA HIV Funding Sources by Recipient, County, Funding Source, and Available Funds ($)**

| Funding Source | Recipient | Brevard | Lake | Orange | Osceola | Seminole | Available $ |
|---|---|---|---|---|---|---|---|
| RWHAP Part A | Orange County HSD | | X | X | X | X | $9,609,809 |
| RWHAP Part A- MAI | Orange County HSD | | X | X | X | X | $835,398 |
| RWHAP Part B | FDOH HFUW | X | | X | X | X | $1,714,310 |
| RWHAP Part B-MAI | FDOH | | | X | | X | $150,000 |
| RWHAP Part C | FDOH – Orange | | X | X | X | | $1,056,765 |
| RWHAP Part C | Unconditional Love | X | | | | | $346,828 |
| RWHAP Part D | FDOH – Orange | X | X | X | X | X | $803,791 |
| RWHAP FDOH ADAP | FDOH – Orange | | | X | | | $343,543 |
| EMA MOE | Orange County HSD | | X | X | X | X | $1,025,909 |
| CHD GR | FDOH - Brevard | | | | | | $100,000 |
| CHD GR | FDOH – Lake | | X | | | | $18,821 |
| CHD GR | FDOH - Orange | | | X | | | $300,000 |
| CHD GR | FDOH - Osceola | | | | X | | $100,000 |
| CHD GR | FDOH - Seminole | | | | | X | $150,000 |
| PCN GR | Orange CHD | | | X | | | $0 |
| PCN GR | Tri-County HFUW | X | | | | | $615,195 |
| FDOH EBI | FDOH - Brevard | X | | | | X | $191,532 |
| FDOH EBI | FDOH – Lake | | X | | | | $0 |
| FDOH EBI | FDOH - Orange | | | X | | | $856,250 |
| FDOH EBI | FDOH – Osceola | | | | X | | $75,000 |
| FDOH EBI | FDOH - Seminole | | X | | | | $75,000 |
| FDOH EBI | FDOH – Orange | | | X | | | $0 |
| FDOH EBI | Hope and Help | | | X | | | $208,000 |
| FDOH EBI | Miracle of Love | | | X | | | $423,000 |
| MAT | OBFH | | | X | X | X | $350,000 |
| HUD HOPWA | UW Brevard | | | X | | | $430,272 |
| HUD HOPWA | City of Orlando | | X | X | X | X | $4,319,150 |
| FDOH TOPWA | FDOH | | | X | | | $155,000 |
| FDOH TOPWA | Miracle of Love | | | X | | | $13,870 |
| FDOH Other | Miracle of Love | | | X | X | | $60,000 |
| FDOH Other | Hope and Help | | | X | X | | $75,000 |
| FDOH Other | The Center | | | X | X | | $65,000 |
| FDOH Other | HCH | | | X | X | | $75,000 |
| CDC DASH | Orange County (EMA-Wide) | | | | | | Unavailable |
| HRSA BPHC EHE Prevention | HCH | X | | | | | $263,810 |
| HRSA BPHC EHE Prevention | Central FL Family Health Center | | | | | X | $361,799 |
| HRSA BPHC EHE Prevention | Community Health Centers | X | | | | | $373,075 |
| SAMHSA SA and HIV Prevention Navigator | 26 Health, Inc. | X | | | | | $199,774 |
| SAMHSA SA and HIV Prevention Navigator | Aspire Health Partners, Inc. | X | | | | | $200,000 |
| SAMHSA SA and HIV Prevention Navigator | Orange County | X | | | | | $200,000 |
| SAMHSA TCE HIV | Aspire Health Partners, Inc. | X | | | | | $525,000 |

| Funding Source | Recipient | Brevard | Lake | Orange | Osceola | Seminole | Available $ |
|---|---|---|---|---|---|---|---|
| SAMHSA TCE HIV | HCH | X | | | | | $525,000 |
| FL AHCA Medicaid Program | OSA-Wide | | | | | | Unavailable |
| Department of Veteran's Affairs | OSA-Wide | | | | | | Unavailable |
| CMS (Medicare) | OSA-Wide | | | | | | Unavailable |
| | | | | | | **TOTAL $** | $27,190,901 |

**Acronym Key:** ADAP (AIDS Drug Assistance Program), AHCA (Agency for Health Care Administration), BPHC (Bureau of Primary Health Care), CHD (County Health Department), CMS (Centers for Medicare and Medicaid Services), DASH (Division of Adolescent School Health), EBI (Evidence-Based Intervention), EMA (Eligible Metropolitan Area) FDOH (FL Department of Health, HCH (Healthcare Center for the Homeless), GR (General Revenue), HSD (Health Service Department), HOPWA (Housing Opportunities for Persons with AIDS), MAT (Medication-Assisted Treatment), MAI (Minority AIDS Initiative), MOE (Maintenance of Effort), OBFH (Orange Blossom Family Health), TCE HIV (Targeted Capacity Expansion HIV Program), TOPWA (Targeted Outreach for Pregnant Women Act), UW (United Way)

**Figure 12: OSA HIV Care Continuum, CY 2021**

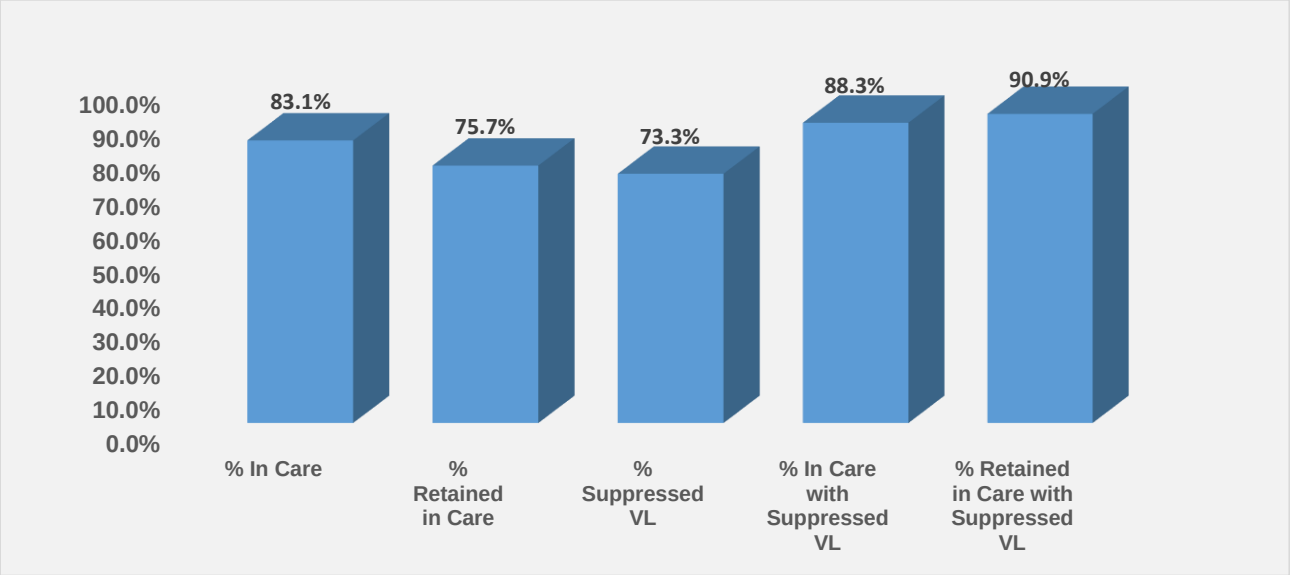



**Figure 13. Variability of Steps in the OSA HIV Care Continuum, By County, CY 2021**

| OSA Counties | % In Care | % Retained in Care | % Suppressed VL | % In Care with Suppressed VL | % Retained in Care with Suppressed VL |
|---|---|---|---|---|---|
| Brevard. | 88.2% | 82.6% | 79.0% | 89.6% | 91.8% |
| Lake. | 88.4% | 81.1% | 78.9% | 89.3% | 91.4% |
| Orange | 81.5% | 74.0% | 71.6% | 87.8% | 90.5% |
| Osceola | 82.9% | 74.0% | 72.7% | 87.8% | 91.6% |
| Seminole | 83.3% | 75.9% | 74.4% | 89.3% | 91.6% |
| **OSA** | **83.1%** | **75.7%** | **73.3%** | **88.3%** | **90.9%** |

