2017-2021

INTEGRATED HIV PREVENTION AND CARE PLAN

Orlando Service Area

The 2017-2021 Integrated HIV Prevention and Care Plan for the Orlando Service Area follows the guidance set forth by the Center for Disease Control (CDC) and the Health Resources and Services Administration (HRSA) and will accelerate reaching the goals in the **NATIONAL HIV/AIDS STRATEGY.**

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

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SECTION I

Statewide Coordinated Statement of Need/Need Assessment

SECTION I: Statewide Coordinated Statement of Need/Need Assessment

A. Epidemiological Overview

a. Geographic Region of the Jurisdiction

The Orlando Service Area consists of five counties in East Central Florida: Brevard, Lake, Orange, Osceola and Seminole. The service area includes the four counties that comprises the Orlando EMA (Lake, Orange, Osceola and Seminole) three of which overlaps with the Part B Consortium or Area 7 (Orange, Osceola and Seminole). The fifth county of the Service Area, Brevard County, completes the four counties that comprise Area 7. Lake County, an EMA County, is one of 15 counties of Area 3/13. Together the five counties represent 14.8% of the total population of Florida. Orange County is home to 42.8% of the population of the Orlando Service Area with a population density of 1,268 persons per square mile. Brevard County has 19.2% of the Orlando Service Area population; Seminole County at 15.1%; Lake County at 10.7%; and Osceola County at 10.3%. Seminole County is the most densely populated at 1,367 persons per square mile. Population density ranges from 202.4 to 535.0 persons per square mile for Osceola, Lake and Brevard counties.

Population estimates from the Florida Department of Health, Office of Health Statistics estimated the total population of the Orlando Service Area at 2,884,534 persons, with 71.0% of the population identifying as White; 18.6% Black, and 29.4% Hispanic. By age, 15.9 percent are 0-12 years; 16.6% are 13-24 years; 26.4% are 25-44 years and 41.2% of the population is 45+ years of age. The general population is younger when compared to the PLWHA population where 60.0% are at least 45 years or older.

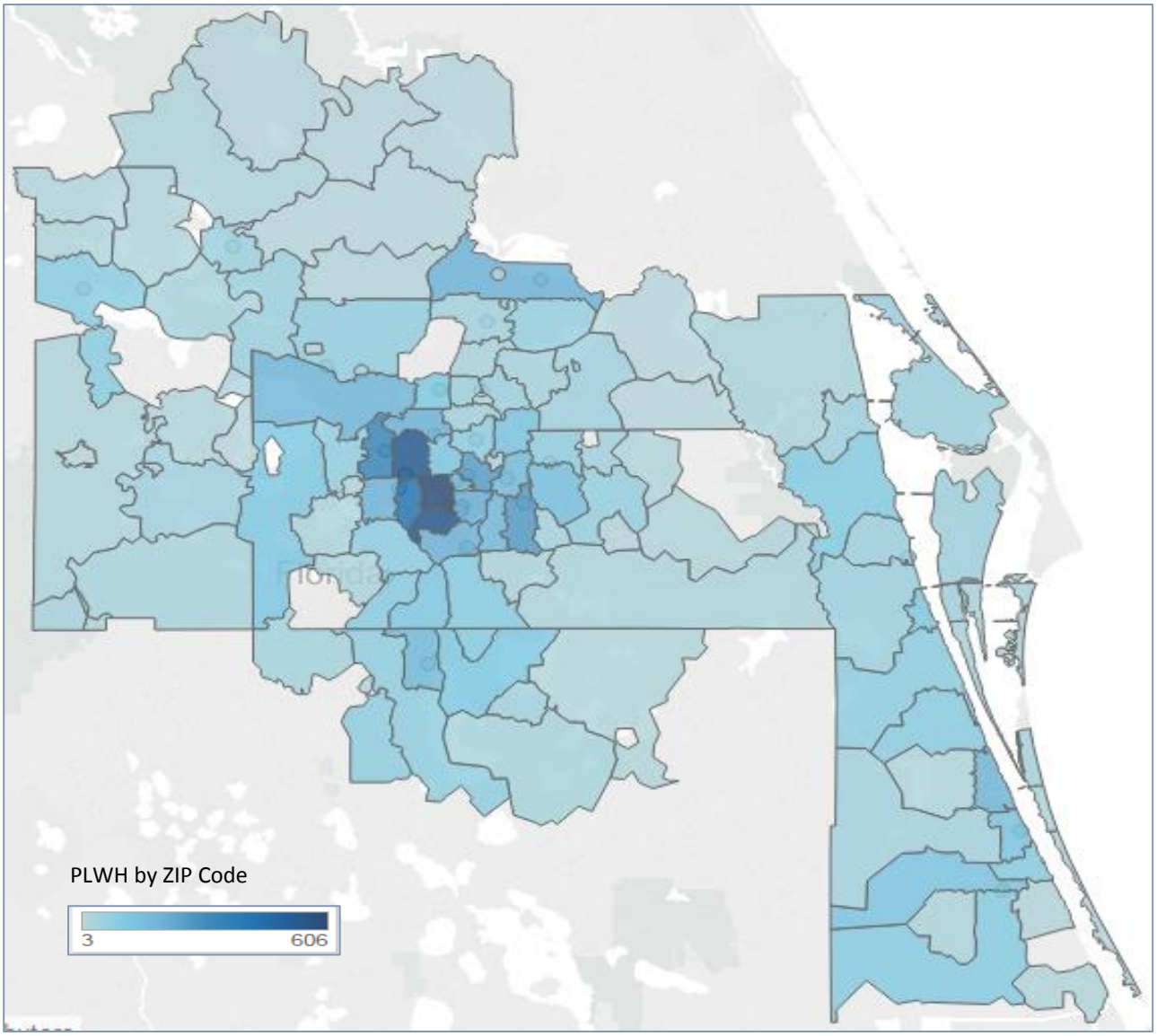
Population growth among the five counties in the Orlando Service Area was greatest in Osceola, at 11.3% from 2010 to 2014. Brevard County's population is older when compared to other counties in the service area. By gender, females represented a slightly larger percentage of the population when compared to their male counterparts, but still well within the 1:1 ratio.

