State of Florida Integrated HIV Prevention and Care Plan, 2022–2026

DRAFT

October 10, 2022

Version 2.0

Prepared for

Division of HIV/AIDS Prevention

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Centers for Disease Control and Prevention

and

HIV/AIDS Bureau

Health Resources and Services Administration

Submitted by

Florida Department of Health,

Division of Disease Control and Health Protection,

Bureau of Communicable Diseases,

HIV/AIDS Section

<Submission Date>

Acknowledgements

- Members of the Florida Comprehensive Planning Network
- Ryan White HIV/AIDS Program Partners
- Staff of the Florida Department of Health (FDOH), Bureau of Communicable Diseases
- Members of the Community Planning Partnerships (Past and Present)
- Members of the Local Area Consortia (Past and Present)
- FDOH County Health Department Staff
- AIDS Service Organizations and Community-based Organization Staff and Volunteers throughout the state
- The AIDS Institute
- State Agency and Association Partners
- Private Sector Partners
- The thousands of Floridians who have provided input to the Integrated Planning Process

Table of Contents

Table of Tables

Table of Figures

Revision History

Version	Date	Author(s)	Revision Notes
1.0	9/30/2022	ISF	Draft to walkthrough with client
2.0	10/10/2022	ISF	Additional content added, edits made

Acronyms

Acronym	Definition
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
AHEC	Area Health Education Center
AIDS	Acquired Immunodeficiency Syndrome
API	Application Programming Interfaces
ART	Antiretroviral Therapy/Treatment
ARTAS	Antiretroviral Treatment and Access to Services
ARV	Antiretrovirals (medication)
ASO	AIDS Service Organization
BPHP	Bureau of Public Health Pharmacy
BRTA	Business Responds to AIDS
CBO	Community-based Organization
CDC	Centers for Disease Control and Prevention
CHAG	Community HIV Advisory Group
CHD	County Health Department
CHW	Community Health Worker
CPPA	Collaborative Pharmacy Practice Agreement
DIS	Disease Intervention Specialist
EBI	Evidence-based Interventions
EHE	Ending the HIV Epidemic
EMA	Eligible Metropolitan Areas

Acronym	Definition
FCPN	Florida Comprehensive HIV/AIDS Planning Network
FDC	Florida Department of Corrections
FDCF	Florida Department of Children and Families
FDOE	Florida Department of Education
FDOH	Florida 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
HBCU	Historically Black Colleges and Universities
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIE	Health Information Exchange
HIP	High-Impact Prevention
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for People with AIDS
HPG	HIV Planning Group
HRSA	Health Resources and Services Administration
IDU	Injection Drug Use
IPC	Integrated Prevention and Care
MAI	Minority AIDS Initiative
MMP	Medical Monitoring Project
MMSC	Male-to-Male Sexual Contact
MSM	Men who have Sex with Men
NHAS	National HIV/AIDS Strategy
nPEP	Non-Occupational Post-Exposure Prophylaxis
OD2A	Overdose Data to Action
PCPG	Patient Care Planning Group
PCS	Planning Council Support
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV

Acronym	Definition
PPG	Prevention Planning Group
PrEP	Pre-Exposure Prophylaxis
PWH	Persons with HIV
PWID	Persons Who Inject Drugs
RW	Ryan White
RWHAP	Ryan White HIV/AIDS Program
SCSN	Statewide Coordinated Statement of Need
SDOH	Social Determinants of Health
SEP	Syringe Exchange Program
SPNS	Special Projects of National Significance
SSP	Syringe Services Program
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
T&T	Test and Treat
TIC	Trauma Informed Care
TOPWA	Targeted Outreach for Pregnant Women Act
UM-AETC	University of Miami AIDS Education and Training Center
US	United States
VA	Veteran's Administration
VL	Viral Load
WCBA	Women of Childbearing Age
WICY&F	Women, Infants, Children, Youth, and Families

1 Executive Summary and Statewide Coordinated Statement of Need (SCSN)

The United States (US) has taken on a bold plan to end the HIV epidemic by the year 2030. In order to reach national goals of reducing new HIV infections by 75 percent by 2025 and by 90 percent by 2030, the country must take aggressive actions by scaling up key HIV prevention and treatment strategies. The presentation of **Florida's HIV Integrated Prevention and Care (IPC) Plan, 2022-2026** is the culmination of several local, state, and federal initiatives including the *National HIV/AIDS Strategy (NHAS)* (2022-2025) and *the Ending the HIV Epidemic (EHE) in the U.S.* (2019), that work in unison to achieve national goals. This plan builds upon the previous work in Florida's Statewide Integrated HIV Prevention and Care Plan, 2017–2021 and Florida's Unified Ending the HIV Epidemic (EHE) Plan, 2020.

The impact of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) in Florida is far reaching with 120,502 persons living with HIV (PWH) through 2021. This represents only 86 percent of all the people with HIV, the remainder of whom are unaware of their status. According to the Centers for Disease Control and Prevention (CDC), in 2020 (the most recent data available), Florida was ranked third highest (15.7 per 100,000 population) for new HIV diagnosis rates in the United States (U.S.) (including the District of Columbia). In 2021, 4,708 persons received an HIV diagnosis in Florida, a 37 percent increase from the 3,441 HIV diagnoses in 2020. In 2021, 83 percent of those newly diagnosed were linked to HIV-related care within 30 days of diagnosis. The number of AIDS cases diagnosed in 2012 in Florida was 2,846, and in 2021 case numbers have dropped to 1,860. The current estimate of 14 percent of PWH in Florida not knowing their status, along with the substantial decrease in AIDS cases over a 10-year period, together underscore the importance of HIV prevention and care service delivery in Florida.

The seven EHE counties make up approximately 11 percent of the total national HIV burden as outlined in the EHE plan and represent 72 percent of the total persons living with an HIV diagnosis in Florida. Five of the EHE counties, Pinellas (77%), Hillsborough (71%), Orange (72%), Broward (70%) and Duval (69%) had a viral suppression rate equivalent to or greater than the state rate of 69 percent, while Palm Beach (65%) and Miami-Dade (63%) had lower viral suppression rates than the state at the end of 2021.

We believe people in Florida have the right to:

- know their HIV status
- have access to Pre-exposure Prophylaxis (PrEP) if they are negative, but at risk for developing the disease
- receive the services they need to achieve or maintain a high quality of life if they have tested positive
- be a voice within their local communities to affect positive change

The Florida Department of Health (FDOH) is pleased to present Florida's IPC Plan, which is intended to re-energize and strengthen a whole-of-society response to the epidemic while supporting people with HIV in Florida and reducing HIV-associated morbidity and mortality.

Florida is a large and diverse state. It has both rural and metropolitan areas, an extensive mix of cultures, and an oscillating population due to seasonal residents, tourists and itinerate workers. These factors make planning processes difficult, especially as they relate to disease control. The IPC Plan is designed to demonstrate coordinated HIV prevention and care activities by assessing resources and service delivery needs across HIV prevention and care systems to ensure the allocation of resources based on data. Florida recognizes that no one entity can solve the HIV epidemic, so this IPC Plan was developed through collaborative efforts that span the continuum of care with a status neutral and health equity approach, including the Florida Comprehensive HIV/AIDS Planning Network (FCPN), local HIV planning bodies, FDOH staff, and communities living with and affected by HIV/AIDS. The IPC Plan also aligns with the previously submitted EHE plan of 2020, Florida's Four Key Component Plan (2016) and the NHAS goals and strategies.

In order to better understand Florida's IPC Plan, it is important to establish funding sources within the state. About 87 percent of people in Florida have health insurance through a private or public health insurance compared to almost 92 percent nationally.

Care and support services are provided by the federal Ryan White HIV/AIDS Program (RWHAP) to low-income Floridians living with HIV or AIDS who have inadequate or no health insurance and are ineligible for Medicaid, Medicare, or any other public insurance programs through different entities. Services such as medical care, pharmaceuticals, dental services, payment of health insurance premiums, laboratory services, substance abuse treatment, and medical case management are provided through the various parts of the RWHAP. Each part has separate eligibility criteria that clients must meet.

Housing Opportunities for Persons Living with HIV/AIDS (HOPWA) Program

FDOH receives HOPWA funding from the U.S. Department of Housing and Urban Development (HUD) and is used to support housing needs and other supportive services for persons with HIV/AIDS. Additionally, cities that are eligible for direct funding from United States Department of Housing and Urban Development (HUD) for HOPWA may re-designate their funds to the state for distribution. Between 2020 and 2021, over 2,034 individuals received HOPWA services to ensure these individuals could access and maintain a stable living environment for themselves and their immediate families.

Six cities or Eligible Metropolitan Statistical Areas (EMSAs) receive and retain management of HOPWA funds they receive directly from HUD, FDOH does not manage the programs for Jacksonville, Tampa, Orlando, West Palm Beach, Fort Lauderdale, and Miami-Dade. The federally funded Florida State HOPWA Program serves those areas of the state that do not directly qualify for HOPWA funding EMSAs.

FDOH contracts with local community organizations and County Health Departments as Project Sponsors to provide HOPWA services in eleven (11) Ryan White Part B consortium geographical areas and six cities throughout the state. Six cities re-designate their funds to the state for distribution and fund management by the State HOPWA Program. However, the re-designated funds are to be spent in the EMSA on housing services in those areas, not the state at large. These cities (counties) include City of Palm Bay (Brevard), City of Cape Coral (Lee), City of Lakeland (Polk), City of Sarasota (Sarasota), City of Port St. Lucie, (St. Lucie), and City of Deltona (Volusia).

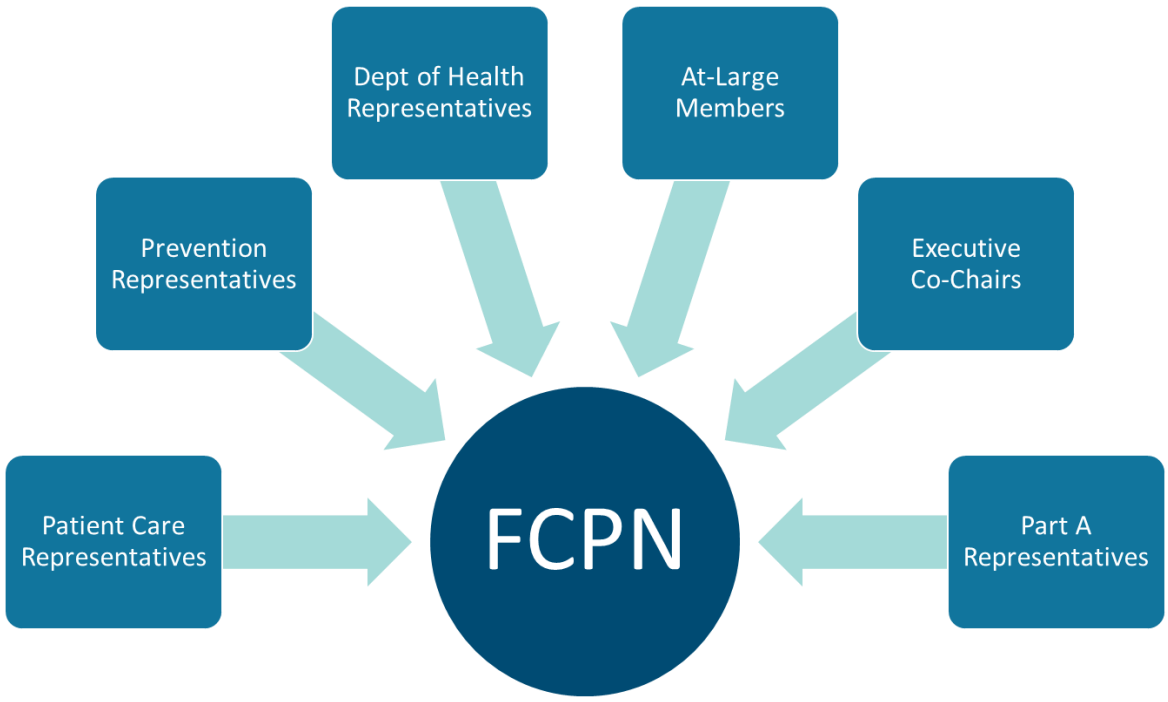
The IPC Plan herein encompasses the State's entire system of HIV prevention and care. Critical information about the IPC Plan has been organized within the following sections:

- Community Engagement and description of Jurisdictional Planning Process (Section 2)
- Contributing Data Sets and Assessments (Section 3), including:
    - a. Epidemiologic Snapshot
    - b. HIV Prevention, Care and Treatment Resource Inventory
    - c. Needs Assessment
- Situational Analysis Overview (Section 4), including priority populations/groups
- CY 2022–2026 Goals and Objectives (Section 5) to be organized by the goals in the HIV National Strategic Plan and inclusive of the strategies: Diagnose, Treat, Prevent, and Respond.
- 2022–2026 Integrated Planning Implementation

1.1 Approach

Plan development was facilitated by The AIDS Institute through the FCPN. The FCPN became an integrated HIV prevention and care planning body in 2017 and is made up of representatives from HIV prevention, care, all parts of the RWHAP, Federally Qualified Health Centers (FQHC), state and local government, academia, service providers, consumers, and advocates. The FCPN typically meets twice per year, in-person (with virtual meeting options for those unable to attend in person) and the FCPN committees (i.e., Membership, Nominations, and Bylaws Committee; Medication Access Committee; Coordination of Efforts Committee; Needs Assessment Committee; and Executive Co-Chairs Committee) meet monthly via Zoom.

FIGURE 1: FPCN MEMBERSHIP DIAGRAM



In 2021, in preparation for developing the IPC plan, the FDOH, in collaboration with the FCPN and Ryan White Part A partners, hosted a series of virtual webinars which were delivered statewide to share information from the Integrated HIV Prevention and Care Plan Guidance, including the Statewide Coordinated Statement of Need, CY 2022- 2026, released by CDC and HRSA in June 2021.

In January 2022, an integrated HIV planning kick-off meeting was held with Florida's State Surgeon General, the FCPN Executive Co-Chairs' Committee, representatives from Florida's six Ryan White (RW) Part A programs, and FDOH HIV, STD, and viral hepatitis staff to discuss Florida's approach to developing the statewide HIV IPC plan for 2022-2026.

The first full-body FCPN meeting was held in April 2022 and was an in-person meeting with virtual attendance options. This meeting was used to develop goals, objectives and strategies that were taken back to local planning bodies for discussion and feedback.

In August 2022, the FCPN met again as a full body to develop activities for the strategies that aligned with NHAS. There were 52 in-person attendees and 85 participated virtually. This meeting included small-group exercises to ensure everyone around the table and attending virtually had a voice and actively participated in the activity development process. All proposed activities were collected, and a survey was distributed after the meeting to allow all attendees to vote on prioritized activities for inclusion in the IPC plan. Additionally, FDOH acquired consulting services from ISF, Inc. to assist in

stakeholder coordination, research, reporting and writing for the 2022–2026 IPC Plan. ISF performed key stakeholder group interviews in each of Florida's 16 HIV service areas and each group included lead representatives for FDOH, Ryan White Part A, Ryan White Part B, and local community planning group members.

The FCPN Fall 2022 meeting was held in October and used to review the first draft of the IPC plan, solicit public comment, and input, and conduct a vote on concurrence with the full membership of FCPN.

Letters of concurrence were drafted in November 2022 and signed by each respective entity for inclusion into the IPC plan. The FDOH also worked to finalize and ultimately submit the IPC plan in December 2022.

The FDOH strives for a collaborative approach and works directly with the six Ryan White Part A areas. Ongoing coordination efforts include monthly calls with Ryan White Part A and B programs which split responsibilities of running calls (each call hosted by one of Florida's Ryan White Part A areas); the monthly calls are used to discuss major issues including the IPC plan.

A data-informed approach was used to develop the IPC plan, taking into account data and activities from Florida's status neutral approach to HIV prevention and care activities, including routine HIV screening, rapid access to treatment and care (Test & Treat), epidemiological data, and other data which help identify priority populations and address health equity. FDOH has also engaged in stigma reduction efforts, participating in the University of Florida (UF) stigma workgroup, and contracting with UF for the provision of evaluation and planning activities that will be used to develop program interventions addressing the stigmas related to HIV. Information from Florida's Ending the HIV Epidemic (EHE) plan was also used to develop content for the updated IPC Plan.

1.2 Documents Submitted to Meet Requirements

In order to meet the submission requirements of the IPC Plan, the table below provides descriptions for each document referenced in the IPC Plan. Documents have also been flagged where new material was created specifically for the IPC Plan or where existing material was utilized. These documents have also been linked to in the Appendix.

TABLE 1: SUPPORTING DOCUMENTATION

Document	Description	Developed for this plan?
Centers for Disease Control and Prevention (CDC) IPC Plan Guidance, 2022-2026	Developed to support the submission of the IPC Plan for each state for the 2022–2026 cycle.	No (Existing)
Florida's Unified EHE Plan, 2020	Unified plan representing the state and the seven counties identified as Phase 1 EHE jurisdictions:	No (Existing)

Document	Description	Developed for this plan?
	Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, and Pinellas.	
State of Florida IPC Plan, 2017–2021	Developed collaboratively across Florida stakeholders to eliminate HIV transmission and reduce HIV related deaths for the 2017–2022 cycle.	No (Existing)
Meeting Notes from the August and October FCPN meetings	The August FCPN meeting was used to identify Florida specific activities to address the Goals, Objectives and Strategies identified by the CDC. The October FCPN meeting was used to review the IPC Plan DRAFT with stakeholders, receive their feedback, and incorporate that feedback into the FINAL version of the IPC Plan.	Yes (New)
Local Area Resource Inventories	Includes grantee and community resources for prevention and patient care across sixteen services areas within the State of Florida.	No (Existing)
Local Area Interview Questionnaires	Interviews were held with all sixteen planning bodies and questions were raised to gather feedback in supporting multiple areas of the IPC Plan.	Yes (New)
Local Area Engagement Activities	Provided meeting summaries and feedback from a variety of engagement activities such as local area town halls.	No (Existing)
Documentation of Community Engagement	Describes Florida's partners and the voices engaged along with engagement efforts at the statewide level and seven major metropolitan areas. Interviews were held with all sixteen areas to identify community groups active on local planning councils.	No (Existing)
Florida HIV Continuum of Care Dashboard	Consolidates "Resource Inventories" across the state.	No (Existing)
Florida's Ryan White (RW) HIV Care Needs Assessment: Key Findings 2019	Survey to determine met and unmet service needs for persons with HIV (PWH) in Florida.	No (Existing)
RW Part A Plans	Represents the latest collaborative effort for each Part A service area in developing their unique IPC Plan	No (Existing)
PS19-1906 EHE Plan Executive Summary Florida	Key points, including strategic partnerships and planning support, from Florida's EHE Plan.	No (Existing)

2 Community Engagement and Jurisdictional Planning Process

Community engagement is an overriding element of Florida's 4 Key Component Plan which intersects with the four pillars of the EHE initiative and the NHAS. Community members were engaged in all phases of the planning process and will continue with the implementation of strategies and activities to build a pathway to eliminate HIV transmission in Florida.

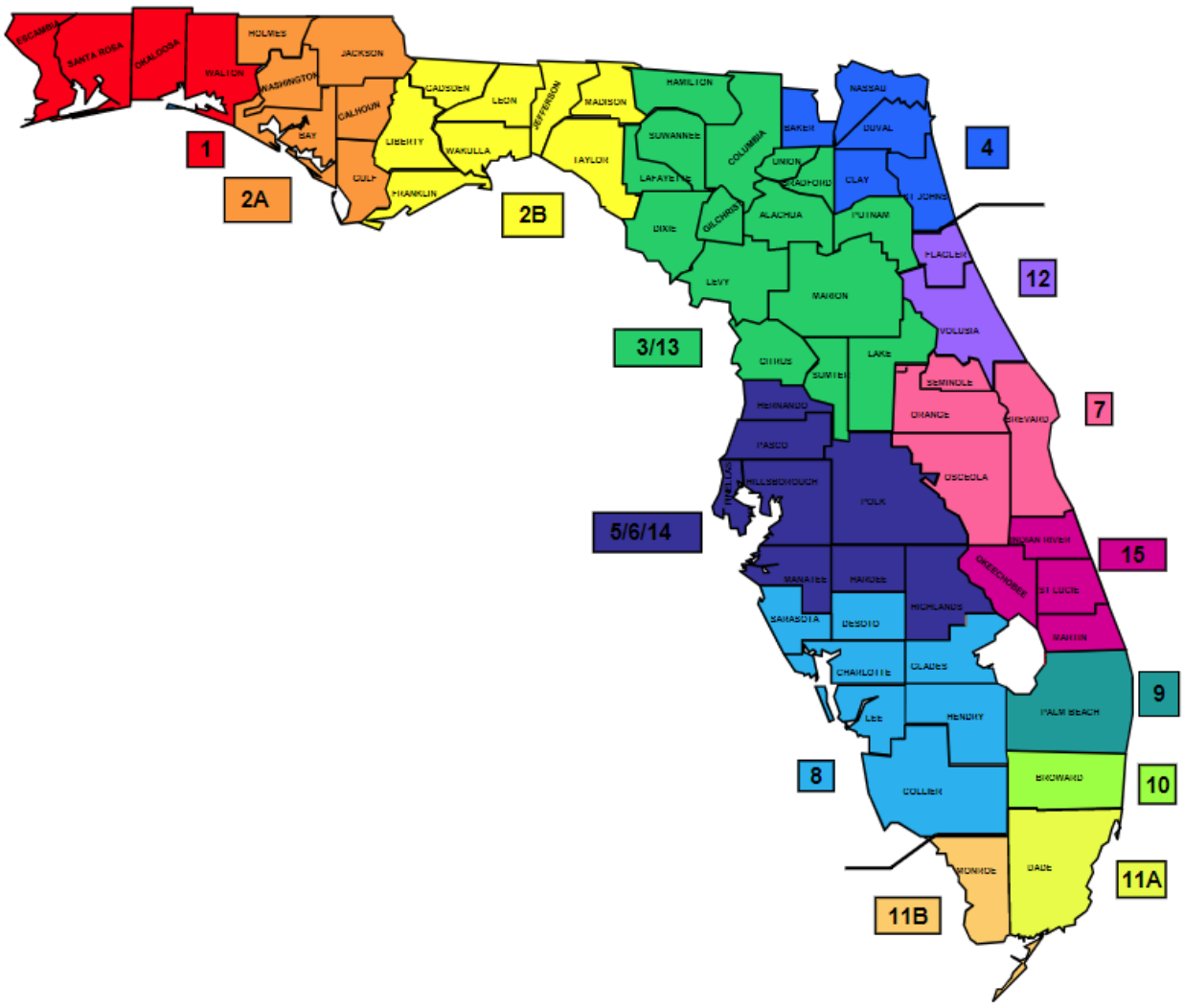
During 2021 and 2022, varying degrees of community engagement took place at state and local levels in preparation for developing the IPC plan. In addition to community engagement activities performed October 2019 through October 2020 for EHE planning and implementation, additional community engagement activities were conducted in each HIV service area to ensure stakeholders were included in the integrated HIV planning process.

The HIV Planning Process

The State of Florida's HIV planning process operates with the principle that determining the best way to support HIV prevention and care needs is through coordinated decision making with local entities, which collectively informs the State's overall IPC plan. As such, FDOH engaged stakeholders and community members to create an IPC plan for HIV efforts across the state. The remainder of this section outlines the planning process, inputs into the IPC Plan, analysis performed, priority goals and objectives, and a detailed plan to support successful implementation.

The FDOH, HIV/AIDS Section arranges the state into 16 areas (shown in figure 2 below), each with an HIV/AIDS Program Coordinator (HAPC) to oversee prevention and care program operations in the HIV service area. HAPCs assure that program activities are planned in an inclusive and collaborative manner to assure other local resources and specific client needs are considered and addressed.

FIGURE 2: FLORIDA HIV SERVICE AREAS



Consortia are community-based regional planning entities established by RWHAP Part B grantees. The consortia plan and prioritize RWHAP Part B funds allocated to their area, promote coordination of services, 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 to perform contract administration as a fiscal agent.

Local jurisdictions around the state drive community engagement with the goal to educate and raise awareness about HIV, and ensure programs and services are culturally and linguistically appropriate and developed with input from the populations intended to be reached. The local jurisdictions host focus groups, town halls, events for HIV/AIDS observance days, host multiple outreach events, media interviews, teach public health classes at local universities and use their social media presence.

Table 2 shows how local jurisdictions engage with the community by partnering with the following groups/organizations:

TABLE 2: HIV PREVENTION AND CARE PLANNING PARTICIPANTS

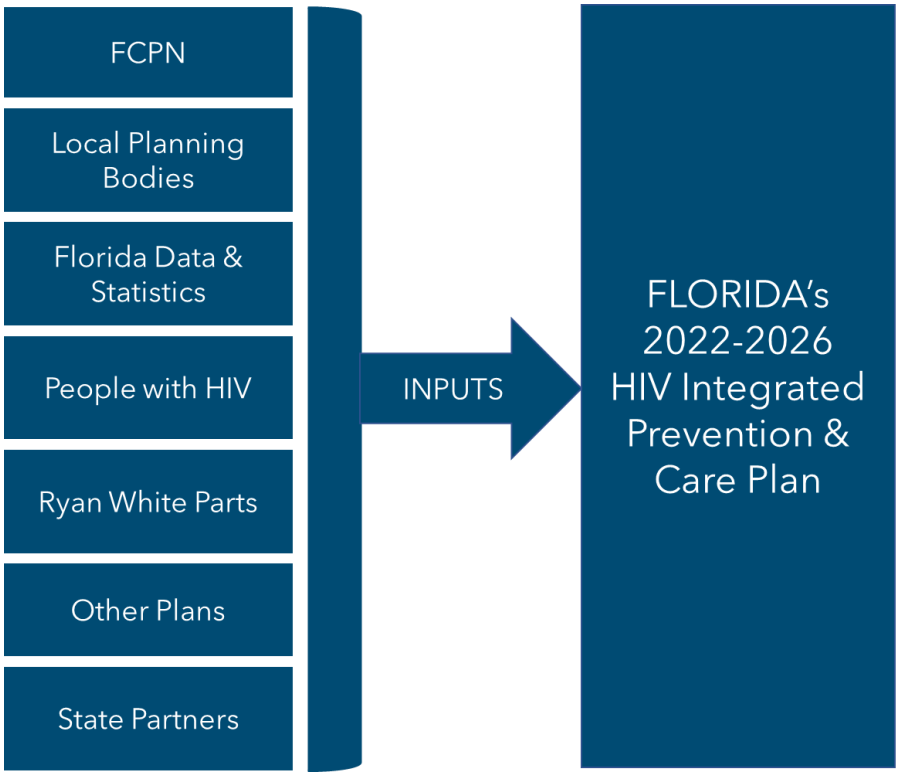
Local Jurisdiction Partnership Groups
• Existing community advisory boards • Community members resulting from new outreach efforts • Community members that represent the demographics of the local epidemic (e.g., race, ethnicity, gender, age, etc.) • Community members unaligned or unaffiliated with agencies currently funded through Health Resources and Services Administration (HRSA) and/or CDC • STD clinics and programs • City, county, tribal, and other state public health department partners • Local, regional clinics, and school-based healthcare facilities; clinicians; and other medical • Providers • Medicaid/Medicare partners and private payors • Correctional facilities, juvenile justice, local law enforcement and related service providers • Community- and faith-based organizations, including civic and social groups • Professional associations • Local businesses • Local academic institutions • Industry partners

For a full list of specific community resources by service area, you can refer to Appendix section 9.3: Executive Summary and Statewide Coordinated Statement of Need (SCSN)Service Area Resource Inventories.

Florida's new IPC plan for 2022–2026 was built upon the foundational goals, strategies and activities from the Florida Statewide Integrated HIV Prevention and Care Plan, 2017-2021, Florida's Unified Ending the HIV Epidemic Plan, 2020, the National HIV/AIDS Strategy, and input from local planning bodies and community members.

Figure 3 below shows the different inputs used to develop the 2022-2026 IPC Plan.

FIGURE 3: INPUTS TO THE 2022 HIV INTEGRATED PREVENTION & CARE PLAN



The FDOH HIV/AIDS Section works in partnership with the statewide planning body, FCPN. Members of FCPN include PWH and representatives across the state representing patient care and prevention groups, local planning bodies, CBOs, academic institutions, local and regional clinics, city, and county governments, RWHA Program recipients, the transgender community, advocacy groups, substance use and social service providers and behavioral science groups. The table below shows some of the community engagement and planning efforts across the state.

TABLE 3: COMMUNITY ENGAGEMENT EFFORTS

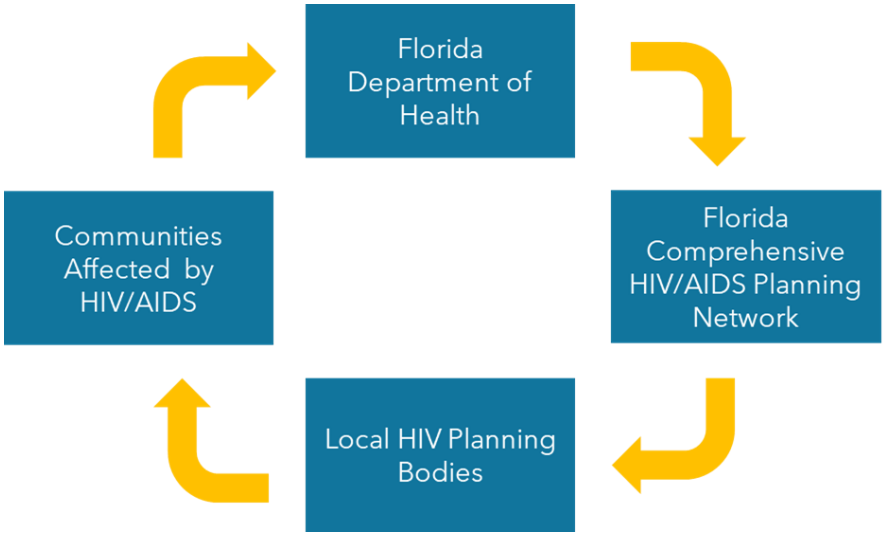
Location	Involvement
Statewide	Five ad-hoc consultations with representatives from priority populations (30+ participants per session), began Florida's U=U Campaign launch. The FDOH, HIV Section hosted virtual meetings (180+ reached) for FCPN, statewide planning body and community guests to refine the elements of the unified EHE plan from the state perspective.
Area 1 Counties: Escambia, Santa Rosa, Okaloosa, Walton	###engagement activities not provided###

Area 2A **Counties:** Bay, Calhoun, Gulf, Holmes, Jackson, Washington	Partnered with BASIC NWFL for HIV and HCV testing and condom distribution. PanCare of Florida (FQHC) conducted mobile HIV testing.
Area 2B **Counties:** Franklin, Gadsden, Jefferson, Leon, Liberty Madison, Taylor, Wakulla	Partnered with four community resources for the provision of Antiretroviral Therapy (ART); three community resources for HIV testing, and diagnosis; and one partner for HIV Education/Community Outreach. Town Hall meeting (10 clients attended), mailed 14 surveys
Area 3/13 **Counties:** Alachua, Citrus, Lake, Marion, Putnam, Hamilton, Suwannee, Columbia, Lafayette, Gilchrist, Dixie, Levy, Bradford, Sumter	###engagement activities not provided###
Area 4 **Counties:** Nassau, Baker Duval, Clay, St Johns	Held two Provider Meeting/Town Halls Part A: Creation of local EHE committee, provider survey (68 reached), community-wide listening sessions (115+ reached), faith-based workshops to address stigma and the social justice aspect of the HIV epidemic, and exclusive focus groups (50+ reached) with priority populations.
Area 5/6/14 **Counties:** Hernando, Pasco, Pinellas, Hillsborough, Manatee, Polk, Hardee, Highlands	Part A: An online community survey (72 reached), focus groups (eight reached) with youth, community members, and private sector leaders, individual phone interviews (39 reached), virtual town hall meetings per pillar (34 across all meetings), and an HIV care needs survey (600+ reached). Focus groups facilitated by representatives of key priority populations (55 reached across all sessions), a virtual interview with local radio station to engage the community (1,000+ reached), virtual EHE Advisory Council meetings to engage new and existing stakeholders, and Teen Talk Thurzdaze, monthly webinars facilitated by representatives revered by youth (50+ reached per meeting) and listening sessions with HIV service providers (45 reached).
Area 7 **Counties**: Seminole, Orange, Osceola, Brevard	Conducted three Town Hall meetings Part A: Key informant interviews (27 reached), EHE and HIV stigma conversations on Facebook Live with iHeart Media, eight virtual town hall meetings with key priority populations (98 individuals participated across all town halls, viewed by 3,356 individuals on Facebook Live), quarterly provider meetings to discuss EHE plans and implementation, eight pop-up HIV testing events, listening sessions with HIV service providers, and community-wide surveys (300+ reached)—one tailored to the community members and the other tailored to providers.
Area 8	###engagement activities not provided###

Counties: Sarasota, Desoto, Charlotte, Glades, Lee, Hendry, Collier	
Area 9 **County:** Palm Beach	Part A: Service provider interviews (19 reached), focus groups with PWH (10 reached), and Palm Beach Resident Phone Interviews in English, Haitian-Creole, and Spanish (253 reached).
Area 10 **County:** Broward	Part A: Twenty-eight community presentations, community-wide listening session, listening session with youth (nine reached), outreach sessions with college students (40+ reached) and five focus groups with providers, persons of trans experiences, Men who have Sex with Men (MSM), Black heterosexual women, Latinx individuals), student survey (130 reached), 40 key informant interviews with community members and service providers, and needs- based surveys for providers (430 reached) and community members (1,780 reached) in multiple languages
Area 11A **County:** Miami-Dade	Conducted several "listening sessions" at different venues, met with workgroups, focus groups outside the RWP or FDOH-MDC Part A: Key informant interviews with local CBOs and local government (23 reached), online community forums with facilitators representing priority populations (250+ reached), an exclusive focus group for transgender persons (15 reached), 11 community listening sessions with community mobilization groups that primarily serve Black, Latinx and transgender communities, and two needs-based surveys tailored to HIV service providers (37 reached) and community members (1,158 reached) in multiple languages
Area 11B **County:** Monroe	###engagement activities not provided###
Area 12 **Counties:** Volusia, Flagler	###engagement activities not provided###
Area 15 **Counties:** Indian River, Okeechobee, St. Lucie, Martin	###engagement activities not provided###

The figure below shows some of the community engagement and planning groups involved across the state.