**Analytic Specifications Used by FDOH to Calculate the HIV Care Continuum of Counties in the OSA**

- The OSA includes Brevard, Lake, Orange, Osceola, and Seminole Counties
- Persons with HIV is defined as the number of persons living with an HIV diagnosis in this area at the end of each respective calendar year, as of 6/30/2022.
- HIV diagnoses include persons whose HIV diagnosis occurred in the period specified, data as of 6/30/2022.
- In Care: PWH with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2021 through 3/31/2022, data as of 6/30/2022.
- Out of Care: PWH with no documented VL or CD4 lab, medical visit, or prescription from 1/1/2021 through 3/31/2022, data as of 6/30/2022.
- Retained in Care: PWH with two or more documented VL or CD4 labs, medical visits, or prescriptions at least three months apart from 1/1/2021 through 6/30/2022, data as of 6/30/2022.
- Suppressed VL: PWH with a suppressed VL (<200 copies/mL) on the last VL from 1/1/2021 through 3/31/2022, data as of 6/30/2022.
- In Care with Suppressed VL: PWH with at least one documented VL or CD4 lab, medical visit, or prescription from 1/1/2021 through 3/31/2022 that also has a suppressed VL (<200 copies/mL) on the last VL from 1/1/2021 through 3/31/2022, data as of 6/30/2022.
- Retained in Care with Suppressed VL: PWH with two or more documented VL or CD4 labs, medical visits, or prescriptions at least three months apart from 1/1/2021 through 6/30/2022 that also has a suppressed VL (<200 copies/mL) on the last VL from 1/1/2021 through 3/31/2022, data as of 6/30/2022.
- No VL: No documented VL lab from 1/1/2021 through 3/31/2022, data as of 6/30/2022.
- Late Diagnosis: AIDS diagnosis within three months of HIV diagnosis.

# SECTION IV. SITUATIONAL ANALYSIS

## 1. Summary of the Situational Analysis

This section offers an overview of the strengths, challenges, and needs for HIV prevention and care services in the OSA. This Section synthesizes information gathered from the Community Engagement and Planning Process (Section II) and Contributing Data Sets and Assessments (Section III). The situational analysis addresses the four EHE pillars:

- **Diagnose** all people with HIV as early as possible (Pillar 1);
- **Treat** PWH rapidly and effectively to reach sustained viral suppression (Pillar 2);
- **Prevent** new HIV transmissions by using proven interventions (e.g., PrEP and SSPs) (Pillar 4);
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them (Pillar 4).

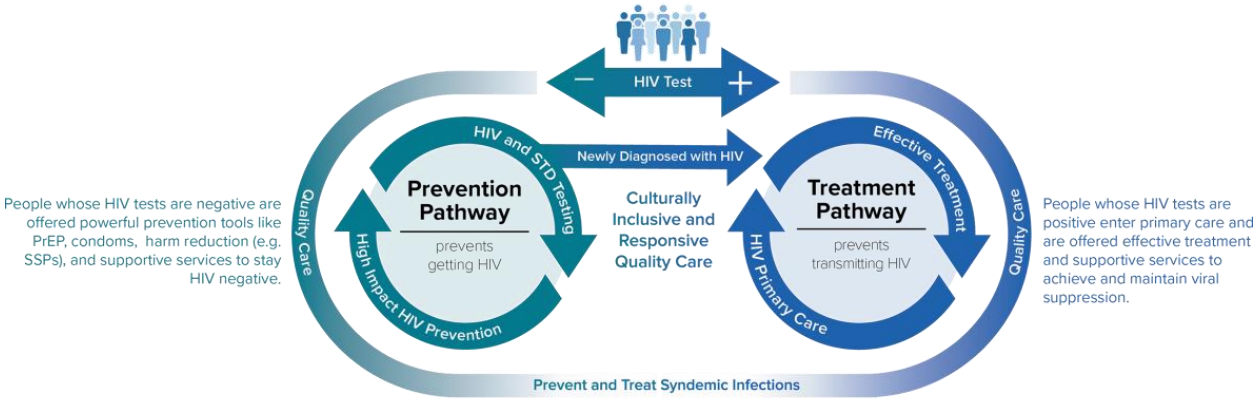
We have focused the summary of our analysis on one key topic per goal.

This section also identifies OSA's priority populations whose prevention and care needs will be addressed.

### a. Application of Status-Neutral Approach to HIV Prevention and Care

The CDC recommends high-impact initiatives that apply a status-neutral approach to HIV prevention and care. This approach involves initial HIV testing services as the entry point to HIV prevention and/or care services, regardless of the result. **Figure X** illustrates the approach.

**Figure X: Status-Neutral Approach to HIV Prevention and Care**




Source: https://hivgov-prod-v3.s3.amazonaws.com/s3fs-public/NHAS-2022-2025.pdf

The OSA will apply the status neutral model to HIV prevention and care services proposed in the Integrated HIV Plan. The OSA proposes initiatives and strategies that align with the EHE pillars described below. We highlight strengths, challenges, and identified needs of the HIV prevention and care delivery system.

## 4.1 Improve HIV-Related Health Outcomes among PWH

**Goal 2: Improve HIV-Related Health Outcomes Among PWH**
**EHE Pillar: DIAGNOSE**

Objective 2.1 Rapidly link PWH to care after diagnosis and provide low-barrier access to HIV care and treatment.

Objective 2.2: Identify, engage, or reengage PWH not in care or in care but not virally suppressed.

Objective 2.3: Increase retention and adherence to treatment to achieve and maintain long-term viral suppression.

### Test and Treat Program and Rapid Access to ART

Since 2016, FL has had a robust rapid access to ART model called Test and Treat (T&T). This approach offers patients newly diagnosed with HIV, as well as patients who have been lost to care and are returning to care. Patients may be scheduled for expedited medical visits, labs, and ART, combined with a support system of retention-in-care specialists, to reduce barriers to care engagement. PWHs have immediate access to a medical provider who can initiate ARVs immediately. T&T has assisted in engaging individuals in care at a much faster rate than those not diagnosed through the program. Since the program's inception, FL's T&T program has enrolled more than 7,374 clients statewide (comprised of 3,342 newly diagnosed individuals and 4,032 previously diagnosed individuals returning to care).

The OAS has several HIV clinics that have applied the T&T model. FDOH reports that compared to those diagnosed in FL not part of T&T, it takes on average 38.3 days from initiation of treatment compared to 5.6 days for those newly diagnosed through T&T. Furthermore, the mean time to achieve viral suppression is much lower for patients who are initiated treatment rapidly through T&T— 92.2 days compared to 146.4 days for those not engaged in T&T. Wider expansion and adoption of this strategy is needed to impact linkage, retention, and VL suppression rates.

## 4.2 TREAT PWH Rapidly and Effectively to Reach Sustained Viral Suppression

### Stigma

Stigma around HIV affects healthcare seeking behavior. Stigma related to HIV/STI screening can occasionally lead individuals to report that they are uninsured to avoid disclosure of HIV infection to health insurers. Similar confidentiality concerns exist for young people who receive health insurance coverage through their parent or guardian (e.g., Explanation of Benefits). Fear of disclosure of confidential health information can deter youths and adults from seeking out HIV/STI screening and PrEP services. HIV testing locations that are associated with ASOs are also perceived as more stigmatizing, with clients citing additional disclosure concerns. There is a need for integration of HIV testing locations with other healthcare services and screenings to minimize stigma.

The MMP surveillance system also asks questions to understand the various types of stigmas PWH have experienced, including anticipated, enacted, and internalized stigma using a 10-item scale ranging from zero (no stigma) to 100 (high stigma) that measures four dimensions of HIV stigma: personalized stigma since HIV diagnosis, current disclosure concerns, current negative self-image, and current perceived public attitudes about people living with HIV. Analysis of the 2015–2020 FL MMP data found that females (n=44) experienced a higher level of stigma compared to transgender individuals (n=39) and males (n=32). Black/African American persons (n=37) experienced a higher level of stigma than White (n=32) and Latino (n=32) persons who

**GOAL 3: Reduce HIV-Related Disparities and Health Inequities**

**Pillar: TREAT**

Objective 3.1 Reduce HIV-related stigma and discrimination

Objective 3.2. Reduce disparities in new HIV infections, awareness of HIV status, and along the HIV Care Continuum

Objective 3.3: Address social determinants of health and co-occurring conditions that contribute to HIV-related disparities.

experienced the same level of stigma. Heterosexuals or straight people (n=38) experienced a higher level of stigma than bisexual persons (n=36). Lastly, it was also found that those ages 18–29 experienced a higher level of stigma (n=43) than ages 40–49 (n=36), and ages 30–39 (n=35). It was found that ages 50 and higher experienced the lowest level of stigma (n=32).