Osceola County had the highest percentage of those living in poverty (2014) in the Orlando Service Area at 19.3%. Orange County, with poverty at 18.2% was higher than the poverty rates in Brevard County at 14.5%, Lake County at 13.8% and Seminole County at 11.8%.

According to the American Community Survey (2010-2014), Osceola County had the highest rate of uninsured adults at 23.3%, while Lake County adults were the lowest at 15.7%. Uninsured among adults in Brevard County, at 16.0% was lower that the percentages in Orange, at 21.6% and Seminole, at 16.6%.

The number of PLWHAs by zip code was mapped to depict the geographical areas where there were high concentrations of HIV prevalence. Each county had several zip codes where the rates of PLWHA were very high when compared to other zip codes within the Orlando Service Area. The map below highlights the number of PLWHA by zip code for the five-county area. The very dark shaded areas are located in Orlando and had the highest rates of PLWHA in the Orlando Service Area.

Figure 1: PLWH by ZIP Code for the Orlando Service Area



Source: eHARS

b. Socio-Demographic Characteristics

As of 2014, a total of 12,659 persons were living with HIV/AIDS in the Orlando Service Area. PLWHA are predominately Black males, ages 45+ years with a transmission exposure of MSM. The Black population is disproportionately represented as they account for 39% of PLWHA but only comprise 18.6% of the general population. The White and Hispanic populations are underrepresented as they account for 71.6% and 29.4% of the general population, respectively, but 35.0% and 24.0% of the PLWHA population. Among the PLWHA population, 66% are below the age of 45 years, with 16% between 13-24 years.

Figure 2: Number and Percent of HIV, AIDS, and PLWHA in the Orlando Service Area (as of 12/31/2014)

Indicator	HIV Incidence		AIDS Incidence		PLWHA	
	Number	Percent	Number	Percent	Number	Percent
Total	**845**	**100%**	**381**	**100%**	**12,659**	**100%**
White, Non-Hispanic	280	33%	107	28%	4,405	35%
Black, Non-Hispanic	279	33%	173	45%	4,925	39%
Hispanic	259	31%	90	24%	3,056	24%
Other	27	3%	11	3%	273	2%
Male	667	79%	267	70%	9,174	72%
Female	192	23%	114	30%	3,485	28%
0-12 yrs.	4	0%	0	0%	24	0%
13-24 yrs.	138	16%	33	9%	527	4%
25-44 yrs.	419	50%	185	49%	4,504	36%
45+yrs.	284	34%	163	43%	7,604	60%
MSM	537	64%	196	51%	6,781	54%
IDU	47	6%	37	10%	1,373	11%
MSM/IDU	26	3%	15	4%	464	4%
Hetero	224	27%	133	35%	3,804	30%
Other	9	1%	0	0%	215	2%

Source: eHARS

According to the CDC, individuals with sexually transmitted diseases and TB are at a higher risk of HIV infection than that of the general population who are disease-free. The table below contains the number of individuals in the Orlando Service Area who had been diagnosed with an STD in 2014.