FIGURE 4: COMMUNITY ENGAGEMENT AND PLANNING



In describing how the jurisdiction approached the planning process, the subsequent sections will address steps used in the planning process, the groups involved, and representation from the priority populations:

- Entities Involved in the Process (Section 2.1)
- Role of Planning Bodies and Other Entities (Section 2.2)
- Collaboration with RWHAP Parts (Section 2.3)
- Engagement of People with HIV (Section 2.4)
- Social Determinants and Health Equity (Section 2.5)
- Priorities (Section 2.6)
- Updates to Other Strategic Plans Used to Meet Requirements (Section 2.7)

2.1 Entities Involved in the Process

Florida has a long history of both engaging PWH and the broader community in developing plans for prevention and care services. This has been accomplished primarily through what is now known as the FCPN, which has been in existence since 1994. Currently, the filled member seats of FCPN total 39 individuals; there are currently 22 vacant seats (representatives and alternates). The FDOH, in collaboration with the FCPN Membership, Nominations and Bylaws Committee will develop a plan of action to recruit for the remaining vacant seats. Of the current FCPN members, one-quarter (n=10) disclosed living with HIV, with another three persons preferring not to disclose. Nearly 60 percent of the current FCPN members are between the ages of 50 and 60+ years of age. Of the 39 current members, gender identity is as follows: 49 percent male, 46 percent female, 3 percent transgender women and 2 percent transgender men. More than 50 percent of members reported their sexual orientation as

heterosexual or straight; 33 percent gay or same gender loving; 5 percent queer; 5 percent bisexual; and 1 percent lesbian. Race/ethnicity for members is as follows: White (52%), Black (19%), Hispanic/Latino (19%), Asian/Pacific Islander (6%), multi-racial (2%), and American Indian/Alaskan Native (2%). FCPN members are recruited statewide to represent local or at-large positions from patient care and prevention groups, local planning bodies, community-based organizations, academic institutions, local and regional clinics, city, and county governments, the six RWHAP Part A recipients, the transgender community, advocacy groups, substance use and social service providers and behavioral science groups.

Prior to 2017, the FCPN was made up of two planning bodies: the Patient Care Planning Group and the Prevention Planning Group. In 2017, the FCPN became fully integrated—merging prevention and care planning bodies. Membership of the integrated planning body is made up of persons with and those affected by HIV, FDOH staff, representatives from mental health and substance use, psychologists, social workers, case managers, AIDS service organizations (ASOs), CBOs, RW Part A providers, RW Part B lead agencies, advisory groups and FQHCs. The FCPN maintains a bi-annual, integrated meeting structure and members are responsible for disseminating information from the meetings back to their respective areas of representation, as well as bringing concerns from those same areas to such meetings, ensuring that the voice of PWH in Florida are part of the integrated planning process. The HIV/AIDS Section oversees the composition of these groups, ensuring that they are representative of Florida's HIV epidemic within the various geographic regions, using the principle of Parity, Inclusion and Representation.

The HIV/AIDS Section routinely communicates and coordinates with other state partners such as The AIDS Institute, health planning councils, Medicaid, Agency for Health Care Administration, Department of Corrections (FDC), Department of Children and Families (FDCF), FDOH programs such as the STD, Viral Hepatitis, and TB programs and other state partners, and the Florida HIV/AIDS Advocacy Network (FHAAN). The AIDS Institute is a national nonprofit organization that promotes a full spectrum of HIV activities including prevention, care, and treatment, through public policy, research, advocacy, and education. Medicaid, FDC, FDCF, and the STD, Viral Hepatitis, and TB programs are all state programs that impact and serve PWH. Medicaid is the single largest funder of HIV care in Florida. The HIV/AIDS Section contracts with FDC for pre-release planning services that link discharged inmates with HIV services upon release. FDCF oversees mental health services and several housing and homeless programs. The STD Section is a key partner to the HIV Prevention Program, with Disease Intervention Specialist (DIS) providing partner services and following up with newly diagnosed individuals. FHAAN is a statewide effort comprised of PWHs, community advocates, HIV/AIDS and industry professionals, and anyone wanting to be involved to coordinate HIV advocacy efforts.

Collaborations, partnerships, and stakeholder engagement exist in many forms throughout Florida; however, opportunities exist to expand partnerships further and engage new and non-traditional partners in more regular communication (for example, Department of Veterans' Affairs and Indian Health Services) to further the objectives and support the strategies of Florida's Statewide IPC Plan.

2.2 Role of Planning Bodies and Other Entities

The HIV/AIDS section works in partnership with the integrated care and prevention statewide planning body, FCPN. Currently, there are a total of 61 representative, alternate and at-large seats on the FCPN. Of those seats, 39 are currently filled, leaving 22 vacant seats (representatives, alternates and at-large).

Members of FCPN include PWH and representatives across the state representing state partnerships and coordinated planning are a continuous work in progress, designed to ensure optimal access to care and improved health outcomes for PWH.

FDOH HIV/AIDS Section uses several work and advisory groups. These groups consist of both members of the community as well as PWH. These groups are the Gay Men's HIV/AIDS Workgroup, the HIV/AIDS Section Workgroup on ADAP, and the CHAG.

Each group consists of approximately 20 consumers/community members selected through an application process and reflective of the profile of the HIV/AIDS epidemic in Florida. Applicants must be or have been involved in other HIV-related community-based groups. Members are appointed for a period of two years and may reapply for subsequent terms. These groups exist to provide a mechanism in which consumers and the community have meaningful input into the development of policies and programs to address their needs with and under the auspices of FDOH and the HIV/AIDS Section. The biggest challenge has been to identify and re-engage PWH who are not in care to ensure medical adherence and viral suppression. Many areas of the state have dedicated staff to find PWH not currently in care and FDOH works closely with local surveillance specialists to identify and re-engage those individuals.

In order to gain a truer understanding of community engagement on the local level, interviews were held with each Area, for a total of 72 participants. Participants included local FDOH staff, RWHAP Part A and B representatives, lead agencies, and other community planning body members. During each interview, participants were asked to report on efforts to recruit non-traditional members from within their community, challenges with particular groups, best practices, collaboration with other areas and what they think sets their planning body apart from others.

Area Interview Results

All but one area reported difficulty recruiting PWH. Most areas met the goal of having PWH represent 33 percent of their voting membership because the individual is a part of a community organization on the voting board and happens to be HIV-positive. Several strategies were used to try and entice "everyday PWH" to become part of the local planning bodies. Many areas offered incentives, one area converted planning body meetings from formal events (using Roberts Rules of Order and scientific-speak) to more informal meetings using lay language and fewer acronyms to some success, and others sent out mailers to PWH emphasizing their ability to have their voice heard and help the greater good. Other members that areas had difficulty recruiting and keeping were elected officials, faith-based leaders, hospital and healthcare planning agencies, and law enforcement.

To incorporate the perspective of PWH, almost every area sent surveys to clients about services they received and how satisfied they were with those services. This information is used to determine whether some services need to be enhanced, reworked, or streamlined. It is also used for gap analysis purposes to determine future funding.

About half of the areas reported a working relationship with local prisons and jails but felt more could be done to increase testing and treatment efforts. Areas overwhelmingly found value in monthly calls hosted by the FDOH HIV/AIDS Section and saw it as a chance to exchange best practices.

A theme that was consistent among planning areas that considered themselves highly functional was their ability to work together to make service delivery appear seamless to clients, regardless of what organization was providing the service. Longevity in leadership positions and the sharing of funds were also considered detrimental to highly functional areas.

2.3 Collaboration with RWHAP Parts

RW Part A, C, and D programs are key local partners and are at the table as planning activities are performed as no single RWHAP part can meet the needs for services. The RW Part F program collectively funds the SPNS projects, as well as the AETC that provide support and training to the medical community in treating patients, and dental programs for PWH.

The planning process is informed by local resource inventories, demographics, satisfaction surveys and service needs expressed locally by consumers. Given the multitude of RWHAP Parts, as well as programs funded by other federal, state, and local sources, funding allocation necessitates collaboration and coordination at the local planning body level. Therefore, consortia and/or planning councils require coordination in RWHAP planning, which involves consideration of other programs in such areas as assessment of needs, priority setting and resource allocation. Needs assessments must determine existing resources, regardless of funding stream, to identify areas of unmet need. Likewise, in setting priorities, other resources must be considered in terms of how they help meet service demands so that RWHAP resources can be used to fill gaps.

The HIV/AIDS Section routinely communicates with the RW Part A administrators to ensure that they are informed of program activities and have an opportunity to comment and contribute to various projects. Regular monthly calls are used to communicate program updates, policy changes, opportunities for collaboration and solicit feedback. The hosting of the calls rotates, with one of the six Part A areas leading the call each month. Examples of areas of collaboration include the transition of RW clients to the Insurance Marketplace, work on the statewide IPC plan, and development of the ADAP HCV treatment project.

The HIV/AIDS Section allocates RWHAP Part B funding for administration, planning and evaluation, clinical quality management and core and support services to 14 lead agencies annually to perform planning activities in their respective areas. Upon receiving RWHAP Part B funds from the Section, 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 Part B planning requirements for the program area and advise the lead agencies during the priority setting and resource allocation process. Lead agencies facilitate a provider selection process (internal services, external vendors, or competitive procurement process) through a network of local partners (CBOs, CHDs, consumers, planning bodies, etc.).

As the recipient of RW Part B funds, the FDOH is required to develop and maintain a clinical quality management (CQM) program to ensure quality healthcare services are provided to persons living with HIV. The purpose of the HIV/AIDS Patient Care CQM Program is to provide a systematic approach for planning, measuring, implementing, evaluating, and improving the quality of RW funded care services delivered to PWH in Florida. Routine review of established performance measures leads to the identification of specific CQM goals for each quality improvement project. Stakeholders who are internal and external to the CQM committee review measures through formally established

mechanisms using evidence-based quality improvement methods. For 2019–2022, the following goals were identified:

- Percentage of Patients on ART – Ensure equitable access to RWHAP funded HIV services in the State for PLWH and ensure equitable results in HIV health outcomes; patients receiving ambulatory outpatient care are also on ART.
- Improving Viral Suppression for PLWH – Drive maximum viral suppression for PLWH in the State. 90% of PLWH achieve viral suppression by 2022.
- Eligibility – Ensure PLWH in the State have complete eligibility documentation for all services received. Complete eligibility documentation prevents gaps in care and can help identify additional services for which the client has need. 90% of all clients have accurately completed eligibility documentation by 2022.

2.4 Engagement of People with HIV

The State strives to actively involve key partners, stakeholders, and people with HIV and, in doing so, incorporates feedback received, for the IPC Plan and otherwise, on an ongoing basis. The jurisdiction understands that to best serve those most marginalized, their voices must be involved in all aspects of the process. "Nothing about us, without us" is a call to action that informs the need for cultural shifts in programming, provisions of services, and community engagement. Changes have already been made to the planning process where a greater focus has been placed on creating an environment that is more welcoming to prospective members who represent communities most affected by HIV

PWH were influential in the development of the Statewide IPC Plan. PWH contributed by participating in the Statewide Needs Assessment, serving on local RW Part B consortia, local prevention planning bodies, RW Part A planning councils, as well as RW Parts C and D consumer advisory boards. There are also many robust peer-driven navigation and prevention programs that contribute greatly to PWH involvement on many different levels. They have helped us identify what is working well (or not), barriers to care, and in accessing prevention and patient care services, as well as helping to develop the state's unmet need matrix.

Further, PWH have participated widely in providing feedback to the HIV/AIDS Section by attending various town hall meetings that have helped develop goals and improve service delivery around eligibility, medical case management guidelines, High-Impact Prevention (HIP), PrEP, Post-Exposure Prophylaxis (nPEP), ADAP and many of the other programs overseen by the section. They have also played a key role in the success of the medical monitoring project (MMP) in Florida by willingly volunteering their time to be interviewed for this significant program. Florida has a very active Community HIV Advisory Group (CHAG) which also serves as the MMP's Community Advisory Board. Proposed changes in policy are reviewed and feedback is provided by this group of dedicated individuals.

2.5 Social Determinants and Health Equity

To reduce new HIV diagnoses in Florida, it is critical to ensure that everyone with HIV is aware of their status, is linked to and retained in HIV medical care, and maintains viral suppression. Collaborative efforts from prevention and patient care programs at the state and local levels, including by county health departments (CHDs), RWHAP partners, community-based organizations (CBOs), and health care

providers, are an integral part of ending the HIV epidemic in Florida. There must also be a focus on the social determinants of health that preclude people from engaging in prevention activities, seeking treatment, and acquiring an adequate level of health literacy. Key social determinants for the state include homelessness, poverty, racism, violence, stigma, homophobia, and transphobia. Initiatives such as anti-stigma campaigns and collaborations with faith-based organizations, as well as those that address social determinants, will aid in ending the HIV epidemic.

In the past decade Florida has seen a general decline in HIV diagnoses in Florida, however, the Black and Hispanic/Latino populations are disproportionally impacted with higher rates of new diagnoses compared to the white population. Additionally, late-stage HIV or AIDS are also higher in the Black population. For males diagnosed with HIV in 2021, Black men were 6 times more likely to be diagnosed with HIV compared to the white men, additionally, Hispanic/Latino men were 4 times more likely to be diagnosed HIV compared to white men. Similar trends are observed for females, where Black and Hispanic/Latina women were 12 and 3 times respectively more likely to be diagnosed with HIV compared to white women. In 2021, the majority (61 percent) of new HIV diagnoses in 2021 were men who had sexual contact with men (MSM), followed by 31 percent who were persons who had heterosexual contact, and 4 percent who were persons who inject drugs (PWID). Through the identification of priority populations disproportionately impacted by HIV, Florida will continue to engage with and seek input from members of those communities in order to address health disparities and social determinants of health.

Florida's incorporation of the status neutral approach and U=U into HIV prevention and care service delivery is a key component in addressing social determinants of health and stigma that may prevent individuals from engaging in HIV prevention and care services. In June 2020, the FDOH announced its endorsement of the Prevention Access Campaign's U=U. In becoming a U=U partner, FDOH joined nearly 1,000 organizations around the world supporting the science-backed message that people living with HIV who use antiretroviral therapy and have an undetectable viral load in their blood have effectively no risk of sexually transmitting HIV.

2.6 Priorities

The IPC Plan priorities are based on the 2022–2025 NHAS four goals:

1. Prevent new HIV infections
2. Improve HIV-related health outcomes for people with HIV
3. Reduce HIV-related disparities and health inequities
4. Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders

Table 4 below highlights the goals, objectives, strategies and major activity themes of the IPC plan, which also align with the NHAS strategies.

TABLE 4: GOALS, OBJECTIVES, AND STRATEGIES

Goal 1: Prevent New HIV Infections
Objective 1.1. Increase awareness of HIV
NHAS Strategies 1.1.1.–1.1.3 **Major Themes:** • Development of toolkits, campaigns and task forces at local levels • Work with law enforcement to find opportunities to incorporate HIV information into programs that serve youth • Identify ways to expand culturally competent sexual health education for youth outside of schools • Increase digital and social media presence and increase topic-based and population-specific messaging
Objective 1.2. Increase knowledge of HIV Status
NHAS Strategies 1.2.1–1.2.4 **Major Themes:** (Content being developed)
Objective 1.3: Expand and Improve Implementation of Effective Prevention Interventions
NHAS Strategies 1.3.1–1.3.6 **Major Themes:** (Content being developed)
Objective 1.4 Increase capacity of healthcare delivery systems, public health, and health workforce to prevent and diagnose HIV
NHAS Strategies 1.4.1–1.4.4 **Major Themes:** (Content being developed)
Goal 2: Improve HIV-Related Health Outcome of PWH
Objective 2.1. Link people to care rapidly after diagnosis and provide low-barrier access to HIV treatment
NHAS Strategies 2.1.1–2.1.2 **Major Themes:** (Content being developed)
Objective 2.2: Identify, engage, or reengage people with HIV who are not in care or not virally suppressed
NHAS Strategies 2.2.1–2.2.2

Major Themes: (Content being developed)
Objective 2.3: Increase retention and adherence to treatment to achieve and maintain long-term viral suppression.
NHAS Strategies 2.3.1–2.3.4 **Major Themes:** (Content being developed)
Objective 2.4: Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV
NHAS Strategies 2.4.1–2.4.3 **Major Themes:** (Content being developed)
Objective 2.5 Expand capacity to provide whole-person care to older adults with HIV and long-term survivors
NHAS Strategies 2.5.1–2.5.5 **Major Themes:** (Content being developed)
Objective 2.6: Advance the development of next-generation HIV therapies and accelerate research for HIV cure.
NHAS Strategies 2.6.1–2.6.2 **Major Themes:** (Content being developed)
Goal 3: Reduce HIV-related Disparities and Health Inequities
Objective 3.1. Reduce HIV-related stigma and discrimination
NHAS Strategies 3.1.1–3.1.5 **Major Themes:** (Content being developed)
Objective 3.2. Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum
NHAS Strategies 3.2.1–3.2.2 **Major Themes:** (Content being developed)

Objective 3.3. Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV
NHAS Strategies 3.3.1–3.3.2 **Major Themes:** (Content being developed)
Objective 3.4: Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities
NHAS Strategies 3.4.1–3.4.6 **Major Themes:** (Content being developed)
Objective 3.5: Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations.
NHAS Strategies 3.5.1–3.5.3 **Major Themes:** (Content being developed)
Objective 3.6: Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and health care mistrust.
NHAS Strategies 3.6.1–3.6.5 **Major Themes:** (Content being developed)
Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Interested Parties
Objective 4.1. Integrate programs to address the syndemic 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
NHAS Strategies 4.1.1–4.1.5 **Major Themes:** (Content being developed)
Objective 4.2 Increase coordination among and sharing of best practices from HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with public and private health care payers, faith-based and community-based organizations, the private sector, academic partners, and the community
NHAS Strategies 4.2.1–4.2.4 **Major Themes:** (Content being developed)

Objective 4.3 Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continua data and social determinants of health data
NHAS Strategies 4.3.1–4.3.3 **Major Themes:** (Content being developed)
Objective 4.4: Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances.
NHAS Strategies 4.4.1–4.4.3 **Major Themes:** (Content being developed)

For a full list of activities suggested to support each strategy, refer to Appendix section 9.1 Strategy and Activity Table.

Additionally, the EMA's local priorities align with the NHAS, and the four pillars outlined in the EHE: diagnose, treat, prevent, and respond. All goals and objectives include various local initiatives with some overlap between several CDC and HRSA grants.

Due to the disproportionate impact of HIV within Black and Latino populations, local efforts throughout the RW/IPC patient care and CDC/IPC funded prevention grants have determined to focus on Latino, Black, and youth (13-24) populations. Within these populations there is a special emphasis on those who engage in male-to-male sexual contact (MMSC) and women of childbearing age (WCBA).

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

While setting goals and priorities, Demanding Better: An HIV Federal Policy Agenda by People Living with HIV was referenced to ensure the Meaningful Involvement of People with HIV/AIDS (MIPA) in decision-making, at every level of the response. In Demanding Better, The US People Living with HIV (PLHIV) Caucus outlines five recommendations which must be centered in every aspect of the federal HIV response:

1. Concretely elevating the meaningful involvement of people living with HIV and disproportionately impacted communities in the HIV response
2. Proactively creating an affirming human rights environment for people living with HIV
3. Addressing inequities in the federal response by attending to racial and gender disparities
4. Adding sex workers and immigrants living with HIV as priority populations
5. Affirmatively committing to improving quality of life for people living with HIV

MIPA requires dedication, planning and assessment, organizational buy-in, and a champion to help usher its development and continued assessment. Although The HIV National Strategic Plan did not largely address these recommendations in the final version, the EMA's IPC Plan will do so to the greatest extent possible, as they were created by and for people living with HIV.

2.7 Updates to Other Strategic Plans Used to Meet Requirements

Local jurisdictions perform an annual needs assessment, based on core questions developed through the FCPN Needs Assessment Committee. The needs assessments are created using multiple sources of information from people with HIV and other stakeholders. Interviews are conducted of PWH and stakeholders to incorporate their feedback and needs. Additionally, surveys are sent out to clients and focus groups are held with the community to understand any changing of needs and priorities. Ongoing feedback of people with HIV and stakeholders in accomplished by broadly advertising public meetings, allowing public access to all draft, and completed reference documents through online postings, and encouraging participation by members and guests at all meetings. Further, following completion, the IPC Plan will be presented to the groups who contributed to ensure ongoing community engagement. With greater representation comes additional perspectives that are pivotal to evaluating and improving all planning processes, including the IPC Plan.

Florida's new IPC plan for 2022–2026 was built upon the foundational goals, strategies and activities from the Florida Statewide Integrated HIV Prevention and Care Plan, 2017-2021, Florida's Unified Ending the HIV Epidemic Plan, 2020, the National HIV/AIDS Strategy, and input from local planning bodies and community members.

3 Contributing Data Sets and Assessments

In analyzing contributing data sets and assessments used to describe how HIV impacts the jurisdiction, the subsequent sections will detail HIV prevention services, barriers to accessing those services, and gaps in the service delivery system:

- Epidemiological Snapshot, including Data Sharing and Use (Section 3.1)
- HIV Prevention, Care and Treatment Resource Inventories including strength and gaps, and approaches and partnerships (Section 3.2)
- Needs Assessment including priorities, actions taken and approach (Section 3.3)

3.1 Epidemiologic Snapshot

The full Epidemiological Profile of HIV in Florida, 2017-2021 is attached separately. Below is a brief snapshot of the key points.

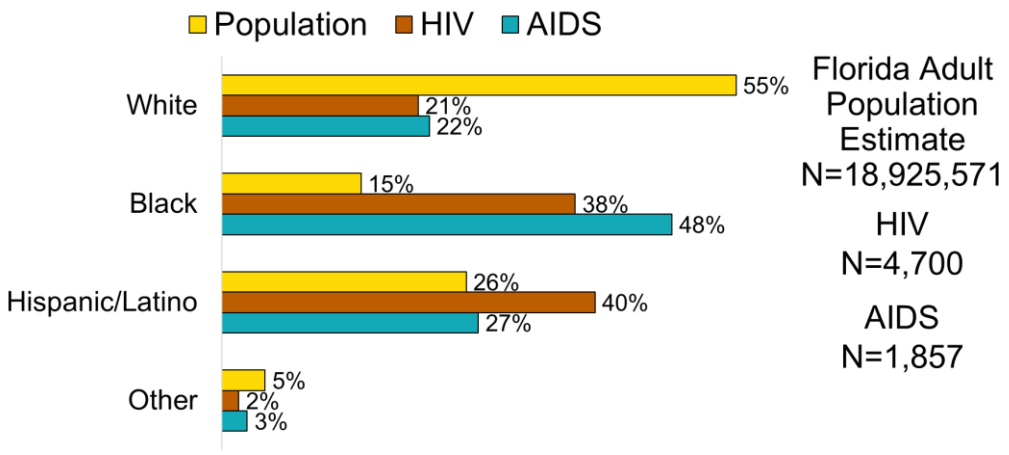
According to the Centers for Disease Control and Prevention, in 2020,[42], Florida had the third highest number of HIV diagnoses and was the third highest for new HIV diagnosis rates per 100,000 population in the United States (U.S.) (including the District of Columbia). In 2021, 4,708 persons received an HIV diagnosis in Florida, a 37 percent increase from the 3,441 HIV diagnoses in 2020; however, these data should be interpreted with caution due to impacts from the COVID-19 pandemic which impacted testing, access to care and surveillance activities. In 2021, 83 percent of those newly diagnosed were linked to HIV-related care within 30 days of diagnosis. There were 120,502 persons with HIV (PWH), regardless of AIDS status, living in Florida through 2021. This represents only 86 percent of all the PWH in Florida, the remainder of whom are living with the disease but are unaware of their HIV status. Among the PWH, 73% were retained in care and 69% were had a suppressed viral load at the end of the year. Twenty percent of PWH had no care in 2021.

Geographical Region and Socio-Demographic Characteristics of Florida

Florida is a southern state that spans a geographic region of 53,624 square miles, comprises 67 counties and 283 cities and has a mix of urban, suburban, and rural areas. The 2021 population in Florida was 22.0 million residents, with over 410 residents per square mile. Approximately 20 percent of the population is under the age of 18 and 21 percent is over the age of 65. According to the U.S. Census Bureau, in 2020, 12.4 percent of Floridians were living in poverty and 16 percent of Floridians under the age of 65 were without health insurance. The population of Florida is very diverse, with approximately 20.8 percent of persons residing in the state being foreign born (born outside the continental U.S.). Although most new HIV diagnoses in 2021 were among those born in the U.S. (58.1%), 41.9 percent of people newly diagnosed with HIV in Florida were born outside the U.S. mainland.

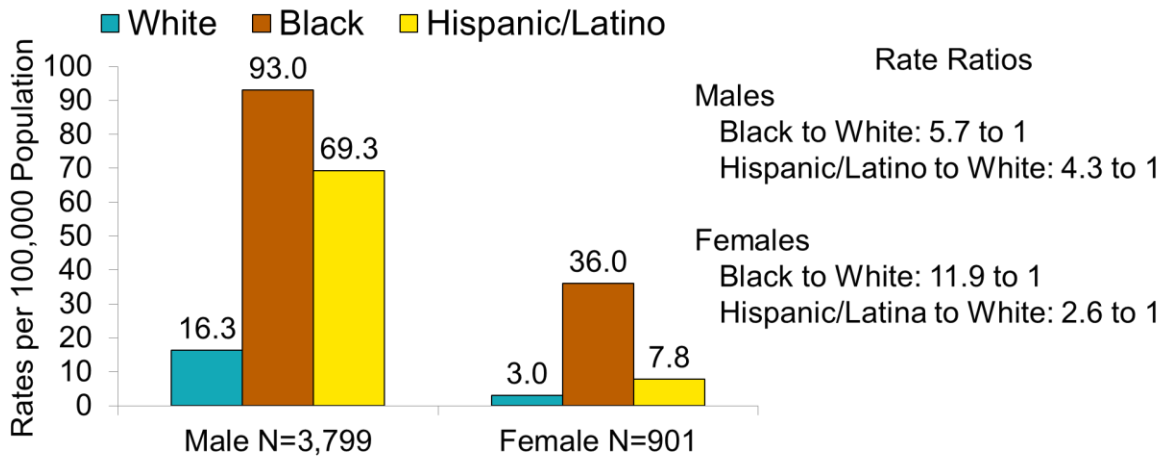
The racial distribution among the adult population (age 13 and above) in Florida in 2021 was 55 percent White, 15 percent Black, 26 percent Hispanic/Latino and five percent other races including American Indian, Asian, or mixed race. There were 4,708 HIV diagnoses among adults in 2021. The greatest burden was among the Black population, which received 38 percent of the new HIV diagnoses in 2021 despite only representing 15 percent of the adult population in Florida. Hispanic/Latino people were also disproportionately represented for new HIV diagnoses, with 40 percent of the new HIV diagnoses, compared to 21 percent among White people for 2021 as shown in Figure 5.

FIGURE 5: ADULT (AGE 13+) HIV AND AIDS DIAGNOSES AND POPULATION BY RACE/ETHNICITY, 2021, FLORIDA



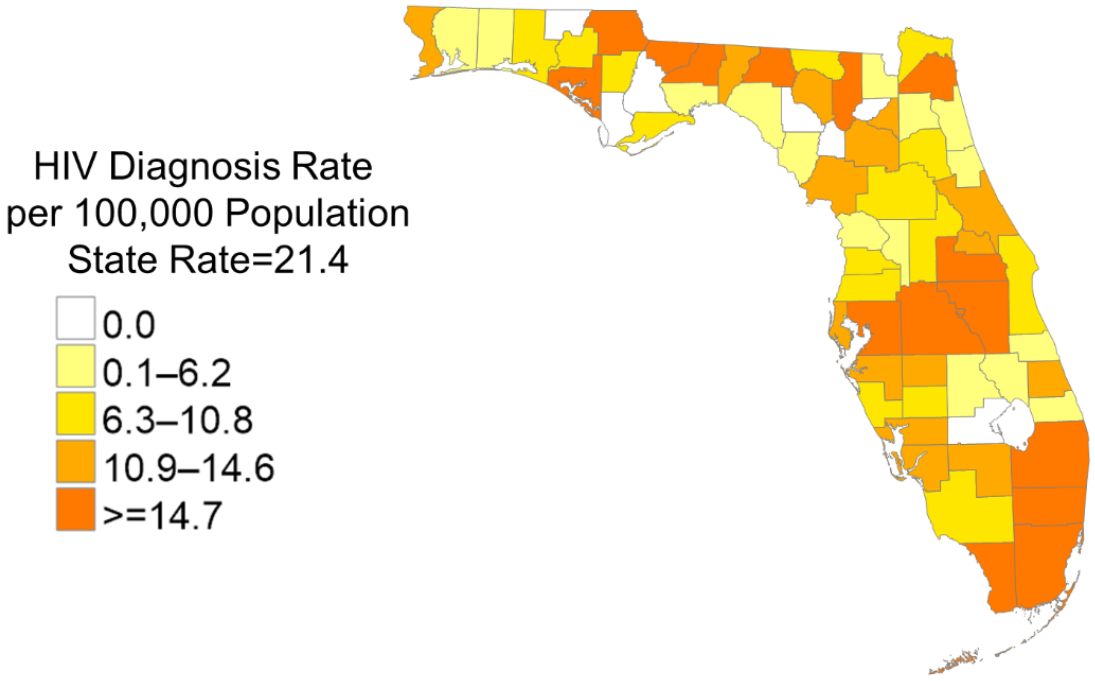
In 2021, Florida continued to see disparities in HIV diagnoses among adults, despite an annual decrease in the HIV diagnosis rate among Black persons in the past five years. The HIV diagnosis rate per 100,000 population among Black males (93.0) was nearly six times higher than for White males (16.3) and the rate for Hispanic/Latino males (69.3) was more than four times higher than for White males. The HIV diagnosis rate among Black females (36.0) was twelve times higher than for White females (3.0); the rate for Hispanic/Latina females (7.8) was more than two times higher than for White females (Figure 6 below). Black persons had a lower statewide viral suppression (<200 copies/mL) rate of 64 percent compared to 77 percent for White persons and 71 percent for Hispanic/Latino persons.

FIGURE 6: ADULT (AGE 13+) HIV DIAGNOSIS RATES BY SEX AND RACE/ETHNICITY, 2021, FLORIDA



In 2021, there was at least one HIV diagnosis in all but seven counties in Florida and the state HIV diagnosis rate was 21.4 per 100,000 population (Figure 7 below) Miami-Dade (42.1), Broward (33.5), Orange (30.3), Duval (30.2), and Palm Beach (21.7) counties had rates higher than that for the state in 2021. The greatest numbers of HIV diagnoses were from the seven counties identified in the national Ending the HIV Epidemic (EHE) initiative: Miami-Dade (N=1,204), Broward (N=652), Orange (N=439), Hillsborough (N=323), Duval (N=300), Palm Beach (N=322) and Pinellas (N=130). These seven counties diagnosed a combined total of 3,370 cases in 2021, or 72 percent of the statewide total.

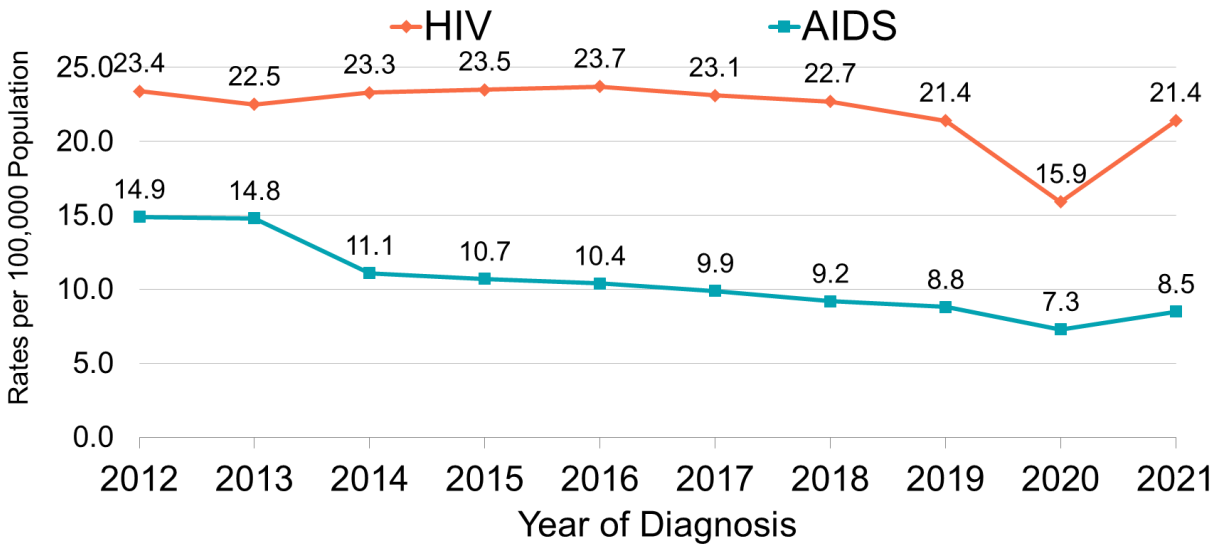
FIGURE 7: HIV DIAGNOSIS RATE BY COUNTY IN 2021, FLORIDA



Trends in HIV Diagnosis

Data for 2020 and 2021 should be interpreted with caution due to the impact of COVID-19 on HIV testing, care-related services, and case surveillance activities in state and local jurisdictions. (Figure 8 below) shows that over the past 10 years (2012–2021), the rates of diagnosed HIV and AIDS in Florida have decreased nine percent and 43 percent, respectively.

FIGURE 8: TEN-YEAR TREND (2012–2021) OF HIV AND AIDS RATES PER 100,000 POPULATION IN FLORIDA



The number of HIV diagnoses decreased by four percent from 2018 to 2019 and increased by 3 percent from 4,556 (2019) to 4,708 (2021). Additionally, the number of new HIV diagnoses increased by 6 percent among adult men and decreased by six percent among adult women from 2019 to 2021. The number of new HIV diagnoses over the past five years (2017–2021) decreased among all but two age groups: persons aged 30–39 (15 percent increase) and persons aged 40–49 (2 percent increase). The number of new HIV diagnoses over the past five years decreased among all race/ethnicity groups except Hispanic/Latino persons, where a 25 percent increase was observed.

Male-to-male sexual contact (MMSC) continues to be the primary mode of exposure for HIV among cis-gender men (77 percent in 2021), followed by heterosexual contact (18%) and injection drug use (IDU) (3%). Over the past five years (2017–2021), transmissions among cis-gender men that observed an increase in HIV diagnoses were MMSC (1%) and IDU (28%), whereas transmissions that decreased were MMSC/IDU (12%) and heterosexual contact (1%).