Findings from a FDOH report (a Bayesian spatial-temporal analysis of racial disparities in HIV clinical outcomes and a pilot stigma intervention protocol for people living with HIV in FL) indicate that disparities in immune restoration and viral suppression vary by county. Identification of counties where these disparities are most severe provides useful information for FDOH and other decision makers to reduce racial disparities in HIV clinical outcomes by implementing targeted interventions, with the ultimate objective of achieving HIV elimination goals in FL. Stigma remains a key barrier to care engagement and ultimately achieving viral suppression and immune restoration. The preliminary work in this study outlines the development and validation of an updated measure of stigma, which could be implemented to better monitor stigma and its impacts, and an intervention to improve patient-provider communication about HIV-related stigma. The intervention was generally well received by participants and several potential routes of dissemination were identified.

#### 4.3 PREVENT New HIV Transmissions by Using Proven Interventions (e.g., PrEP and SSPs)

### Access to PrEP and nPEP

**Goal 1. Prevent New Infections**

**EHE Pillar: PREVENT**

Objective 1.1. Increase HIV awareness

Objective 1.2. Increase knowledge of HIV status

Objective 1.3: Expand and improve implementation of effective prevention interventions.

The use of ARV medications to prevent HIV transmission in persons at risk for acquiring HIV is an effective prevention tool. Part of CDC's high-impact prevention (HIP) approach includes PrEP, and in 2014, CDC issued clinical PrEP guidelines for healthcare providers. CDC recommends PrEP as a prevention tool for persons at increased risk for HIV: persons in sero-different relationships, gay and bisexual men who have sexual partners of unknown HIV status, and PWID. As of December 2018, FDOH CHDs in each of FL's 67 counties are providing PrEP services (counseling, medications, follow-up testing) with support from state funding. CHDs provide PrEP primarily through the STI and family planning clinics, and medication is provided at no cost to the client (repeatedly) through FL's supply of medication. Since the launch of FDOH's PrEP drug assistance program (i.e., 2018), over 11,319 CHD clients have received PrEP medications. Current challenges to PrEP delivery throughout FDOH CHDs include clinician/staffing shortages and limited capacity for clinicians in smaller CHDs (e.g., fewer clinicians performing multiple duties within the clinic).

The FDOH publicly funded PrEP drug assistance program only accounts for a small portion of all PrEP services statewide. Numerous private-sector partners—including private physicians, FQHCs, community health centers, sexual health clinics, community-based organizations, and high-impact prevention (HIP) providers—are screening, prescribing, and maintaining people on PrEP throughout FL. Also, over the past two years, HRSA has funded approximately 22 FQHCs through their EHE Primary Care HIV Prevention funding opportunity for health centers to expand access to medication to prevent HIV (including PrEP and related services), connect people to care, and ensure care services are well coordinated. According to the latest data available on AIDSVu, FL has seen an increase in the rate of PrEP users per 100,000 population since 2016 and as of 2021, the rate was 226 per 100,000. FL now ranks third among states and jurisdictions with the highest rate of PrEP users, behind Washington D.C. and New York. PrEP data from AIDSVu reflect the number of people prescribed PrEP in a calendar year. AIDSVu uses data from

a database that contains anonymized individual-level prescription records collected electronically from U.S. retail pharmacies, traditional pharmacies, specialty mail-order pharmacies, long-term care facilities, and other pharmacies (e.g., in-hospital pharmacies, HMO pharmacies).

Disparities in the uptake of PrEP and nPEP still exist among key priority populations (e.g., Black, and Hispanic men and women, including transgender women). Taking a sexual history and discussing sexual health with patients should be a routine practice for primary healthcare providers; however, limited time for office visits and the reluctance of some providers to discuss sex with their patients presents barriers to routinization. There is a need for increased access to PrEP services in non-traditional settings FL and through innovative practices. PrEP delivery via telehealth (or "TelePrEP") was recommended by community groups, clients, and providers as a mechanism by which people facing transportation and employment barriers could access PrEP and increase adherence to follow-up testing. Partnerships with retail pharmacies and clinics and through mobile applications may assist in bridging gaps in PrEP and nPEP access. In 2020 and leveraging the existing state telehealth practitioner team, FDOH launched a TelePrEP program where patients can access PrEP services through the CHD system.

Currently, federal funding requires the implementation of PrEP and nPEP services but does not allow states to allocate funding for medications and limitations for covering associated clinical costs exist. While there are patient assistance programs available to offset the cost of medications, medical visit and lab testing costs still pose a significant barrier to already disproportionately impacted populations. Clients receiving PrEP have reported that returning every three months for follow-up testing is a barrier to remaining adherent, and in rural and semi-rural areas of FL, transportation to follow-up medical appointments can present further challenges. Clients also cited the cost of medical visits and lab tests and not being able to get time off from work for appointments as barriers to PrEP initiation and maintenance. As a result, more clinics and pharmacies have started to offer non-traditional and after-hours services to increase access to PrEP and nPEP. In late December 2021, Apretude (cabotegravir extended-release injectable suspension) received FDA approval for HIV PrEP. Injectable PrEP provides a new option to prevent HIV that does not involve taking a daily pill—which for some people, presents challenges. In Summer 2022, the FDOH initiated a pilot project to test the feasibility of delivering Apretude through CHD clinics. Three CHD clinics (Alachua, Hillsborough, and Miami-Dade) were chosen to participate in the pilot project and represent geographic areas with varying HIV incidence.

In 2019, the USPSTF issued a Grade A recommendation for offering PrEP with effective antiretroviral therapy to persons at increased risk of HIV acquisition. Under the Affordable Care Act, most private insurance plans must cover preventive services with an "A" or "B" recommendation from the USPSTF without copays or deductibles. This means that at least one PrEP option should be available at no cost to qualifying individuals on these plans.

Additionally, increased public/private partnerships are needed to fill gaps in access to nPEP services. Many CHD clinics have traditional hours, making them ill-suited as delivery points. Access to nPEP is needed quickly after exposure to HIV (within 72 hours) to prevent seroconversion. Clients requesting nPEP tend to do so more often during evening hours and weekends. Partnerships with retail pharmacies, rape crisis centers, and sexual assault nursing teams in hospital EDs are needed to expand access points to nPEP

Access and adherence to HIV treatment is important to promote optimal health outcomes for PWH and harnessing the benefits of "treatment as prevention"– when someone takes their HIV medications as prescribed and the amount of HIV in the body is kept at such a low level, they reach viral suppression. Patients that are virally suppressed essentially have no risk of transmitting HIV to others sexually. Treating PWH rapidly after diagnosis will help PWH to achieve

and maintain viral suppression, which is part of the current HIV treatment guidelines and is a major pillar in EHE.

The CDC reports that about 80% of new HIV transmissions occurring annually are from persons who are not receiving HIV-related care and ARVs. One issue is that the availability of treatments is not evenly accessible or distributed, compounding health disparities and the social and structural determinants of health that fuel further transmission of HIV within the community. This represents a need for expanded access points, hours of operation (to include non-traditional hours and locations) and telehealth capabilities to reach persons with transport or other access issues. Other challenges exist around identifying and re-engaging PWH who are not in care to ensure medical adherence and viral suppression. All areas of FL have dedicated FDOH linkage staff to not only link persons newly diagnosed with HIV but also identify PWH currently not in care and re-engage them into HIV care and treatment.

### 4.4 RESPOND Quickly to Potential HIV Outbreaks to Get Prevention and Treatment Services to People Who Need Them

**Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Interested Parties**

**Pillar: RESPOND**

Objective 4.1 Integrate programs to address the Syndemics of HIV, STIs, viral hepatitis and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence.

Objective 4.2 Enhance the quality, accessibility, dissemination, and application of aggregate data and analytic analyses, including data regarding HIV prevention and care continuum and social determinants of health.

#### People with Co-Occurring HIV and HCV

The current opioid and crystal methamphetamine epidemics are fueling the number of co-infections. It is estimated that 60–90% of people who contracted HIV from intravenous drug use also have HCV. People living with HCV often have difficulty accessing HCV treatment and related healthcare. In recent years, there have been improved HCV treatments that can cure HCV in as little as 8–12 weeks. ADAP clients living with HCV have access to assistance with HCV treatments. The FL ADAP formulary was updated in 2017 to include HCV treatments without the need for prior authorizations. Between 2020 and 2021, the ADAP assisted over 650 ADAP clients with access to HCV treatment supported by ADAP. There are opportunities for more uninsured HCV patients to be treated at FQHCs, private practices, and LHDs, but many patients are unaware of where to go when they are first diagnosed.