Figure 3: Persons at Higher Risk for HIV Infection

	Syphilis	Gonorrhea	Chlamydia	TB	Hepatitis A	Hepatitis B	Hepatitis C
Total	**231**	**2,503**	**10,917**	**84**	**5**	**16**	**2,246**
White, Non-Hispanic	81	404	1,912	14	3	12	430
Black, Non-Hispanic	69	1,097	3,095	26	1	1	87
Hispanic	58	230	1,345	22	1	2	62
Other	23	772	4,565	22	0	1	1,667
Male	223	1,426	2,922	57	1	12	1,350
Female	8	1,076	7,979	27	4	4	891
0-12 yrs.	0	0	0	1	0	0	6
13-24 yrs.	56	1,369	7,064	6	1	0	150
25-59 yrs.	173	1,119	3,831	57	5	13	1,552
60+yrs.	2	15	22	20	0	3	538

Source: Florida Department of Health, Bureau of Communicable Disease, HIV/AIDS Section

The clients in the Ryan White system of care tend to have lower employment rates, live in poverty, have unstable housing, and higher than average rates of poverty. The socioeconomic data that was reported by the RSR is found in the table below. It should be noted that Insurance Status was unknown/not reported for 1,283 clients.

Figure 4: Ryan White Clients by Health Insurance Status and Poverty

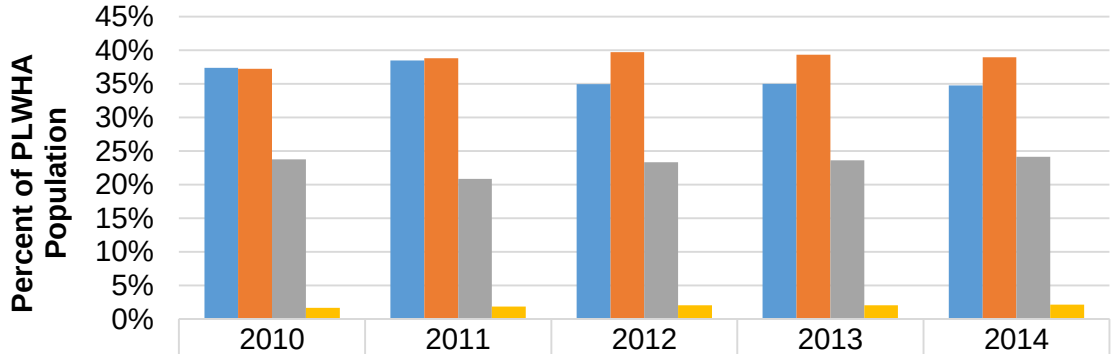
Socioeconomic Indicator	Number	Percent
Medicaid	106	5.4%
Medicare	23	1.2%
Marketplace Exchanges	181	9.3%
Uninsured	527	27.0%
138% FPL	232	12.6%
400% FPL	644	34.9%

Source: RSR Clinical Summary Report FY 2014

c. Describe the Burden of HIV

The number of PLWHA grew from 10,548 in 2010 to 12,659 in 2014, which represented an 18.5% increase of those living with HIV infection. Among population groups, Blacks represented 18.6% of the Orlando Service Area population. However, they represented 33.0% of the new HIV cases, 45.0% AIDS cases, and 38.9% of PLWHA in the Orlando Service Area. Hispanics represented 27% of the general population and comprised 29% of the new HIV cases and 26% of new AIDS cases. The most significant increases were among new AIDS and HIV cases in the Hispanic population when comparing eHARS data from 2012 to 2014. They are as follows: among Hispanic MSM new AIDS cases increased 52% and new HIV cases 106.2%; HIV cases among Hispanic male IDU increased 141.7%; HIV case among Hispanic male youth (13-24 years) increased 45%; HIV cases among Hispanic female youth increase from 1 case in 2012, to 5 cases in 2014 (400%); and new AIDS cases among Hispanic Women of Childbearing Age (WCBA) were up 85.7% while new HIV cases for this population increased 181.8%.