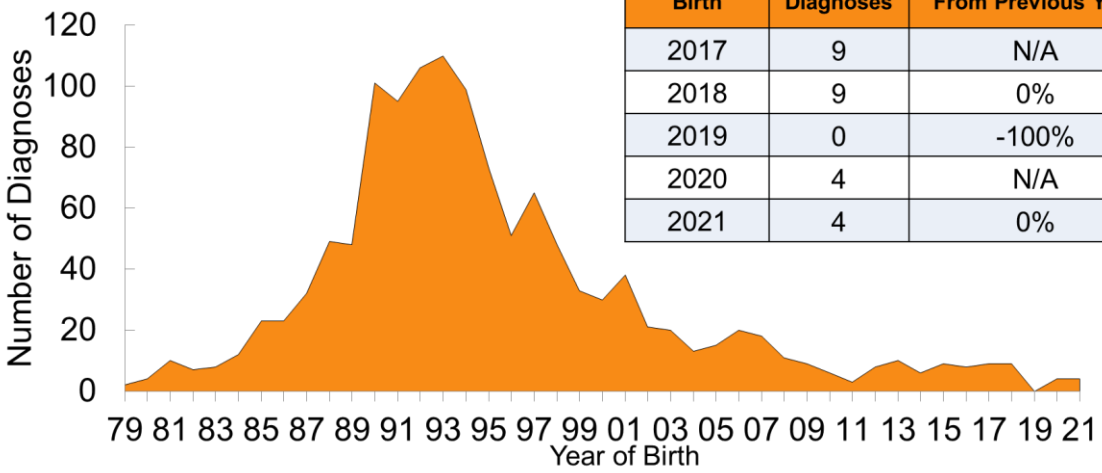
Heterosexual contact is the primary mode of exposure for HIV among cis-gender women (92 percent in 2021), followed by IDU (8%). Over the past five years (2017–2021), decreases in HIV diagnoses among cis-gender women were observed among both transmissions: heterosexual contact (11%) and IDU (13%).

Thirty-eight out of the 67 counties (57%) saw a decrease in new diagnoses of HIV from 2018 to 2019. Whereas 28 out of the 67 counties (42%) saw a decrease in new diagnoses of HIV from 2019 to 2021. All but two of the seven EHE counties in Florida saw a decrease in HIV diagnoses from 2019 to 2021 (Pinellas [32%], and Orange [5%]). Palm Beach County saw a 31 percent increase from 2019 (N=245) to 2021 (N=322), and Hillsborough County saw a 12 percent increase from 2019 (N=288) to 2021 (N=323). The three remaining EHE counties (Duval, Miami-Dade, and Broward) all saw a three percent increase from 2019 to 2021.

Perinatal HIV Transmission

A strategic long-term goal in Florida is to reduce or eliminate the annual number of babies born in Florida with perinatally acquired HIV. Since the introduction of azidothymidine (AZT) in 1992, perinatally acquired HIV diagnoses have drastically declined (Figure 9). Over the past three years (2019 to 2021), there were eight perinatally acquired HIV diagnoses with an average transmission rate of 0.006. For the first time in the history of the HIV epidemic, there were no perinatally acquired HIV diagnoses born in Florida in 2019. There were four in 2020, and four in 2021.

FIGURE 9: PERINATALLY ACQUIRED HIV DIAGNOSES, 1979–2021, BABIES BORN IN FLORIDA



Year of Birth	Number of Diagnoses	Percentage Change From Previous Year
2017	9	N/A
2018	9	0%
2019	0	-100%
2020	4	N/A
2021	4	0%

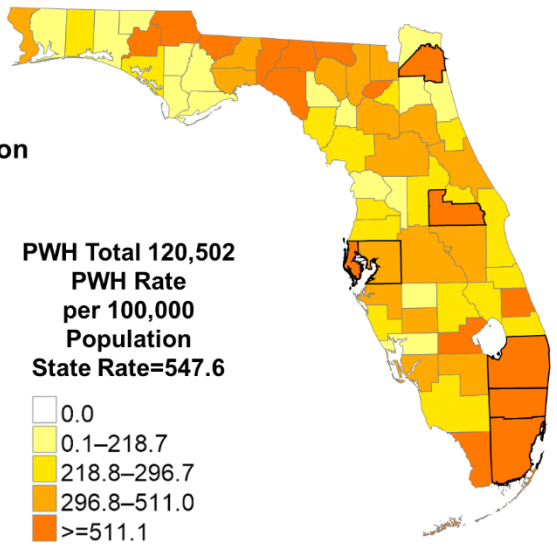
[1]AZT, short for azidothymidine, is an antiretroviral medication used during childbirth to prevent vertical transmission of HIV.

Prevalence of PWH in Florida

The rate of PWH in Florida in 2021 was 547.6 per 100,000 population, with the majority of PWH living in the large metropolitan areas and the seven counties outlined in the EHE plan. However, there is also a high rate of PWH living in smaller, more rural counties, such as those in Northern Florida (Figure 10). There were 120,502 PWH living in Florida in 2021. Among the adult PWH (N=120,379), 44 percent were Black, 28 percent were White, 26 percent were Hispanic/Latino and two percent were American Indian, Asian, or multiracial. More than one-half (57 percent) were over the age of 50. MMSC was the mode of exposure for 71 percent of males and heterosexual contact was the mode of exposure for 86 percent of females. Ten percent of PWH had a history of IDU. Among the PWH in 2021, 484 were transgender women and 19 were transgender men. Among those persons, sexual transmission was their primary (90 percent) mode of exposure. Florida continues to try to overcome the barriers to obtaining complete identification and HIV surveillance of transgender men and women with HIV. Florida collects data and information on transgender persons from case report forms and laboratory imports and matches with other HIV databases to increase understanding of the burden of HIV among our transgender population. All data on transgender persons are validated to maintain integrity of the data.

FIGURE 10: PWH, LIVING IN FLORIDA, BY COUNTY OF RESIDENCE, YEAR-END 2021

7 EHE Counties	Number of PWH	PWH Rate per 100,000 Population
Miami-Dade	27,782	971.2
Broward	21,014	1079.4
Orange	9,703	669.7
Palm Beach	8,417	565.9
Hillsborough	7,742	511.0
Duval	6,754	678.9
Pinellas	5,065	511.6



Late HIV Diagnosis and Resident Deaths Due to HIV/AIDS

HIV/AIDS-related deaths in Florida decreased markedly (30%) from 1995 (N=4,004) to 1996 (N=2,796) after the advent of highly active antiretroviral therapy (HAART) in 1996. Furthermore, HIV-related deaths in Florida from 2012 to 2021 decreased 34 percent over the past ten years, 16 percent over the past five years and seven percent in the past year from 659 in 2020 to 612 in 2021. The Black community has been disproportionality affected by HIV in Florida since the epidemic began in 1981 and despite a great decrease in the rate of HIV-related deaths among Black persons (43 percent since 2012), disparities still exist among Florida's Black population. In 2021, rates of HIV-related deaths were five times higher for Black men (11.9 per 100,000 population) compared to White men (2.6 per 100,000 population) and nearly 11 times higher for Black women (7.5 per 100,000 population) compared to White women (0.7 per 100,000 population) with HIV.

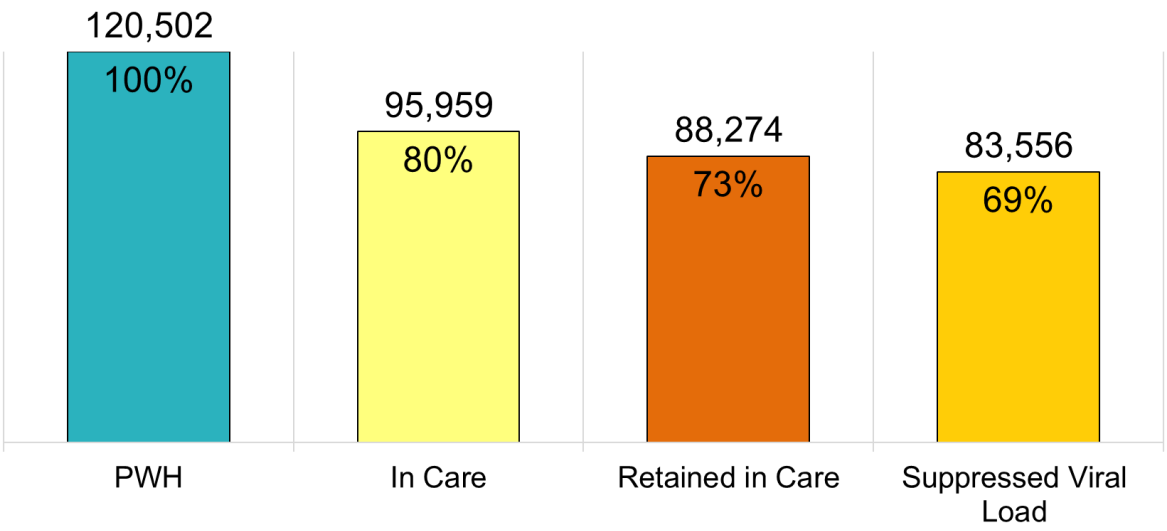
Of the 4,708 HIV diagnoses in 2021, 19 percent (N=895) were late diagnoses, which are defined as persons receiving an AIDS diagnosis within 90 days of their confirmed HIV diagnosis. By race/ethnicity, 20 percent of Black persons, 21 percent of White persons and 16 percent of Hispanic/Latino persons were late diagnoses. Among adults (age 13+), the two groups with the highest proportion of late diagnoses by age and mode of exposure were persons aged 50 and over (29%) and males with a history of IDU (29%), respectively.

HIV Care Continuum

The HIV Care Continuum is a diagnosis-based model that reflects the series of stages from initial diagnosis to being retained in care and achieving viral suppression. The HIV Care Continuum has four main stages: HIV diagnosis, linkage to care, retention in care, and viral suppression. It demonstrates the proportion of individuals diagnosed and living with HIV who are engaged at each stage. This model is used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to PWH across the entire continuum

In 2021, despite the COVID-19 pandemic, of the 120,502 PWH in Florida, 80 percent (N=95,959) were reported to be in care (received at least one documented VL or CD4 lab, medical visit, or HIV-related prescription in 2021), 73 percent (N=88,274) were retained in care (had HIV-related care 2 or more times at least 3 months apart), and 69 percent (N=83,556) were virally suppressed. As Figure 11 below shows, of the persons retained in care, 90 percent had a suppressed viral load (<200 copies/mL). Twenty percent (N=24,543) did not receive any HIV-related care in 2021.

FIGURE 11: PWH LIVING IN FLORIDA ALONG THE HIV CARE CONTINUUM, YEAR-END 2021



Note: 90% of persons retained in care had a suppressed viral load.

The seven EHE counties make up approximately 11 percent of the total national HIV burden as outlined in the EHE plan and represent 72 percent of the total persons living with an HIV diagnosis in Florida. Five of the EHE counties, Pinellas (77%), Hillsborough (71%), Orange (72%), Broward (70%) and Duval (69%) had a viral suppression rate equivalent or greater than the state rate of 69 percent, while Palm Beach (65%) and Miami-Dade (63%) had lower viral suppression rates than the state at the end of 2021.

The five populations ranked lowest in the percentage of suppressed VL (<200 copies/ml) in 2021, in descending order, were as follows:

1. Male PWID (58%)
2. Black Cisgender Males with Heterosexual Contact (59%)
3. Black MSM (65%)
4. Persons 25–39 years of age (66%)
5. Persons 13–24 years of age (67%)

When compared with the HIV Care Continuum for Florida, the above five populations demonstrated significant disparities, particularly in the last stage, suppressed VL (<200 copies/ml). In 2021, 69 percent of PWH in Florida had a suppressed viral load. The five populations of concern in this section clearly show suppressed VL percentages below 69 percent. This is significant to note in observing the ultimate health outcome of treatment adherence and an individual living with HIV leading a healthier life.

HIV-Related Co-Morbidities

Sexually transmitted infections (STIs) and hepatitis B (HBV) and C (HCV) have been steadily increasing in Florida over the past five years, including a four percent increase in chlamydia, a 40 percent increase in gonorrhea and an 88 percent increase in early syphilis. Co-infection of PWH with STIs also increased during this same time period, with an increase of 67 percent for HIV/gonorrhea, 72 percent for HIV/chlamydia and 76 percent for HIV/early syphilis. In 2021, there were 302 adults who were also co-infected with HBV, 86 percent of whom were male; 59 percent of the males reported MMSC exposure and 30 percent of females reported IDU exposure. There were 537 PWH who were coinfected with HCV in 2021, the majority of whom were males (82%) with an MMSC (66%), IDU (13%), or heterosexual (11%) exposure. Forty-eight percent of female PWH co-infected with HCV had IDU exposure. Increased need for routine screening of all STIs, HIV and hepatitis is needed to capture and prevent disease burden.

HIV Transmission Clusters and Networks

One aspect of the Florida IPC and the Florida EHE plan is to detect and respond to rapidly growing HIV transmission clusters and networks and prevent future HIV diagnoses using data and laboratory results collected through routine public health surveillance. Cluster network analyses are conducted using data from point-of-care HIV-1 genotypic resistance testing to identify genetic (molecular) links of similar virus strains by comparing those with similar HIV genetic sequences; those data are then used to identify networks of recent and rapid transmission for prevention and linkage-to-care interventions. The observed HIV transmission rate in molecular clusters identified across the U.S. is on average 11 times higher than the transmission rate within the general HIV population according to the CDC, thus indicating the importance to intervene quickly using proven interventions to stop further transmission of HIV. HIV molecular clusters are considered rapidly growing when there have been five or more new HIV diagnoses within the previous 12 months. FDOH is actively conducting surveillance and investigation for HIV clusters. FDOH routinely conducts monthly analysis to detect rapidly growing molecular clusters and time-space clusters of public health significance. Additionally, a state level

cluster review committee is convened monthly to review cluster data, discuss challenges, and brainstorm strategies to improve the statewide response. Since Fall 2021, the FDOH Bureau of Communicable Diseases has established routine communication with CHDs experiencing clusters to coordinate and guide local responses to investigate and respond to clusters. Florida's updated HIV Cluster Detection and Response plans were submitted to CDC in Fall 2021 and will be updated in the future.

Since the beginning of FDOH's cluster detection program in November 2017, the HIV/AIDS Section has identified 44 clusters at a 0.5 percent genetic distance between strain of HIV demonstrating rapid growth. These molecularly linked transmissions comprise a total of 739 persons receiving an HIV diagnosis in Florida with a much larger, often underdefined risk network. Though members of molecular clusters live across the state, 415 (56%) received a diagnosis in an EHE Phase 1 county. Furthermore, of those diagnosed and currently living in the state of Florida as of September 8, 2020, 482 (71%) have a current residence within one of the seven EHE counties.

3.2 Data Sharing and Use

De-identified HIV, viral hepatitis, STD, and TB data are routinely shared via ad-hoc requests to surveillance programs with outside entities including by not limited to, academic institutions, community partners, RWHAP Parts, internal agency partners and collaborators, and the public.

Each of these programs provide annual data which is uploaded into FLHealth CHARTS (Florida Community Health Assessment and Resource Tool Set) (https://www.flhealthcharts.gov/charts/CommunicableDiseases/default.aspx). In addition, FL Health CHARTS is updating the FLHealth CHARTS website (a web-based platform that provides easy access to health indicator data at the community and statewide level for the State of Florida from a multitude of sources) with a new dashboard (at the county level) that will incorporate a multitude of HIV/AIDS indicators, including but not limited, to demographic and socio-economic indicators, partner services data, testing/treatment facilities, PrEP, and other data not previously included on FL Health CHARTS. By ensuring all these data and information are made readily accessible and user-friendly, the new dashboard will help local and state planning bodies develop more effective and efficient programs and corresponding activities and monitor progress of IPC strategies and activities.

All data are protected securely and confidentially, adhering to FDOH internal policies and strictly adhere to CDC guidelines "National Centers for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) data security and confidentiality guidelines."

Summarized ad-hoc data requests are honored based on the ability of the program to generate the requested data within the time constraints of the request. Data requests for zip code data will receive suppressed data (data by zip code with 3 or more cases) based on internal FDOH ZIP code suppression rules.

Epidemiological Data

Summarized annual data are also uploaded to the FDOH HIV/AIDS Section web page (http://floridaaids.org/) and are also available on an internal SharePoint site for internal use at the state and county health department level. Annual data releases include a comprehensive epidemiological profile for the state and for each partnership area, a state slide set presented annually to FCPN, and other annual data products. The epidemiological (epi) profiles are an expanded Excel workbook with multiple tabs containing 5-year trend analyses of HIV (demographics, diagnosis, AIDS, deaths, and continuum of care), STIs, HBV, HCV, and TB.

Factsheet and Slide Sets to Support Stakeholder Engagement and Planning

Various factsheets are generated to portray epidemiology and disease highlights for a demographic population. These fact sheets address the various HIV/AIDS awareness day topics as well as highlighting summary data for high-risk population groups. These fact sheets are updated annually, shared with community stakeholders, and uploaded to the FDOH external web and internal SharePoint sites. Integrated slide sets and epidemiological profile tables are generated to support stakeholder engagement and planning. The FDOH HIV/AIDS Section has generated compressive slides sets and epi profiles specifically for each of the 16 partnership areas each year since the 1990s. These slide sets and epi profiles are shared with the RW Part A entities, community stakeholders, field surveillance staff and others who may request these data. These data are frequently used as tools for program planning and evaluation.

Other Data Sources

Along with HIV data, FDOH summarizes data from MMP and NHBS surveillance along with FDOH PrEP, test and treat, and HIV counseling and testing data. Data from the needs assessments are also shared in reports sent out to FCPN membership.

Data Sharing Agreement

For persons requesting de-identified data in a database format that can be analyzed for public health research purposes, the researcher must first submit a concept proposal with research aims, benefit to public health, and required data variables and time frame for the requested data. An internal FDOH research committee reviews the feasibility of the project, including for potential human subjects impacts and ethical considerations, once approved the requestor must complete a Data Use Agreement (DUA) and obtain a study approval or study exemption letter from the FDOH Institutional Review Board. Once received, the DUA is routed for legal review and signatures. Data are provided via secure FTP format and can only be housed on secure servers as part of the DUA.

Any program outside of the FDOH that is approved to receive HIV data through a Data Sharing Agreement (DSA) for the purpose of linking or re-engaging HIV clients into care must be in full

compliance with the NCHHSTP Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, STD, and TB Programs, the FDOH security and confidentiality policies, Health Insurance Portability and Accountability Act (HIPAA) guidelines, have documented active client consent to share. Data sharing with programs outside the FDOH requires approval of the overall responsible party, HIV/AIDS Section administrator and legal counsel. A memorandum of understanding or DSA must be completed between the FDOH and the program requesting data. The HIV Surveillance Program will provide only the minimum data required to conduct linkage and re-engagement to HIV-care and services.

3.3 HIV Prevention, Care and Treatment Resource Inventory

To ensure that the state of Florida is meeting the goals and objectives set forth to best address the needs of PWHs, we must prioritize the financial resources and assess the capacity to provide the services outlined. The following section provides a comprehensive HIV financial and human resources inventory for Florida. Components include but are not limited to statewide public and private funding sources for HIV prevention, care, and treatment services; the dollar amount and the percentage of the total available funds for each funding source; program or service delivery; and how Florida's HIV Care Continuum is impacted.

Resource inventories have been provided by all 16 service areas within the State of Florida. Each service area provided separate inventories for prevention and patient care which can be found in Appendix section 9.3 Service Area Resource Inventories. The table below represents Funding for all HIV service areas.

Table 5: Resource Inventory Funding

Funding Source and Area	Funding Amount ($)	Percent of Total Funding (%)	Services Delivered	HIV Care Continuum Steps Impacted*
HRSA RW Part A (EMA/TGA)**				
Fort Lauderdale	$15,724,848		Medical case management (including treatment adherence), oral health care, EIS, mental health services, substance abuse treatment (outpatient), case management (nonmedical), food bank/home-delivered meals, health education/risk reduction, housing services, legal services, medical transportation services, psychosocial support services	2,3,4,5
Jacksonville	$5,886,669			
Miami	$26,432,895			
Orlando	$10,445,207			
Tampa	$10,352,255			
West Palm Beach	$7,304,638			
HRSA RW Part B				
Base	$30,031,995		Medical case management services (including treatment adherence), case management (non-medical), food bank/home-delivered meals, health education/risk reduction, psychosocial support services, quality management, evaluation	2,3,4,5
MAI	$1,253,307		Increase in enrollment in health care services, AIDS Drug Assistance Program (ADAP), Medicaid, or other health care coverage	2,3,4,5
ADAP Earmark	$84,839,389		ADAP medications, Insurance Continuation	4
ADAP Rebates	$165,647,438		ADAP medications, Insurance Continuation	4
Emerging Communities	$468,324			4
HRSA RW Part B – Supplemental	**$2,888,725**		ADAP medications	3,4,5
HRSA RW Part B – ERF	**$5,211,950**		ADAP medications	3,4,5
CDC Integrated Prevention and Surveillance	**$38,756,445**			1,2,3,4,5
FDOH Headquarters	$30,671,550		Core prevention and surveillance programs including HIV testing and linkage to care; comprehensive prevention services and services for HIV-positive individuals; condom distribution; policy initiatives; evidence-based interventions for at-risk populations; social marketing, media, and	
FDOH Statewide total distribution (counties)	$8,084,895			

			mobilization; jurisdictional HIV prevention planning; PrEP and nPEP initiatives; capacity-building and technical assistance; program planning, monitoring, and evaluation; and quality assurance.	
CDC Ending the HIV Epidemic	**$11,280,419**			
FDOH Headquarters [1]	$2,613,537		Prevention and surveillance programs which complement existing work under the state's HIV prevention and surveillance cooperative agreement (CDC-PS18-1802) and use innovative strategies to addressing ending the HIV epidemic.	1,2,3,4,5
Community	$862,949			
Broward	$1,949,187			
Duval	$615,372			
Hillsborough	$674,419			
Miami-Dade	$2,624,940			
Orange	$880,968			
Palm Beach	$794,010			
Pinellas	$457,986			
HRSA RW Part C -Early Intervention	**$10,668,448**			
Borinquen Health Care Center, Inc. (Miami)	$699,183		Early Identification Services (management, and administration EIS), core medical services, support services, quality management and administration.	1,2,3,4,5
Empower U (Miami)	$679,903			
University of Miami (Miami)	$933,332			
Charlotte De Soto County Health Department (Arcadia)	$273,835			
Collier Health Services (Immokalee)	$468,290			
Duval County Health Department (Jacksonville)	$300,912			
Hendry County Health Department (Labelle)	$317,459			
Manatee County Rural Health Services, Inc. (Palmetto)	$499,050			
Monroe County Health Department (Key West)	$521,839			
Neighborhood Medical Center, Inc. (Tallahassee)	$545,577			
North Broward Hospital District (Fort Lauderdale)	$875,925			

Okaloosa County Health Department (Fort Walton Beach)	$306,167			
Orange County Health Department (Orlando)	$1,072,229			
Pancare of Florida, Inc. (Panama City)	$300,000			
Polk County Health Department (Bartow)	$546,633			
St. Johns County Health Department (St. Augustine)	$357,926			
The McGregor Clinic, Inc. (Fort Myers)	$339,544			
Unconditional Love, Inc. (Melbourne)	$346,828			
University of Florida (Gainesville)	$350,484			
University of Miami (UM) (Miami)	$933,332			
HRSA RW Part D	**$7,593,769**			
Bond Community Health Center, Inc. (Tallahassee)	$493,499		Medical services, clinical quality management, support services, and administration.	1,2,3,4,5
Children's Diagnostic & Treatment Center, Inc. (Fort Lauderdale)	$2,016,919			
Florida Department of Health (Tallahassee)	$829,678			
University of Florida (Gainesville)	$729,616			
University of Miami (Miami)	$2,058,949			
University of South Florida (Tampa)	$1,465,108			
HRSA RW Part F				
NOVA Southeastern University, Inc. (Fort Lauderdale)	$219,230		Assistance for accredited dental schools, post-doctoral dental programs, and dental hygiene education programs for uncompensated costs incurred in providing oral health treatment to patients with HIV	3
State General Revenue	**$42,210,855**			
FDOH Headquarters	$22,748,209		HIV prevention and care staff, services, and supplies.	1,2,3,4,5
County Health Departments[1]	$12,427,076			
Pharmacy	$7,035,570		HIV prevention and treatment medications	4
State Line-Item Appropriations				

UM Center for AIDS Research (CFAR)	$1,000,000		HIV cure research through UM CFAR	
TOPWA	$500,000		Perinatal HIV prevention services	1,2,3,4,5
Hispanic & Haitian Outreach	$239,000		HIV outreach and education to Hispanic and Haitian communities	1,2
HOWPA (HUD)- State				
FDOH Statewide	$8,364,929		Housing assistance and related support services for low-income persons with HIV/AIDS and their families	3,4,5
HOWPA (HUD)- Direct Funding to Cities				
Fort Lauderdale	$7,088,032		Housing assistance and related support services for low-income persons with HIV/AIDS and their families	3,4,5
Jacksonville	$2,601,336			
Miami	$11,924,914			
Orlando	$4,586,699			
Tampa	$4,378,068			
West Palm Beach	$3,202,608			
CDC Medical Monitoring Project	**$861,929**		Population-based project which provides information about the behaviors, clinical outcomes, quality of care, and barriers to care and viral suppression among people with diagnosed HIV.	4,5
CDC NHBS	**$433,710**		National HIV Behavioral Surveillance Study (Miami, FL)	1,2,3,4,5
CDC Integrated Hepatitis Surveillance Prevention	**$774,500**		Improve hepatitis surveillance data collection systems to systematically collect, analyze, interpret and disseminate data. Increase hepatitis testing and vaccination for high-risk populations.	1,2,3,4,5
CDC STD Grants	**$35,813,552**			1,2,3,4,5
STD PCHD	$5,696,617		Surveillance, investigation and intervention for syphilis, gonorrhea, chlamydia, and HIV. Limited clinical support.	1,2
DIS Workforce Development Supplement	$29,068,863		Expanding public health workforce capacity to respond to infectious disease outbreaks.	1,2
Ssun	$340,000.		Enhanced surveillance of gonorrhea via extended patient and provider interviews.	1,2
ELC	$633,071		Routine syphilis screening at non-traditional venues (hospital emergency department and syringe	1,2

			services program) to reduce congenital syphilis rates.	
Childbearing Capacity in Jails (NACCHO)	$75,000		Routine syphilis screening for women of child-bearing age to reduce congenital syphilis rates.	1,2
Other external funding sources that do not go directly to FDOH				
CDC Directly-Funded Service Providers				1,2,3,4,5
SAMHSA-Formulary				
Substance Abuse Prevention and Treatment Block Grant	$309,005,551		Funding for mental health services, substance abuse prevention, and substance abuse treatment	1,2,3,4,5
Community Mental Health Services Block Grant	$200,719,072			
Projects for Assistance in Transition from Homelessness (PATH)	$4,334,339			
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	$1,823,324			
SAMHSA-Discretionary				
Mental Health	$102,340,448		Funding for mental health services, substance abuse prevention, and substance abuse treatment	1,2,3,4,5
Substance Abuse Prevention	$5,422,332			
Substance Abuse Treatment	$120,836,993			
Veteran's Affairs	**$194,668,373**		Funding to support services for Florida veterans	1,2,3,4,5
Indian Health Services	***		Funding to support services for Florida's federally-recognized tribes and tribal organizations	1,2,3,4,5
TOTAL				

[1] State General Revenue includes the following funding categories: 4B000, 4BNWK, and 4BAPS.

* HIV Care Continuum: 1 = HIV Testing and Diagnosis: Staff, services and systems that help to identify and test persons who are unaware of their HIV status; 2 = Linkage to Care: Staff, services, and systems that help connect newly diagnosed PWHA to care; 3 = Retention in Care: Staff, services, and systems that help PWH remain engaged in care and treatment services; 4 = Provision of ART: Staff, services, and systems that help PWH access and remain adherent to antiretroviral medication; 5 = Viral Suppression: Staff, services and systems that help PWH achieve and maintain viral suppression. ** Part A figures represent 2020–2021 funding amounts ***Unable to obtain Florida-specific funding levels

Other sources of funding include funds from the State of Florida General Revenue, HOPWA, CDC Prevention Programs for Health Departments, CDC Integrated HIV Prevention and Surveillance, CDC MMP, CDC NHBS, Veteran's Administration (VA), and private pharmaceutical funding.

The Florida HIV Care Continuum Dashboard Tool was developed as a mechanism to gather information related to how statewide funds are distributed and RWHAP services are delivered by geographic area. The purpose and goal of the tool was to provide a snapshot of HIV prevention and patient care funding and assess HIV prevention and patient care activities across the care continuum by each of the 16 HIV service areas.

The tool provides a listing of resources within health departments and local communities, as well as illustrates gaps and unmet needs by contrasting regional differences and highlighting areas of need. The information in the Florida HIV Care Continuum Dashboard Combined Tool was self-reported by each local area, therefore slight differences may appear in terms of funding or data reported. Additionally, specific caveats may apply since they may have alternate funding streams coming into their local areas or enhanced best practices or collaborative efforts which result in increased funding as reported by the state.

The purpose of this inventory is to provide a snapshot of HIV prevention and patient care funding by area. The goal of this inventory is to help assess HIV prevention and patient care activities across the continuum of care by area. The inventory provides a snapshot of resources within health departments and communities. Individual area resource inventories can be found in Appendix section 9.3 Service Area Resource Inventories

3.3.1 Strengths and Gaps

Through the development of Florida's Unified EHE Plan and through local community engagement activities, additional gaps, needs, and barriers were identified which span across all pillars as described in the table below:

TABLE 6: GAPS, NEEDS AND BARRIERS

Summary	Description
Meaningful Community Engagement with Priority Populations	FDOH received feedback from community partners on the perceived effectiveness of current public health initiatives. Partners identified across all IPC pillars determined there is a need for increased and meaningful community engagement with all of Florida's populations that are disproportionately affected by and/or living with HIV. Transgender persons and gay and bisexual men continue to be disproportionately impacted by HIV, and increased engagement with these populations is needed along with more sensitivity training for public health staff and health care providers.

Summary	Description
	FDOH recognizes that Florida's racial/ethnic minority populations continue to increase in size, correlating with persistent and often growing health disparities. Despite improvements in HIV outcomes over the last decade, substantial gaps continue to exist for Black persons, Hispanic persons, Native Americans, and Asians/Pacific Islanders compared to the state's majority population. For Florida's racial/ethnic minority populations, HIV outcomes have not improved for everyone at the same rate due to health disparities and inequities related to many social determinants of health. While Florida has maintained the BRTA and FRTA initiatives for over a decade, additional efforts are needed to involve faith-based and business leaders. Faith-based leaders, as trusted members of their communities, are well-poised to educate and mobilize Black and Hispanic populations around HIV/AIDS. Feedback received from Black gay men indicates that churches sometimes perpetuate stigma associated with HIV (e.g., homophobia, transphobia). There is a need for business leaders and leaders of faith-based institutions to help raise awareness and educate their congregants, employees, and customers in communities highly impacted by HIV.
Geography and Transportation	Whereas there are major metropolitan areas in the state, 30 of Florida's 67 counties (45%) are designated as rural per the 2010 U.S. Census.[39] Many Floridians live in areas that have both rural and urban characteristics, which makes addressing the needs of these communities challenging. Transportation is often a barrier for clients attempting to access HIV care services and can lead to missed appointments, decreased medication adherence, and disengagement from care.[20]
Poverty and Education	In 2020, 13.3 percent of people living in Florida reported living below the federal poverty level.[20] Counties with the highest poverty rates included DeSoto, Hamilton, Hardee, Hendry, and Madison Counties. In 2016–2020, 88.5 percent of people aged 25 years and older living in Florida had at least graduated from high school (compared to 89.4 percent for the U.S.).[20] Counties with the fewest individuals with at least a high school diploma included DeSoto, Glades, Hamilton, Hendry, and Lafayette Counties. Counties with the lowest education levels were found in central and northern Florida.

Summary	Description
Mental Health and Substance Use Disorders	Persons experiencing mental health and/or substance use disorders are at increased risk for HIV and frequently lack access to HIV/STI education, prevention, and care services.[22] In 2020, nearly 18 percent (7,842) of the 44,577 reported drug overdose deaths in Florida involved opioids.[23] There was an approximate 28 percent increase in the number of persons treated for addiction with self-reported injection drug use (IDU) between 2014 and 2018.24 There was a 2 percent increase in HIV diagnoses from 2017-2021 among persons with an IDU-related mode of exposure.[6] Over that same time period acute HCV infections increased by 366 percent in Florida, whereas injection drug use is the primary mode of exposure among persons diagnosed with acute HCV. Efforts are needed to ensure organizations providing behavioral health and substance use treatment services are providing education around HIV, STIs, and HCV and are knowledgeable about local testing and treatment resources.
Multicultural and Multilingual Issues	Florida population estimates for 2020 show racial/ethnic distributions as follows: 51.5 percent White (non-Hispanic), 14.5 percent Black (non-Hispanic), 3.0 percent Asian American, and 0.2 percent Native American. Hispanic/Latin persons make up over a quarter (26.5%) of the population. Florida ranks within the top five states with the highest Hispanic/Latinx populations in the U.S. and has one of the largest Black/African American populations in the country. Florida's Asian population is growing, particularly in Gulf Coast locations. The state is home to two federally recognized American Indian tribes (the Seminole and the Miccosukee, in South Florida) and many more non-federally recognized tribes, bands, and clans. The Miami metropolitan area (along with New York City) maintains one of the highest populations of Caribbean immigrants, with approximately 63 percent of Caribbean immigrants in the U.S. living in these two metro areas. Just over 20 percent of Florida's population is foreign-born, and nearly 30 percent of households in Florida speak a language other than English.[5] There is a lack of bilingual and multilingual health care providers and media/marketing messages in certain regions of the state.25
Racism, Discrimination, and Medical Mistrust	Persons experiencing racism and discrimination are less likely to remain adherent to care and more likely to have poorer health outcomes.26 Medical mistrust tends to be higher among Black/African American and American Indian populations in Florida. The Tuskegee Study conducted by the U.S. Public Health Service left lasting impacts on the way Black/African American persons view health care, particularly public health.27 Similarly, studies have shown the sterilization of American Indian women by the Indian Health Service in the 1960s and 70s created a culture of distrust of government-funded health care services.28

Summary	Description
In-Migration, Transient, and Mobile Populations	Florida sees more than one hundred million tourists each year, many of whom are drawn to popular beach towns and cities like Miami, Fort Lauderdale, and Key West.29 Its many theme park attractions and over 8,400 miles of coastline make Florida a destination for tourists from around the world. The state also has a large population of seasonal residents—students, seasonal workers (in industries such as hospitality, agriculture, and tourism), and those who reside here part time to avoid harsh winters. In addition, Florida is home to several state and private higher learning institutions, including HBCUs. These colleges and universities are often located in major metropolitan areas, which have higher than average HIV incidence.
Immigration	Over the past few years, foreign-born individuals and individuals born in U.S. dependent areas immigrating to Florida have accounted for roughly half of the population's growth; more than one in five Florida residents is an immigrant.30 Individuals born outside the continental U.S. comprise roughly 20 percent of the state's population, and in Miami-Dade County, more than 60 percent of the population is foreign-born. Among non-U.S. born residents in Florida, persons born in Haiti, Cuba, Venezuela, and Columbia experienced the highest numbers of HIV diagnoses in 2021.This presents a need for increased cultural humility training to ensure health education, prevention, and care services are delivered in a culturally and linguistically appropriate manner.
Criminal Justice	According to the National Corrections Institute, Florida's incarceration rate (prisons and jails) was 371 per 100,000 population in 2020 (Source: https://nicic.gov/state-statistics/2020/florida-2020) . In 2020, the U.S. Bureau of Justice Statistics ranked Florida 11th among states in terms of incarceration rates.32 Most incarcerated PWH were diagnosed prior to entering the correctional system; however, HIV testing within a correctional setting may be the first time persons who are incarcerated take advantage of testing and prevention education. Section 945.355, Florida Statutes, requires inmates of FDC to be offered HIV testing prior to release, while jails (which are governed by each county) do not have statewide HIV testing policies. Over time, FDOH has built relationships with county jails to establish HIV testing and linkage programs. Increased partnerships with county jails are needed to expand HIV, STI, and HCV testing.
Environmental Impact	Severe weather events can disrupt and interrupt HIV prevention and care delivery systems. Florida is a state particularly vulnerable to frequent

Summary	Description
	hurricanes. When Hurricane Michael hit the Florida panhandle in October 2018 as a category 5 storm, it caused mass destruction. Thousands of homes were destroyed, and many residents were displaced. PWH in the area had trouble accessing services and medications due to widespread devastation. Many people were forced to find housing elsewhere in Florida or even in other states. Emergency medication fills were available through the ADAP program, however increased efforts are needed to identify PWH in need of re-engagement in care and ancillary services following a natural disaster.