A HRSA-funded national evaluation of access to HCV screening and treatment found that clinicians practicing in RWHAP, FQHC, and LHD settings were able to successfully treat HCV. Rates of completion of a course of medication were high, while HCV re-infection rates were low even among PWID.

RWHAP clinics in FL and elsewhere have been found to insufficiently conduct HCV screening. Opportunities are likely in the OSA for improved HCV screening and treatment to reduce disease burden and cure PWH of a debilitating disease.

HCV rates decreased marginally in all OSA counties from 2017-2019. The rates decreased overall from 106.3 in 2017 to 96.62 in 2019- or a 9.1% decrease in the number of reported cases. The 2019 rate was highest in Orange County (110.1) and the lowest among those living in Seminole County (63.0). The greatest change was in Osceola County where the rate in 2017 (118.4) dropped to 81.6 in 2019- a 31.1% decrease. It is unclear the extent to which PWH with HCV infection are able to access treatment, as well as the rates cure for PWH initiating treatment.

#### a. Priority Populations

The priority populations identified in the OSA Integrated HIV Plan for 2022-2026 include PWH

with the following self-identified characteristics:

- Hispanic/Latinx PWH with HIV risk related to MMSC,
- BNHs with HIV risk related to MMSC,
- BNHs with HIV risk related to heterosexual transmission, and
- WNHs with HIV risk related to MMSC.

Selection of these priority populations by the CFHPC reflects the results of the extensive community engagement process, as well as the analytic results of qualitative and quantitative assessment processes.

Selection of those priority populations reflect the results of the Community Engagement and Planning Process described earlier in Section II, as well as Contributing Data Sets and Assessments reviewed summarized in Section III.

It is noteworthy that the same priority populations were included in the Integrated HIV Plan for 2017-2021. Their selection in the two planning periods speak to the strong association between HIV infection and being racial, ethnic, and sexual minorities.

# SECTION V. 2022-2026 GOALS AND OBJECTIVES

## 1. Goals and Objectives Description

In this section, we identify and NHAS goals and objectives for how the OSA will diagnose, treat, prevent, and respond to HIV. **Figure 14** describes OSA's goals and related NHAS pillars, objectives, and strategies for 2022-2026. Activities, responsible parties, and data indicators are included for each proposed strategy. The timeframe for all goals is the five-year period of 2022-2026. We propose that 2022 be used as the baseline for determination of achievement of the Plan's goals, objectives, and strategies. We further propose that at the beginning of 2023, an annual workplan will be developed to assess accomplishments, identify newly emerging barriers and facilitators, and recognize newly established policies, clinical guidelines, and availability of funds. The annual workplans will be adjusted for newly identified objectives and strategies as the HIV prevention and care delivery system contribute to ending the OSA HIV epidemic.

In conducting 2022 OSA planning efforts, local stakeholders agreed to support the goals and objectives of the FDOH statewide Integrated HIV Plan. Broad population-wide efforts to improve Floridian's awareness of HIV status are best addressed at the state-level. Similarly, efforts to support statutory changes and raise State General Revenue for HIV prevention and care services are also best accomplished at the state level.

With these factors in mind, the OSA Integrated HIV Plan focuses on improving the HIV prevention and care delivery system in the five-county area. The OSA Integrated HIV Plan is envisioned to be implemented largely by and for OSA residents. It is recognized, however, that some goals and objectives of the OSA Integrated HIV Plan will be heavily dependent on federal supplemental and competitive grant funding. In turn, FDOH funding priorities may not be aligned with those of the OSA. Other service areas may be considered to be higher priorities for funds an FDOH personnel.

### a. Updates to Other Strategic Plans Used to Meet Requirements

No other strategic plans were used to meet the requirements of the guidance.

**Figure 16. OSA integrated HIV Plan Goals and Related NHAS Pillars, Objectives, and Strategies for 2022-2026**

## Goal 1. Prevent new HIV infections.

### EHE Pillar: PREVENT

**Objective 1.1 Increase HIV awareness**

**Strategy 1.1.1 Develop and implement campaigns and resources to provide education about comprehensive sexual health; HIV transmission risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.**

| Activities | Responsible Party | Data Indicators |
|---|---|---|
| Increase the use of digital media resources to include messaging on dating apps (e.g., Grindr) and social media apps (e.g., TikTok). | Part A and subrecipients | Insight data from messaging and social media sites (i.e., # of messages sent, demographic data, etc.) |
| Develop stigma toolkit/campaign and localized stigma task forces (survey to become part of toolkit). | Peer Support Space, HIP and EHE providers | # of individuals participating in stigma taskforce meetings (determined by sign-in sheets). Workplan/SOW, meeting minutes and/or agendas |
| Increase culturally competent sexual health education outside of the school systems. | HIP providers | # of educational sessions conducted |

**Strategy 1.1.2 Increase awareness of HIV among people, communities, and health workforce in disproportionately impacted areas.**

| Activities | Responsible Party | Data Indicators |
|---|---|---|
| Increase targeted outreach and education efforts specific to specialized groups, (e.g., FQHCs, local gang taskforces, and other geographically disproportionate communities. | HIP and EHE providers | # of outreach sessions conducted and types of providers participating |
| Offer in-person learning opportunities for basic HIV 101 education and increase the number of trained HIV 101 educators. | Areas 7 and 3/13 HIP providers | # of classes and participants for each completing each training |
| Provide HIV education and information to youth-centered outreach stakeholders to encourage buy-in and adoption of culturally competent sexual health education curriculum. | HIP and EHE providers | # of educational sessions conducted and types of providers participating |

| Strategy 1.1.3 Integrate HIV messaging into existing campaigns and other activities pertaining to other parts of the Syndemics, such as STIs, viral hepatitis, and substance use and mental health disorders. | | |
|---|---|---|
| **Activities** | **Responsible Party** | **Data Indicators** |
| Collaborate with local partners to educate providers across multiple platforms on Syndemics and work to incorporate HIV messaging in the platforms' communicable disease content. | RWHAP and FLDOH STI providers | # of local educational sessions conducted and # of Syndemics partners who participate |
| Increase awareness and collaboration with existing SSP to incorporate hepatitis, STIs, mental health and substance abuse messaging in campaigns. | RWHAP and FDOH STI providers, IDEA Orlando | # of campaign efforts completed |
| **Objective 1.2 Increase knowledge of HIV status.** | | |
| **Strategy 1.2.1 Test people for HIV according to the most recent USPSTF recommendations and CDC guidelines.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Address and overcome barriers to routine HIV and other STI screening in healthcare settings and priority testing in non-healthcare settings. | RWHAP and FDOH STI providers | # of routine HIV and STI screenings conducted in healthcare and non-healthcare settings |
| Expand routine HIV and other STI testing to include additional medical settings (e.g., EDs, urgent care facilities, OB/GYNs, and PCPs) while addressing barriers. | RWHAP and FDOH STI providers, acute care hospitals, healthcare systems, urgent care facilities, and community-based medical practices | # of routine HIV and STI screenings conducted in healthcare settings |
| **Strategy 1.2.2: Develop new and expand existing implementation of effective, evidence-based or evidence-informed models for HIV testing that improve convenience and access.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Target testing resources to areas experiencing high transmission rates. | HIV testing providers | # of testing resources provided in ZIP Codes with high HIV infection rates |
| Adopt and adapt interventions designed for populations with high exposure rates (MSM, trans people, etc.). | HIP, EHE, and RWHAP providers | # of interventions adopted, # of subpopulations receiving interventions |