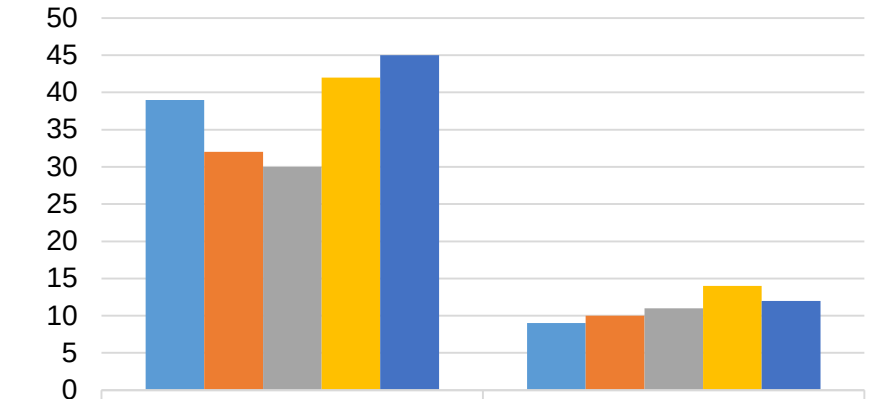
Figure 5: PLWH by Race/Ethnicity, 2010-2014



	2010	2011	2012	2013	2014
White, Non-Hispanic	37%	38%	35%	35%	35%
Black, Non-Hispanic	37%	39%	40%	39%	39%
Hispanic	24%	21%	23%	24%	24%
Other	2%	2%	2%	2%	2%

Source: eHARS

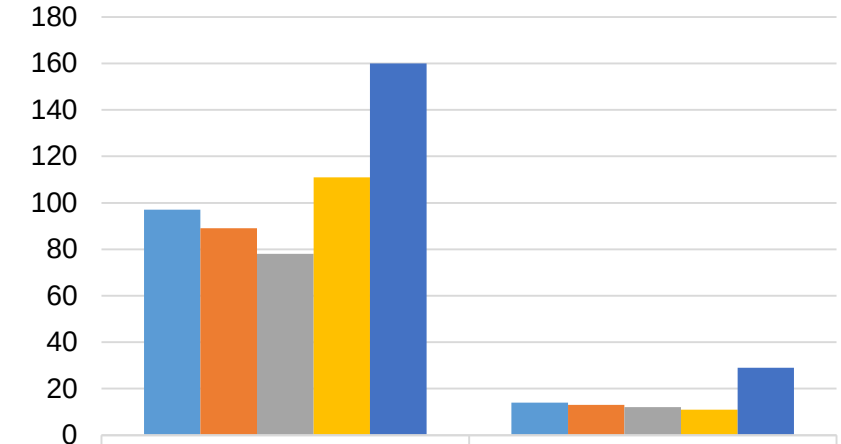
Figure 6: New AIDS Cases for Hispanic MSM and Hispanic Male IDU, 2010-2014



	MSM	IDU
2010	39	9
2011	32	10
2012	30	11
2013	42	14
2014	45	12

Source: eHARS

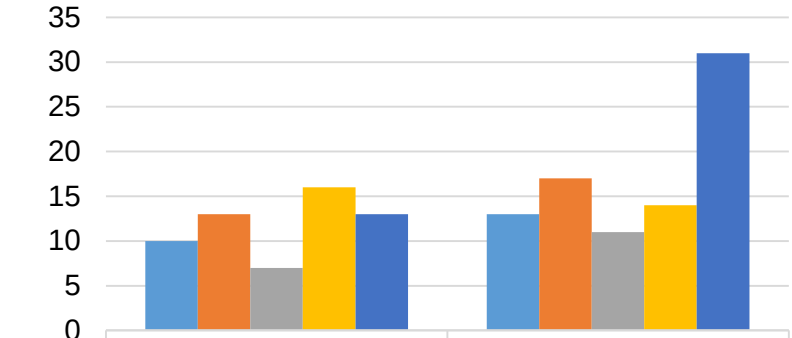
Figure 7: New HIV Cases for Hispanic MSM and Hispanic Male IDU, 2010-2014