3.3.2 Approaches and partnerships

As mentioned previously, HIV service regions are broken down into 16 areas, each with a HAPC to oversee prevention and care program operations in the area and assure that program activities are planned for in an inclusive and collaborative manner to assure the other local resources and specific client needs are considered and addressed. They work closely with RWHAP grantees, health district resources, other county programs, and academic and university resources as available.

The HIV/AIDS Section also works closely with the STD, TB, and Viral Hepatitis and Outbreak Response Sections, Children's Medical Services, local CBOs, and CHDs, universities, FDC, FDOH state laboratories in Jacksonville and Miami, and central pharmacy.

The six RW Part A EMAs/TGAs, and the RW Part C, D, and F programs collectively bring more than $94.6 million to Florida and are key resources in meeting the service needs of PWHs in their service area. The RW Part C program directly funds local projects to support service capacity building as well as early intervention services; there are 20 RW Part C programs in Florida. The RW Part D program directly funds a local Tampa project that provides clinical services to WICY&F; there are six RW Part D programs in Florida.

The HIV/AIDS Section routinely communicates with the RW Part A administrators to ensure that they are informed of program activities and have an opportunity to comment and contribute to various projects. Areas of collaboration have been on the transition of RW clients to the Insurance Marketplace, work on the Statewide IPC Plan, and development of the ADAP HCV treatment pilot project.

Over the past two years, there have been multiple meetings to plan for a uniform methodology to select insurance plans and move clients to the Marketplace. Determining eligibility criteria for insurance coverage, planning for the provision of wrap- around services, and the potential local coverage of additional clients were main topics of discussion. This project has been very successful; clients, regardless of whether they receive services from RW Part A, Part B ADAP, or are mutual clients, have the same options for insurance selection criteria and process to enroll into the Marketplace for insurance coverage.

The FDOH HIV Surveillance Program works closely with each local area to provide customized data reports that reflect key information about the epidemic in each area. These data reports are provided to the local CHDs, planning bodies, and each of the RW Part A areas to assist them in preparing grant applications and other reports. Local planning bodies use epidemiologic data, demographic, and service data, focus groups, resource inventories, and client and provider satisfaction surveys to gauge areas of program strengths and weaknesses.

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.

Stakeholder engagement occurs on a regular basis through the FCPN and assists FDOH in planning patient care and prevention activities. The FCPN is composed of representatives from FDOH, all parts of the RW Program, FQHCs, academia, service providers, CBOs, PWHs, and advocates. The FCPN reviews and gives feedback on projects the HIV/AIDS Section develops, such as the Needs Assessment, the SCSN and Statewide IPC Plan, other programs funded with state general revenue, as well as various program standards, and guidelines.

Collaborations, partnerships, and stakeholder engagement exist in many forms throughout Florida; however, opportunities exist to expand partnerships further and engage new and non-traditional partners in more regular communication (for example, Department of Veterans' Affairs and Indian Health Services) to further the objectives and support the strategies of Florida's Statewide IPC Plan.

3.4 Needs Assessment

The information gained from the 2019 HIV Care Needs Survey represents a statewide comprehensive assessment of the needs of PWH in Florida. Survey questions were designed to better understand the current demographics of PWH in Florida and the HIV medical care, patient care services, jail/prison release services, and housing services that were needed and delivered during the 12 months prior to the time the survey was taken.

To ensure that services provided through the Patient Care Program are appropriate and contribute to improving health outcomes for PWH, the HIV/AIDS Section conducted the 2019 HIV Care Needs Survey

throughout the state. The primary focus of the survey was to determine met and unmet service needs for PWH in Florida. Data collected from this survey is intended to help statewide and local planning stakeholders determine the best ways to distribute funds and resources. This survey was launched on May 28, 2019 and continued to completion on September 6, 2019. The survey was delivered via Survey Gizmo and paper to Floridians living with HIV who sought HIV care services in each of the 14 program areas of the Ryan White Patient Care Program.

Limitations

Using the convenience sampling method to collect input for this type of assessment has its advantages, disadvantages, and limitations. Surveys collected using this method can yield rich qualitative data for review and planning in a comparatively cost-efficient manner. Data are available relatively quickly to match the pace of planning needs and are useful to signal changes or shifts in attitudes, behaviors, and outcomes. Among the disadvantages of collecting assessment data via convenience sampling are the potential for bias in data collection and sampling errors that could introduce inaccuracies. Surveying processes that use the convenience sampling method have limitations. Survey participants were self-selected, which introduced selection bias.

3.4.1 Methodology

Survey questions were grouped into sections that included general demographics, HIV medical care, patient care services, jail/prison release services, housing services, and prevention services. Questions were related to the past 12 months of service. Distribution of the survey was facilitated by the sixteen consortia lead agencies throughout Florida. A sample size for each county was calculated based on the number of PWH. Each county was provided the minimum number of surveys to be sent to reach 25 percent of total PWH at a 10 percent response rate. RWHAP Part B lead agencies, in collaboration with RWHAP Part A recipients, worked with local providers, community members, and other stakeholders to obtain the survey responses. The survey was made available in three languages: English, Haitian-Creole, and Spanish. Paper surveys were collected locally and mailed to the HIV/AIDS Section for data entry and analysis.

A total of 4,114 surveys were conducted by the end of the survey period: 3,758 in English, 334 in Spanish, and 22 in Haitian-Creole. Of these, 3,777 were complete, 147 were partial, and 190 were disqualified. (Respondents had to answer the demographic questions about age, gender, race, and county to qualify.)

This document presents the key findings of the 2019 HIV Care Needs Assessment. Results from this survey will be used to help guide service implementation and resource allocation within Florida's HIV/AIDS Patient Care Program.

Survey respondents' counties of residence were reported for 66 of Florida's 67 counties. Union County was not surveyed because there are no PLWH in that county. A total of 3,879 respondents answered the question about residence. Table 7 lists the number of respondents from each county.

TABLE 7: FLORIDA COUNTY OF RESIDENCE

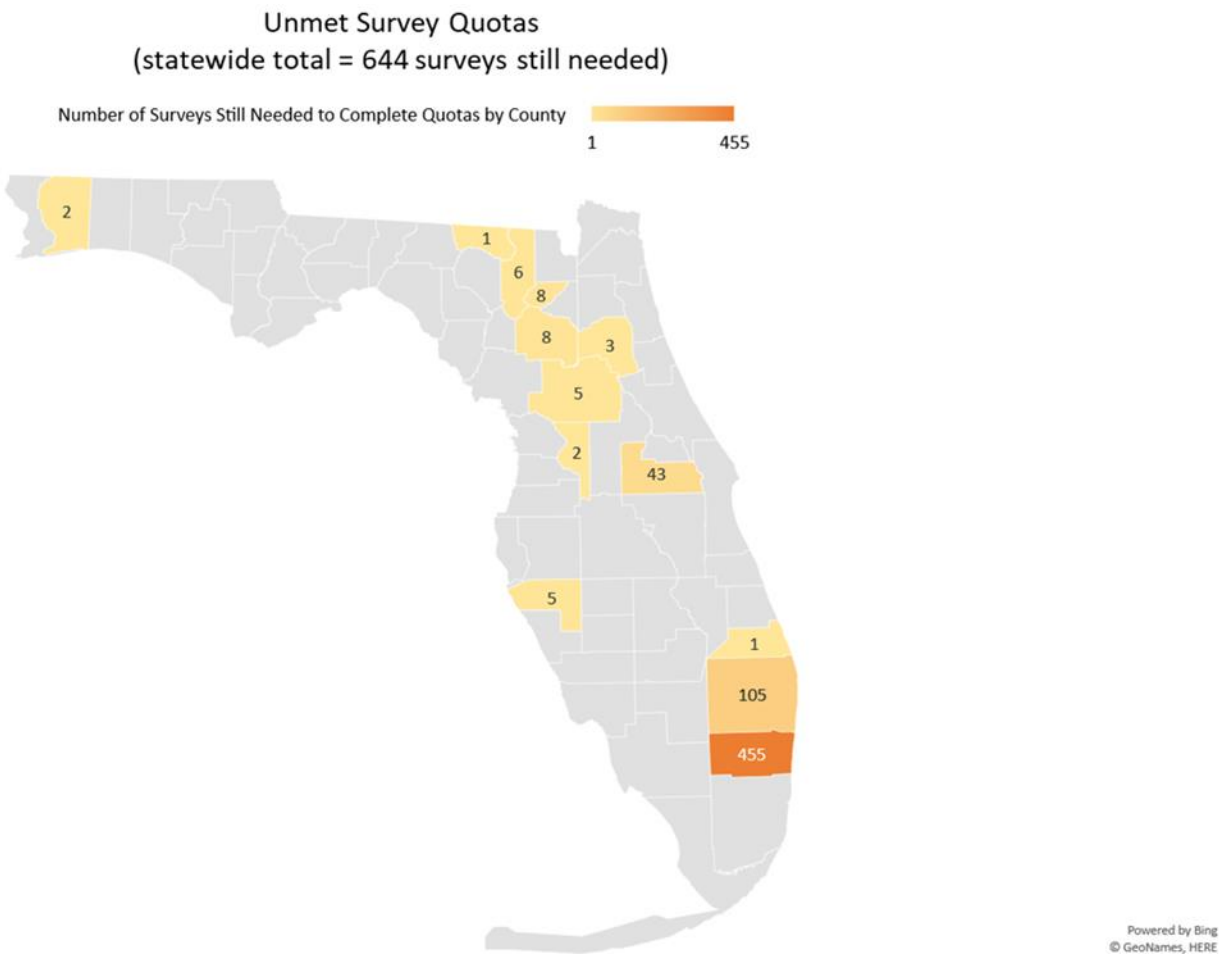
County	Count	Percent	County	Count	Percent
Alachua	20	0.52%	Lake	45	1.16%
Baker	3	0.08%	Lee	76	1.96%
Bay	29	0.75%	Leon	221	5.70%
Bradford	3	0.08%	Levy	5	0.13%
Brevard	244	6.29%	Liberty	4	0.10%
Broward	65	1.68%	Madison	11	0.28%
Calhoun	1	0.03%	Manatee	22	0.57%
Charlotte	24	0.62%	Marion	23	0.59%
Citrus	8	0.21%	Martin	22	0.57%
Clay	16	0.41%	Miami-Dade	765	19.72%
Collier	29	0.75%	Monroe	37	0.95%
Columbia	3	0.08%	Nassau	4	0.10%
DeSoto	14	0.36%	Okaloosa	17	0.44%
Dixie	3	0.08%	Okeechobee	7	0.18%
Duval	230	5.93%	Orange	187	4.82%
Escambia	47	1.21%	Osceola	53	1.37%
Flagler	25	0.64%	Palm Beach	107	2.76%
Franklin	5	0.13%	Pasco	78	2.01%
Gadsden	49	1.26%	Pinellas	319	8.22%
Gilchrist	1	0.03%	Polk	76	1.96%
Glades	2	0.05%	Putnam	3	0.08%
Gulf	1	0.03%	Santa Rosa	5	0.13%
Hamilton	3	0.08%	Sarasota	68	1.75%

County	Count	Percent	County	Count	Percent
Hardee	2	0.05%	Seminole	51	1.31%
Hendry	7	0.18%	St. Johns	12	0.31%
Hernando	37	0.95%	St. Lucie	63	1.62%
Highlands	13	0.34%	Sumter	5	0.13%
Hillsborough	475	12.25%	Suwannee	5	0.13%
Holmes	2	0.05%	Taylor	5	0.13%
Indian River	18	0.46%	Volusia	164	4.23%
Jackson	14	0.36%	Wakulla	9	0.23%
Jefferson	3	0.08%	Walton	5	0.13%
Lafayette	2	0.05%	Washington	7	0.18%
			Total	3,879	

A sample size for each county was calculated based on the number of PWH. Each county was provided the minimum number of surveys to be sent to reach 25 percent of total PWH at a 10 percent response rate. The three counties with highest unmet quotas were:

- Broward
- Palm Beach
- Orange

FIGURE 12: UNMET SURVEY QUOTAS BY COUNTY



3.4.2 Approach

The FCPN Needs Assessment Committee has worked diligently since 2019 to develop the 2022 HIV Care Needs Survey and Needs Assessment Toolkit and it was released in October 2022. The purpose of the toolkit is to familiarize areas statewide with the importance, components, and processes of needs assessment. The toolkit provides the information needed for active involvement in the needs assessment process by individuals with little or no prior experience in community planning or community-based assessments. The needs assessment process is designed to gather data to inform patient care services both locally and statewide with meaningful input from people impacted by HIV. The survey is expected to stay open through December 31, 2022. Once results are received and analyzed, this information will be used to update the Statewide Coordinated Statement of Need (SCSN).

The 2019 survey questions were grouped into sections that included general demographics, HIV medical care, patient care services, jail/prison release services, housing services, and prevention services. Questions were related to the past 12 months of service. Distribution of the survey was facilitated by the 14 consortia lead

agencies throughout Florida. A sample size for each county was calculated based on the number of PWH. Each county was provided the minimum number of surveys to be sent to reach 25 percent of total PWH at a 10 percent response rate. RW Part B lead agencies, in collaboration with RW Part A recipients, worked with local providers, community members, and other stakeholders to obtain the survey responses. The survey was made available in three languages: English, Haitian-Creole, and Spanish. Paper surveys were collected locally and mailed to the HIV/AIDS Section for data entry and analysis.

A total of 4,114 surveys were conducted by the end of the survey period: 3,758 in English, 334 in Spanish, and 22 in Haitian-Creole. Of these, 3,777 were complete, 147 were partial, and 190 were disqualified. (Respondents had to answer the demographic questions about age, gender, race, and county to qualify.)

3.4.3 Priorities

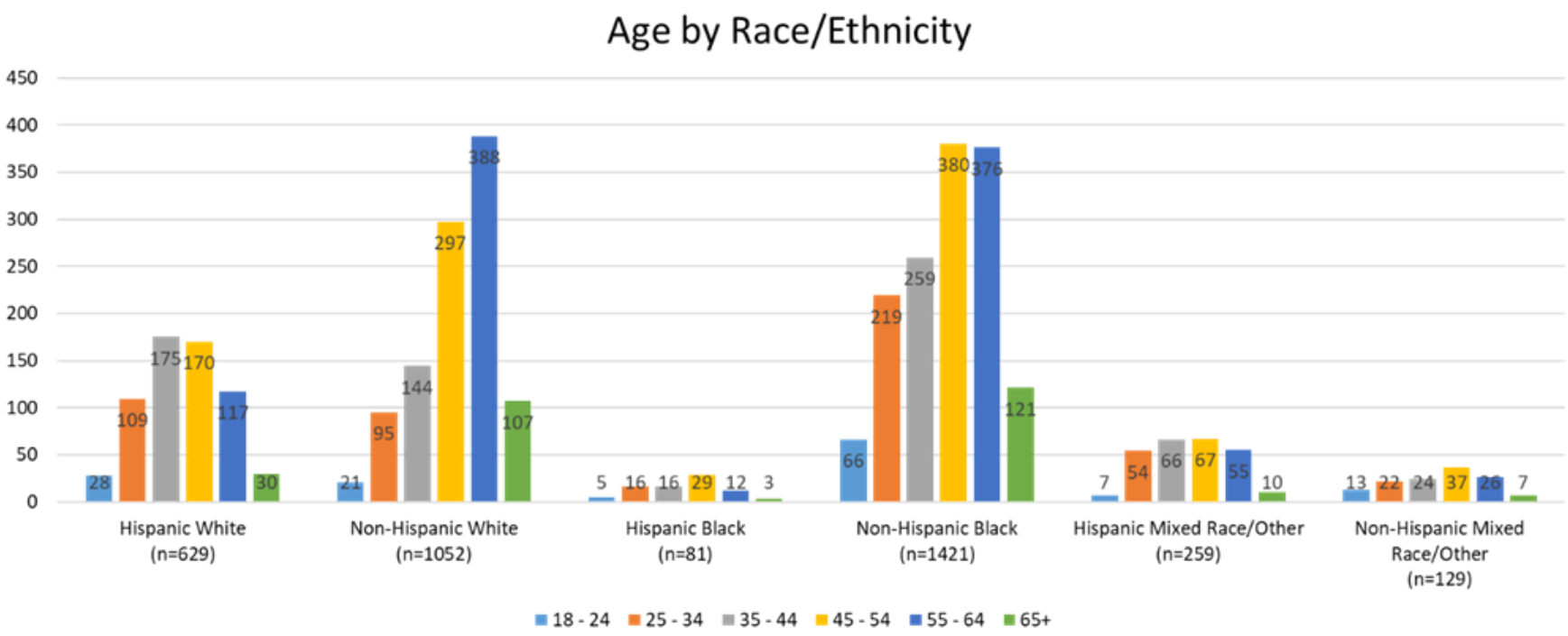
The needs assessment process identified the following key priority areas: Demographics, HIV Medical Care, Patient Care Services, Jail/Prison Release Services and Housing.

Demographics Summary

Appropriate sample sizes for each county were calculated based on the number of PWH. Each county was provided the minimum number of surveys to be sent to reach 25 percent of total PWH at a 10 percent response rate. The five counties with the most survey respondents were Miami-Dade, Hillsborough, Pinellas, Brevard, and Duval. Most counties met their quotas, but 13 did not. The three counties with highest unmet quotas were Broward, Palm Beach, and Orange.

Overall, most survey respondents fell into two age groups: 55–64 years old and 45–54 years old. Stratified by race/ethnicity (Figure 13), this trend held true for those who identified as non-Hispanic White, non-Hispanic Black, and non-Hispanic mixed race/other. However, for those who identified as Hispanic White, Hispanic Black, and Hispanic mixed race/other, the trend was that most fell into the 35–44 years old and 45–54 years old categories.

FIGURE 13: AGE GROUPS OF SURVEY RESPONDENTS

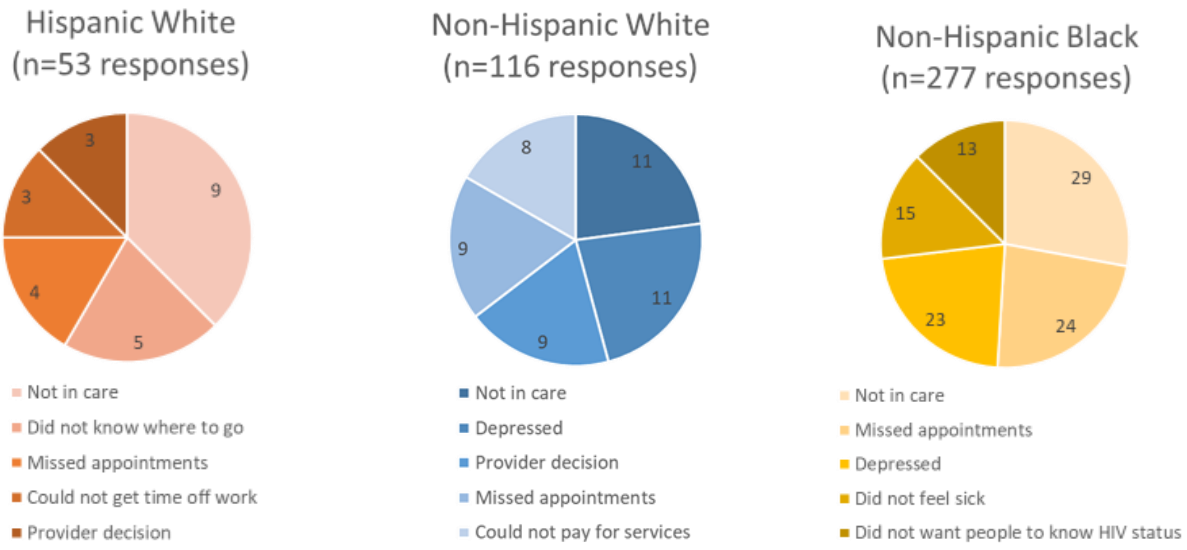


Most survey respondents reported working a full-time job for the past 12 months. The second largest group reported not being able to work due to disability. About half of respondents reported that their 2018 household gross income (before taxes) was less than $15,000, and roughly one-third reported incomes that were between $15,000 and $30,000. Stratified by race/ethnicity, most of those categorized as earning less than $15,000 and those earning between $15,000 and $30,000 were non-Hispanic Black. Most of those categorized as earning between $30,000 and $50,000, between $50,000 and $100,000, and more than $100,000 were non-Hispanic White.

HIV Medical Care Summary

Most survey respondents reported that they had seen a doctor about their HIV during the past 12 months. When asked about the frequency of HIV-related care, most reported receiving care two or three times during the past 12 months. For respondents who reported that they had not received HIV-related care or had received care fewer than two times in the past year, the most common reasons overall were that they were not in care, were depressed, or missed their appointments. When stratified by race/ethnicity, the most common reason given by Hispanic Whites, non-Hispanic Whites, and non-Hispanic Blacks remained that they were not in care. The second and third most common reasons given by Hispanic Whites were not knowing where to go and missing their appointments, respectively. For non-Hispanic Whites, the second and third most common reasons were that they were depressed and that this was their provider's decision, respectively. For non-Hispanic Blacks, the second and third most common reasons were that they missed their appointments and were depressed, respectively. The total numbers of responses from those who identify as Hispanic Black, Hispanic mixed race/other, and non-Hispanic mixed race/other about reasons for not receiving care were very low (8, 31, and 8, respectively).

FIGURE 14: TOP 5 REASONS RESPONDENTS HAD NOT BEEN IN CARE BY RACE/ETHNICITY



*Hispanic Black, Hispanic Mixed Race/Other, & Non-Hispanic Mixed Race/Other not shown due to low number of responses

The overwhelming majority of survey respondents received HIV-related medical care in the county where they live. For the small number of respondents who received care in a different county from where they live, the most common reasons given were that doctors or services were not available in their county of residence, preference/better doctors in a different county, continuity of care with an established provider, convenience/closer to home, and confidentiality.

Most survey respondents reported that they always take their HIV medications just as their doctor prescribed them. For those who reported that they did not always take their medications as prescribed, the reasons given included that the medication made them feel bad/sick, they could not afford the cost, they were on a medication break as directed by their physician, they did not know where to get medication, and forgetting.

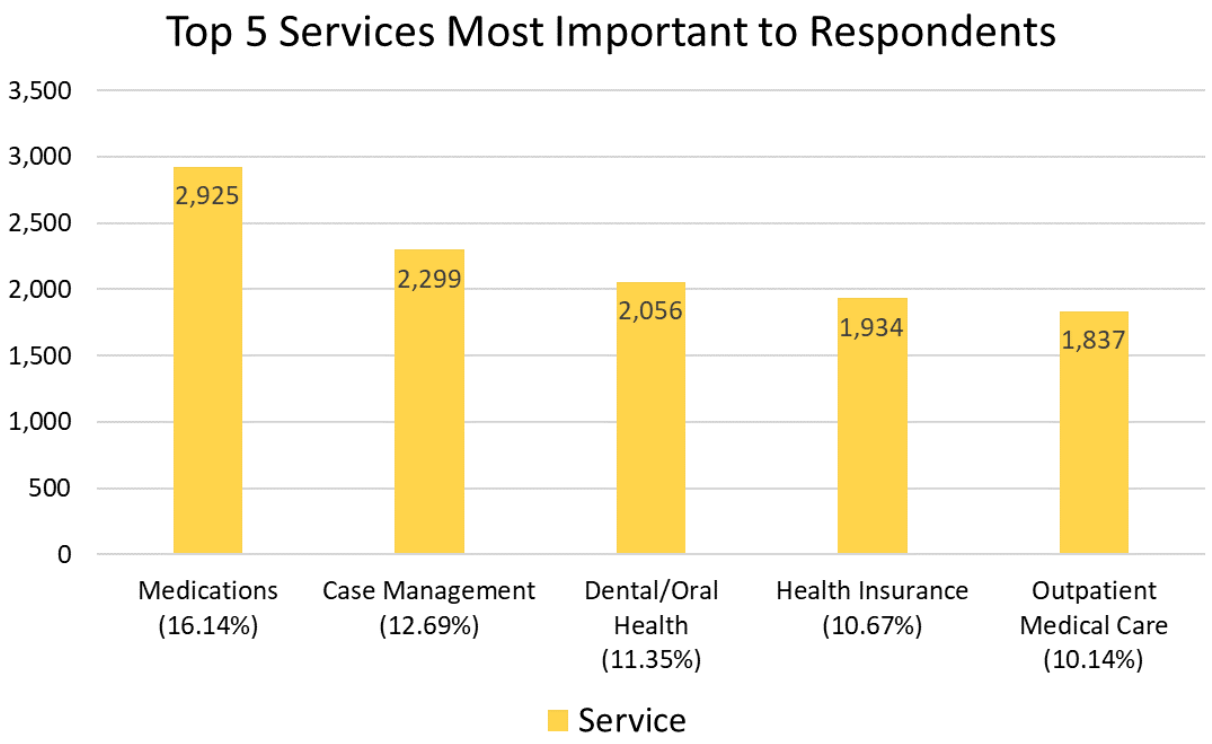
Patient Care Services Summary

Most survey respondents reported that they did get the patient care services they needed during the past 12 months. For those who did not get needed services, the five most common barriers listed were not knowing where to get services, being depressed, not having transportation, not being able to pay for services, and missing appointment(s). When stratified by race/ethnicity, the most common barrier listed for all race/ethnicity categories (except Hispanic Blacks) was not knowing where to get services. The top barrier to care for Hispanic Blacks was depression.

Overall, the top five patient care services deemed by respondents as most important for the state to provide for PWH were (in order of priority):

- Medications
- Case management
- Dental/oral health
- Health insurance
- Outpatient medical care

FIGURE 15: TOP FIVE PATIENT CARE SERVICES MOST IMPORTANT TO SURVEY RESPONDENTS.

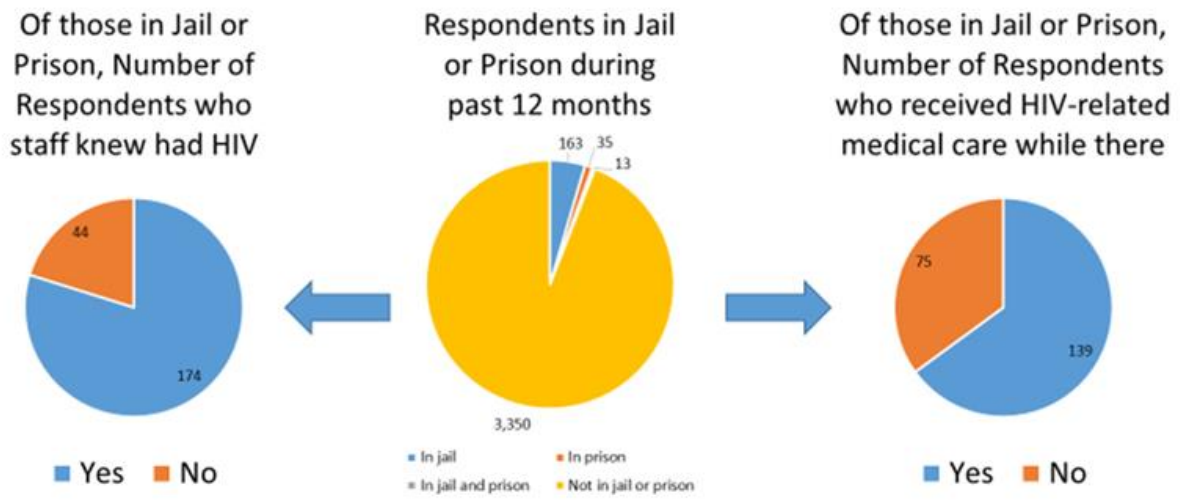


When stratified by race/ethnicity, the top two services reported by respondents as most important remained medications and case management across all race/ethnicity categories, but the priorities for dental/oral health, health insurance, and outpatient medical care were ranked differently (though they remained in the top five).

Jail/Prison Release Services Summary

The overwhelming majority of survey respondents reported that they had not been in jail or prison during the past 12 months. Of the 211 who reported having been incarcerated (5.9 percent of all respondents), 82.5 percent reported that the jail/prison staff knew of their HIV status, and most (65.9%) reported that they did receive HIV-related medical care. Upon release from jail/prison, 40.3 percent of respondents reported that they did not receive any HIV-related information or assistance. Of those who did receive care/assistance, 29.4 percent received a supply of HIV medication to take with them, 24.2 percent received referral to medical care, 22.3 percent received referral to case management, and 10.9 percent received information about finding housing.

FIGURE 16: SURVEY RESPONDENTS IN JAIL/PRISON DURING PAST 12 MONTHS AND WHETHER SERVICES WERE RECEIVED WHILE INCARCERATED



Of the 240 respondents who answered the question about barriers to getting needed HIV services after release from jail/prison, most (59.6%) indicated that this question did not apply to them because they did get needed services. For those who experienced barriers to care, the most frequent barriers reported were:

- No insurance/financial reasons
- No transportation to services
- Did not know where to go for services
- Could not get away from drugs
- Had trouble finding trustworthy friends
- Did not want others to know of their HIV status

Housing Summary

Overall, survey responses indicated that most respondents did not experience barriers to taking care of HIV related to their current housing situation. Of those who did experience housing-related barriers, the top three were not having money to pay rent, being afraid of others knowing their HIV status, and not having enough food to eat. When stratified by race/ethnicity, barriers varied in rank, but the top three barriers from the overall responses consistently remained in the top three across race/ethnicity categories.

TABLE 8: HIV HOUSING SERVICES RESPONDENTS NEEDED OR RECEIVED IN THE PAST 6 MONTHS

	Received Needed Services		Needed Service, But Could Not Get Service		Needed Service, But Did Not Know About Service		Did Not Need Service		Total Responses
	Count	Row %	Count	Row %	Count	Row %	Count	Row %	Count
Help finding an affordable place to live	357	11.26%	345	10.88%	303	9.56%	2,165	68.30%	3,170
Permanent, independent housing	258	8.62%	312	10.42%	266	8.88%	2,158	72.08%	2,994
Temporary short-term housing	141	4.91%	181	6.30%	152	5.29%	2,397	83.49%	2,871
Housing where my child(ren) can live with me	108	3.80%	69	2.43%	98	3.45%	2,567	90.32%	2,842
Nursing home	81	2.88%	48	1.71%	53	1.88%	2,633	93.53%	2,815
Money to pay utilities	281	9.49%	289	9.76%	319	10.78%	2,071	69.97%	2,960
Money to pay rent/mortgage	304	10.20%	319	10.70%	343	11.51%	2,015	67.59%	2,981
Housing for persons living with HIV	174	5.91%	249	8.46%	237	8.05%	2,285	77.59%	2,945

	Received Needed Services		Needed Service, But Could Not Get Service		Needed Service, But Did Not Know About Service		Did Not Need Service		Total Responses
Assisted living facility	99	3.49%	82	2.89%	91	3.20%	2,568	90.42%	2,840
Column Totals	1,803		1,894		1,862		20,859		26,418
% of Overall Total	6.82%		7.17%		7.05%		78.96%		100.00%

Overall, most survey responses indicated that respondents did not need any of the available housing services offered through Florida's HIV/AIDS Patient Care Program. For those who were in need, the services most frequently reported as being received, needed but unable to get, or needed but unaware of where to get (approximately 30 percent of all the survey responses given for each of the following services) were:

- Help finding an affordable place to live
- Money to pay rent/mortgage
- Money to pay utilities
- Permanent, independent housing

Between 65 percent and 70 percent of respondents in need of these services either could not get them or did not know about them. When stratified by race/ethnicity, non-Hispanic Blacks represented the largest number of responses across the board for all services respondents needed but could not get. This same trend held true for all services respondents needed but did not know about.

Overall, for those who needed services, most survey responses (approximately 60 percent) indicated that respondents did not experience barriers to getting needed housing services and were able to get them. But a sizeable proportion of responses (nearly 40 percent) indicated barriers to getting needed housing services. The top three barriers reported were that the respondent:

- Did not know where to get services
- Did not qualify for services
- Was put on the waiting list

3.4.4 Actions Taken

The following recommendations were developed to identify key activities to address needs and barriers of the key priority areas:

Demographics Recommendations

It is of concern that the three counties with the largest unmet survey quotas are also three of the counties that have high prevalence of PWH. Collectively, those counties were 603 surveys below quota. Given that this represents 20.6 percent of the total number of surveys needed to meet quota, it may present a significant deficit of information that is important to consider regarding allocation of resources for HIV care/services. Going forward, planning for increased staffing and/or concentrated efforts ahead of survey implementation may help mitigate unmet quotas in counties with high prevalence of PWH.

If survey results are representative of PWH in Florida, they indicate that most are non-Hispanic Black males between the ages of 45 and 64 who have full-time employment but are living below the poverty level. This highlights the continued disparities minorities face and the economic disadvantage of populations most affected by HIV. Giving priority to this priority population for outreach, staffing, and resources may be warranted to promote health equity.

With the development and release of the 2022 HIV Care Needs Survey and Needs Assessment Toolkit in October, Florida hopes to increase the number of surveys completed by PWH.