| | | |
|---|---|---|
| Continue and expand reviews of perinatal HIV transmission cases to determine how to improve systems can. | Part C, TOPWA, OBGYNs, pediatricians, labor and delivery unit staff | # of case reviews conducted |
| Provide easy-to-access home test kits, including those distributed by self-serve vending machines and as add-ons to other self-administered tests (e.g., COVID-19, pregnancy). | FDOH Areas 7 and 3/13 (home test kits), FDOH (pregnancy and COVID tests), TOPWA | # of HIV home test kits issued, # of HIV test kits distributed by vending machines, # of HIV test distributed as add-ons to other self-administered kits |
| Improve reporting structures to increase linkage to prevention, care, and treatment among people using self-administered HIV test. | FDOH | # number of new policies implemented and # of existing policies updated |
| **Strategy 1.2.3: Incorporate a status-neutral approach to HIV testing, offering linkage to prevention services for people who test seronegative and immediate linkage to HIV care and treatment for PWH.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Develop and disseminate status muti-medica neutral resources, including education materials related to HIV/STI prevention, testing, linkage, care, and treatment. | FDOH | # of resources developed and # disseminated |
| Support informational campaigns and social media messaging around HIV/STI testing, PrEP, PEP, and linkage to care. | HIV testing providers and HIP, EHE, RWHAP providers | # of campaigns and Insight data |
| **Strategy 1.2.4: Provide partner services to people with HIV or other STIs and their sexual or needle-sharing partners.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Increase the capacity of partner services by increased funding for DIS positions. | FDOH | # of full-time equivalent DIS positions |
| Increase the capacity of partner services by conducting telehealth to conduct sessions. | FDOH | # of telehealth partner sessions |
| Increase the capacity of partner services by expanding hours of operation. | FDOH | # of partner service programs increasing their hours of operation |
| Use partner services to provide partners with access to PrEP and educational materials. | FDOH | # of HIV seronegative partners referred to PrEP and # of HIV seronegative partners receiving educational materials |
| Increase the number of harm reduction programs to increase the capacity of prevention services. | Boards of County Commissioners, RWHAP and FDOH providers, IDEA Orlando | # of harm reduction programs |

| Objective 1.3: Expand and improve implementation of effective prevention interventions. | | |
|---|---|---|
| **Strategy: 1.3.1: Engage people at risk for HIV in traditional public health and healthcare delivery systems, as well non-traditional community settings.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Increase the number of community mobilization initiatives and partnerships in communities, (e.g., FRTA/BRTA). | HIP and EHE providers | # of businesses agreeing to become a FRTA/BRTA provider |
| Increase collaboration with local Prevention Interventions Taskforces in raising awareness, sharing resources, and providing referrals to HIV testing (e.g., using non-healthcare events), share resources, and provide referrals. | EHE, HIP, and RWHAP providers | # of collaborating taskforces and # of collaborative events |
| Increase academic detailing in primary care community solo and group practices, urgent care centers, and EDs to raise awareness of HIV prevention interventions. | RWHAP Part A, AETC, FDOH Areas 7 and 3/13 lead agencies | # of academic detailing events and # of settings in which academic detailing events are conducted |
| Increase targeted outreach and education efforts specific to individual youth and organizations serving youth. | Parts A, B, C, EHE, and HIP providers, FDOH Areas 7 and 3/13 lead agencies, Scale it Up Florida | # of outreach and education events targeting individual youth and organizations serving youth and # of youth and teen groups receiving targeted outreach and education efforts |
| **Strategy 1.3.2: Scale-up treatment as prevention by diagnosing PWHs as early as possible and engaging them in care and treatment to achieve and sustain viral suppression.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Expand and increase the capacity of local Rapid Access Taskforces to expand the number of rapid access programs. | Parts A, B, and C, EHE, and HIP providers | # of Rapid Access Taskforces created and # of people attending Taskforce meetings |
| Increase the number of peers providing care and treatment support and healthcare navigation services. | Parts A, B, and C, EHE, and HIP providers | # of peers employed to provide treatment support and navigation services, # of PWH receiving peer services, # of units of peer services received per PWH, % of PWH with suppressed VL, % of PWH with sustained viral suppression over time (applying HAB performance measures) |

| | | |
|---|---|---|
| Scale up HIV injectables programs. | Part A, B, and C, EHE, and HIP providers, ADAP | # of injectables programs for treatment and PrEP services |
| **Strategy 1.3.3: Make HIV prevention, including condoms, PrEP, PEP, SSPs easier to access and support continued use.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Increase the number of PrEP and PEP prescribers through provision of academic detailing and education. | HIP and EHE providers, AETC | # of PrEP providers and # number of academic detailing activities conducted |
| Increase the # of SSP (including clean needle distribution and exchange) statewide and ensure local sites are placed in proximity of known overdose events or deaths. | BCC (for counties that have not implemented an SSP program), Areas 7 and 3/13 lead agencies, PART A, IDEA Orlando | # of SSPs established and # of known overdoes |
| **Strategy 1.3.4: Implement culturally competent and linguistically appropriate models and other innovative approaches for delivering HIV prevention services.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Provide linguistically appropriate HIV messaging in English, Spanish, and Haitian Creole. | Parts A, B, and C, EHE, and HIP providers, Areas 7 and 3/13 lead agencies | # of HIV messages in English, Spanish, and Haitian Creole |
| Increase cultural competency training workshops and other linguistically appropriate trainings for delivering HIV prevention services. | Part A, Part B, EHE, and HIP, providers, Areas 7 and 3/13 lead agencies, AETC | # of trainings conducted |
| Engage with local and state, civic, political, community, and spiritual leaders to increase HIV awareness among populations living with or affected by HIV. | Part A, Part B, EHE, and HIP, providers, Areas 7 and 3/13 lead agencies | # of local, state, civic, political, and community leaders, # of spiritual leaders engaged in HIV awareness outreach sessions, and # of HIV training sessions to spiritual leaders |
| **Goal 2: Improve HIV-related health outcomes among PWH.** | | |
| **EHE Pillar: DIAGNOSE** | | |
| Objective 2.1 Rapidly link PWH to care after diagnosis and provide low-barrier access to HIV care and treatment. | | |
| **Strategy 2.1.1 Increase linkage to HIV medical care within same day to 30 days of HIV diagnosis.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |

| | | |
|---|---|---|
| Increase awareness among local healthcare providers by disseminating messaging on T&T and rapid ARV protocols. | Part A, Part B, EHE, and HIP, providers, Areas 7 and 3/13 lead agencies | # of messages on T&T and rapid ARV protocols created and distributed and # of healthcare providers receiving messages on T&T and rapid ARV protocols |
| Fund food and transportation vouchers, as well as phones to support linkage to care among PWH not in care. | Part A, Part B, EHE, and HIP, providers, Areas 7 and 3/13 lead agencies | # of food vouchers provided to PWH linking to care, # of transportation vouchers provided to PWH linking to care, # of phones distributed to PWH linking to care |
| Expand the number of healthcare and other organizations offering T&T services including rapid access to ARVs. | Part A, Part B, EHE, and HIP providers, Areas 7 and 3/13 lead agencies | # of organizations offering T&T services |
| **Strategy 2.1.2 Provide same-day ARV initiation or rapid start (within seven days) for PWH meeting HHS Clinical Guidelines.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Expand routine HIV and STI testing to additional healthcare settings (e.g., pediatricians, primary care practices, and student health centers). | Parts A and B, EHE, and HIP, providers, Areas 7 and 3/13 lead agencies, healthcare agencies, clinicians | # of healthcare settings providing routine HIV and STI testing. |
| **Objective 2.2: Identify, engage, or reengage PWH not in care or in care but not virally suppressed.** | | |
| **Strategy 2.2.1: Expand uptake of D2C models through data use agreements, integration data systems, and use of surveillance, clinical services, pharmacy, and social/support services data to identify and engage people not in care or not virally suppressed.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Collaborate with local partners and providers across more platforms to incorporate more T&T facilities that will offer rapid ART and PrEP/PEP medications. | Parts A and B, EHE, HIP providers, Areas 7 and 3/13 lead agencies | # of T&T facilities that offer rapid ART and PrEP/PEP medications |
| Execute cooperative agreements and/or DUAs with jails, prisons, and contracting healthcare providers to link PWH before or upon released | Parts A, B, C, EHE, and HIP providers, Areas 7 and 3/13 lead agencies, FL DOC, County Jails | # of cooperative agreements and/or DUAs created with jails, prisons, and contracting healthcare providers and # of recently released inmates linked to care services. |
| **Objective 2.3: Increase retention and adherence to treatment to achieve and maintain long-term viral suppression.** | | |

| Strategy 2.3.1 Develop and implement effective, evidence-based/informed interventions and support services that improve retention in care. | | |
|---|---|---|
| **Activities** | **Responsible Party** | **Data Indicators** |
| Collaborate with local partners to educate healthcare providers on Syndemics and incorporate HIV into primary care and internal medicine practices. | Parts A and B, EHE, and HIP providers, Areas 7 and 3/13 lead agencies, medical practices, AETC | # of providers trained, # of primary care practices that incorporate routine HIV care, |
| Expand peer linkage and CHWs to implement ARTAS intervention strategies and adherence measures. | Parts A and B, EHE, and HIP providers, Areas 7 and 3/13 lead agencies, certification programs | # of peers and CHWs trained and # of CHWs certified |