	MSM	IDU
2010	97	14
2011	89	13
2012	78	12
2013	111	11
2014	160	29

Source: eHARS

Figure 8: Hispanic WCBA New AIDS and HIV Cases, 2010-2014



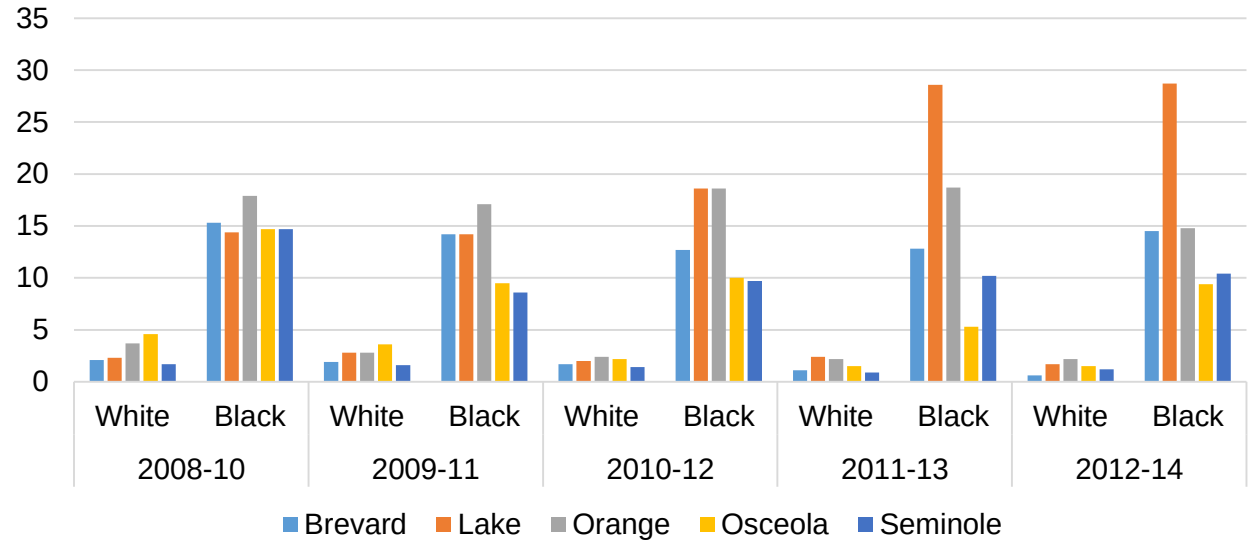
	New AIDS Cases	New HIV Cases
2010	10	13
2011	13	17
2012	7	11
2013	16	14
2014	13	31

Source: eHARS

There were ten communities within the Service Area that experienced a disproportionate share of infection in 2014. They are as follows: Melbourne and Palm Bay in Brevard County; Leesburg, Mt. Dora, and Clermont in Lake County; Parramore, Pine Hills, and Holden/Oakridge in Orange County; Kissimmee in Osceola County; and Altamonte Springs and Sanford in Seminole County. A county health department provider of Outpatient Ambulatory Health Services (OAHS) is located within each county in the zip code with the highest HIV/AIDS population, with the exception of Osceola County where the health department is located in a contiguous zip code and Brevard County where the health department is located in a zip code with the second highest PLWHA population. Providers of other health services are all located in Orange County zip codes with a disproportionate share of PLWHA.

An analysis of death rates from HIV/AIDS revealed the rates among those in the Black population was at least three times the rates among Whites. In 2012-14, deaths rates among Whites ranged from 0.6/100,000 in Brevard County to 2.2/100,000 in Orange County. Among the Black population, rates ranged from 9.4/100,000 in Osceola County to 28.7/100,000 in Lake County. HIV/AIDS deaths rates by county among Hispanics were very similar to those of Non-Hispanics with the exception of Orange County where Hispanic deaths were twice the rate of Non-Hispanics.

Figure 9: Deaths from HIV/AIDS by Race by County, 2008-10 to 2012-14 (rate per 100,000 population)



Source: Florida CHARTS, Office of Vital Statistics

d. Indicators of Risk for HIV Infection

The Youth Risk Behavioral Surveillance System (YRBSS) is administered to Orange County, Florida high school students. Although Orange County is the only county in the Orlando Service Area to participate in the survey, the data is relevant as Orange County bears the larger burden of disease when compared to the other four counties.