HIV Prevention

One of the priorities for the FDOH HIV/AIDS Section is the development of a comprehensive HIV prevention needs assessment through surveys administered to and through HIP providers to address services provision (PrEP, HIV testing, Test & Treat, harm reduction needs) for persons at risk for HIV. Other entities to be included in the needs assessment include CHDs and operational SSPs. The section hopes to accomplish this in 2023.

Policy Barriers

Currently, Florida laws do not present barriers to HIV testing or patient care services. Minor limitations exist within state laws allowing for syringe exchange programs and include prohibitions on using state, county, or municipal funds to support the operation of the program and permitting a one-to-one exchange of syringes.

HIV Medical Care Recommendations

The top reasons given for not receiving care or receiving less frequent care were missed appointments and not in care. To ensure that all PWH in Florida receive the appropriate frequency of HIV-related care,

it may be necessary to determine why they were not in care and why they missed appointments. Depression was another top reason given for not receiving care. This points to the importance of educating care providers to be aware of potential mental health and HIV comorbidities and the possible need to implement a protocol for mental health screening along with HIV care visits. To best address these needs and allocate resources appropriately, detailed attention to the top reasons for not receiving care within race/ethnicity categories may be helpful.

In counties where providers and/or services for HIV-related care are not available, the magnitude of those affected should be investigated and solutions to this problem should be explored. The desire for confidentiality was reported as a reason for seeking HIV-related care in a county other than the respondent's county of residence. More efforts are needed to address HIV stigma and normalize HIV prevention and care seeking behaviors.

Because HIV medications, when taken as prescribed, are highly effective in attaining viral loads (VL) that are undetectable and therefore untransmittable, it is imperative that all PWH receive appropriate medication and take it as directed by their physician. It is encouraging that most survey respondents reported that they always take their medications just as prescribed. However, even though the number of those who reported noncompliance with taking their medications is low (12.9%), other personal or biological issues may hinder persons from achieving sustained viral suppression. Reasons given by respondents for not taking medications as prescribed should be investigated further, and solutions or services should be found to overcome these barriers.

Patient Care Services Recommendations

Although most respondents received patient care services they needed, a large proportion (43.4%) did not. Barriers to care centered mostly around logistics, depression, and personal finances. To address logistics and personal finance barriers, allocating more resources for outreach and public information campaigns providing awareness of available HIV/AIDS services for those with low or no income may be helpful. Regarding depression, again we stress the importance of educating care providers to be aware of potential mental health and HIV comorbidities and the possible need to implement a protocol for mental health screening along with HIV care visits. Additionally, partnering and finding more accessible mental health service providers is key.

Of the four patient care services reported as most important to respondents, (1) dental/oral health, (2) medication, (3) case management, and (4) health insurance was also high on the list of needed services that respondents reported they could not get or did not know about. This is an area of concern. Further investigation into this issue is warranted.

Jail/Prison Release Services Recommendations

Based on survey responses, the HIV status of 17.5 percent of those respondents who were incarcerated was not known to jail/prison staff. In addition, 34.1 percent of those incarcerated did not receive HIV-

related medical care while in jail/prison, and 40.3 percent did not receive HIV-related information or assistance upon release. These numbers represent care intervention opportunities lost. Improvement for collaboration with jail/prison systems to improve continuity of HIV care and post-release accessibility is needed.

Housing Recommendations

Overall, survey results show that most respondents did not need housing services. This is a likely a limitation of the persons who responded to the needs assessment. Opportunity could be to ensure that there is a separate avenue with HOPWA to address this in future. Most who did need services did not experience barriers to getting these services, nor did they experience barriers to taking care of their HIV that were related to their current housing situation. But for those who needed housing services, most centered around needing help to find housing and help to pay for housing and utilities. Because needed housing services for a sizeable proportion of respondents were unmet, with the race/ethnicity category most represented in this proportion being non-Hispanic Black, further investigation focusing on this disparity is warranted.

Lastly, the most frequently reported barriers to getting needed housing services reveal distinctly different issues. The most common barrier was not knowing where to get services, which may indicate that public awareness campaigns for this may be needed. Florida does have a HOPWA campaign (Housing for Better Health - Assistance for persons with HIV/AIDS in Florida). However, its effectiveness and reach may need to be evaluated. The second most common barrier was that respondents did not qualify for services. This may indicate a disconnect between actual need and the program criteria currently in place to determine need. The third most common barrier to getting housing services was that the respondent was put on the waiting list. Causes for this may include limited housing availability and/or resources and a need for more staffing to process housing services.

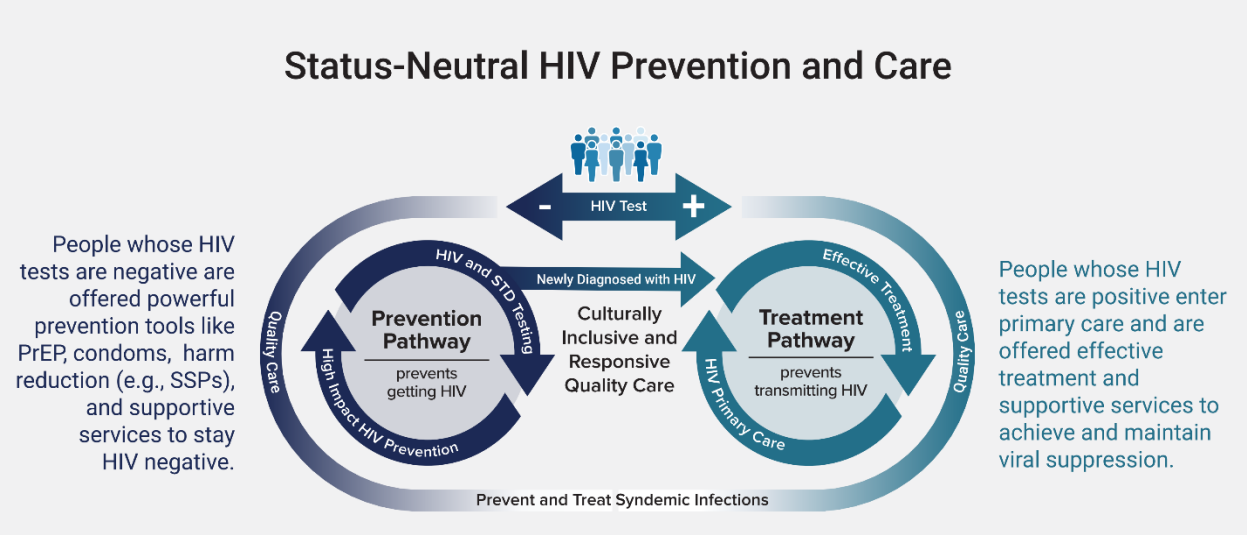
4 Situational Analysis

Florida is one of the most culturally diverse states in the nation with a vast array of residents from a wide variety of ethnic, racial, national, and religious backgrounds. The state has long attracted immigrants, particularly from Cuba, Haiti, Columbia, Venezuela, and Mexico. In fact, almost 21 percent of Florida's population are foreign born persons. (US Census Data - Quick Facts - Florida, 2021) With this diversity comes a higher incidence of disease burden from those in the emerging racial/ethnic minority populations from rural, socio-economically disadvantaged, and medically underserved backgrounds. FDOH recognizes that Florida's racial/ethnic minority populations continue to increase in size, correlating with persistent and often growing health disparities, hence why health equity, social determinants of health and the intersectionality of those are themes woven throughout the ICP.

Florida is at a critical juncture in determining the best strategies to build a path to eliminate HIV among racial/ethnic minorities and other underserved groups. HIV prevention needs exist among PWH, Black and Hispanic gay and bisexual men, Black heterosexuals, including Black cisgender WCBA, and transgender persons of all races/ethnicities. For those who are already diagnosed and living with HIV in Florida, activities centering around access to HIV care, including ART, retention in HIV care, and viral suppression, should be focused on priority populations of Black heterosexuals (specifically Black cisgender WCBA), gay and bisexual men of all races/ethnicities, and transgender persons of all races/ethnicities.

To further move the needle in reducing new HIV diagnoses in Florida, the FDOH HIV/AIDS Section is proposing several high-impact initiatives based on the status-neutral approach to HIV prevention and care. The HIV status-neutral approach to reducing new HIV diagnoses involves initial HIV testing services as the entry point to HIV prevention and/or care services irrespective of a positive or negative test result. See Figure 17, below.

FIGURE 17: STATUS-NEUTRAL APPROACH TO HIV PREVENTION AND CARE



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

The strategies proposed include 1) the statewide expansion of routine HIV, HCV and syphilis screening within hospitals, emergency departments and other health care settings; 2) increasing PrEP/PEP awareness and uptake; 3) expansion and awareness of rapid antiretroviral therapy (ART) starts, i.e., Test and Treat; 4) improving stigma, social and structural determinants of health through awareness and education; and 5) improving health outcomes in aging populations with HIV.

To implement HIV prevention and care services based on the status neutral approach, Florida will employ the initiatives and strategies which align with the EHE pillars below. The information below also highlights the strengths, challenges, and identified needs related to HIV prevention and care in Florida, the subsequent sections describe each of the following areas:

- Diagnose all people with HIV as early as possible (Section 4.1.1)
- Treat people with HIV rapidly and effectively to reach sustained viral suppression (Section 4.1.2)
- Prevent new HIV transmissions by using proven interventions, including PrEP and syringe services programs (SSPs) (Section 4.1.3)
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them (Section 4.1.4)
- Priority Populations (Section 4.1.5)

4.1 DIAGNOSE People with HIV as Early as Possible

Routine HIV, STI, and HCV Testing in Health Care Settings

In July 2015, the Florida Legislature amended Florida's HIV testing law to remove the need for separate informed consent prior to HIV testing in health care settings. In September 2016, Florida Administrative Code Rule 64D-2.004 was adopted to implement the amended HIV testing law. The intent of this amendment was to simplify routine HIV testing in health care settings, improve the identification of new or existing HIV infections, and help to normalize HIV testing as a routine component of primary health care. There was no change in the law regarding non-health care settings. These changes align Florida more closely with the CDC's 19 HIV Screening Recommendations.[44]

Since 2015, FDOH, including CHDs, have developed a collaborative model for routine communicable disease screening with the Gilead Sciences' Frontlines of Communities in The United States (FOCUS) initiative. FOCUS is a national initiative that works in cities across the U.S. to increase HIV, HCV and more recently syphilis screening in community health centers, emergency departments/hospitals, and other health care settings. This initiative works with partners to develop and share replicable model programs that embody best practices in providing routine HIV, HCV and syphilis screening and linkage to care within these settings. Gilead Sciences provides time-limited funding to these hospitals and community health centers to support their testing efforts. The program works with a diverse range of partners across 55 cities nationally.

Florida FOCUS partners include FQHC and large hospital systems. FDOH public-private partnership with Gilead's FOCUS initiative began in 2016 with the establishment of the very first site–Homestead Hospital in Miami-Dade County. A FDOH DIS or Linkage to Care Coordinator works with each FOCUS emergency department partnership to assist with linkage to care and other services.

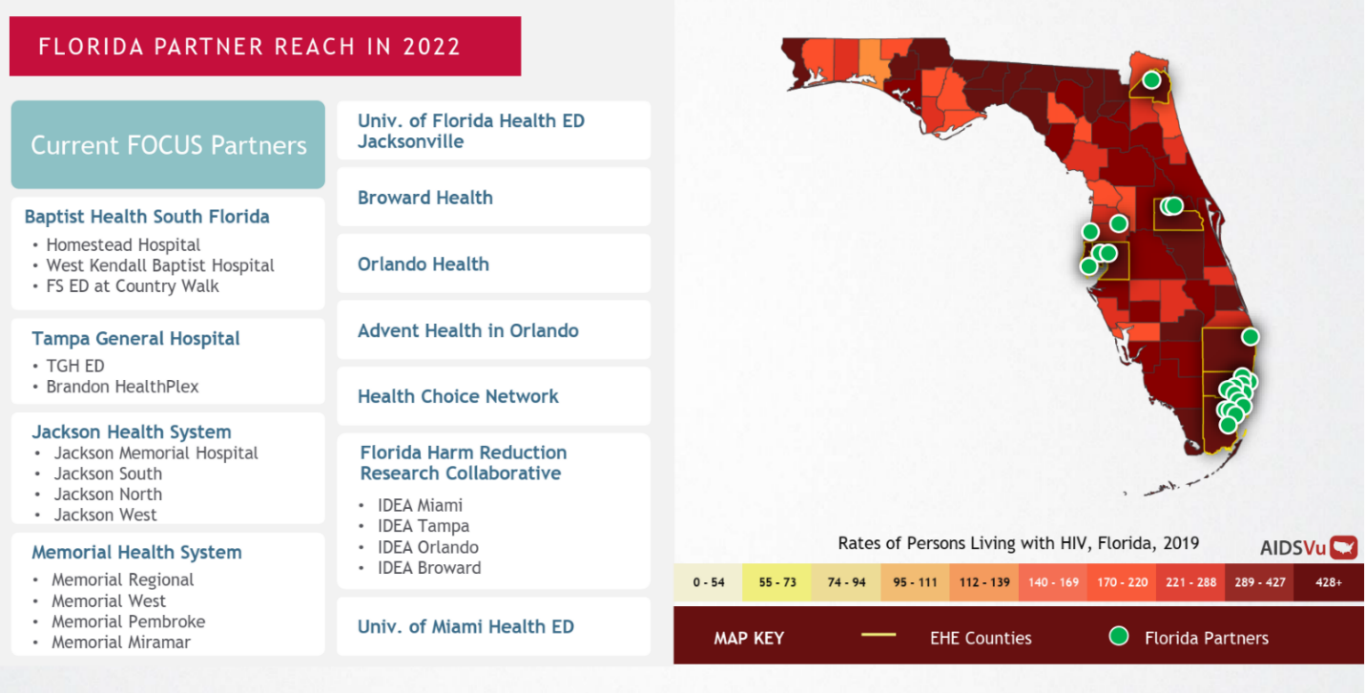
Currently, the Florida FOCUS program has 22 partners across the state (see map below) and in 2021, sites conducted 156,288 HIV tests (1.2% positivity), 86 percent linked to care. Additionally, 74,910 HCV tests (4.6% HCV Ab positivity) were conducted, and 75 percent linked to care. In 2022, Florida FOCUS projects to complete 187,000 HIV tests and 104,500 HCV tests and commits to onboard facilities to also conduct syphilis testing.

There is no monetary relationship between FDOH and Gilead Sciences and as the partners age out of their relationship with Gilead, FDOH looks to use grant funding to continue the testing and linkage to care programs.

Current efforts to support expansion include the inclusion of this initiative as an objective within the State Health Improvement Plan, where by December 31, 2026, FDOH and external partners aim to increase the number of emergency room or acute care hospitals that are conducting opt-out HIV

screening, routine HCV screening and syphilis testing with a smart screen algorithm from 1 (2021) to 15. The figure below visualizes 2022 partner reach for the state of Florida.

FIGURE 18: FLORIDA PARTNER REACH IN 2022



Gaps still exist in the implementation of routine HIV, STI, and HCV testing in hospital EDs and primary health care settings. Accounts of individuals seeking medical care in hospital EDs for symptoms akin to acute HIV infection are frequent, and, oftentimes, persons visit the ED several times before being tested for HIV, diagnosed, and linked to care. Approximately seven in 10 people with HIV saw a healthcare provider in the 12 months prior to diagnosis and failed to be diagnosed. (Source: Daily et al., MMWR Weekly Report, 2017; Skarbinski et al., JAMA, 2015; Gopalappa et al., Med Decision Making, 2017)

From June 2019 to April 2020, the University of Miami AIDS Education and Training Center (UM-AETC) performed outreach to health care facilities in the highest HIV incidence areas throughout Miami-Dade and Broward counties to conduct assessments and academic detailing. Facilities included community health centers and primary care and internal medicine clinics. Assessments examined the status of health care facilities in implementing routine HIV testing and PrEP provision in accordance with CDC guidelines and in implementing or extending third-party billing for routine HIV screening. Less than a quarter (20%) of the health care provider practices reported offering routine HIV screening services to all patients ages 13–64, regardless of symptoms or demographics. Of the remaining clinics, 28.6 percent reported that they test patients based on symptoms and demographics, and 30 percent reported testing only those who requested an HIV test. Among barriers to rapid HIV testing, most practices indicated that they never considered rapid HIV testing as a service (30%). Other barriers to

providing rapid HIV testing were the perceived need to obtain consent, staff lacking training for administering and billing, the concern that testing would not be reimbursed by payors, and uncertainty about the implementation of in-office rapid testing.

To eliminate these barriers, FDOH has done or will do the following:

- Conducted a Routine Screening Expansion Roundtable, which took place May 26, 2022. The purpose of this meeting, hosted by the Lieutenant Governor, was to bring together a wide variety of external stakeholders to discuss how to expand routine opt-out HIV, syphilis, and HCV screenings in emergency departments and acute care settings and move toward ending these syndemics in Florida.
- Under Chapter 64D-3, FAC, "Control of Communicable Diseases and Conditions which may Significantly Affect Public Health", providers and laboratories are required to report only positive HIV test results to the FDOH. FDOH is currently working to update the Administrative Code to include the mandatory reporting of all HIV test results to:

    1. Improve the reporting and surveillance of stage zero or acute diagnoses to understand the burden of recent transmission for intervention and prevention

    2. Understand the scope and total HIV testing being conducted in Florida and calculate a state positivity rate that can be used to drive future interventions and prevention efforts.

- Conduct an assessment on current Florida FOCUS partners to understand who is aging out of the program and when and use current grant funding to support testing and linkage to care efforts.
- Conduct an assessment to determine future costs for expansion and areas of expansion and use information to create a Budget Impact Proposal for the legislative session 2023/2024.
- Develop a Public Service Announcement video and associated messaging to gain buy-in from the public and private sector medical providers on following U.S. Preventative Services Taskforce HIV testing recommendations for persons aged 15–65, specifically in health care settings.
- Work with directly funded RW Part A programs within the seven metropolitan areas of the state to collaborate on supporting routine screening efforts in those areas.

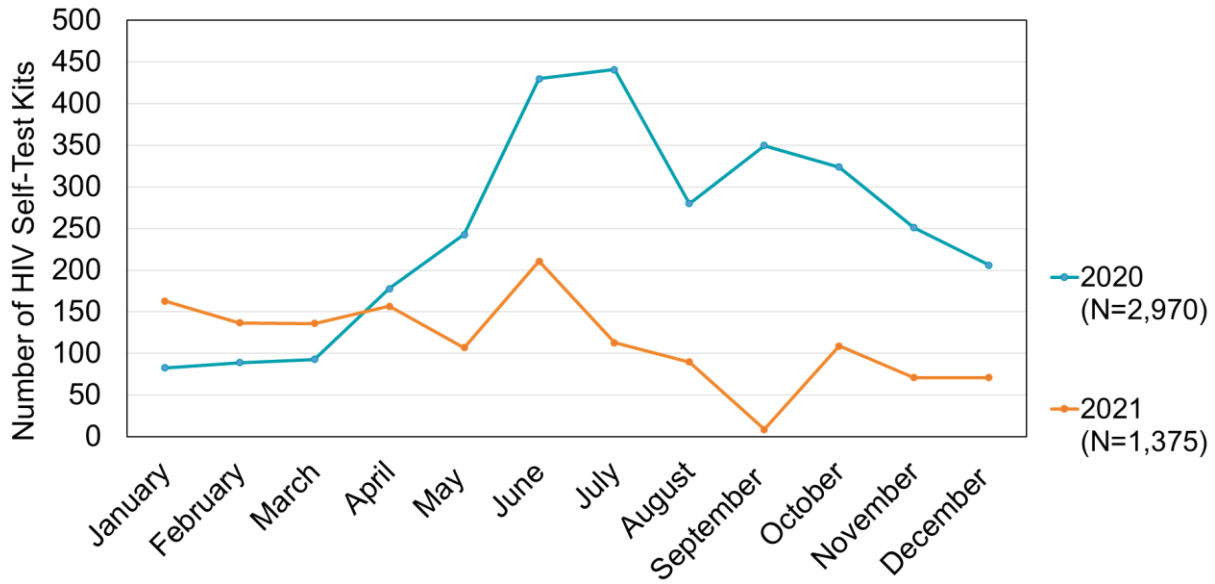
In addition to the FOCUS program, the HIV/AIDS Section also has a $250,000 annual contract funded through federal grants with the University of Central Florida HealthARCH program that aims to assess the readiness of health systems within the seven metropolitan counties of high HIV burden and onboard them to modify their electronic health records and offer routines screening for HIV.

Rapid HIV Testing through Non-Traditional Settings and Modalities

Considering Florida's percentage of PWH unaware of their status (14%), increased access to rapid HIV testing is required. Feedback received through community engagement indicated a need for expanded use of mobile testing units, HIV self-test kits, social/sexual network screening, and testing at non-traditional settings and hours. FDOH currently supports more than 1,600 registered HIV testing sites around the state that conduct targeted HIV testing in non-health care settings in areas and communities with high HIV incidence. FDOH supports these sites with rapid HIV test kits at no cost to the site. Sites must register with FDOH and submit HIV testing data as criteria to receive rapid HIV test kits. In 2021, FDOH conducted 73 rapid test trainings and certified 1,032 individuals to perform rapid HIV testing. FDOH will continue to conduct rapid HIV testing trainings to certify individuals to perform rapid HIV testing in non-health care settings.

In June 2019, FDOH began an HIV self-testing pilot program to provide rapid HIV self-test kits to individuals, at no cost through an online request form (available at KnowYourHIVStatus.com). This program was particularly important as COVID-19 closures and restrictions fueled increases in the demand for alternative options for HIV testing. Monthly requests for HIV self-test kits rose sharply beginning in April 2020 and continuing through July 2020. Monthly requests tapered slightly from September through December 2020. In 2021, monthly requests for HIV self-test kits decreased but are still higher than pre-COVID levels. Since the program's inception, more than 4,600 rapid HIV test kits have been distributed. The HIV/AIDS Section continues to look for opportunities to collaborate, especially with internal FDOH partners such as the Bureau of Tobacco Free Florida to advertise the availability of free, in-home testing kits.

FIGURE 19: HIV SELF-TEST KITS DISTRIBUTED THROUGH KNOWYOURHIVSTATUS.COM, FLORIDA, 2020 VS. 2021



Additional funds will be needed to support and sustain the expansion of the in-home and point-of-care HIV testing program. Concerns around linkage to care for persons using HIV self-test kits exist, and mechanisms will need to be developed to ensure appropriate follow-up and timely linkage to care.

Partner Notification Services

Per section 384.26, Florida Statutes, FDOH is the only entity authorized to perform HIV and STI partner services and notification, and these activities are carried out by trained DIS. While Florida maintains a mature and robust HIV/STI partner services program, opportunities to strengthen the DIS workforce and update partner notification mechanisms exist. Extensive training needs, high caseloads, and low staff retention not only contribute to high DIS turnover rates, averaging 40 percent annually over the past five years, but also impact the effectiveness of partner elicitation. Numbers of claimed partners have decreased as numbers of anonymous partners reported through mobile dating applications has increased, creating challenges for intervention. In 2017, FDOH piloted the usage of mobile dating applications as an added partner notification tool for persons exposed to HIV/STIs, with marginal success. Additional strategies are being explored to allow for HIV partner notification via text messaging or phone calls. Since Summer 2022, the Bureau of Communicable Diseases has been working to secure approval to allow for text messaging by the DIS work force as a tool to initiate confidential first contact with clients and enable DIS to conduct partner services for STI/HIV partner notification.

Florida is unique in that there are now four qualified staff to teach the week-long Passport to Partner Services training. In 2022, the STD Section will enter a contract with the University of South Florida to establish a learning academy and completely revamp the existing core training curriculum for DIS and STD program supervisors.

Third-Party Billing and Reimbursement

Billing third-party insurance was reported as a barrier to billing and reimbursement by almost one-third of providers assessed by UM-AETC and was the most prominent barrier encountered. Most clinics reported staff lack of knowledge regarding billing/coding and corporate decisions to be the greatest barriers to implementing routine HIV screening. Other notable barriers were lack of time/staffing capacity to perform billing, challenges in contracting with third-party payors, and difficulty managing multiple contracts with third-party payors.

Stigma

Stigma related to HIV/STI screening can occasionally lead individuals to state they do not possess insurance coverage for the service. 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 HIV/AIDS service organizations are also perceived as more stigmatizing, with clients citing additional disclosure concerns. There is a need for integration of HIV testing locations with other health care 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 ten-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 Florida MMP data found that females (44) experienced a higher level of stigma compared to transgender individuals (39) and males (32). Black/African American persons (37) experienced a higher level of stigma than White (32) and Latino (32) persons who experienced the same level of stigma. Heterosexuals or straight people (38) experienced a higher level of stigma than bisexual persons (36). Lastly, it was also found that those ages 18–29 experienced a higher level of stigma (43) than ages 40–49 (36), and ages 30–39 (35). It was found that ages 50 and higher experienced the lowest level of stigma (32).

Findings from a FDOH report[43] (A Bayesian spatial-temporal analysis of racial disparities in HIV clinical outcomes and a pilot stigma intervention protocol for people living with HIV in Florida) indicate that disparities in immune reconstitution 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 Florida. Stigma remains a key barrier to care engagement and ultimately achieving viral suppression and immune reconstitution. 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.

4.2 TREAT People with HIV Rapidly and Effectively to Reach Sustained Viral Suppression

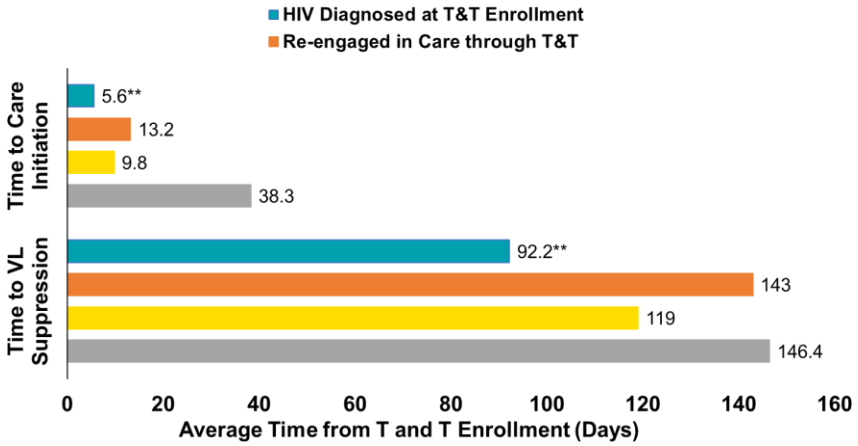
Access and adherence to HIV treatment is important to promote optimal health outcomes for PWH and harnessing the benefits of "treatment as prevention"– when someone takes their HIV medications as prescribed and the amount of HIV in the body is kept at such a low level, they reach viral suppression. Those virally suppressed essentially have no risk of transmitting HIV to others sexually. Treating people with HIV 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. According to the CDC, approximately 80 percent of new HIV transmissions occurring annually are from persons who are not

receiving HIV-related care and medications. 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.

Test and Treat Program & Rapid Access to ART

Since 2016, Florida has had a robust rapid access to ART program called Test and Treat (T&T). This program offers patients newly diagnosed with HIV, as well as those who have been lost to care and are returning to care, an opportunity to obtain expedited practitioner office visits, labs, and ART, combined with a support system of retention-in-care specialists, to reduce barriers to care engagement. In this expedited "red-carpet" scenario, PWH have immediate access to a medical provider who can start them on ARV medications 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, Florida'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). Compared to those diagnosed in Florida not part of T&T (Figure 20 below), 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 average time to achieve viral suppression is much lower for those 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. Almost all of Florida's 67 counties have a HRSA-designated Health Professional Shortage Area (areas categorized as rural, partially rural, or non-rural), which represents a need to recruit and train more primary health care and dental service providers. Additionally, needs exist for expanded access points, hours of operation (to include non-traditional hours and locations), and expanded telehealth capabilities to reach persons in rural areas. There is also a need for increased access to treatment for persons diagnosed and living with co-occurring HCV/HIV.

FIGURE 20: TIME FROM T&T ENROLLMENT TO CARE INITIATION AND VL SUPPRESSION, MARCH 2016–DECEMBER 2020, FLORIDA



Below are activities that can help overcome the challenges related to T&T:

- Address gaps in the level of knowledge about the RW system of care among non-RW network health care providers. More education and training are needed for providers on the services available to clients (including ADAP), eligibility requirements, and access points within their service regions.

- Address the need for more training and resources for health care providers related to trauma-informed care (TIC) and intersectionality. Past and current traumatic experiences have an impact on whether a person acquires HIV, is diagnosed, is linked to care, and retained, and maintains viral suppression. Because HIV disproportionately impacts marginalized communities, it is important to consider intersectionality in concert with TIC.

- Intersectionality is a framework for conceptualizing a person, group of people, or social issue as affected by several discriminations and disadvantages; it considers people's overlapping identities and experiences to better understand the complex prejudices they may face. Examples of social categorizations that inform identity include race/ethnicity, class, gender, sexual orientation, poverty/homelessness, and substance use.

Housing

Many Floridians experience homelessness or unstable housing, which presents a barrier to wellness for PWH as well as those at increased risk for HIV acquisition. Stable housing is closely linked with and is often one of the main determinants affecting HIV health outcomes. Florida's Council on Homelessness annual report showed that prior to the emergence of the COVID-19 pandemic, homelessness in Florida has declined steadily from 57,551 identified as homeless in January 2010 to 28,328 in January 2020 —a 50.8 percent reduction in homelessness over the last 10 years. The homeless in Florida currently

include: 2,436 homeless veterans, 2,294 persons in homeless families, and 5,812 chronically homeless and disabled persons. While the federal Fair Housing Act makes it illegal to discriminate against PWH in the provision of housing, consumers frequently cite discrimination, fear of disclosure, and stigma as barriers to safe and affordable housing.[35]

Having a stable living environment plays a major role in the health of people, including those with HIV. To meet the housing needs of low-income PWH and their families, FDOH administers the HOPWA program. The HOPWA program is a federally-funded initiative that helps people maintain stable housing and have access to treatment and support services—which can all lead to better health. In Florida, eleven regional agencies and six cities deliver HOPWA-funded housing services. In addition to the State HOPWA Program there are six city HOPWA programs administered locally. Between 2020 and 2021, over 2,034 individuals received HOPWA services to ensure these individuals could access and maintain a stable living environment for themselves and their immediate families. An assessment of the state's HOPWA program is needed to identify gaps and barriers in order to make changes to the program in 2023.

Patient and Peer Navigation

HIV health navigators (both patient and peers) have a positive impact on the health and well-being of people living with HIV. Patient navigation programs for persons newly diagnosed with HIV or those previously diagnosed and returning to care have consistently proven to be efficacious in ensuring individuals get linked to and are retained in treatment. Peer navigators' lived experiences are drivers for meeting the diverse needs of newly diagnosed individuals who may be overwhelmed by the thought of entering a health care system as complex as the HIV system of care. In addition, peer navigators act as a support line for persons newly entering or re-entering the care system, providing non-judgmental guidance. There is also a need for expanded patient or peer navigation among persons diagnosed with HCV. The current opioid epidemic is fueling the number of co-infections. It is estimated that 60%-90% of people who contracted HIV from intravenous drug use also have HCV.[36] People living with HCV often have difficulty accessing HCV treatment and related health care. 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 ADAP formulary was updated in 2017 to include HVC treatments without the need for prior authorizations. Between 2020 and 2021, the ADAP assisted over 650 There are opportunities for more uninsured HCV patients to be treated at some free clinics, FQHCs, private clinics, and a limited number of CHDs, but many patients are unaware of where to go when they are first diagnosed. Expanded patient navigation is also needed for HIV-negative partners of PWH seeking services.

Expanded Pharmacy Benefits Manager (PBM) for Uninsured or Underinsured ADAP Clients

ADAP has two types of clients, an uninsured or underinsured client is an ADAP client who does not have access to insurance coverage and receives all ADAP formulary medications through direct dispense. An

insured-only client is an ADAP client with active insurance who receives medications when the program pays deductible and copay expenses related to that insurance. The ADAP program aims to achieve at least 95 percent of clients who achieve viral suppression regardless of their insurance status. For those in the insured program, approximately 97 percent achieved viral suppression in 2021, however, for those not insured, there is a clear disparity with only 89 percent achieving viral suppression in 2021.

In October 2022, the ADAP implemented a PBM network of pharmacies to its uninsured direct-dispense client population. With this initiative, the ADAP will increase equity among insured and uninsured clients by providing expanded access to medications through a network of independent pharmacies and commercial chains. The PBM will provide the network of 340B pharmacies and manage the claims using a replenishment model in which Direct-Dispense clients can access ADAP medications statewide with the main goal of increasing access points and convenience for ADAP clients in Florida. The PBM pharmacy network will assure access to ADAP formulary medications for enrolled clients served in the Direct-Dispense within 24 hours. ADAP eligibility files are shared with the contracted PBM entity multiple times throughout the day to ensure newly enrolled clients can access ADAP services during the same day they enroll in the program. The PBM entity will assist clients with their prescriptions by reviewing utilization data, addressing medication adherence issues, and collaborating with prescribers to resolve incorrect regimens and drug interactions. The PBM entity will also develop and provide training to case managers and health care providers; develop educational materials for providers and clients and maintain a program information website for providers and clients.

Case Management

Case management plays a critical role in the care coordination of PWH as it assists patients in accessing services, identifying needs, and addressing gaps in services. Case manager caseloads are high and continue to increase, impacting the ability to effectively manage complex issues, such as providing medication adherence counseling, helping navigate the health care system, and staying informed and educating PWH on available health care coverage plans. There is a need for additional resources and training to support the case management workforce.

Minority AIDS Initiative (MAI)

MAI seeks to address the gaps in medical care capacity and increase the accessibility and availability of HIV medical care and related HIV services in minority communities through outreach and education. MAI funds are received from the HRSA and are designed to improve access to comprehensive care for low-income racial and ethnic minorities who are living with HIV/AIDS. FDOH receives the MAI funding allocation through the state's RW Part B grant and these funds support six community-based providers in Florida counties with the highest HIV incidence. In fiscal-year 2021, Florida's funded MAI providers enrolled 1,033 clients, of which 64 percent were Black and 32 percent were Hispanic/Latino. Many participants are individuals who had a previous HIV diagnosis but have fallen out of care and have not received care for more than six months. The FDOH HIV/AIDS Section will continue to look for ways to

strengthen the network of MAI providers with the development and release of the next funding solicitation.

Expansion of Telehealth

The HIV/AIDS Section began offering telehealth (TH) services in August 2018. The TH program provides on-demand and scheduled PrEP, post-exposure prophylaxis, same day ART (T&T) and HIV and STD primary care evaluation and treatment visits. The HIV TH service is available to all 67 CHDs. As of May 2021, FDOH is averaging over 100 services per month and have provided TH services to 1,604 CHD patients. In 2020, FDOH launched a TelePrEP program where patients can access PrEP services through the CHD system via a dedicated telehealth practitioner team. Further credentialing of the HIV TH team of three providers in other CHDs is occurring to allow for these services to be provided by the team. Florida plans to expand and promote the use of telehealth and other new technologies to help alleviate barriers and improve access to HIV prevention and care services.