## GOAL 3: Reduce HIV-related disparities and health inequities.

### Pillar: TREAT

**Objective 3.1 Reduce HIV-related stigma and discrimination**

| Strategy 3.1.1 Ensure that healthcare professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or at risk for HIV. | | |
|---|---|---|
| **Activities** | **Responsible Party** | **Data Indicators** |
| Identify and disseminate continuing education opportunities and training for healthcare professionals and front-line workers on HIV stigma. | Parts A and B, EHE, and HIP, providers, Areas 7 and 3/13 lead agencies, AETC, AHEC | # of materials or resources created and # of materials or resources distributed |
| Work with professional organizations to encourage the adoption of HIV stigma training as part of professional standards for healthcare professionals and front-line staff. | Part A, Part B, EHE, and HIP, providers, Areas 7 and 3/13 lead agencies, AETC, local medical society chapters | # of stigma trainings conducted, # of trainees, # of professional organizations that adopt HIV stigma training |

| Strategy 3.1.2 Ensure HIV educational resources are focused on the communities and populations where the need is greatest (e.g., Black, Hispanic/Latino, American Indian/Alaska Native, and other people of color, gay and bisexual men, transgender people, people who use substances, sex workers, and immigrants). | | |
|---|---|---|
| **Activities** | **Responsible Party** | **Data Indicators** |

| | | |
|---|---|---|
| Create and/or adopt informational materials focusing on communities and population where the need is greatest. | Parts A, B, EHE, and HIP providers, Areas 7 and 3/13 lead agencies, AETC | # of informational materials created or adopted |
| Support ongoing and new initiatives and programs specifically focused on communities and populations where the need is greatest. | Parts A, B, EHE, and HIP providers, Areas 7 and 3/13 lead agencies, AETC, CBOs | # of new initiatives funded and # of established programs funded |
| Increase the number of mobile medical units and street outreach to bring services and resources to communities and populations where the need is greatest. | Parts A, B, EHE, and HIP providers, Areas 7 and 3/13 lead agencies, AETC, CBOs | # of people receiving outreach encounters (e.g., HIV testing, materials, etc.) |
| **Objective 3.2 Reduce disparities in new HIV infections, awareness of HIV status, and along the HIV Care Continuum** | | |
| **Strategy 3.2.1 Increase awareness of HIV-related disparities in the OSA through data collection, analysis, and dissemination of findings.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Develop and/or expand the use of easy-to-read materials (e.g., infographics, one-pagers) to help audiences of varying types (e.g., the public, PWH, providers) to highlight disparities. | Part A, Part B, EHE, and HIP providers, Areas 7 and 3/13 lead agencies | # of materials created and/or adopted |
| Expand the use of data dashboards and provide education to relevant groups on how to access and use the information to increase awareness of HIV-related disparities. | Part A | # of data dashboards created and # of individuals using the data dashboards |
| **Objective 3.3: Address social determinants of health and co-occurring conditions that contribute to HIV-related disparities.** | | |
| **Strategy 3.3.1 Adopt policies that reduce barriers to improving accessibility of clinical and support services for PWH.** | | |
| **Activities** | **Responsible Party** | **Data Indicators** |
| Create consistencies (e.g., longer time between recertification, reciprocal eligibility) within the RWHAP-funded care system to eliminate barriers to HIV care. | Parts A and B | # of new policies and procedures that ensure consistency and efficiency in RWHAP enrollment and redetermination |

| | | |
|---|---|---|
| Explore the incorporation of afterhours and weekend services for PWH to promote retention in care and adherence to treatment. | Parts A and B, Areas 3 and 3/13 lead agencies | # of HIV care and support service agencies providing after hours and/or weekend services |

## Goal 4: Achieve integrated, coordinated efforts among all partners and interested parties who wish to address the HIV epidemic.

### Pillar: RESPOND

**Objective 4.1 Integrate programs to address the Syndemics of HIV, STIs, viral hepatitis and substance use and mental health disorders in the context of social and structural/institutional factors including stigma, discrimination, and violence.**

**Strategy 4.1.1 Integrate HIV awareness and services into outreach and services for issues that intersect with HIV such as intimate partner violence, homelessness, housing instability, STIs, viral hepatitis, and substance abuse/mental health disorders.**

| Activities | Responsible Party | Data Indicators |
|---|---|---|
| Expand marketing and advertising campaigns of internal and external partners to promote increased awareness of resources and services. | Parts A and EHE, and HIP providers, Areas 7 and 3/13 lead agencies | # of advertising campaigns created and # of internal and external partners participating in marketing and advertising campaigns |
| Increase partnerships with providers to conduct mobile HIV awareness and services. | Parts A and EHE, and HIP providers, Areas 7 and 3/13 lead agencies | # of partnerships created with providers that conduct mobile services |
| Use social media and outreach to disseminate program results and success stories. | Parts A and EHE, and HIP providers, Areas 7 and 3/13 lead agencies | # of success stories and program results disseminated via social media |

**Objective 4.2 Enhance the quality, accessibility, dissemination, and application of aggregate data and analytic analyses, including data regarding HIV prevention and care continuum and social determinants of health.**

**Strategy 4.2.1 Promote collection, electronic sharing, and use of HIV risk, prevention, care, and treatment data using interoperable data standards, including data from EHRs, in accordance with applicable federal and FL law.**

| Activities | Responsible Party | Data Indicators |
|---|---|---|

| | | |
|---|---|---|
| Create a centralized system or dashboard to disseminate aggregate HIV-related data (e.g., testing, treatment, surveillance) internally and externally that can be readily used to assess local area disease burden, obtain information needed for funding requests, and data required for time sensitive action and response. | Part A | # of data dashboards created and # of DUAs established |
| Collaborate with FDOH to create a reciprocal client informed consent form and release of information to acknowledge that data may be shared to improve service provision, linkage, and retention services. | Parts A, B, C and FDOH | # of policies and procedures developed to create a reciprocal client informed consent and release of information |

# SECTION VI. 2022-2026 INTEGRATED HIV PLANNING IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW-UP

In this section we describe the infrastructure, procedures, systems, and tools to support the key phases of integrated HIV planning to accomplish the OSA Integrated HIV Plan's goals and objectives. The key phases include: (1) implementation, (2) monitoring, (3) evaluation, (4) improvement, and (5) reporting and dissemination.

## 1. 2022-2026 Integrated HIV Planning Implementation Approach

The CFHPC will continue to lead OSA-wide integrated HIV planning and implementation activities. In this role and in collaboration with the Part A and B Recipients, it will spearhead efforts to accomplish the five integrated HIV planning phases. The Planning Council will collaborate with PWH, CDC and RWHAP recipients, FDOH prevention and care subrecipients, Part B lead agencies in Areas 7 and 3/13, community stakeholders, and others to:

- **Implement** the OSA Integrated HIV Plan by expanding the capacity of the HIV prevention and care delivery system; addressing unmet need; undertaking innovative and evidence-based interventions; and addressing emerging barriers as they emerge.
- **Monitor** OSA participating entities' service delivery, expenditures, billing to insurers and other payers as required by the RWHAP, performance assessment, process measures, and key outcomes. A Continuous Quality Improvement (CQI) framework is used to identify and address opportunities for service provider, organizational, and systemwide **improvement**.
- **Evaluate** performance and quality to determine fidelity with service models, funder requirements, performance indicators, process measures, client and provider satisfaction, and impact on OSA residents generally, as well priority populations specifically. A goal attainment model will be used to measure the extent to which the OSA Integrated HIV Plan's goals, strategies, and objectives achieve the desired impact on the OSA population, HIV prevention and care system, and PWH clinical outcomes.
- **Report** accomplishments achieved by OAS Integrated HIV Plan implementation, efforts to expand community engagement, and results of provider and agency performance and outcomes. CDC and HRSA also require reporting of programmatic metrics, performance measures, and outcomes. Local reporting contributes to awareness of national EHE efforts and their impact on the HIV epidemic.
- **Disseminate** results of monitoring, improvement, and evaluation activities to the CFHPC and their committees, PWH Community Meetings, townhall meetings, provider groups, funders, and other audiences. Dissemination efforts will also be designed to contribute to FDOH and the FCPN as they undertake the statewide Integrated HIV Plan.

### a. Implementation

The Orlando Part A Recipient is designated by HRSA and CDC policy as the lead agency for OSA integrated HIV planning. The chief elected official in the largest jurisdiction in the MSA selected the OCHSD to design and implement plans for the periods of 2017-2021 and 2022-2026. The Part A Program is uniquely positioned for this role as they are also responsible for implementing Part A planning and services delivery, as well as MAI, EIIHA, and EHE planning and implementation. HUD also funds OCHSD to manage Orange County's HOPWA Program.