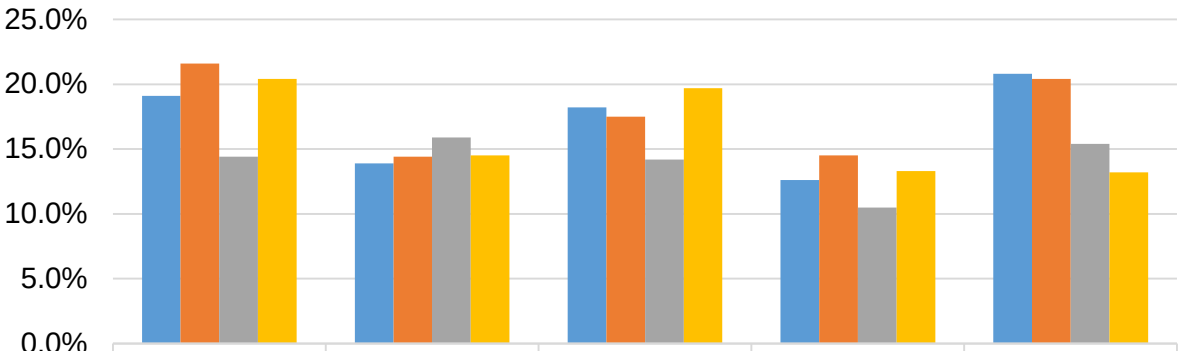
Figure 10: YRBSS 2013 Orange County, Florida Students

YRBSS Question	Percent	Sample
Ever taken any illegal drug	2.0%	1,625
Had sexual intercourse before age 13 years	6.2%	1,509
Had sexual intercourse with 4 or more persons (Lifetime)	9.4%	1,501
Did not use a condom before last sexual intercourse	37.4%	334
Did not use both a condom and birth control before last sexual	97.6%	329
Drank alcohol or used drugs before last sexual intercourse	21.8%	340
Were never taught in school about HIV/AIDS infection	16.0%	1,597

Source: YRBSS 2013 Orange County, Florida

The 2013 Behavioral Risk Factor Surveillance System (BRFSS) did not contain any questions related to the risk for HIV/AIDS infection, testing, sexual orientation or gender identity. Information was available for adults who engaged in binge drinking, which is defined as consuming 5 alcoholic drinks for men or four alcoholic drinks for women in one session. According to the Center for Disease Control and Prevention (CDC), binge drinking is associated with sexual disease transmission.

Figure 11: Adults who engaged in binge drinking, 2007-2013



	Brevard	Lake	Orange	Osceola	Seminole
2002	19.1%	13.9%	18.2%	12.6%	20.8%
2007	21.6%	14.4%	17.5%	14.5%	20.4%
2010	14.4%	15.9%	14.2%	10.5%	15.4%
2013	20.4%	14.5%	19.7%	13.3%	13.2%

Source: BRFSS 2013

The estimated number of people who are HIV positive and are unaware of their status is based on a methodology created by the Centers for Disease Control and Prevention (CDC). According to the CDC, 15.8% of people who are living with HIV/AIDS do not know their status nationally. In Florida, the percentage is between 10 and 12% due to the number of tests conducted in the state.

Based on this estimate, the following is a calculation of people living in the service area who are HIV+ and unaware of their status:

- National Proportion Undiagnosed HIV (21%) = p
- Number of individuals diagnosed with HIV and living per FDOH =11,186
- Local Undiagnosed = p/1-p multiplied by the number of diagnosed living (11,186 in the Orlando Service Area) = the number of people living in the Orlando unaware of their HIV positive status.

According to this calculation, 2,973 people are living in the Orlando Service Area unaware of their HIV+ status.

Figure 12: Newly Diagnosed Positive at HIV Testing Events

Population	Total HIV Tests	Reactive	Confirmed New Positive	Linked to Care	Referred Partner Services	Rec'd Partner Services	Referred Prevention Services	Rec'd CD4 & VL tests
Black/AA, Females 15-44 Yrs.	1,585	8	8	7	8	6	2	7
White MSM	1,155	25	25	17	24	20	14	17
Black/AA, MSM	429	35	35	21	33	31	14	21
Total	**3,169**	**68**	**68**	**45**	**65**	**57**	**30**	**45**