Insurance Coverage and Affordable Health Care

Florida remains a non-Medicaid expansion state, and from 2015 to 2020, an average of 12.7 percent of people in Florida did not have health insurance coverage (compared to 8.7 percent for the U.S.).[38] The Affordable Care Act (ACA) has enabled more individuals to enroll in health insurance , but some, particularly those who live just above the federal poverty level (i.e., the working poor), are still unable to afford the cost of coverage. Individuals who fall into this category who need health care are often forced to make difficult choices based on competing life priorities.

As a Part B grant recipient through the RW HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), FDOH administers the ADAP. Florida ADAP provides FDA-approved medications to low-income people with HIV between 0–100 percent FPL who have limited or no health coverage from private insurance, Medicaid, or Medicare. ADAP assists with some premiums and with out-of-pocket costs for drugs on the program formulary. Out-of-pocket costs can be deductibles, co-pays, coinsurance or similar costs for Medicare Part C or D. Health insurance assistance funded through ADAP is part of ADAP, not a separate program. The strategy of enrolling these clients in the direct-dispense program is more cost-effective than enrolling them in the insurance program. Clients in the direct-dispense program have access to the RW system of care, which includes access to outpatient ambulatory health services, case management, and other allowable services. ADAP clients enrolled in the direct-dispense program achieved a VL suppression rate of 89 percent.

In addition, approximately 93 percent of ADAP clients enrolled in the program at least six months have undetectable HIV VL, indicating their HIV disease is under control and unlikely to be spread sexually. The ADAP program aims to achieve at least 95 percent of clients enrolled in the program at least six months who achieve viral suppression regardless of their insurance status. For those in the insured program, approximately 98 percent achieved viral suppression in 2021, however, for those not insured,

there is a clear disparity with only 89 percent achieving viral suppression in 2021. The approach that Florida ADAP takes constitutes a close working relationship between the ADAP state health office team, Florida's 67 CHDs, and three contracted statewide service providers: CVS Caremark for PBM services for ADAP insured clients, Magellan Rx for PBM services for ADAP uninsured and underinsured clients and Broward Regional Health Planning Council (BRHPC) for Insurance Benefits Management (IBM) services for clients seeking enrollment and premium assistance with health insurance coverage. The FDOH ADAP is operationalized at the CHDs, where ADAP staff assist clients with enrollment by assuring eligibility determinations and re-certifications. AP staff at CHDs use the ADAP database, called Provide, to upload client eligibility documentation. Eligibility files are shared with the contracted PBM and IBM providers multiple times throughout the day to ensure newly enrolled clients can access ADAP services during the same day they enroll in the program. Provide also helps ADAP staff keep track of their client caseload; the system also helps identify clients who should be enrolled in the direct-dispense or insurance program based on the information presented during their enrollment. CHD ADAP staff also work closely with the provider community and RW case managers to coordinate efforts with clients to promote medication adherence and retention in care.16

Additional Unmet Needs of PWH

The MMP is a surveillance system designed to understand the met and unmet needs of PWH. Among those surveyed in Florida from 2015 to 2020 the most common unmet need was access to dental services (24%), followed by shelter or housing services (14%), SNAP or WIC (12%), and meal or food services (9%). Other unmet needs included mental health services (8%) transportation assistance (8%), HIV case management services (8%), HIV peer group support (6%), medicine through ADAP (4%), and patient navigation services (5%).

4.3 PREVENT New HIV Transmissions by Using Proven Interventions, Including PrEP, and Syringe Services Programs (SSPs)

Access to PrEP and nPEP

The use of ARV medications to prevent HIV infection in persons at risk for acquiring HIV is an effective tool in HIV prevention. Part of CDC's high-impact prevention (HIP) approach includes PrEP, and in 2014, CDC issued clinical PrEP guidelines for health care providers. CDC recommends PrEP as a prevention tool for persons at increased risk for HIV: persons in serodiscordant relationships, gay and bisexual men who have sexual partners of unknown HIV status, and persons who inject drugs (PWID). As of December 2018, all 67 FDOH CHDs 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 the state's supply of medication. Since the beginning of the FDOH's PrEP Drug Assistance Program (i.e., 2018), over 11,319 CHD clients have received PrEP medications.

According to the latest data available on AIDSVu, Florida 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. Florida 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 TDF/FTC or TAF/FTC for PrEP in a calendar year. AIDSVu's PrEP data reflect a weighted estimate of the number of PrEP users in each state and county in the U.S. by 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). Source: AIDSVu. https://aidsvu.org/local-data/united-states/south/florida/#prep

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 health care 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 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.

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 the state, 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.

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.

Syringe Services Programs (SSPs), Drug User Health

Section 381.0038(4), Florida Statutes, or the Infectious Disease Elimination Act (IDEA), was passed by the Florida Legislature in 2016 and the Governor signed a 2019 bill amending IDEA to allow county commissions to authorize syringe exchange programs in their county by way of county ordinance. A CDC Determination of Need for Florida for Syringe Services Program (SSP) was approved on February 1, 2020. The CDC Determination of Need supports federal funding applications for SSPs and other organizations. In Florida there are five approved and currently operational syringe services programs (SSPs): the Infectious Disease Elimination Act (IDEA) Exchange Miami (located in Miami-Dade) operated by the University of Miami Miller School of Medicine, the SPOT (in Broward County) operated by Care Resource, the Rebel Recovery SSP (in Palm Beach County) implemented by Rebel Recovery FL, IDEA Exchange Tampa (in Hillsborough County), and IDEA Orlando (in Orange County) implemented by Hope and Help. An SSP in Pinellas County will be opening their doors in 2022.

Currently, FDOH supports the IDEA Exchange Miami to provide training and technical assistance to new SSPs, as well as education to local communities on the evidence behind SSPs in the prevention of HIV, HCV, and overdose. Another project supported by the congenital syphilis grant routinely screens women who inject drugs for HIV and syphilis to reduce the likelihood of babies born with congenital syphilis and link women to treatment and care. And finally, using the hepatitis elimination grant to increase routine HCV screening and access to medication assisted therapies and linkage to HCV treatment among PWID.

During FY 2021–2022, FDCF deployed HIV Early Intervention Services set-aside funding from the SAMHSA Substance Abuse Prevention and Treatment Block Grant to conduct 18,313 HIV tests across 47 treatment provider sites. A total of 163 tests were positive for HIV.

Comprehensive Sexual Health Education and Interventions for Youth

In 2020, more than 31,656 persons between 15 and 19 years of age in Florida were diagnosed with a bacterial STI (syphilis, chlamydia, gonorrhea), for a rate of 2,611 per 100,000 population. These numbers are down slightly from previous years due to the lack of testing and access to testing during the COVID-19 crisis. The presence of an STI increases a person's risk of acquiring HIV. To see reductions in the rates of STIs and HIV among this age group, progress is needed to expand the delivery of comprehensive sexual health education for Florida's youth. Section 1003.42(2)(n), Florida Statutes, requires comprehensive health education that incorporates both sex education and disease prevention and includes language on the benefits of sexual abstinence and the consequences of teenage pregnancy. Specific content in any subject matter is determined by local school district policy, which gives districts the latitude to determine the type of education program that is implemented. The different types of programs school districts can choose to implement are Abstinence-Based (Plus), Abstinence-Only, Abstinence-Only Until Marriage, and Comprehensive Sexuality Education. Florida plans to look for alternative settings in which to reach youth such as recreation centers, after-school programs, faith-based programs, and youth coalitions.

Perinatal HIV Prevention Efforts

Perinatal transmission of HIV is when HIV is passed from a woman with HIV to her child during pregnancy, childbirth, or breastfeeding. The use of HIV medicines and other strategies have helped to lower the rate of perinatal transmission of HIV to 1 percent or less in the US and Europe.37. In Florida, the HIV/AIDS Section is actively managing the following perinatal HIV projects:

- **Targeted Outreach for Pregnant Women Act (TOPWA)** – Section 381.0045, Florida Statutes, also known as the "Targeted Outreach for Pregnant Women Act of 1998" provides a state funding appropriation for programs to provide outreach and linkage services to pregnant women who may not seek proper prenatal care, who suffer from substance-use disorders, or who are living with HIV or are at increased risk for HIV acquisition. TOPWA providers serve pregnant women and pregnant women living with HIV to ensure they are linked to and receiving adequate prenatal care and adhering to medical treatment to prevent perinatal transmission. There are seven funded TOPWA programs in Florida and they provided services to 1,772 clients in 2021. Black women represented 45 percent of enrollees, Hispanic women represented 44 percent, and white women represented 7 percent. Women living with HIV made up just under 8 percent of TOPWA enrollments.

- **Fetal Infant Mortality Review (FIMR)/HIV Prevention Methodology** – FDOH is developing a FIMR/HIV Prevention Methodology in conjunction with a Community Action Team. These efforts are part of a larger effort the FDOH is undertaking to reduce communicable diseases in WCBA to include congenital syphilis, Hepatitis B (HBV), HCV.

- **Baby Rxpress** – The FDOH Baby Rxpress program provides a six-week course of ARV medication to newborns with HIV exposure, lowering the risk of mother-to-child HIV transmission to less than one percent. In 2020, Baby Rxpress filled 344 prescriptions for ARV medications for 256 newborns with HIV exposure at a cost of $13,556.00, or just under $53 per baby. Baby Rxpress maintains over 85 participating pharmacies across the state. Participating partners include Empath Health Pharmacy, Health Matters Pharmacy, Walgreens Co., Jackson Pharmacy (3 specialty locations), Scripts Pharmacy and Jackson Drugs.

HIV High-Impact Prevention (HIP) Provider Network

In early 2019, the FDOH made awards for HIP Request for Applications (RFA) 18-001. HIP RFA 18-001 was released in Fall 2018 and provided non-profit and CBOs an opportunity to apply for funding provided by FDOH through CDC's PS18-1802 funding award. FDOH allocated $10 million from the state's integrated HIV prevention and surveillance grant (CDC-PS18-1802) and a total of 44 awards were made to agencies around the state who serve Florida's priority populations. Three-year contracts were executed beginning January 1, 2019, and going through December 31, 2021, with the option for up

to three, one-year renewals. These awards have the ability to be continued through December 31, 2024.

Funded HIP providers deliver a wide array of services, depending on the category of funding and includes, but is not limited to routine and prioritized testing, integrated STI screening, linkage and re-engagement to prevention and care services, interventions for PWH and persons at increased risk of acquiring HIV, PrEP and nPEP services, condom distribution, outreach, education, community engagement, social media and marketing, and essential support services.

HIV Minority Media Campaign

In 1999 FDOH established a statewide minority media campaign for HIV prevention, as required by section 381.046, Florida Statutes. This campaign was most recently rebranded in 2017 with the theme "Protect Yourself". In 2020, the campaign evolved to include the stories and testimonials of real individuals from Florida. The figure below provides an example of how the Protect Yourself Campaign images was utilized.

FIGURE 21: PROTECT YOURSELF CAMPAIGN IMAGE

The Protect Yourself campaign is implemented across all industry standard platforms including broadcast radio and television, digital/mobile advertising, out-of-home advertising (billboards, bus stops, etc.), a dedicated website, social media, and public outreach events. The FDOH works with local areas to supplement media buys as applicable. FDOH will update the campaign annually with input from community advisory groups. During COVID-19, the HIV media campaign was instrumental in getting out social media messaging and website content to populations at risk for or living with HIV. More recently, the HIV media campaign was used to quickly disseminate information and messaging for HIV priority populations related to hepatitis A, meningococcal disease, and monkeypox virus. Moving forward, FDOH plans to broaden the scope of the campaign to address syndemics (STIs, viral hepatitis).

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

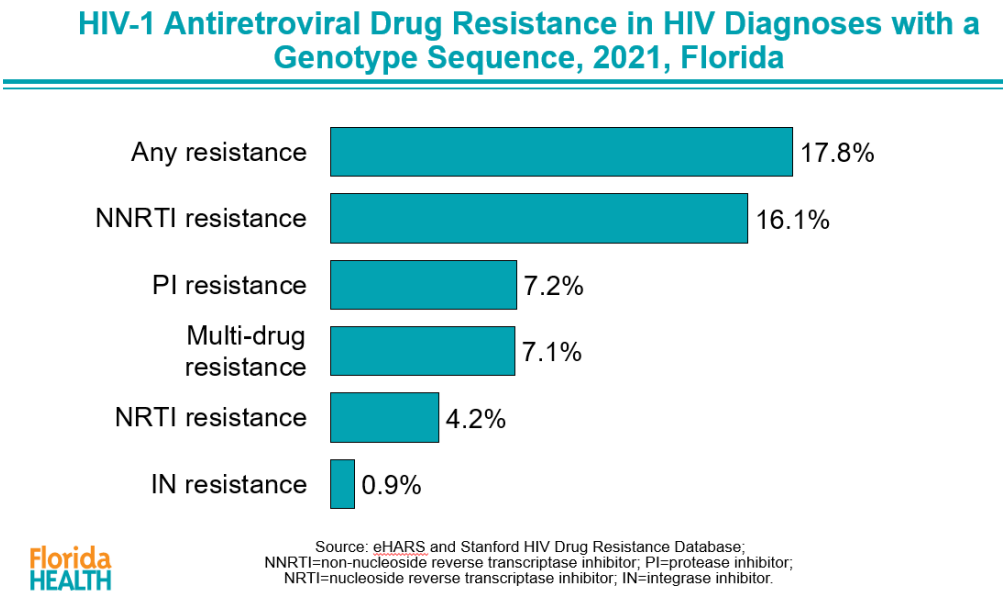
Cluster Detection and Response Plan

FDOH is actively conducting surveillance and investigation for HIV clusters. FDOH routinely conducts monthly analysis to detect rapidly growing molecular clusters and time-space clusters of public health significance. Additionally, a state level cluster review committee is convened monthly to review cluster data, discuss challenges, and brainstorm strategies to improve the statewide response. Since Fall 2021, the state health office has established routine communication with CHDs experiencing clusters to coordinate and guide local responses to investigate and respond to clusters. Florida's updated HIV Cluster Detection and Response plans were submitted to CDC in fall of 2021 and will be updated in the future. The FDOH Bureau of Communicable Diseases plans to engage community stakeholders in further development of the cluster detection and response plan and will accomplish this through the FCPN and associated workgroups, RWHAP partners, and other stakeholders.

Increase Receipt of Genotype Test Results

As the number of analyzable HIV-1 genotype sequences reported to the state has decreased and the number of physicians ordering those tests has also decreased, FDOH will enhance physician capacity to order genotype testing for those newly diagnosed or those not on ART returning to care.

FIGURE 22: HIV-1 ANTIRETROVIRAL DRUG RESISTANCE IN HIV DIAGNOSES WITH A GENOTYPE SEQUENCE, 2021, FLORIDA



FDOH is engaging laboratories to improve the completeness and timeliness of electronic laboratory reporting of all reportable HIV lab results including genotype consensus sequences used in transmission network analyses. To increase the receipt of genotypes test results, FDOH and its partners are:

- Developing a protocol with the FDOH Bureau of Public Health Laboratories to facilitate access to HIV genotype testing.
- Engaging and educating providers on current HRSA recommendations to order baseline genotypes for newly diagnosed and those returning to care and increase understanding of clinical and epidemiological importance of these tests.
- Educating providers and laboratories on statutory reporting requirements for HIV.
- Educating provider population on response and genotype testing.
- Creating a health care provider letter demonstrating the importance of genotype testing.
- Collaborating with the University of Florida to conduct focus groups on molecular surveillance.
- Conducting laboratory survey on current types and volume of HIV testing in Florida.
- Conducting provider survey on current test ordering strategies.
- Creation of a laboratory report card for laboratories and providers to facilitate improvements.

Data to Care (D2C)

HIV is a reportable disease where routinely collected surveillance data are used as a strategic tool to trigger HIP activities. The D2C initiative is a HIP activity that relies on the use of surveillance data to generate lists of persons living with HIV not in care in Florida. Linkage services are offered to those not receiving treatment by connecting them with HIV care. Florida is a high morbidity state that has implemented a statewide D2C program since 2015, with the goal of reaching individuals who were not linked to HIV care within one month of diagnosis or if not virally suppressed and part of an HIV transmission cluster and network. In partnership with the six RW Part A programs located within the seven EHE counties and through funding received by Georgetown University, FDOH is embarking on a data sharing effort to improve linkage to HIV care for persons out of care within those jurisdictions. Enhancing and expanding on the prioritization of D2C activities by focusing on priority populations that need linkage to care, for example, homeless persons, non-white minorities, non-U.S. born, and persons who inject drugs are populations with the highest rate (>21%) of being out of care (no care in the past 12 months) in 2021, compared to the state (20%). Furthermore, males with IDU, Black men, and persons aged 13-39 are populations with the lowest percentage of viral suppression rates (<68%) in 2021, compared to the state (69%). FDOH is also increasing linkage-to-care staff training to include cultural competency and health equity.

Education and Outreach

As part of the ongoing efforts to respond to HIV transmission clusters and outbreaks, FDOH collaborates to provide education, outreach, and community engagement with Floridians at risk for HIV or currently living with HIV, informing them of available HIV prevention and treatment options and

other resources in their area. The FDOH will complete the following activities to improve awareness of HIV-related services and cluster detection and response actions:

- Generate an annual surveillance summary detaining the community-level response to transmission networks in areas of high HIV burden.
- Create and develop education materials to improve awareness and reduce anxiety surrounding HIV transmission network response activities citing standard public health practice.

4.5 Priority Populations

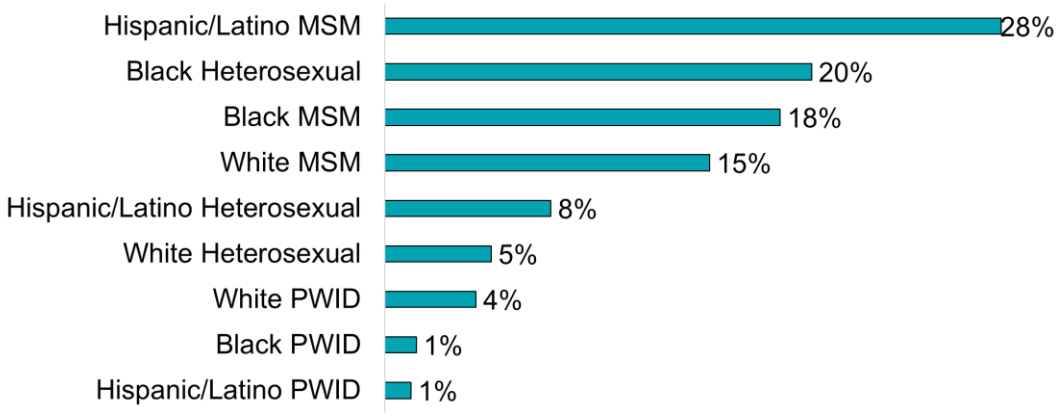
Priority populations for primary HIV prevention are derived from the average proportion of each of the race/mode of exposure groups diagnosed with HIV in the last three years (2019-2021). This information is used to address those at the highest risk of acquiring HIV and with the greatest need for primary prevention services. The top five priority populations are Hispanic/Latino Men who have sex with Men (MSM) (28 percent of new diagnoses over the past three years), Black heterosexual men and women (20%), Black MSM (18%), White MSM (15%), and Hispanic/Latino heterosexual men and women (8%).

Priority populations for prevention for PWH represent the proportion of each of the race/mode of exposure groups to the total PWH. This information is used to prevent HIV transmission through care services provided to PWH in these affected demographic groups. For 2021, top priority groups include Black heterosexual men and women (25%), White MSM (22%), Hispanic/Latino MSM (18%), Black MSM (15%), and Hispanic/Latino heterosexual men and women (6%). Efforts to reduce the transmission of HIV include improving viral suppression among Black men and women and among WCBA (aged 15–44).

PRIORITY POPULATIONS AT RISK FOR HIV

Priority populations for primary HIV prevention are derived from the average proportion of those diagnosed with HIV in the last three years (2019–2021) and can be seen in Figure 23 below. This information is used to address those at highest risk of acquiring HIV and having the greatest need for primary prevention services. The top five priority populations are Hispanic/Latino MSM (28 percent of new diagnoses over the past three years), Black heterosexual men and women (20%), Black MSM (18%), White MSM (15%) and Hispanic/Latino heterosexual men and women (8%).

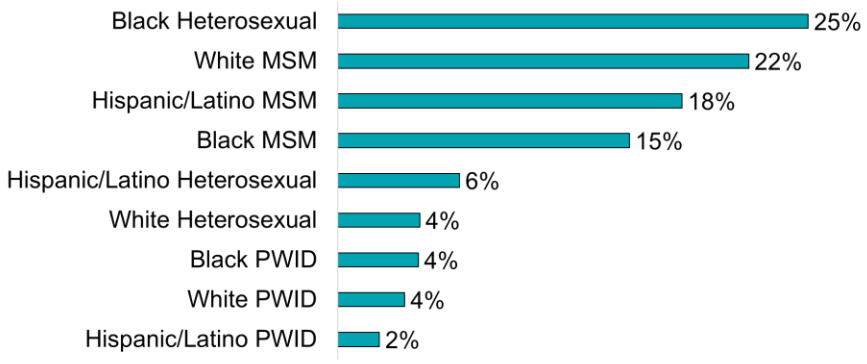
FIGURE 23: PRIORITY POPULATIONS FOR PRIMARY HIV PREVENTION IN 2021, FLORIDA



MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive. Data is for HIV diagnoses 2019–2021. Rounding may cause percentages to total more or less than 100.

Priority populations for prevention for PWH represent the proportion of each of the race/mode of exposure groups to the total PWH. This information is used to prevent HIV transmission through care services provided to PWH in these affected demographic groups. For 2021, those top priority groups include Black heterosexual men and women (25%), White MSM (22%), Hispanic/Latino MSM (18%), Black MSM (15%) and Hispanic/Latino heterosexual men and women (6%). Efforts to reduce the transmission of HIV include improving viral suppression among Black men and women and among women of childbearing age (aged 15–44) as seen in Figure 24 below.

FIGURE 24: PRIORITY PREVENTION POPULATIONS FOR PWH IN 2021, LIVING IN FLORIDA



MSM=MMSC and MMSC/IDU diagnoses, and PWID=IDU and MMSC/IDU diagnoses; thus, the data are not mutually exclusive. Rounding may cause percentages to total more or less than 100.

The full Epidemiological Profile for HIV in Florida, 2021 is included as a separate attachment. It was developed in accordance with the Integrated HIV Prevention and Care Plan Guidance, including the SCSN, CY 2022- 2026 issued by the CDC and HRSA in June 2021. This document provides a comprehensive data overview of HIV, STDs, and Hepatitis C Virus (HCV) in Florida. The full Epidemiological Profile for HIV in Florida, 2021 will also be used to address CDC-PS18-1802 grant requirements.

5 2022–2026 Goals and Objectives

In January 2021, the U.S. Department of Health, and Human Services (HHS) released the HIV National Strategic Plan: A Roadmap to End the Epidemic 2021–2025 which creates a collective vision for HIV service delivery across the nation. IPC Plans created for every jurisdiction address four goals:

1. Prevent new HIV infections
2. Improve HIV-related health outcomes for people with HIV
3. Reduce HIV-related disparities and health inequities
4. Achieve integrated, coordinated efforts that address the HIV Epidemic among all partners and stakeholders

Objectives have been identified for each of the four goals, and the details of such are outlined in the subsequent section.

The table below outlines the goals and objectives for how Florida will address the national strategies to diagnose, treat, prevent, and respond to HIV; the goals and objectives align with the NHAS. Actionable activities have been identified to address each of the goals and objectives, along with other pertinent information to inform a plan of action. Those additional details are described in the Appendix section 9.1 Strategy and Activity Table.

TABLE 9: GOALS AND OBJECTIVES

Goal	Objective
Goal 1: Prevent New HIV Infections	Objective 1.1. Increase awareness of HIV
	Objective 1.2. Increase knowledge of HIV Status
	Objective 1.3: Expand and Improve Implementation of Effective Prevention Interventions
	Objective 1.4 Increase capacity of healthcare delivery systems, public health, and health workforce to prevent and diagnose HIV
Goal 2: Improve HIV-Related Health Outcome of PWH	Objective 2.1. Link people to care rapidly after diagnosis and provide low-barrier access to HIV treatment
	Objective 2.2: Identify, engage, or reengage people with HIV who are not in care or not virally suppressed
	Objective 2.3: Increase retention and adherence to treatment to achieve and maintain long-term viral suppression.

Goal	Objective
	Objective 2.4: Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV
	Objective 2.5 Expand capacity to provide whole-person care to older adults with HIV and long-term survivors
	Objective 2.6: Advance the development of next-generation HIV therapies and accelerate research for HIV cure.
Goal 3: Reduce HIV-related Disparities and Health Inequities	Objective 3.1. Reduce HIV-related stigma and discrimination
	Objective 3.2. Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum
	Objective 3.3. Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV
	Objective 3.4: Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities
	Objective 3.5: Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations.
	Objective 3.6: Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and health care mistrust.
Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic Among All Partners and Interested Parties	Objective 4.1. Integrate programs to address the syndemic 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 Increase coordination among and sharing of best practices from HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with public and private health care payers, faith-based and CBOs, the private sector, academic partners, and the community
	Objective 4.3 Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continua data and social determinants of health data
	Objective 4.4: Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances.

6 2022–2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up

To break down the approach for Integrated Planning Implementation, Monitoring and Jurisdictional follow up, the subsequent sections will detail how best to ensure the success of IPC Plan goals and objectives through the following five key phases:

- Implementation (Section 6.1.1)
- Monitoring (Section 6.1.2)
- Evaluation (Section 6.1.3)
- Improvement (Section 6.1.4)
- Reporting and Dissemination (Section 6.1.5)

6.1 Implementation

The FDOH will continue to coordinate and collaborate with internal and external partners and stakeholders to meet the objectives of the IPC plan. FDOH RW Part B and CQM and partners such as the RW Part A, C, D and F programs, PWH and other members of the FCPN, associated committees, workgroups, and advisory groups (FL Gay Men's HIV Workgroup, Community HIV Advisory Group), HIV prevention and care providers, state/local agency administrators, and persons at increased risk for HIV will be included in each step of the IPC plan implementation, monitoring and evaluation. Through this coordinated implementation approach, the FDOH and partners can explore opportunities to better leverage funding streams supporting Florida's HIV prevention, care, and treatment services (e.g., CDC and HRSA funding to state and local entities). Implementation progress of the IPC plan will also be used to identify where more resources (e.g., funding, staffing) may be needed to ensure IPC plan objectives are met.

6.2 Monitoring

The goal of the monitoring and evaluation plan is to assess successful implementation of the unified IPC Plan as measured by:

1. Completion of stated strategies and activities.
2. Annual progress toward the target measurements of stated goals, objectives, and benchmarks.

Data are used to direct efforts to ensure the program achieves the intended results and to help identify additional operational and process improvement opportunities.

Through bi-annual meetings and monthly committee calls, the FDOH HIV/AIDS Section and the FCPN will actively participate in regular monitoring of strategies and activities set forth in the unified IPC

Plan. FDOH, in collaboration with the FCPN Coordination of Efforts Committee, will establish mechanisms and timeframes the state will use to monitor, evaluate, and update the IPC Plan, as necessary. This committee leads efforts to ensure data indicators for plan activities are being tracked and that progress is communicated with appropriate programs and partners to meet plan objectives. Data on performance indicators will be collected and disseminated through a status report to statewide partners. Regular FCPN meetings are the principal mechanism for updating planning bodies and stakeholders on the progress of plan implementation as well as soliciting and using feedback from stakeholders for ongoing plan improvements.

The IPC Plan will receive a detailed annual review by FDOH HIV/AIDS Section leadership. As part of the annual review, the section will use surveillance and program data to assess health outcomes along the HIV Care Continuum that impact the quality of the HIV service delivery system. This will allow for adjustments to be made in response to changing conditions, and information from the review will be provided to FCPN for feedback.

The FDOH, HIV/AIDS Section, with the engagement of stakeholders, will review the strategic plan using identified measures and indicators to analyze, assess, and evaluate outcomes and determine whether modifications to the IPC Plan are necessary. The diverse range of perspectives—knowledge, values, needs, and abilities—of stakeholders will be applied through a participatory planning and evaluation process. The collaborative approach, structured and arranged to interweave state and local community partnerships with shared discretion and responsibilities, will help to achieve the IPC Plan objectives more effectively than each program could on its own. This approach will align with, support, and advance the goals of the IPC initiative, the NHAS, and FDOH as well as meet CDC and HRSA requirements. As the state of Florida moves forward in ending the epidemic, regularly scheduled events to inform all stakeholders and researchers of relevant data and evidence for improving or more precisely monitoring and evaluating the implementation and impact of the IPC Plan is essential. These opportunities will ensure that plan implementers are working with the best available evidence to work toward ending the epidemic.

6.3 Evaluation

Meaningful measures and indictors will be used to monitor both operational performance and progress on objectives, strategies, and activities within the strategic plan. Data are used to make program decisions and direct efforts to ensure the state achieves the intended results and also to help identify additional operational and process improvement opportunities.

The IPC Plan will receive a detailed annual review by HIV/AIDS Section leadership subsequent to Florida's legislative session and FDOH budget planning process. As part of the annual review, the section will use surveillance and program data to assess health outcomes along the HIV Care Continuum which impact the quality of the HIV service delivery system. This will allow for adjustments

to be made in response to changing conditions and information from the review will be provided for input and feedback to the FCPN.

Strategic planning, the process generating the Statewide IPC Plan, helps focus resources on vital objectives chosen to move the Patient Care and Prevention Programs toward fulfillment of the NHAS Goals. The IPC Plan identifies key objectives that Florida will pursue in the next five years, along with strategies and activities that will guide and facilitate the necessary actions required to achieve the desired outcomes. Plan objectives each have a corresponding measure for ongoing monitoring. Using meaningful measures and data indicators will ensure FDOH HIV/AIDS Section leadership, RW Part A partners and the FCPN planning body members are able to manage and track efforts toward the intended results, while identifying improvement opportunities over the course of the five-year period.

Evaluation ensures the strategies and activities are making changes that positively affect outcomes of the IPC Plan objectives. Evaluation that focuses on project outputs, provides accountability for public resources relating to specific actions. It establishes the empirical basis needed for the ongoing cycle of collaborative planning and the actions that need to be accomplished. The evaluation component is an extension of the integrated Plan, Do, Study, Act (PDSA) cycle which is a continuous process. The IPC Plan must be flexible to allow for adjustments as there are changes to external or internal conditions; yet a meaningful evaluation must be integrated in the planning process and include a review and analysis of the intended outcome. The HIV/AIDS Section, with the engagement of stakeholders, will review the strategic plan utilizing meaningful performance measures and indicators to analyze, assess and evaluate outcomes and determine whether modifications to the IPC Plan are necessary. Through participatory evaluation and diverse range of perspectives—knowledge, values, needs and abilities of stakeholders will be applied to the planning and evaluation process.

6.4 Improvement

Through routine (biannual) monitoring and communication of progress in achieving the goals and objectives outlined in the IPC plan, the state will identify areas in need of improvement and make necessary adjustments to the IPC plan. Revisions will be made on an annual basis and items for proposed revision will be reviewed with RW Part A jurisdictions, members of the FCPN and associated workgroups and advisory bodies, and other key stakeholders, voted on and implemented. The collaborative approach—structured and arranged to interweave state and community partnerships with shared discretion and responsibilities—will help to achieve the IPC program objectives more effectively than each program could on its own. This approach will align, support, and advance the goals of the NHAS, the FDOH, as well as meet CDC and HRSA requirements, to ensure improvement in the access to and quality of HIV prevention and care services throughout Florida.

6.5 Reporting and Dissemination

Summarized annual data are also uploaded to the FDOH HIV/AIDS Section web page (http://floridaaids.org/) and are also available on an internal SharePoint site for internal use at the state and county health department level. Annual data releases include a comprehensive epidemiological profile for the state and for each partnership area, a state slide set presented annually to FCPNR and WHAP partners, and other annual data products. The epidemiological (epi) profiles are an expanded Excel workbook with multiple tabs containing 5-year trend analyses of HIV (demographics, diagnosis, AIDS, deaths, and continuum of care), STIs, HBV, HCV, and TB.

Various factsheets are generated to portray epidemiology and disease highlights for a demographic population. These fact sheets highlight summary data for priority population groups. These fact sheets are updated annually, shared with community stakeholders, and uploaded to the FDOH external web and internal SharePoint sites. Integrated slide sets and epidemiological profile tables are generated to support stakeholder engagement and planning. The FDOH HIV/AIDS Section has generated compressive slides sets and epi profiles specifically for each of the 16 partnership areas each year since the 1990s. These slide sets and epi profiles are shared with the RW Part A entities, community stakeholders, field surveillance staff and others who may request these data. These data are frequently used as tools for program planning and evaluation. Data Sharing and Use

De-identified HIV, viral hepatitis, STD, and TB data are routinely shared via ad-hoc requests to surveillance programs with outside entities including by not limited to, academic institutions, community partners, RWHAP Parts, internal agency partners and collaborators, and the public.

Each of these programs provide annual data which is uploaded into FLHealth CHARTS (Florida Community Health Assessment and Resource Tool Set) (https://www.flhealthcharts.gov/charts/CommunicableDiseases/default.aspx). In addition, FL Health CHARTS is updating the FLHealth CHARTS website (a web-based platform that provides easy access to health indicator data at the community and statewide level for the State of Florida from a multitude of sources) with a new dashboard (at the county level) that will incorporate a multitude of HIV/AIDS indicators, including but not limited, to demographic and socio-economic indicators, partner services data, testing/treatment facilities, PrEP, and other data not previously included on FL Health CHARTS. By ensuring all these data and information are made readily accessible and user-friendly, the new dashboard will help local and state planning bodies develop more effective and efficient programs and corresponding activities and monitor progress of IPC strategies and activities.

Along with HIV data, FDOH also summarizes data from MMP and NHBS surveillance along with FDOH PrEP, test and treat, and HIV counseling and testing data. Data from the needs assessments are also shared in reports sent out to FCPN membership.

7 Letters of Concurrence

###Content To Be Developed: Letters to be sent post-October FCPN###

For the purpose of this IPC Plan, the FCPN membership served as the designated entity to certify concurrence with the strategies and activities included in the IPC Plan. The FCPN membership held the concurrence session on <DATE>, to officially adopt Florida's Statewide Integrated HIV Prevention and Care Plan, 2022-2026. Moving forward, all updates to concurrence will be completed through the state's integrated HIV planning process.