OCHSD has considerable resources to manage federal, state, and local funds; undertake

community engagement and planning, monitor subrecipient performance, evaluate services, and undertake QI. The Part A Program also supports the CFHPC in fulfilling its RWHAP Part A statutory role in community engagement, coordinated and collaborative planning, PSRA, recipient oversight, and other responsibilities.

**Procurement, Contracting, and Programmatic and Fiscal Monitoring:** The Part A Recipient will collaborate with CDC and HRSA recipients to implement the OSA Integrated HIV Plan's objectives, strategies, and activities related to launching new services and expanding existing ones. Based on collaborating recipients and subrecipients' roles, they may focus RWHAP or CDC-funded programs or other activities identified in **Figure 16**. OSA integrated HIV Plan Goals and Related NHAS Pillars, Objectives, and Strategies for 2022-2026. These activities will be undertaken using existing organizational procurement, contracting, monitoring, and reporting processes.

**Outreach and Collaborative Efforts:** Identifying and establishing collaborative efforts with agencies outside of the federal and state-funded sectors will be an important responsibility of the Part A Recipient. In these roles, the Part A Recipient will collaborate with members of the Service Systems, Quality, and Needs Assessment Committee to expand and strengthen the HIV prevention and care delivery system to include HRSA BPHC FQHCs and look-alike CHCs, acute care inpatient hospitals and their EDs and labor and delivery units, urgent care centers, VA medical centers and outpatient clinics throughout the OSA, medical societies, and community-based medical practices.

Collaborative efforts with CBOs will be conducted to expand HIV awareness, prevention, and support services. Similarly, collaboration with the faith-based community will be initiated to organize health fairs, concerts, and other community events throughout the OSA.

The Part A Recipient collaborate with FDOH in outreach to the FL AHCA, the state's program responsible for healthcare regulation and Medicaid financing, other publicly financed insurance programs, and Medicaid managed care plans.

Based on the OSA Integrated HIV Plan's five-year goals and objectives, the Part A Recipient may also identify other key sectors for targeted outreach, collaboration, and coordination. Such efforts are important in achieving goals such as increasing awareness of HIV status and expanded primary and secondary HIV prevention services.

Outreach by the Part A Recipient to healthcare professional education and training programs is also critical. As reported earlier in the Integrated HIV Plan, recruitment of personnel and addressing turnover and staff shortages has become critical in the OSA as elsewhere in the US. As described in the Resource Inventory, lack of collaboration between OSA HIV prevention and care and funders and training programs must be addressed. Expanding the OSA "pipeline" of health professionals and allied health workers. Collaborative efforts to create practicums, residencies, and fellowships in HIV clinics, FDOH LHD, and CBOs is likely to promote interest in careers in these sectors. Ideally, funds used to recruit and train replacement personnel can be invested instead in increased salaries and benefits.

### Implementation Oversight and Community Engagement

The CFHPC serves as the statutorily required Part A Planning Council for the Orlando EMA. In that role, the CFHPC provides implementation oversight for Part A, MAI, EIIHA, EHE, and related programs. The CFHPC oversaw implementation of the *2017-2021 Integrated HIV Plan*. They continued in this role in 2022 while awaiting the CDC and HRSA Guidance. The CFHPC will continue in its oversight role in implementing the 2022-2026 Integrated HIV Plan. It is also

proposed that CFHPC expand its efforts to guide the Part A Recipient in community engagement and solicitation of supplemental funds.

The Part A Recipient will continue to make monthly presentations to the CFHPC on implementation of the OSA Integrated HIV Plan. In early 2023, the Recipient will provide the CFHPC with an overview of the Integrated HIV Plan, goals, objectives, and strategies. The Recipient will discuss the proposed roles of the CFHPC and its committees. In subsequent reports to the CFHPC, the Part A Recipient will discuss accomplishments made to undertake Plan strategies, barriers and facilitators for accomplishing the Plan, upcoming community engagement and organizational outreach activities, and funding opportunities.

In additional to its oversight role, it is proposed that CFHPC committees continue to collaborate with the Part A Recipient on implementation activities. **Figure 17**summarizes those activities.

**Figure 17. Roles of CFHPC Committees in Supporting OSA Integrated HIV Plan Implementation, 2023-2026**

| |
|---|
| **Membership, Public Relations, and Marketing Committee** (the committee is slated to be returned to separate two committee structure in 2023) |
| Develop marketing and recruitment strategies to expand community engagement efforts related to implementing the Integrated HIV Plan Workplan for 2023-2026. |
| Develop marketing materials related to HIV awareness, testing, PrEP, PEP, linkage to care, and retention in care. |
| Develop content and post Plan-related content on the CFHPC social media platforms and website |
| Advise the Part A Recipient on effective methods for disseminating public information and education related to prevention and care services. |
| Coordinate community events and activities related to the Plan. |
| Advise the Part A Recipient in designing compelling requests for additional funds to support OSA HIV prevention, care, and treatment services |
| **Service Systems, Quality, and Needs Assessment Committee** |
| Provide feedback and recommendations on the Plan's goals, objectives, and strategies to be addressed in yearly Workplans, including ways to strengthen the HIV prevention and care delivery systems. |
| Provide feedback and recommendations for the design and implementation of Plan-related needs assessments, QI projects (QIPs), evaluations and related reports, special studies, and questions to be addressed by attendees in town hall meetings, surveys, listening sessions, and other community engagement efforts. |
| Recommend strategies for using Provide Enterprise data to strengthen multi-agency care management and referral systems to improve retention in care and outcomes. |
| Review Plan-related quantitative and qualitative data summaries, identify methods for assessing the impact of the Plan on priority populations, and manage Plan-related data presentations to the CFHPC and key stakeholders. |
| Update Standards of Care relevant to process measures and clinical outcomes, monitor performance of CQM activities related to the Plan. |

### b. Monitor

Monitoring implementation of the OSA Integrated HIV Plan will be undertaken at several levels:

- Monitoring and oversight in implementing the Integrated HIV Plan will be provided by the CFHPC and its committees, as described in the Implementation section above and

- Programmatic and financial monitoring consistent with CDC and HRSA grant monitoring requirements. With this approach, participating recipients will monitor their subrecipients using methods and reporting requirements that may vary by federal, state, and/or county-level funders.

Using the third monitoring model, collaborating recipients will conduct subrecipient program monitoring by measuring the extent to which the data indicators are fully, moderately, or inadequately achieved in each Plan implementation year (2023-2026). 2022 will serve as the baseline year to measure improvement, as specified in **Figure 18.** OSA integrated HIV Plan Goals and Related NHAS Pillars, Objectives, and Strategies for 2022-2026*.* Programmatic monitoring will be achieved through virtual monitoring site visits by recipients to assess various aspects of programmatic performance as required by the funder. The recipients will also assess the fidelity of the services provided to Standards of Care, DHS clinical guidelines, USPSTF recommendation, and other standards.

Financial monitoring will be conducted by Recipients using the methods specified in grant awards and federal and state fiscal monitoring policies. Desk audits may be conducted, for example, to confirm that subrecipients applied federal accounting regulations in their management of federal funds.

Based on the results of programmatic and financial monitoring, the recipient may request that a subrecipient conduct a Corrective Action Plan (CAP). CAPs are required by recipients from subrecipients whose performance did not meet established targets or did not conduct required programmatic or fiscal activities. The recipient will conduct a follow-up session with the subrecipient to monitor implementation and anticipated improvement.

Specific activities conducted by subrecipients will be monitored to determine the extent to which data indicators reflect achievement of objectives. The application of the data indicators will measure progress being made toward addressing the overall objectives. These indicators will be assessed through data reported by subrecipients. Specific numerators and denominators for each indicator will be developed and training will be undertaken to ensure consistency in methods used. Performance data will be obtained from Provide Enterprise, CAREWare, attendance rosters, lab tests conducted, etc. as reported by subrecipients. Aggregate data will be summarized in reports to recipients or directly to the funder (e.g., CDC directly funded grants). Quarterly aggregate data reports will be submitted to the CFHPC and the CQM Steering Committee, subrecipients, and other stakeholders. Such reports will apply plain language methods, apply graphic presentations, and other strategies to ensure that they can be understood by a variety of audiences.