Source: Florida Department of Health

Figure 13: Previously Diagnosed Positive at HIV Testing Event

Population	Total HIV Tests	Reactive	Confirmed Positive	Linked to Care	Referred Partner Services	Rec'd Partner Services	Referred Prevention Services	Rec'd CD4 & VL tests
Black/AA, Females 15-44 Yrs.	1,585	10	10	7	10	10	5	7
White MSM	1,155	7	6	3	7	6	2	3
Black/AA, MSM	429	4	4	3	4	4	1	3
Total	**3,169**	**21**	**20**	**13**	**21**	**20**	**8**	**13**

Source: Florida Department of Health

The Recipients continue to support testing activities at health fairs, awareness days, festivals, etc. The majority of Part A and B providers offer rapid testing. Their efforts help provide a seamless transition from Prevention to Patient Care activities (Referring and Linking to care) in the event of an individual testing HIV positive. Regularly scheduled EIIHA strategy meetings are convened to identify possible strategies and collaborative partnerships to enhance service delivery.

The target populations for the Early Identification of Individuals with HIV/AIDS (EIIHA) Plan are based on epidemiological data made available from the Florida Department of Health (FDOH). Data made available from FDOH was used to trend mode of exposure, age, gender, race, ethnicity, and county of residence, with some of it cross tabulated to identify target populations. Based on the available data, the following target populations have been identified for the FY16 EIIHA Plan: (1) White MSM, (2) Black Heterosexual both male and female and (3) Black MSM. These groups were selected based on several sources of information available. The first data source was recent epidemiological data, which showed these groups as having higher rates of infection compared to other groups, as well as being more likely to be out of care compared to other groups. Other data sources which were used in identifying these target groups originated from reports developed by the FDOH regarding certain populations, among them the African American community ("Silence is Death"), men ("Man Up: The Crisis of HIV/AIDS Among Florida's Men"), and women ("Organizing to Survive: The HIV/AIDS Crisis Among Florida's Women"). They were also selected in part due to historical data, trending out prevalence and incidence rates over the last five years.

The Orlando Service Area continues to respond to the epidemic by supporting initiatives such as:

1) The Test Orlando Campaign which aims to:
- Promote Routine HIV Testing
- Improve Orange, Osceola, Seminole and Brevard Counties resident's understanding of HIV
- Reduce the transmission of HIV by knowing your status – Getting to Zero

2) The Black Treatment Advocates Network (BTAN) – Melbourne Chapter which aims to:
- Link individuals with HIV into care and treatment
- Strengthen local leadership
- Connect influential peers
- Raise HIV science and treatment literacy in the community

- Advocate for policy change and research priorities

In September 2006, CDC released *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings*. These revised recommendations advise routine HIV screening of adults, adolescents, and pregnant women in health care settings in the United States.

Many infected persons decrease behaviors that transmit infection to sex or needle-sharing partners once they are aware of their positive HIV status. HIV-infected persons who are unaware of their infection do not reduce risk behaviors. Because medical treatment that lowers HIV viral load might also reduce risk for transmission to others, early referral to medical care could prevent HIV transmission in communities while reducing a person's risk for HIV-related illness and death.

In addition to the target populations selected for the EIIHA plan, all proposed activities are intended to reach all newly infected individuals, as well as those who are high risk negatives.

Activities to be implemented begin in collaboration with the counseling and testing sites to support targeted testing activities. It is critical to expand activities and look for novel ways to identify and test them. In addition, both the Part A and B Recipients will be funding linkage coordinators through Early Intervention Service (EIS) funds beginning in FY 2016 in order to assist newly diagnosed people to get linked into primary medical care, to reach heterosexual men and women, encourage testing and promote safe behavior, initiatives must focus less on prevalence and zip code data, to locations where socialization occurs. To reach White MSM, similar efforts must be made. To reach Hispanic MSM, expanded testing efforts, the increase of rapid testing sites in addition to targeted testing would reduce environmental barriers in high prevalence zip code areas.