The concurrence process included:

- Several virtual IPC planning sessions that reflected the progression of the Unified IPC Plan to ensure that members of the committee were aware of goals, objectives, strategies, and activities proposed within the IPC Plan.
- Opportunities for committee members to submit their feedback to the state health office representatives with a response to their inquiry and/or recommendations.
- An opportunity for the IPC committee to vote to accept the IPC Plan.

7.1 CDC Prevention Program Planning Body Chair(s) or Representative(s)

7.2 RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)

7.3 RWHAP Part B Planning Body Chair or Representative

7.4 Integrated Planning Body

7.5 IPC Planning Body

8 References

1. U.S. Census Bureau. (2020). QuickFacts: Florida, 2019. Retrieved from www.census.gov/quickfacts/FL. P54
2. World Health Organization. (2017). WHO community engagement framework for quality, people-centered and resilient health services (No. WHO/HIS/SDS/2017.15). Geneva: World Health Organization.
3. Centers for Disease Control and Prevention. (HIV Surveillance Report, 2018, May 2020). HIV Surveillance Report, vol. 31. Retrieved from www.cdc.gov/hiv/library/reports/hiv-surveillance.html
4. Florida Department of Health. (2018). Florida Community Health Assessment Resource Tool Set (FL Health CHARTS).Retrieved from www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=PopAtlas.PopulationAtlasDASHBOARD&rdRequestForwarding=Form
5. Florida Department of Health. (2019, August 1). Florida Behavioral Risk Factor Surveillance System, 2018. Retrieved from www.floridahealth.gov/statistics-and-data/survey-data/behavioral-risk-factor-surveillance-system/2018BRFSSReportFinalUpdated.pdf
6. Florida Department of Health, HIV/AIDS Section. HIV Surveillance Data, 2022. Accessed 06/30/2022
7. Golub, S. A. (2018). PrEP stigma: implicit and explicit drivers of disparity. Current HIV/AIDS Reports, 15(2), 190-197.
8. NASTAD. (2018). Trauma Informed Approaches Toolkit. Retrieved from www.nastad.org/sites/default/files/Uploads/2019/nastad_traumatoolkit_12122018.pdf
9. Giordano, T., Gallagher, K., Davich, J., Rathore, M., Borne, D., Davies, E., & Cabral, H. (2018). The Impact of Housing and HIV Treatment on Health-Related Quality of Life Among People With HIV Experiencing Homelessness or Unstable Housing. American Journal of Public Health, 108(S7), S531-S538.
10. Florida Council on Homelessness. (2020, June 30). Annual Report. Retrieved from Florida Council on Homelessness: www.myflfamilies.com/serviceprograms/homelessness/docs/2020CouncilReport.pdf
11. Florida Department of Health. (2020). Housing for Better Health. Retrieved from: www.housingforbetterhealth.com
12. Genberg, B. L. (2016). Improving engagement in the HIV care cascade: a systematic review of interventions involving people living with HIV/AIDS as peers. AIDS and Behavior, 2452-2463.
13. Dan, C. (2019, May 16). Curing Hepatitis C Coinfection among People Living with HIV. Retrieved from U.S. Department of Health and Human Services: www.hhs.gov/hepatitis/blog/2018/05/16/curing-hcv-co-infection-in-people-living-with-hiv.html
14. U.S. Census Bureau. (2019, November). Health Insurance Coverage in the United States: 2018. Retrieved from www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf

15. Florida Department of Health. (2019). ADAP: AIDS Drugs Assistance Program. Retrieved from: www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html
16. Florida Department of Health, STD, and Viral Hepatitis Section. (2018). STD Surveillance Data.
17. Mehta, S., Schairer, C., & Little, S. (2019). Ethical issues in HIV phylogenetics and molecular epidemiology. Current Opinion in HIV and AIDS, 14(3), 221-226.
18. Florida Department of Health. (2017). Florida Gay Men's HIV/AIDS Workgroup Consultation Summary Report.
19. Florida Department of Health. (2019). Medical Monitoring Project Data, 2018.
20. U.S. Census Bureau. (2020). American Community Survey 5-year Estimates, Poverty: 2016 to 2020 American Community Survey Briefs, Detailed Tables generated using data.census.gov. Washington: U.S. Census Bureau.
21. Rosenberg, S., Trumbetta, S., Mueser, K., Goodman, L., Osher, F., Vidaver, R., & Metzger, D. (2001). Determinants of risk behavior for human immunodeficiency virus/acquired immunodeficiency syndrome in people with severe mental illness. Comprehensive Psychiatry, 42(4), 263-271.
22. National Institute on Drug Abuse (NIDA). (2020, April 3). Florida: Opioid-Involved Deaths and Related Harms. Retrieved from www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/florida-opioid-involved-deaths-related-harms
23. Office of Substance Abuse and Mental Health. (2019). Persons self-reporting IDU and admitted in the particular calendar year. Tallahassee: Florida Department of Children and Families.
24. Florida Department of Health. Establishing a Baseline: Informing Efforts through Community Engagement, 2016–2017. Updated October 12, 2017.
25. Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. Journal of Health Disparities Research and Practice, 1(1), 93-108.
26. Thrasher, A. D., Earp, J. A. L., Golin, C. E., & Zimmer, C. R. (2008). Discrimination, distrust, and racial/ethnic disparities in antiretroviral therapy adherence among a national sample of HIV-infected patients. JAIDS Journal of Acquired Immune Deficiency Syndromes, 49(1), 84-93.
27. Visit Florida Tourism Board. (2020, June 1). Estimates of Visitors to Florida by Quarter, 2019. Retrieved from VisitFlorida: www.visitflorida.org/resources/research/
28. Florida Department of Health, HIV/AIDS Section. (2010, January 23). The Shawl Circle: American Indian Women's Conference. Florida Department of Health.
29. American Immigration Council. (2020, August 6). Immigrants in Florida Fact Sheet. Retrieved from www.americanimmigrationcouncil.org/research/immigrants-florida
30. Florida Department of Health. (2019). State of Epidemic, 2018 slide set. Retrieved from State HIV Slide Sets: www.floridahealth.gov/diseases-and-conditions/aids/surveillance/epi-slide-sets.html
31. U.S. Bureau of Justice Statistics. (2018). National Statistics, 2017. Retrieved from www.bjs.gov/index.cfm?ty=tp&tid=1
32. National HIV/AIDS Strategy for the United States 2022-2025 https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf

33. Exemplary IPC Plan Sections, IHAP TA Center May 2018 https://targethiv.org/ihap/exemplary-integrated-hiv-prevention-and-care-plan-sections
34. Florida Department of Law Enforcement, Drugs Identified in Deceased Persons by Florida Medical Examiners, 4/2022, https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2020-Annual-Drug-Report-FINAL.aspx
35. United States Interagency Council on Homelessness https://www.usich.gov/homelessness-statistics/fl/
36. Florida Department of Health website, 2/2022, https://www.floridahealth.gov/diseases-and-conditions/hepatitis/co-infection.html
37. HIVinfo.NIH.gov, HIV Prevention, August 2021 https://hivinfo.nih.gov/understanding-hiv/fact-sheets/preventing-perinatal-transmission-hiv
38. United States Census Bureau, 2020, Selected Characteristics of Health Insurance Coverage in the United States, Table 2701, https://data.census.gov/cedsci/table?q=uninsured%20us%202020
39. 2010 Census Urban and Rural Classification and Urban Area Criteria, https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural/2010-urban-rural.html
40. 2020: DEC Redistricting Data (PL 94-171) https://data.census.gov/cedsci/table?q=florida%202020%20population&tid=DECENNIALPL2020.P1
41. United Health Foundation America's Health Rankings Uninsured in Florida, 2021 ttps://www.americashealthrankings.org/explore/annual/measure/HealthInsurance/state/FL
42. Diagnoses of HIV Infection in the United States and Dependent Areas 2020 https://www.cdc.gov/hiv/library/reports/hiv-surveillance/vol-33/index.html
43. A Bayesian spatial-temporal analysis of racial disparities in HIV clinical outcomes and a pilot stigma intervention protocol for people living with HIV in Florida)
44. Recommendation: Human Immunodeficiency Virus (HIV) Infection: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

9 Appendix

9.1 Strategy and Activity Table

The table below provides details on the activities suggested to address each strategy. Strategies are categorized by the Goal and objective that they fall within.

9.1.1 Goal 1: Prevent New HIV Infections

9.1.1.1 Objective 1.1. Increase awareness of HIV

TABLE 10: STRATEGIES AND ACTIVITIES

Strategy 1.1.1	Develop and implement campaigns and resources to provide education about comprehensive sexual health; HIV risks; options for prevention, testing, care, and treatment; and HIV-related stigma reduction.	
Data Indicators	• Number of new HIV diagnoses • Number of people receiving prescriptions for PrEP • Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis • Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis • Percent of PWH retained in care • Percent of PWH who are virally suppressed	
Priority Populations	PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth	
Timeframe	**Responsible Parties**	**Activities**
By 12/31/2026	• FDOH	• Develop stigma toolkit/campaign and localized stigma task forces
Planning Areas		

Statewide	• Community-based organizations • Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites. • Behavioral health care settings • Mobile units • STD clinics • Drug treatment programs • Case managers • Health educators • Peer workers	• Engage with law enforcement around HIV awareness and stigma, and HIV information in their curriculum for youth intervention programs • Increase culturally competent sexual health education outside of schools • Increase the use of digital media resources to include messaging on dating apps (e.g., Grindr) and social media apps (e.g., TikTok) • Solicit and execute agreement with new media vendor to deliver HIV media services statewide, to add campaign material to increase awareness of HIV testing, PrEP, treatment, prevention, and stigma awareness among priority groups (e.g., Black women, MSM, transgender persons).

<table>
<tr><th>Strategy 1.1.2</th><th colspan="2">Increase awareness of HIV among people, communities, and the health workforce in geographic disproportionately affected.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Case managers
• Health educators
• Peer workers</td><td>• Increase targeted outreach and education efforts specific to specialized groups, (e.g., FQHCs, local gang taskforces, and other geographically disproportionate communities).
• Increase the number of BRTA/FRTA initiatives and partners statewide to increase HIV awareness and reach within communities.
• Offer in person learning opportunities for basic HIV 101 education and increase the number of trained HIV 101 educators (as a result of increased HIV 101 train the trainer opportunities).
• Provide HIV education and information to school district stakeholders to encourage buy-in and adoption of culturally competent sexual health education curriculum.</td></tr>
</table>

<table>
<tr><th>Strategy 1.1.3</th><th colspan="2">Integrate HIV messaging into existing campaigns and other activities pertaining to other parts of the syndemic, such as STIs, viral hepatitis, and substance use and mental health disorders.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• SSPs
• Drug treatment programs
• Case managers
• Health educators
• Peer workers</td><td>• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV messaging within messaging related to other communicable disease areas.
• Increase awareness and collaboration with existing SSP to incorporate Hepatitis, STIs, mental health and substance abuse messaging in campaigns.
• Collaborate with non-traditional and new partners to deliver HIV, STI, substance use and mental health messaging across multiple platforms (e.g., radio, print, digital, social media, out-of-home, venue/event-based). Ensure all messaging is culturally and linguistically appropriate.
• Identify and engage with other organizations and coalitions that have existing campaigns for STIs, viral hepatitis, substance use, mental health, behavioral health, etc. to encourage these groups to include HIV prevention and care messages in their efforts
• Partner with SAMHSA grantees to update or create messaging related to the nexus between HIV/STIs and HCV, substance use, and/or mental health.
• Collaborate with other local EMAs, RW providers (e.g., Part C clinics), and FQHCs to incorporate additional HIV messaging into existing activities and/or campaigns.</td></tr>
</table>

9.1.1.2 Objective 1.2. Increase knowledge of HIV Status

<table>
<tr><th>Strategy 1.2.1</th><th colspan="2">Test all people for HIV according to the most current USPSTF recommendations and CDC guidelines.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of publicly-funded HIV tests performed
• Number of HIV self-test kits distributed
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Gay, bisexual and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Develop messaging that normalizes routine HIV testing and reduces stigma surrounding HIV testing. Utilize peers and/or popular opinion leaders to increase testing in communities.
• Ensure providers are kept up to date through education and communication.
• Implement routine HIV and STIs screening in health care settings and priority testing in non-health care settings. Expand routine HIV testing to include additional medical settings (e.g., emergency departments, urgent care facilities, OB/GYN, and PCP).
• Increase opportunities for HIV testing and address barriers to testing in traditional and non-traditional settings
• Increase testing accessibility through increased partnerships with outside-the-box providers, such as non-traditional medical settings, civic groups, local papers, event planners, faith-based groups, population-based care providers, and others. Ensure testing is where people are.</td></tr>
</table>

<table>
<tr><th>Strategy 1.2.2</th><th colspan="2">Develop new and expand implementation of effective, evidence-based or evidence informed models for HIV testing that improve convenience and access</th></tr>
<tr><th>Data Indicators</th><td colspan="2">Number of new HIV diagnoses
Number of publicly-funded HIV tests performed
Number of HIV self-test kits distributed
Number of people receiving prescriptions for PrEP
Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>FDOH
Community-based organizations
Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
Behavioral health care settings
Mobile units
STD clinics
Drug treatment programs</td><td>Assess current HIV Testing laws for opportunities to consider increasing testing requirements in additional circumstances.
Decrease barriers to testing by increasing testing beyond traditional venues and work hours and normalizing knowing your status.
Identify barriers to testing and care from people with lived experience and develop improvements to delivery.
Provide easy access to home test kits, including through self-serve vending machines and as add-ons to other self-tests (such as COVID, pregnancy); improve reporting structures to increase self-test linkage.
Routinize HIV testing as part of the standard of care during an annual physical as well as during other health or wellness visit appointments or opportunities.</td></tr>
</table>

<table>
<tr><th>Strategy 1.2.3</th><th colspan="2">Incorporate a status neutral approach to HIV testing, offering linkage to prevention services for people who test negative and immediate linkage to HIV care and treatment for those who test positive</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Number of publicly-funded HIV tests performed
• Number of HIV self-test kits distributed
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Develop and provide status neutral resources around testing, treatment, prevention, etc.
• Educate private providers about status neutral HIV prevention and care services.
• Ensure strong linkage to PrEP/ Post Exposure Prophylaxis (PEP) infrastructure exists.
• Increase the use of combined testing and vaccination efforts as a means of destigmatizing HIV prevention and testing services
• Support and expand the use of a ‘no wrong door’ approach for HIV prevention and care services in a variety of organizations</td></tr>
</table>

<table>
<tr><th>Strategy 1.2.4</th><th colspan="2">Provide partner services to people diagnosed with HIV or other STIs and sexual or needle sharing partners</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of people receiving HIV partner services interviews
• Number of partners of newly diagnosed HIV-positive persons who report being aware of PrEP
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Increase collaboration with needle exchange/harm reduction programs.
• Increase partner services capacity, whether by increasing funding for DIS positions, allowing additional FDOH staff to provide partner services, or allowing non-FDOH organizations to provide partner services.
• Provide partner services during non-traditional hours and via telehealth to reduce barriers.
• Reduce barriers around partner disclosure/referral.
• Use partner services to provide negative partners access to PrEP, educational materials, and other preventative resources and services.</td></tr>
</table>

9.1.1.3 Objective 1.3: Expand and Improve Implementation of Effective Prevention Interventions

<table>
<tr><th>Strategy 1.3.1</th><th colspan="2">Engage people at risk for HIV in traditional public health and health care delivery systems, as well as in nontraditional community settings</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of publicly-funded HIV tests performed
• Number of HIV self-test kits distributed
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Gay, bisexual and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Correctional health settings
• SSPs</td><td>• Create local Prevention Interventions Taskforces to work collaboratively to raise awareness (e.g., utilizing non-healthcare events), share resources, and provide referrals.
• Incorporate additional public health professionals in care settings
• Increase academic detailing in Primary Care, Urgent Care, and Emergency Department settings to raise awareness for prevention interventions.
• Increase the number of community mobilization initiatives and partnerships in communities, (e.g., FRTA/BRTA).
• Partner with additional social service organizations, (e.g., domestic violence care providers, human trafficking organizations, United Way, YMCA, Boys and Girls club, etc.) to expand HIV testing, prevention, and care services.</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.2</th><th colspan="2">Scale-up treatment as prevention/U=U by diagnosing all people with HIV, as early as possible and engaging them in care and treatment to achieve and maintain viral suppression.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of publicly-funded HIV tests performed
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Correctional health settings
• SSPs</td><td>• Create local Rapid Access Taskforces to work collaboratively to expand and increase rapid access programs.
• Increase viral suppression rates by increasing the use of peers in programs and using messaging that focuses on living a healthy life.
• Review programs with low VL suppression to identify areas for technical assistance and increase the number of trained Evidence-based Intervention (EBI) providers within those programs to assist in navigation services and other interventions to reduce community VL
• Scale up of injectables programs</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.3</th><th colspan="2">Make HIV prevention, including condoms, PrEP, PEP, SSPs easier to access and support continued use.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of condoms distributed statewide
• Number of people receiving prescriptions for PrEP
• Number of people receiving PEP
• Number of operational SSPs</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Correctional health settings
• SSPs</td><td>• Create local Prevention Interventions Taskforces to work collaboratively to raise awareness, share resources on PrEP, PEP, condoms, and SSP, in order to provide referrals and increase accessibility of services.
• Increase the number of PrEP providers through academic detailing and education.
• Increase the number of SSP (including clean needle distribution and exchange) statewide and ensure local sites are placed in proximity of known overdose events or deaths.
• Promote the use of the Provider PrEP hotline</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.4</th><th colspan="2">Implement culturally competent and linguistically appropriate models and other innovative approaches for delivering HIV prevention services.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Number of publicly-funded HIV tests performed
• Number of HIV self-test kits distributed
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Correctional health settings
• SSPs</td><td>• Embrace the adoption of assessing quality of life instead of limiting approach to focusing on health outcomes only.
• Engage with local and state civic, political, community, and spiritual leaders to increase awareness of HIV and populations living with and affected by HIV
• Increase cultural competency trainings and other linguistically appropriate trainings for delivering HIV Prevention services.
• Partner with FDOE to open conversations for how to evaluate outcomes of current sex education programs for success
• Provide HIV messaging in English, Spanish, and Haitian-Creole</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.5</th><th colspan="2">Support research into the development and evaluation of new HIV prevention modalities and interventions for preventing HIV transmissions in priority populations.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Gay, bisexual and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="3">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Academia
• SSPs</td><td rowspan="3">• Expand frameworks for evaluation of EBIs through collaborative efforts and partnerships
• Expand the use of economic modeling to optimize public health strategies and interventions (e.g., PrEP 2-1-1) in additional jurisdictions.
• Strengthen partnerships with HIV-related research entities (e.g., FCHAR) to increase knowledge sharing and build expertise</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

<table>
<tr><th>Strategy 1.3.6</th><th colspan="2">Expand implementation research to successfully adapt EBIs to local environments to maximize potential for uptake and sustainability.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Academia
• SSPs</td><td rowspan="2">• Adapt interventions frameworks to be more inclusive of all communities (including the transgender community).
• Conduct listening sessions with those currently implementing interventions and those participating in interventions to uncover best practices and lessons learned.
• Increase collaboration with national entities, SMEs, CBA/TA providers to share information and findings that may lead to innovation and strategies</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

9.1.1.4 Objective 1.4 Increase capacity of healthcare delivery systems, public health, and health workforce to prevent and diagnose HIV

<table>
<tr><th>Strategy 1.4.1</th><th colspan="2">Provide resources, incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent, linguistically appropriate, and accessible HIV testing, prevention, and supportive services especially in areas with shortages that are geographic, population, or facility based.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Correctional health settings
• SSPs
• Case managers
• Health educators
• Peer workers</td><td>• Collaborate with local, state, and national training partners to increase and expand training cultural competency and humility trainings
• Collaborate with local, state, and national training partners to provide additional training for the public health workforce and front-line staff on PrEP/PEP prescribing, mental health, and substance use/misuse
• Expand awareness and use of the Collaborative Pharmacy Practice Agreement (CPPA) which gives pharmacists authority to provide specific patient care services, including PrEP
• Expand partnerships with rural health networks
• Explore opportunities to incentivize the expansion of the health care workforce and health care facilities</td></tr>
</table>

<table>
<tr><th>Strategy 1.4.2</th><th colspan="2">Increase the diversity of the workforce of providers who deliver HIV prevention, testing, and supportive services.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Case managers
• Health educators
• Peer workers</td><td rowspan="2">• Determine areas that lack providers and find ways to incentivize organizations to serve as HIV CBOs.
• Encourage HIV testing as a workplace activity.
• Engage community hubs and community leaders to broaden their social services by provided HIV testing.
• Use all available training resources (local and national) to create a diverse testing force across the state in both traditional and non-traditional settings.</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

<table>
<tr><th>Strategy 1.4.3</th><th colspan="2">Increase inclusion of paraprofessionals on prevention teams by advancing training, certification, supervision, financing, and team-based care service delivery.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Case managers
• Health educators
• Peer workers</td><td rowspan="2">• Assess barriers to antiretroviral therapy (treatment or PrEP) in communities).
• Develop a community-based workforce that is able to provide more service in a single visit.
• Find creative ways to combat critical workforce attrition.
• Increase the number of peer navigators providing services.
• Leverage partnerships with private entities to increase access to prevention services.</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td><td></td><td></td></tr>
</table>

<table>
<tr><th>Strategy 1.4.4</th><th colspan="2">Increase the diversity and capacity of health care delivery systems, community health, public health, and the health workforce to prevent and diagnose HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of people receiving prescriptions for PrEP
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Case managers
• Health educators
• Peer workers</td><td>• Aim to increase the number of local care providers of color in order to reflect the burden of the epidemic in a county.
• Increase the number of inclusive sexual health services being offered by providing training on sexual orientation and gender identity
• Provide outreach to academic institutions (e.g., public health programs, nursing, other paramedical programs) to encourage integration of testing and prevention training into curriculum to increase the number of certified testers.
• Require HIV education and training of school personnel
• Require HIV education in clinical licensure</td></tr>
</table>

9.1.2 Goal 2: Improve HIV-Related Health Outcome of PWH

9.1.2.1 Objective 2.1. Link people to care rapidly after diagnosis and provide low-barrier access to HIV treatment

<table>
<tr><th>Strategy 2.1.1</th><th colspan="2">Increase linkage to HIV medical care within 30-days of diagnosis, as early as the same day.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Allow peers, medical providers, and eligibility staff the ability to link clients to care and access rapid ART medications.
• Collaborate with local partners and providers across multiple platforms to incorporate more T&T facilities that will offer rapid access to ART and PrEP/PEP medications.
• Increase awareness with local providers to incorporate messaging on T&T and rapid ART protocols.
• Support the use of incentives such as food/transportation vouchers and phones to assist with linkage to care activities.</td></tr>
</table>

<table>
<tr><th>Strategy 2.1.2</th><th colspan="2">Provide same-day initiation or rapid start (w/in 7 days) of ART for those who are able to take it.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Establish youth ambassadors/advocates; collaborate with academic institutions (e.g., Scale It Up Florida)
• Expand routine HIV and STI testing to include additional medical settings. (e.g., pediatricians, primary care, and student health centers)
• Increase targeted outreach and education efforts specific to specialized youth and teen groups.
• Increase the number of culturally competent sexual health education in educational, recreational, and faith-based organizations, facilities, and groups.</td></tr>
</table>

9.1.2.2 Objective 2.2: Identify, engage, or reengage people with HIV who are not in care or not virally suppressed

<table>
<tr><th>Strategy 2.2.1</th><th colspan="2">Expand uptake of data-to-care models using data sharing agreements, integration and use of surveillance, clinical services, pharmacy, and social/support services data to identify and engage people not in care or not virally suppressed.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH enrolled in Test & Treat
• Number of PWH re-engaged through D2C
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Collaborate with local partners and providers across more platforms to incorporate more T&T facilities that will offer rapid ART and PrEP/PEP medications.
• Develop a single point eligibility data system integrated with multi data systems that will support all RW parts assist with linkage and retention services.
• Execute cooperative agreements and/or data sharing agreements with local providers, jails, and prisons to link and refer clients to care who are soon to be released from an institution.
• Support data sharing efforts and educate peers, DIS, medical providers, pharmacists, and eligibility and outreach staff on how to assist in linking clients to care and accessing rapid ART medications.</td></tr>
</table>

<table>
<tr><th>Strategy 2.2.2</th><th colspan="2">Identify and address barriers for people who have never engaged in care or who have fallen out of care.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH enrolled in Test & Treat
• Number of PWH re-engaged through D2C
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Expand opportunities to increase awareness and education of local providers on how to incorporate messaging and/or services for mental health, substance use, homelessness, and other wrap-around services.
• Expand routine HIV/STI testing, and substance use counseling to additional settings such as homeless shelters, urgent care centers, substance use treatment centers.
• Expand RW drug formularies to include more treatment drugs for comorbidities.
• Expand the use of mobile units to assist with linkage and re-engagement efforts
• Support the use of peers to assist with linkage, re-engagement, and retention efforts</td></tr>
</table>

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

<table>
<tr><th>Strategy 2.3.1</th><th colspan="2">Support the transition of health care systems, organizations, and clients to become more health literate in the provision of HIV prevention, care, and treatment services.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Number of PWH enrolled in Test & Treat
• Number of PWH re-engaged through D2C
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td>• Develop plain language processes and materials to assist clients who are newly diagnosed or returning to care.
• Offer in person and virtual learning opportunities for basic HIV 101 education and increase the number of trained HIV 101 educators and clients (as a result of increased HIV 101 train the trainer opportunities).
• Support the use of peers to assist with linkage, re-engagement, and retention efforts</td></tr>
</table>

<table>
<tr><th>Strategy 2.3.2</th><th colspan="2">Develop and implement effective, evidence based or evidence-informed interventions and supportive services that improve retention in care.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of PWH enrolled in Test & Treat
• Number of PWH re-engaged through D2C
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs</td><td rowspan="2">• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) into primary care practice.
• Expand peer linkage and community health workers (CHWs) to implement ARTAS intervention strategies and adherence measures.
• Integrate best practices on peer programs from similar states and jurisdictions
• Review EBI/EI interventions for effectiveness by using validated tools to predict engagement. Ensure EBI interventions include target audience. Establish rapid response protocols.
• Streamline clinical protocols to eliminate client burden by reducing the frequency of CD4/VL labs, providing 3-6 months of medications at one time, and offering telehealth clinical and case management services.</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

<table>
<tr><th>Strategy 2.3.3</th><th colspan="2">Develop and implement effective, evidence-based, or evidence-informed interventions such as HIV telemedicine, accessible pharmacy services, CHWs and peer navigators, and others, that improve convenience and access, facilitate adherence, and increase achievement and maintenance of viral suppression.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of PWH enrolled in Test & Treat
• Number of PWH re-engaged through D2C
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Pharmacies
• Peer workers
• Case managers
• Community health workers
• SSPs</td><td>• Allow 3-6 months of ART medications to be dispensed at one time.
• Create funding opportunities for community-based providers to support recruitment and retention of staff.
• Develop a single point eligibility data system integrated with multi data systems that will support all RW parts. Implement a centralized eligibility determination system for all RW Parts.
• Expand access to health insurance coverage to eligible clients.
• Provide training to health workers and peers that will support or increase adherence measures.</td></tr>
</table>

<table>
<tr><th>Strategy 2.3.4</th><th colspan="2">Support ongoing clinical, behavioral, and other research to support retention in care, medication adherence and durable viral suppression.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of PWH enrolled in Test & Treat
• Number of PWH re-engaged through D2C
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia</td><td rowspan="2">• Encourage persons living with HIV to participate in the research by making research findings easier to understand.
• Engage and collaborate with local colleges/universities to increase research opportunities at the local level.
• Engage local organizations such as FQHC to assist with research and interventions.
• Provide paid incentives to encourage persons living with HIV, students, or researchers to get involved in the research.
• Provide updates to providers on ongoing or recruiting efforts on clinical trials.</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

9.1.2.4 Objective 2.4: Increase the capacity of the public health, health care delivery systems, and health care workforce to effectively identify, diagnose, and provide holistic care and treatment for people with HIV

<table>
<tr><th>Strategy 2.4.1</th><td colspan="2">Provide resources, value-based and other incentives, training, and technical assistance to expand workforce and systems capacity to provide or link clients to culturally competent and linguistically appropriate care, treatment, and supportive services especially in areas with shortages that are geographic, population, or facility based.</td></tr>
<tr><th>Data Indicators</th><td colspan="2">Number of new HIV diagnoses
Number of PWH enrolled in Test & Treat
Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
Percent of PWH retained in care
Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">FDOH
Community-based organizations
Healthcare settings including hospitals, FQHCs, community health centers, private physician practices, and reproductive health sites.
Behavioral health care settings
Mobile units
STD clinics
Drug treatment programs
Pharmacies
Peer workers
Case managers
Community health workers
SSPs</td><td rowspan="2">Collaborate with the AETC to assist with training efforts.
Establish a statewide conference for medical providers.
Expand telehealth to increase capacity for services and utilize mobile units to increase outreach efforts.
Increase culturally competent HIV trainings to local providers.
Increase targeted outreach and education efforts specific to specialized providers.</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

<table>
<tr><th>Strategy 2.4.2</th><th colspan="2">Increase the diversity of the workforce of providers who deliver HIV and supporting services.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Peer workers
• Case managers
• Community health workers
• SSPs</td><td>• Allow peers, medical providers, and eligibility staff the ability to link clients to care and access rapid ART medications.
• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) into primary care practice.
• Increase staff and providers of black and brown communities.
• Offer in person and virtual learning opportunities for basic HIV 101 education and increase the number of trained HIV 101 educators (as a result of increased HIV 101 train the trainer opportunities).</td></tr>
</table>

<table>
<tr><th>Strategy 2.4.3</th><th colspan="2">Increase inclusion of paraprofessionals on teams by advancing training, certification, supervision, reimbursement, and team functioning to assist with screening/management of HIV, STIs, viral hepatitis, and mental and substance use disorders and other behavioral health conditions.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• Peer workers
• Case managers
• Community health workers
• SSPs</td><td>• Collaborate with social service organizations on screening/management of HIV, STIs, viral hepatitis, and mental and substance use disorders and other behavioral health conditions.
• Identify support staff who can be trained to provide support services in a range of industries (i.e., medical COE)
• Develop and implement a Peer Certification program statewide.
• Increase training and inclusion opportunities for CHWs.
• Collaborate with other social service providers to increase screening/management of HIV, STI, viral hepatitis, and mental and substance abuse.
• Expand collaboration with public school nurses to provide support to the younger population.
• Identify and promote trainings for paraprofessionals regarding social determinants of health and the syndemics facing Florida.</td></tr>
</table>

9.1.2.5 Objective 2.5 Expand capacity to provide whole-person care to older adults with HIV and long-term survivors

<table>
<tr><th>Strategy 2.5.1</th><th colspan="2">Identify, implement, and evaluate models of care that meet the needs of people with HIV who are aging and ensure quality of care across service.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Older persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia</td><td>• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) into primary care practice.
• Offer in person and virtual learning opportunities for basic HIV 101 education and increase the number of trained HIV 101 educators (as a result of increased HIV 101 train the trainer opportunities).
• Broaden the scope of partnerships to include established entities who serve PWH over the age of 50 providing primary, specialty and pharmacy services.
• Utilize statewide advisory groups to identify barriers in the model of care for people with HIV who are aging.
• Collaborate with existing service providers (e.g., Eldersource, Dept. of Elder Affairs, Visiting Angels) that work with the elderly to integrate in HIV prevention, care, and support services.
• Increase HIV and Aging education in senior centers, assisted living facilities, retirement communities, etc.
• Collaborate with geriatric care providers to educate on risk of aging people with HIV. Also educate them on risk for older patients who may be at risk of acquiring HIV, e.g., how to talk to engage older adults in sexual health conversations.</td></tr>
</table>

<table>
<tr><th>Strategy 2.5.2</th><th colspan="2">Identify and implement best practices related to addressing psychosocial and behavioral health needs of older people with HIV and long-term survivors including substance use treatment, mental health treatment, and programs designed to decrease social isolation.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Older persons living with diagnosed HIV infection</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia</td><td>• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) and behavioral health into primary care practice.
• Increase provider knowledge on aging HIV population and the effects on dementia.
• Expand partner networks to include organizations already addressing psychosocial and behavioral health for older people living with HIV and survivors.
• Engage national aging institutions to advise on establishing the most effective program design to address psycho-social and behavioral needs of the aging population including substance use and mental health treatment.
• Review existing research and best practices from mainstream non-HIV oriented care providers and integrate into HIV-oriented care.
• Establish Long Term Survivor Empowerment Teams which can foster individual virtual or in-person mental health sessions assessing the needs of patients and ensuring their needs are met accordingly.
• Reach out to existing elder services providers to learn more about what they offer, what's working, and ask how HIV prevention and support could be added into their efforts.</td></tr>
</table>

<table>
<tr><th>Strategy 2.5.3</th><th colspan="2">Increase HIV awareness, capability, and collaboration of service providers to support older people with HIV, including in settings such as aging services, housing for older adults, substance use treatment, and disability and other medical services.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Older persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia</td><td>• Collaborate with local Area Agencies on Aging
• Collaborate with local partners to educate providers across more platforms on syndemics and work to incorporate HIV (including aging HIV population) and behavioral health into primary care practice.
• Establish a long-term survivor peer empowerment team (statewide)</td></tr>
</table>

<table>
<tr><th>Strategy 2.5.4</th><th colspan="2">Promote research, cross-agency collaborations, and sharing of research discoveries that address specific aging-related conditions in people with HIV, and other comorbidities and coinfections that can impact people with HIV of all ages.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Older persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia</td><td>• Create housing opportunities for the aging HIV population.
• Expand funding to allow medical and support care for comorbidities.
• Integrate cross-agency collaborations to include access to all client level data to all RW parts.
• Provide education around HIV and aging to local partners and service organizations
• Provide HIV education to the FL Insurance Commission’s office to promote less insurance burdens on HIV care.</td></tr>
</table>

<table>
<tr><th>Strategy 2.5.5</th><th colspan="2">Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing people living with HIV at various life stages to support healthy aging with HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Mobile units
• STD clinics
• Drug treatment programs
• SSPs
• Academia</td><td>• Expand RW services to offer geriatric case management and offer partner prevention services.
• Explore opportunities to educate local and state legislators on the important role medical marijuana plays in the management of HIV disease
• Increase awareness with local providers to incorporate messaging on T&T and rapid ART protocols, HIV stigma and care, and aging HIV population.
• Increase provider knowledge on aging HIV population.</td></tr>
</table>