### c. Evaluation

Our evaluation strategy is similar to that described in the Monitoring discussion above. Additionally, formal and ad hoc evaluations will be conducted by recipient staff on topics aligned with the goals and objectives of the OSA Integrated HIV Plan. Evaluation methods used will be based on the nature of the services provided. For example, population or priority population groups may be invited to participate in surveys conducted through convenience sampling to obtain respondents' awareness of HIV prevention services, such as availability of HIV harm reduction services in a county. Focus groups, key informant interviews, and other qualitative evaluative methods may be used to assess availability, accessibility, and satisfaction with HIV prevention and care services.

Quantitative methods will be applied to client, provider, and agency-level evaluations. This approach is often used in identifying the association between interventions (e.g., disease case management) and retention in care, HIV treatment adherence, and clinical outcomes. Causality commonly cannot be proven in these types of evaluations as the evaluation subjects may

experience multiple interventions simultaneously. A less rigorous approach is often used due to gaps in data points, small cell data, and strong correlation is found between independent variables. For example, client demographic characteristics are often strongly associated, making it difficult to determine accurately which characteristics are contribute to dependent variables. For example, client demographic characteristics associated with HIV treatment adherence may be strongly associated.

Client, provider, and agency-level evaluation methods are greatly strengthened by use of Provide Enterprise by prevention and care recipients and subrecipients. Longitudinal evaluations and trend analyses, for example, allow assessment of the impact of Covid-19 on healthcare utilization and expenditure before, during, and following quarantine and HIV clinic closures. Factors associated with uptake of new services can also be evaluated, such as telehealth visit modalities to conduct virtual medical visits and counseling sessions.

Selection of evaluation topics will be guided in 2023-2026 by recommendations of CDC and HRSA staff and CFHPC, as well as PWH and provider surveys. As in other implementation activities, evaluation topics will also be guided by the goals, objectives, and strategies of the OSA Integrated HIV Plan.

### d. Improvement

The mission of the OSA Clinical Quality Management (CQM) program is to provide high quality core medical and support services to PWH to achieve optimal clinical outcomes. RWHAP recipients' individual CQM programs seeks to develop and expand systems of care to meet the needs of PWH. Each recipient and subrecipient may provide different services, staffing mix, policies, and procedures. Their CQM programs reflect these differences, as well as priorities for improvement based on baseline clinical performance and outcomes. Collectively, the vision of these OSA CQM programs is to maximize the benefit of staff collaboration to increase efficiency and apply innovative strategies to improve health outcomes.

In implementing the OSA Integrated HIV Plan, the overall responsibility for CQM activities rests with the Part A Recipient's CQM team. The team ensures that care is provided in accordance with FDOH and DHHS care and treatment guidelines and OSA Standards of Care. The aim of these efforts is to reduce the number of people who become infected with HIV, increase access to care and treatment, reduce secondary HIV infections through achievement of sustained undetectable HIV, optimize health outcomes, and reduce health disparities.

In implementing the 2017-2021 Integrated HIV Plan, the Part A Recipient formed a joint CQM Team, which plans, directs, coordinates, and improves care in the OSA. The CQM Team facilitates implementation of quality workplans and relevant activities. The CQM Team develops and undertakes systemwide quality initiatives including rapid cycle quality improvement projects (QIPs) that focus on specific high priority QIPs. For example, earlier QIPs improved rates of tuberculosis (TB) screening and treatment, ARV adherence, and retention in care. Subrecipients selected individualized approaches to improved clinical processes, conducted Plan-Do-Study-Act (PDSAs), and refined their processes until they achieved significant improvement over baseline. Subrecipient methods and results were compared to provide benchmarks and share improvement techniques among agencies.

The Part A Recipient Administrator is the chairperson of the CQM Steering Committee, an advisory board overseeing implementation, monitoring, and evaluation of the CQM Program and the development of the multi-year QM Plan. The QM Steering Committee meets quarterly. The Recipient Administrator authorizes the QM Steering Committee to oversee the development of data driven QIPs and measures before implementing performance improvement strategies throughout the provider network. The Recipient Administrator reports to the CFHPC CQM

findings, summary utilization reports, special studies, evaluation of outcomes and indicators from all service categories, emerging issues, and progress.

### e. Reporting and Dissemination

Throughout this section, we have summarized processes used to report about implementation of the 2022-2026 integrated HIV Plan. In summary, reporting will continue by the Part A Recipient to the appropriate CFHPC committees, the Monthly PWH Meetings, and the CFHPC. Reports are also made to the CFHPC by the Parts B and C recipients, HOPWA, and other key programs. Part B reports are made to CFHPC by the Area 7 HAPC. Part B reporting by HAPCs is conducted for Areas 7 and 3/13 to FDOH. Similarly, FDOH prevention program reporting is also conducted by the HAPCs and local prevention programs to the FDOH. FQHCs and other directly funded recipients of CDC and HRSA funds submit reports and aggregate data to their granting programs.

Reporting is also conducted by CDC and HRSA recipients and subrecipients based on grant program requirements such as quarterly and annual EHE reports. Client and subrecipient-level reporting is conducted annually to meet RWHAP requirements for submission of Ryan White HIV/AIDS Program Services Report (RSR) data. Those data are aggregated by HAB at the national level and disseminated to Congress, key stakeholders, recipients, and the public.

The Integrated HIV Plan for 2022-2026 identifies improved and increased dissemination efforts by the Part A Recipient, CFHPC, and its committees. As reported earlier in this section, the CFHPC Membership, Public Relations, and Marketing Committee will provide TA in developing an improved marketing and dissemination strategy, and package materials for dissemination on the CFHPC website and social media sites. Additional dissemination strategies will be collaboratively designed by the Part A Recipient and the Committee to expand awareness of the Plan and its various strategies. In out years, dissemination will focus on dissemination of attainment of the Plans goals and related objectives and strategies. Information about new services and programs will be disseminated through the CFHPC website and its social media accounts. Planned community engagement events will be promoted and the results of community and agency engagement activities will be disseminated.

Finally, the results of evaluations, special studies, and other evaluation-related products will be produced for dissemination. These materials will be designed to be easily read and understood, adopt infographic and other techniques, focus on topical areas of interest to a wide audience. Once again, the guidance of the CFHPC Membership, Public Relations, and Marketing Committee will be sought to ensure uptake of the disseminated materials.

Dissemination strategies will be adopted to ensure that all OSA counties are the focus of reports and materials of relevance to their residents generally as well as PWHs specifically. Advise from PWH residents of those counties will be sought to identify topics of interest through focus groups and key informant interviews to be conducted Part A Recipient staff.

### f. Updates to Other Strategic Plans to Meet Requirements

Not applicable, the jurisdiction did not use portions of another local strategic plan to satisfy this requirement.

# SECTION VII. LETTER OF CONCURRENCE

Jenifer Gray, MA-GME
Public Health Analyst | Project Officer
Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau
Health Resources & Services Administration
301-945-9458
5600 Fishers Lane
Rockville, MD 20857

Central Florida HIV PLANNING COUNCIL

Dear Ms. Gray:

The Central Florida HIV Planning Council *concurs* with the following submission by the Orlando Service Area (Brevard, Lake, Orange, Osceola, and Seminole Counties) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The Planning Council *concurs* that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The Central Florida HIV Planning Council for the Orlando Service Area (OSA) established a collaborative Integrated Plan Ad Hoc Committee to prepare for and develop the 2022-2026 Integrated HIV Prevention and Care Plan. The Committee met once to twice monthly from February to December 2022 and consisted of but was not limited to: members from the Planning Council, including elected representatives of the Florida Comprehensive Planning Network (FCPN), the Area 7 HIV/AIDS Program Coordinator (HAPC) and other representatives from the Area 7 Office, mental health and substance use providers, prevention providers, leaders from HIV Community-Based Organizations and Federally Qualified Health Centers, Ryan White HIV/AIDS Program clients, and representatives from the following offices- the Ryan White Part A Recipient's Office, the Ryan White Part B Lead Agency, and Ryan White Parts C and D. The Committee was responsible for developing strategies to disseminate the state-wide needs assessment survey and for all planning of the community engagement events in each area of the Orlando Service Area, along with post-event data review used to draft the Integrated Plan, specifically the plan's objectives and strategies. The Committee was also responsible for monthly reports on the received feedback and plan progress to the full Planning Council at both business and community meetings. The 2022-2026 HIV Integrated Prevention and Care Plan for the Orlando Service Area was adopted on November 30, 2022 by the Central Florida HIV planning Council.

The signature below confirms the *concurrence* of the planning body with the Integrated HIV Prevention and Care Plan.

DocuSigned by:

12/9/22

Tim Collins
Central Florida HIV Planning Council Sr. Co-Chair

Date