9.1.2.6 Objective 2.6: Advance the development of next-generation HIV therapies and accelerate research for HIV cure.

<table>
<tr><th>Strategy 2.6.1</th><th colspan="2">Promote research and encourage public-private partnerships to accelerate new therapies to achieve sustained viral suppression and to address drug toxicity, viral resistance, adherence, and retention in care and stigma associated with ART use.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of PWH enrolled in Test & Treat
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Collaborate with academic institutions to explore opportunities for research around HIV therapies and an HIV cure
• Explore ways to leverage RW Part A funding to support services for aging PWH
• Provide HIV education to the FL Insurance Commission’s office to promote less insurance burdens on HIV care.</td></tr>
</table>

<table>
<tr><th>Strategy 2.6.2</th><th colspan="2">Increase investment in innovative basic and clinical research to inform and accelerate a research agenda to discover how to sustain viral suppression, achieve ARV-free remission, reduce, and eliminate viral reservoirs, and achieve HIV cure.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td rowspan="2">• Assist with medical providers and insurance companies to reduce the burden of medication interruption.
• Collaborate with academic partners on clinical research and ART clinical trials.
• Increase access to ART injection medications through ADAP and other payer sources.
• Increase provider knowledge on aging HIV population and the effects on dementia.</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td><td></td><td></td></tr>
</table>

9.1.3 Goal 3: Reduce HIV-related Disparities and Health Inequities

9.1.3.1 Objective 3.1. Reduce HIV-related stigma and discrimination

<table>
<tr><th>Strategy 3.1.1</th><th colspan="2">Strengthen enforcement of civil rights laws (including language access services and disability rights), reform state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, and sexism.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Educate local and state law enforcement agencies on culturally competent HIV basics and civil rights
• Educate local and state legislators, political and civic leaders/organizations, and policy makers on basic HIV transmission, prevention, and care; include HIV data specific to local areas
• Support education and skill building opportunities for PWH to promote understanding of civil rights and engagement in policy making</td></tr>
</table>

<table>
<tr><th>Strategy 3.1.2</th><th colspan="2">Ensure that health care professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or at risk for HIV.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Develop and/or identify and disseminate HIV stigma materials and resources for health care professionals and front-line staff
• Identify and disseminate continuing education opportunities and training for health care professionals and front-line staff on HIV stigma; include working with AETCs and Area Health Education Centers (AHECs)
• Work with professional organizations to encourage the adoption of HIV stigma training as part of professional standards for health care professionals and front-line staff</td></tr>
</table>

<table>
<tr><th>Strategy 3.1.3</th><th colspan="2">Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Conduct outreach and education campaigns to train and employ peers to provide education, navigation, and support services
• Create opportunities and invite marginalized individuals to speak/join virtually (and anonymously) to present their perspectives, educate, and stay protected
• Engage community and faith-based leaders at local and state levels to develop and host culturally-tailored trainings that address stigma and HIV misconceptions
• Support local areas to develop general education and social media campaigns and materials to de-stigmatize HIV and those living with or affected by HIV</td></tr>
</table>

<table>
<tr><th>Strategy 3.1.4</th><th colspan="2">Ensure resources are focused on the communities and populations where the need is greatest, especially Black, Latino, and American Indian/Alaska Native and other people of color, particularly those who are also gay and bisexual men, transgender people, people who use substances, sex workers, and immigrants.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Identify or develop information to educate potential funders and philanthropic organizations to increase awareness of HIV-impacted populations and communities
• Support ongoing and new initiatives and programs specifically focused on Priority Populations, including, but not limited to gay and bisexual men, Black, Hispanic/Latino, and other persons of color, transgender people, persons who use substances, sex workers and immigrants.
• Use HIV data to target HIV/STI education and outreach to high priority populations and zip codes which reflect the residents and effectively represent the community
• Use mobile medical units and street outreach to bring services and resources to communities and populations where the need is greatest</td></tr>
</table>

<table>
<tr><th>Strategy 3.1.5</th><th colspan="2">Create funding opportunities that specifically address social and structural drivers of health (SDOH) as they relate to Black, Latino, and American Indian/Alaska Native and other people of color.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Approach private corporations and other entities for sponsorship and educational opportunities to address SDOH
• Develop mini grants and create other opportunities to support programs that address SDOH in Black, Hispanic/Latino and other racial/ethnic communities.
• Explore opportunities to expand the use of IPC and MAI funding and assess outcomes</td></tr>
</table>

9.1.3.2 Objective 3.2. Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum

<table>
<tr><th>Strategy 3.2.1</th><th colspan="2">Increase awareness of HIV-related disparities through data collection, analysis, and dissemination of findings.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Develop and/or expand the use of easy-to-read materials (e.g., infographics, one pagers) to help audiences of varying types (general public, clients, providers) to highlight disparities
• 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
• Focus efforts to educate and gather information from populations and communities impacted by disparities. Include client perspectives/needs in addition to quantitative data</td></tr>
</table>

<table>
<tr><th>Strategy 3.2.2</th><th colspan="2">Develop new and scale up effective, evidence-based, or evidence-informed interventions to improve health outcomes among priority populations and other populations or geographic areas experiencing disparities.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Collaborate with academic institutions and other partners (outside of HIV) to develop EBI focused on Priority Populations and geographic areas impacted by disparities; other partners include mental health, substance use, SAMHSA providers, local homeless coalitions, etc.)
• Develop funding mechanisms to support the development or scale up of interventions to improve health outcomes (e.g., mini-grants, RFAs, purchase orders)
• Support opportunities at local and state levels to develop or scale up EBI, including developing internship programs to engage young professionals
• Use local economic modeling to determine those interventions for scale up (e.g., interventions that have the greatest potential to reduce HIV in communities and populations experiencing disparities)</td></tr>
</table>

9.1.3.3 Objective 3.3. Engage, employ, and provide public leadership opportunities at all levels for people with or who experience risk for HIV

<table>
<tr><th>Strategy 3.3.1</th><th colspan="2">Create and promote public leadership opportunities for people with or at risk for HIV.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Develop and support opportunities for people living with or affected by HIV to serve in leadership roles at state and local levels.
• Establish a statewide peer navigator/educator certification program
• Increase/expand education, training, and mentorship opportunities for PWH to build skills for engaging in a variety of leadership and advocacy roles (social, political, civic, spiritual)</td></tr>
</table>

<table>
<tr><th>Strategy 3.3.2</th><th colspan="2">Work with communities to reframe HIV services and HIV-related messaging so they do not stigmatize people or behaviors.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Engage with Priority Populations and local leaders/influencers to develop HIV-related messaging that does not stigmatize
• Ensure the intentional use of people-first and inclusive language in HIV service delivery, educational materials, and informational campaigns (review existing and incorporate into new products)
• Expand the use the state's health education review panel (the Carlos Alvarez Educational Material Review Panel) to ensure HIV-related messaging and materials are culturally and linguistically appropriate and use people-first language</td></tr>
</table>

9.1.3.4 Objective 3.4: Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities

<table>
<tr><th>Strategy 3.4.1</th><th colspan="2">Develop whole-person systems of care that address co-occurring conditions for people with HIV or at risk.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of syphilis infections in communities and specific populations at risk for STD infection
• Number of HCV infections in communities and specific populations at increased risk for HCV infection,
• including PWID
• STD and HCV co-infection among persons diagnosed and living with HIV
• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Expand local partnerships and collaborate with local providers to address and alleviate barriers to accessing care
• Identify opportunities to centralize eligibility, enrollment services, and health care services for PWH (e.g., HOPWA, RW, ADAP)
• Incorporate other health screenings and services into HIV care
• Pilot health care models and interventions for people at risk for or living with HIV who have co-occurring conditions e.g., substance use disorder (SUD), mental health conditions</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.2</th><th colspan="2">Adopt policies that reduce cost, payment, and coverage barriers to improve the delivery and receipt of services for people with or at risk for HIV.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Centralize eligibility processes and cross-train medical case managers, RW Part B, HOPWA, CBOs
• Streamline clinical practices, reduce annual number of visits, CDH, PVC tests. 3 or 6m ART prescriptions
• Assess cost-effective programs that reduce cost, payment, and coverage barriers to improve the delivery and receipt of services for people with or at risk for HIV and use their findings for adopting related policies.
• Create consistencies within the RW system of care (Part A, Part B, etc.) to eliminate barriers to HIV care (e.g., longer time in between recertification, reciprocal eligibility).
• Explore the incorporation of afterhours/weekend services for HIV clients to assist with retention in and adherence to care.
• Engage in discussions with Florida Office of Insurance Regulation, Medicaid/Medicare (ACHA), and other entities to identify policies that create barriers for delivery of HIV services for people with or at risk for HIV.</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.3</th><th colspan="2">Improve screening and linkage to services for people with or at risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Percent of newly diagnosed PWH linked to HIV medical care within 7 days of diagnosis
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Number of PWH enrolled in Test & Treat
• Number of PWH re-engaged through D2C</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="3">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• STD clinics
• Mobile units
• Drug treatment programs
• SSPs
• Academia</td><td rowspan="3">• Educate providers specializing in co-occurring conditions.
• Expand collaboration with FQHCs (and FQHC look-alikes) at state level to improve screening
• Expand partnerships with agencies to expand routine screening and linkage to care services for persons newly diagnosed with HIV or for persons previously diagnosed who are returning to care
• Address challenges and barriers to screening and linkage to services for people with or at risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.
• For those at risk, educate non-HIV providers to conduct sexual health and substance use risk assessments routinely. Work with medical certification boards to ensure ongoing education and compliance.
• Increase the use of mobile units offering HIV/STI screening, treatment, and prevention services beyond traditional testing hours.</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.4</th><th colspan="2">Develop and implement effective, evidence-based, or evidence-informed interventions that address social and structural determinants of health among people with or at risk for HIV including lack of continuous health care coverage, HIV-related stigma and discrimination in public health and health care systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Expand the use of mobile outreach units and telehealth technology to address SDOH and provide linkage referrals
• Explore opportunities to use peers and/or CHWs as mentors outside of the health care system
• Identify and disseminate information and trainings for clients on their rights, grievance policies/customer feedback, and health literacy</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.5</th><td colspan="2">Develop new and scale up effective, evidence-based/informed interventions to improve health outcomes and QOL for people across lifespan including youth and people over 50 w/ or at risk for HIV, and long-term survivors.</td></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Develop a telehealth provider network
• Expand access to HIV/STI testing and treatment outside of public health; include public-private partnerships
• Identify and disseminate trainings that include cultural competency and sensitivity trainings for providers
• Identify best practices for consortia to find and identify EBI</td></tr>
</table>

<table>
<tr><th>Strategy 3.4.6</th><td colspan="2">Develop new and scale up effective, evidence-based/informed interventions that address intersecting factors of HIV, trauma and violence, and gender especially among cis- and transgender women and gay and bisexual men.</td></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Create opportunities to support providers and agencies implementing EBI that address trauma and violence
• Identify and disseminate provider trainings on TIC
• Identify and/or develop training-of-trainers (TOT) for TIC to ensure all RWHAP are using a TIC approach.
• Provide training opportunities for existing EBI in the mental health practice.
• Identify existing effective, evidence-based/informed interventions that address intersecting factors of HIV, trauma and violence, and gender especially among cis- and transgender women and gay and bisexual men for scaling up.
• Recruit staff with lived experience (HIV, trauma, transgender, etc.) that reflect the people with HIV they are trying to serve
• Educate the HIV/STD/HEP/Substance Use/Mental Health workforce on the intersecting issues. Ensure diverse organizations are involved in the development of new cross-sectional interventions. Seek out or directly provide funds to support collaborative efforts.</td></tr>
</table>

9.1.3.5 Objective 3.5: Train and expand a diverse HIV workforce by further developing and promoting opportunities to support the next generation of HIV providers including health care workers, researchers, and community partners, particularly from underrepresented populations.

<table>
<tr><th>Strategy 3.5.1</th><th colspan="2">Promote the expansion of existing programs and initiatives designed to increase the numbers of non-White research and health professionals.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Non-White research and health professionals</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• Health care professional organizations</td><td rowspan="2">• Create a state-funded program to fill federal gaps
• Cross-train CHWs
• Increase promotion of the HIV field in academic institutions (e.g., MPH programs, Schools of Medicine, Pharmacy, Nursing, Social Work) through career fairs and supporting certifications and training programs
• Provide training and opportunities for partnership with HBCUs around HIV prevention, care, and treatment
• Support funding for SPNS</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td><td></td><td></td></tr>
</table>

<table>
<tr><th>Strategy 3.5.2</th><th colspan="2">Increase support for the implementation of mentoring programs for individuals from diverse cultural backgrounds to expand the pool of HIV research and health professionals.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">HIV research and health professionals</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• Health care professional organizations</td><td rowspan="2">• Identify and support the use of mentorship programs for individuals from diverse backgrounds
• Elevate voices of people living with HIV through increased advocacy and training. Encourage their participation through support groups. Ensure people who represent the population are in positions to assist with peer support services.
• Support implementation of mentoring programs for individuals from diverse cultural backgrounds to expand the pool of HIV research and health professionals.
• Identify organizations that have existing mentoring programs, disseminate the information with other agencies to coordinate efforts.
• Reach out to professional groups that emphasize memberships of color like the National Association for Black Social Workers, HBCUs, sororities/fraternities, civic organizations, etc.</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

<table>
<tr><th>Strategy 3.5.3</th><th colspan="2">Encourage the implementation of effective recruitment of community partners through community-based participatory research and social networking approaches.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• Health care professional organizations</td><td>• Develop professional articles for publication
• Identify opportunities to collaborate with the Florida Center for HIV/AIDS Research (FCHAR)
• Provide information on and encourage community participation in legitimate research studies, grants
• Recruit youth and young adults to participate in local and state HIV planning bodies and advisory workgroups
• Support the use of community opinion leaders and social networking strategies</td></tr>
</table>

9.1.3.6 Objective 3.6: Advance HIV-related communications to achieve improved messaging and uptake, as well as to address misinformation and health care mistrust.

<table>
<tr><th>Strategy 3.6.1</th><th colspan="2">Develop and test strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Assess common myths and misconceptions within and among Priority Populations and identify strategies to combat misinformation
• Promote the use of community sharing experiences and educational opportunities (e.g., community forums, celebrations)
• Ensure messaging is succinct, culturally appropriate, consistent with HIV treatment guidelines, and delivered by persons credible to diverse populations across the state.
• Develop and disseminate anti-stigma campaigns which focus on dispelling myths and misconceptions about HIV
• Expand the use of community gatekeepers and social network strategies to deliver HIV information through culturally-appropriate methods
• Develop a workgroup to assist with developing and testing strategies to promote accurate creation, dissemination, and uptake of information and to counter associated misinformation and disinformation.</td></tr>
</table>

<table>
<tr><th>Strategy 3.6.2</th><th colspan="2">Increase diversity and cultural competence in health communication research, training, and policy.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Create opportunities for advancement among diverse candidates
• Identify ways to create more targeted messaging for specific populations of PWH and consistently use language that is both people-first and inclusive
• Work with HBCU medical colleges such as Pharmacy, Social Work, Nursing, Medical Schools, etc.
• Provide training opportunities for diversity and cultural competence in health communication research, training, and policy (e.g., conferences, webinars, lunch and learns).
• Train and/or hire more people with HIV who are qualified for roles in HIV leadership, research, training, peer support, etc.
• Work with statewide advisory groups and SMEs to identify ways in which diversity and cultural competence can be incorporated into health communication trainings</td></tr>
</table>

<table>
<tr><th>Strategy 3.6.3</th><th colspan="2">Expand community engagement in health communication initiatives and research.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Identify ways to engage Priority Populations and communities in HIV media and messaging initiatives and research
• Increase engagement with CBOs, community resource centers, and social service agencies to help develop new health communication initiatives; activities could include townhall meetings, focus groups, health fairs, community celebrations, cultural events, etc.
• Assess populations that may not be receiving accurate health communications, recruit leaders from those populations and train them to disseminate communications (through staffing agreement).
• Engage with academic institutions (e.g., HBCUs) to solicit feedback on health communication initiatives and research.</td></tr>
</table>

<table>
<tr><th>Strategy 3.6.4</th><th colspan="2">Include critical analysis and health communication skills in HIV programs to provide participants with the tools to seek and identify accurate health information and to advocate for themselves and their communities.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Explore ways in which to incorporate critical analysis and health communication skills into HIV programs and services to increase client skills needed for health literacy and advocacy
• Ensure that needs assessments are conducted, regularly, including questions related to provider communication skills and HIV-related messaging, in order to better respond to community needs and identify areas for improvement.
• Explore educational opportunities for providers, peers, and staff on health literacy, and encourage providers to screen clients for health literacy in order to be able to ensure the successful transfer for health information and health communication.
• Develop health literacy resources for clients that are new to care in order to help orient them to ways they can become more knowledgeable about their health and actively participate in their plan of care.
• Increase provider and staff knowledge for strategies to identify and address misinformation and for strategies that increase the sharing of accurate health information.</td></tr>
</table>

<table>
<tr><th>Strategy 3.6.5</th><th colspan="2">Expand effective communication strategies between providers and consumers to build trust, optimize collaborative decision-making, and promote success of evidence-based prevention and treatment strategies.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia</td><td>• Identify best practices for effective communication strategies between providers and consumers, and to address medical mistrust
• Recruit local leaders, influencers, and gatekeepers to assist with communication initiatives designed to build trust
• Utilize CHWs and peers help to bridge communication gaps between clients and providers
• Offer education and training on leading with empathy, active listening, patient experience, and on TIC to promote understanding amongst clients and providers and to build trust in the client to provider relationship.
• Research best practices in effective communication and explore the creation of a health communication resource compendium.
• Increase the reach of messaging and media by engaging with community leaders and expanding partnerships to include organizations and agencies of all size.</td></tr>
</table>

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

9.1.4.1 Objective 4.1. Integrate programs to address the syndemic 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

<table>
<tr><th>Strategy 4.1.1</th><th colspan="2">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.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of syphilis infections in communities and specific populations at risk for STD infection
• Number of HCV infections in communities and specific populations at increased risk for HCV infection, including PWID
• STD and HCV co-infection among persons diagnosed and living with HIV
• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Viral suppression percentages in communities and specific populations at increased risk for HIV
• Stigma indicator to be developed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• Consumers</td><td>• Develop a Community of Practice (CoP) Program (HUD, Homeless Coalition, FDOE, FDC) to learn, share expertise, and collaborate on focus areas
• Expand marketing and advertising campaigns of internal and external partners to promote and increase awareness of resources and services.
• Identify and disseminate trainings and technical assistance on human trafficking, domestic/intimate partner violence and sexual assault for healthcare staff
• Increase partnerships with mobile service providers
• Leverage social media and outreach to disseminate program results and lesson learned</td></tr>
</table>

<table>
<tr><th>Strategy 4.1.2</th><th colspan="2">Implement a no-wrong-door approach to screening and linkage to services for HIV, STIs, viral hepatitis, and substance use and mental health disorders across programs.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of syphilis infections in communities and specific populations at risk for STD infection
• Number of HCV infections in communities and specific populations at increased risk for HCV infection, including PWID
• STD and HCV co-infection among persons diagnosed and living with HIV
• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Viral suppression percentages in communities and specific populations at increased risk for HIV</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026</td><td rowspan="3">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers</td><td rowspan="3">• Adopt a “client centered approach” focused on streamlining referral processes and linkage to care.
• Establish local referral networking system to increases access to care through assignment of healthcare navigators.
• Establish reciprocal agreements with local community partners</td></tr>
<tr><td>Planning Areas</td></tr>
<tr><td>Statewide</td></tr>
</table>

<table>
<tr><th>Strategy 4.1.3</th><th colspan="2">Identify and address funding, policy, data, workforce capacity, and programmatic barriers to effectively address the syndemic.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of syphilis infections in communities and specific populations at risk for STD infection
• Number of HCV infections in communities and specific populations at increased risk for HCV infection, including PWID
• STD and HCV co-infection among persons diagnosed and living with HIV
• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Viral suppression percentages in communities and specific populations at increased risk for HIV</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health and human rights advocates
• HIV/AIDS policy experts
• Health care providers</td><td>• (could explore ways to use information from the state HIV/AIDS hotline)
• Access statewide resources to identify gaps in service and funding opportunities to combat programmatic barriers
• Conduct local information sessions /workshops with stakeholders to analyze data and identify problematic areas as it relates to the delivery of service.
• Create incident reporting system to identify individuals in need of assistance (e.g., assault, discrimination, housing)
• Engage with local and state legislators to educate and inform on workforce capacity and impacts of staffing shortages</td></tr>
</table>

<table>
<tr><th>Strategy 4.1.4</th><th colspan="2">Coordinate and align strategic planning efforts on HIV, STIs, viral hepatitis, substance use disorders, and mental health care across national, state, and local partners.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of syphilis infections in communities and specific populations at risk for STD infection
• Number of HCV infections in communities and specific populations at increased risk for HCV infection, including PWID
• STD and HCV co-infection among persons diagnosed and living with HIV
• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Viral suppression percentages in communities and specific populations at increased risk for HIV</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers</td><td>• Community Health Improvement Plan/Community Health Assessment inclusive of internal and external partners
• Create a collaborative forum to share and learn about Overdose Data to Action (OD2A) programs across multi-agencies (e.g., faith-based organizations, CBOs, providers, FDOH etc.)
• Ensure the State Health Improvement Plan (SHIP) process and planning inclusive of external groups and partners.
• Establish a local planning body to conduct research into opioid initiatives and networks
• Invite local healthcare facilities to participate in local community health needs assessments</td></tr>
</table>

<table>
<tr><th>Strategy 4.1.5</th><th colspan="2">Enhance the ability of the HIV workforce to provide naloxone and educate people on the existence of fentanyl in the drug supply to prevent overdose and deaths and facilitate linkage to substance use disorder treatment and harm reduction programs.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of HCV infections in communities and specific populations at increased risk for HCV infection, including PWID
• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Viral suppression percentages in communities and specific populations at increased risk for HIV</td></tr>
<tr><th>Priority Populations</th><td colspan="2">General public; PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers
• Law enforcement</td><td>• Educate local and state legislators on the use of fentanyl test strips and alignment with harm reduction practices
• Establish a local planning body across multiple agencies (CHD, community, state, FCPN, OD2A project opioid providers) to support and/participate in Opioid initiatives or the development of an Opioid initiative.
• Implement Naloxone Training Course and Training Program (CDC)
• Increase the number of access points for Naloxone (statewide)
• Integrate OD2A project to RW service delivery system at local levels</td></tr>
</table>

9.1.4.2 Objective 4.2 Increase coordination among and sharing of best practices from HIV programs across all levels of government (federal, state, tribal, local, and territorial) and with public and private health care payers, faith-based and CBOs, the private sector, academic partners, and the community

<table>
<tr><th>Strategy 4.2.1</th><th colspan="2">Focus resources including evidence-based and evidence-informed interventions in the geographic areas and priority populations disproportionately affected by HIV.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Viral suppression percentages in communities and specific populations at increased risk for HIV</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers</td><td>• Develop a mapping tool/interactive map locator/pin map of mobile units.
• Develop regular partnership meetings with internal and external service providers at the local level
• Foster strong public-private partnerships to accelerate advances in HIV by inviting stakeholders outside of typical HIV partnerships to attend awareness days and generate new approaches to addressing the HIV epidemic.
• Identify best practices and interventions from other jurisdictions that address similar Priority Populations
• Increase the use of outreach and education to reach Priority Populations and geographies</td></tr>
</table>

<table>
<tr><th>Strategy 4.2.2</th><td colspan="2">Enhance collaboration among local, state, tribal, territorial, national, and federal partners, and the community to address policy and structural barriers that contribute to persistent HIV- related disparities and implement policies that foster improved health outcomes.</td></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new diagnoses in communities and specific populations at increased risk for HIV
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Viral suppression percentages in communities and specific populations at increased risk for HIV</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health and human rights advocates
• HIV/AIDS policy experts
• Health care providers
• Consumers</td><td>• Appoint community liaisons among local, state, tribal, territorial, national, and federal partners to assess and address barriers and social determinants via policy change and enhanced communication
• Create a centralized information platform to house local, county, state, consortium planning body meeting information, proposed activities/projects.
• Create opportunities to bring a wide variety of partners and stakeholders together to increase cross-collaboration
• Foster strong public-private partnerships to accelerate advances in HIV by inviting stakeholders outside of typical HIV partnerships to attend awareness days and generate new approaches to addressing the HIV epidemic.
• Incorporate three-language formula in marketing and advertising materials to overcome social barriers in disproportionate communities.</td></tr>
</table>

<table>
<tr><th>Strategy 4.2.3</th><th colspan="2">Coordinate across partners to quickly detect and respond to HIV outbreaks.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of HIV transmission clusters identified</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026</td><td rowspan="2">• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Academia
• Health care providers</td><td rowspan="2">• Create a centralized system for outbreak detection, reporting, and notification (i.e., meningitis, monkeypox, HIV, STD, viral hep, etc.)
• Develop intersectional taskforce/teams and protocols that include FDOH-DIS, case managers, local medical and support services providers to share information and rapidly identify and link individuals diagnosed with HIV to care/treatment
• Establish response planning teams across multi-agencies and multi-sectors of the community (e.g., faith-based organizations, CBOs, providers, FDOH etc.) to track HIV outbreak and provide rapid HIV treatment care
• Use HIV cluster data to direct the positioning of mobile units to respond to clusters of active transmission</td></tr>
<tr><th>Planning Areas</th></tr>
<tr><td>Statewide</td></tr>
</table>

<table>
<tr><th>Strategy 4.2.4</th><th colspan="2">Support collaborations between CBOs, public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Educational institutions
• Health care providers
• Housing providers</td><td>• Advocate for the revision of MOAs/contracts to include specific standards, wrap-around services (e.g., housing, and mental health services, participation in planning)
• Assess and review state and national collaborative frameworks to identify and adopt approaches that enhance current and future public-private partnerships that help scale up best practices and advances in HIV prevention and treatment.
• Educate local and state legislators on the state's Priority Populations and geographies
• Form partnerships with non-traditional sites (gas stations, sporting events, public restrooms, rest stops, etc.) for the extension of providing in HIV prevention and treatment.
• Identify best practices for increasing collaborations among CBOs, public health organizations, education agencies and schools, housing providers, and health care delivery systems to provide linkage to and delivery of HIV testing, prevention, care, and treatment services as well as supportive services.</td></tr>
</table>

9.1.4.3 Objective 4.3 Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continua data and social determinants of health data

<table>
<tr><th>Strategy 4.3.1</th><th colspan="2">Promote the collection, electronic sharing, and use of HIV risk, prevention, and care and treatment data using interoperable data standards, including data from electronic health records, in accordance with applicable law.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of data products developed and disseminated
• Number of data sharing agreements established
• Number of new HIV diagnoses
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Educational institutions
• Health care providers</td><td>• Create centralized system or dashboard to share aggregate HIV-related data (e.g., testing, treatment, surveillance) internally and externally that can be readily used to understand local area disease burden, obtain information for grant requirements and using data for action and response.
• Design a data system and process for improving data sharing amongst all RW Parts, Florida ADAP, and service providers to improve client level data sharing and RSR reporting requirements.
• Develop a process to improve and simplify the sharing of HIV-related data both internally and externally to FDOH to improve service provision
• Develop a process to increase working with external partners such as VA, private providers, Medicare, and others to improve data sharing at the state and local level
• Ensure that forms and polices around release of information and methods for release (e.g., text, email, phone) are continuously updated and shared with providers</td></tr>
</table>

<table>
<tr><th>Strategy 4.3.2</th><th colspan="2">Use interoperable health information technology, including application programming interfaces (APIs), clinical decision support tools, electronic health records and health IT products certified by the Office of the National Coordinator's Health IT Certification Program, and health information exchange networks, to improve HIV prevention efforts and care outcomes.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of data products developed and disseminated
• Number of data sharing agreements established
• Number of new HIV diagnoses
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Educational institutions
• Health care providers</td><td>• Assess the ability to create a Health Information Exchange (HIE) and master client index among HIV service providers and link the current Florida HIE to data within the HIV/AIDS section to improve linkage to care efforts.
• Create a reciprocal (e.g., across agencies and all RW parts) client informed consent and release of information to acknowledge that data may be shared to improve service provision and linkage to care needs.
• Develop a process and system to conduct and track electronic referrals to HIV-related prevention, treatment services and other ancillary services.
• Evaluate and promote the use of digital resources and clinical decision support tools
• Identify ways to improve data collection efforts for HIV prevention efforts (e.g., HIV self-test kit information)</td></tr>
</table>

<table>
<tr><th>Strategy 4.3.3</th><th colspan="2">Encourage and support patient access to and use of their individual health information, including use of their patient-generated health information and use of consumer health technologies in a secure and privacy supportive manner.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Health care providers
• Consumers</td><td>• Create a client-centered training module around public health data collection and uses of patient information for public health purposes to assist with alleviating fears about misuse and privacy concerns.
• Provide guidance and supportive information to encourage the use of patient portals from providers and laboratories to ensure that clients have direct access to their medical information.
• Ensure health communication and messaging from provider to client is private, secure, and accessible, and occurs through a HIPAA-compliant platform or channel.
• Explore the incorporation of a centralized patient portal or health information application
• Encourage providers currently using patient portals to offer additional client-centered education on patient portal functionality and utilization.
• Explore the increase of in-app or in-portal patient health education opportunities.
• Explore ways to increase information sharing and patient health education opportunities for people living in rural communities or other areas with limited internet access.</td></tr>
</table>

9.1.4.4 Objective 4.4: Foster private-public-community partnerships to identify and scale up best practices and accelerate HIV advances.

<table>
<tr><th>Strategy 4.4.1</th><th colspan="2">Adopt approaches that incentivize the scale up of effective interventions among academic centers, health departments, CBOs, allied health professionals, people with HIV and their advocates, the private sector, and other partners.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Number of new HIV diagnoses
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Health care providers
• Consumers</td><td>• Assess and review state and national collaborative frameworks to identify and adopt approaches that enhance current and future public-private partnerships that help scale up best practices and advances in HIV prevention and treatment.
• Conduct an annual statewide conference on HIV and invite a wide range of traditional and non-traditional partners to participate and attend and share best practices.
• Foster strong public-private partnerships to accelerate advances in HIV by inviting stakeholders outside of typical HIV partnerships to attend awareness days and generate new approaches to addressing the HIV epidemic.
• Identify public-private partnership EBI for early intervention to scale up the use of antiretroviral starter packs</td></tr>
</table>

<table>
<tr><th>Strategy 4.4.2</th><th colspan="2">Expand opportunities and mechanisms for information sharing and peer technical assistance within and across jurisdictions to move effective interventions into practice more swiftly.</th></tr>
<tr><td>Data Indicators</td><td colspan="2">• Number of new HIV diagnoses
• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><td>Priority Populations</td><td colspan="2">PWH; gay, bisexual, and other MSM; men and women of color; transgender individuals; PWID/persons who use drugs; persons in high seroprevalent areas; youth</td></tr>
<tr><td>Timeframe</td><td>Responsible Parties</td><td>Activities</td></tr>
<tr><td>By 12/31/2026
Planning Areas
Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Health care providers
• Consumers</td><td>• Create a centralized information repository to house and disseminate widely information on best practices, meeting information, and other information that will assist with addressing the HIV epidemic
• Develop local e-newsletters or other mechanisms to disseminate information quarterly on available resources and EBI being used in the state
• Establish local area collaborative coalitions across multi-agencies and multi-sectors of the community (e.g., faith-based organizations, CBOs, providers, FDOH etc.) to support data and information sharing and identify best practices that address the HIV epidemic.
• Identify state subject matter experts and create a state specific technical assistance network that can be called upon to</td></tr>
</table>

<table>
<tr><th>Strategy 4.4.3</th><th colspan="2">Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing persons of all ages living with HIV.</th></tr>
<tr><th>Data Indicators</th><td colspan="2">• Percent of newly diagnosed PWH linked to HIV medical care within 30 days of diagnosis
• Percent of PWH retained in care
• Percent of PWH who are virally suppressed</td></tr>
<tr><th>Priority Populations</th><td colspan="2">Persons living with diagnosed HIV infection</td></tr>
<tr><th>Timeframe</th><th>Responsible Parties</th><th>Activities</th></tr>
<tr><td>By 12/31/2026

Planning Areas

Statewide</td><td>• FDOH
• Community-based organizations
• Healthcare settings including hospitals, FQHCs, private physician practices, and reproductive health sites.
• Behavioral health care settings
• Drug treatment programs
• SSPs
• Health care providers
• Consumers
• Academia</td><td>• Adopt a collaborative implementation science approach to evaluate, design, and implement strategies that improve health-related outcomes and promote the dissemination and replication of successful interventions and best practices locally.
• Create a centralized online platform to collect and respond to complaints, challenges and general enquiries from service providers, clients, stakeholders and public.
• Foster new and existing community, private, and cross-sector partnerships through strengthened communication and by supporting increased collaborative opportunities or MOUs centered on sharing information, discussing strategies, and providing education.
• Increase partnerships and collaboration in order to provide age-appropriate sexual health resources, education, and support services for young people</td></tr>
</table>

9.2 Service Area Interview Questionnaires

SA11 Interview Questionnaire.dotx
SA 10 Interview Questionnaire.dotx
SA 15 Interview Questionnaire.dotx
SA 12 Interview Questionnaire.dotx
SA 11B Interview Questionnaire.dotx
SA 9 Interview Questionnaire.dotx
SA 8 Interview Questionnaire.dotx
SA 7 Interview Questionnaire.dotx
SA 5 6 14 Interview Questionnaire.dotx
SA 3 13 Interview Questionnaire.dotx
SA 2B Interview Questionnaire.dotx
SA 2A Interview Questionnaire.dotx
SA1 Interview Questionnaire.dotx
SA4 Interview Questionnaire.dotx

9.3 Service Area Resource Inventories

###Content To Be Developed: Resource Inventories for Areas 1, 4, 9, and 11B have not yet been shared###

Area 2A Resource Inventory 2022.xlsx
Area 15 Resource Inventory 2022.pdf
Area 12 Resource Inventory 2022.xlsx
Area 11A Resource Inventory 2022.xlsx
Area 10 Resource Inventory 2022.xlsx
Area 8 Resource Inventory 2022.xlsx
Area 7 Resource Inventory 2022.xlsx
Area 5.6.14 Resource Inventory
Area 3_13 Resource Inventory 2022.xlsx
Area 2B Resource Inventory 2022.xlsx

9.4 RW Part A Plans

###Content To Be Developed: Part A Plans have not yet been shared for Ft Lauderdale, Jacksonville, Orlando, and West Palm Beach areas###

Miami-Dade_2022-2026 IP - JIPRT Draft (
Hillsborough_IP 2022-2026 DRAFT 9.

9.5 Epidemiologic Profile

Final draft in progress; will be shared upon completion

9.6 Other Supporting Documentation


Documentation of Community Engage


20220819-FCPN Meeting Notes.docx


Appendix 3 - Florida HIV Continu


Executive Summary_2019_Clier


PS19-1906 EHE Plan Executive Summary_