The Orlando Service Area continues to partner with Prevention. Last year 41,378 tests were conducted in the Orlando Service Area. The state of Florida, the Part B Recipient, consistently tests more individuals than any other state. They have been EIIHA partners from the inception of the initiative, and continue to work with Part A to develop a seamless system from testing to whatever service is most appropriate for the individual. Several counseling and testing agencies within the Orlando EMA are now active partners in the EIIHA efforts: (1) Miracle of Love, (2) Hope and Help Center of Central Florida, Inc., (3) Healthcare Center for the Homeless, and (4) The Gay, Lesbian, Bisexual, Transgender Center. Each of these agencies provides linkage between prevention programs and patient care programs. While the Brevard County providers do not currently participate in EIIHA, DOH-Brevard, Comprehensive Healthcare and Project Response offers HIV testing and provides linkage between prevention and care. Many of the Orlando Service Area providers receive funding from other sources to offer testing, providing a natural connection between counseling, testing, referral, and linkage. An overwhelming majority of the testing and counseling providers hire diverse staff, which helps reach more diverse populations. The Recipients (Parts A and B) will begin funding linkage coordinators through EIS funds in FY 2016 in order to assist newly diagnosed people with getting linked into primary medical care.

Governor Rick Scott of Florida signed legislation into law effective July 1, 2015 that makes HIV testing an opt-out component of routine testing, thereby removing a tremendous legal barrier.

Multiple agency representatives have collaborated since the inception of the EIIHA Plan. Chief among them have been individuals from Part A, Part B, Part C, Part D, Prevention, Counseling and Testing staff, and members of the planning bodies. All have been instrumental in implementing the

EIIHA Plan, primarily the counseling and testing sites, Part A, Part B, and Prevention. FDOH staff has assisted in developing reports to share with the Orlando Service Area to identify the number of individuals linked to care.

The primary outcome of the EIIHA plan has been to create a seamless system of access to and retention in-care among the different Ryan White entities in the Orlando Service Area with the ideal goal of viral suppression for all PLWHA. Collaboration among the Parts, as well as Prevention has been a main driving force behind the EIIHA Plan. A major objective in the Plan has been to work among the different Ryan White Parts and Prevention to develop a data collection strategy to determine the rates at which newly diagnosed individuals are referred and linked into care and support efforts to determine the rates at which high risk negatives are referred to services that keep them from becoming infected. Thanks to collaborative efforts with Prevention and FDOH, reports are available that provide counseling, testing, referral, and linkage information.

One of the outcomes of the EIIHA Plan is to continue to have all of the Parts and Prevention to meet regularly together to discuss collaboration and data collection efforts across the board. A second outcome is to fund linkage coordinators throughout the Orlando Service Area, thereby increasing the overall number of people linked into medical care. These linkage coordinators will be located at each of the five health departments throughout the Orlando Service Area. A third outcome is to communicate EIIHA activities to the Planning bodies and CFAP to keep them informed, whether it is data being collected or on the activities of the linkage coordinators. This ensures the Planning bodies can make decisions based on data. In addition to the funding of Linkage Coordinators, another outcome in the EIIHA Plan will be continuing to partner with the Part B funded Anti-Retroviral Treatment and Access to Services (ARTAS) program to receive EIIHA-related referrals for newly identified positives as well as those positives who have fallen out of care. Finally, the fifth outcome will be the continued support of counseling and testing site activities throughout the Orlando Service Area.

The number of homeless among PLWHA has decreased 14.8% over the past two years. Data from eHARS indicated that 75 homeless PLWHA were living in the Central Florida service area in 2014. Of these 58.7% were Black, 21.3% White and 16.0% Hispanic. The rate of homelessness among those living with HIV/AIDS, at 670.5/100,000 is more than six times that of the general population at 104.6/100,000 as reported by the *Council on Homelessness 2015 Report* prepared by the Department of Children and Families. Providers within the service area are challenged by the complexities of retaining homeless PLWHA in care. One of the reasons that it has been such a daunting task is the lack of housing units as well as not capturing all of the data regarding this sub-populations' need. With the new PROVIDE ENTERPRISE software system, as well as the high priority that is being given to this sub-population, the system will be more capable of meeting their needs.

According to the Department of Corrections, 2,707 offenders returned to the Orlando EMA in 2014. Of these, 73 (2.7%) were HIV positive. This was an increase from HIV positive offenders released in 2013 (2.2%) but still less than 3.0% in 2012. The number of HIV positive inmates released from area jails has yet to be estimated. In Brevard County, there are approximately 58 clients in treatment who had been previously incarcerated. Some of these clients were in the Part B system of care before incarceration while others were new to the system. The 2013 Ryan White Consumer Survey data showed that 80 respondents reported living in jail and/or prison in the past 12 months. Providers in each county have developed processes to link individuals to care prior to their release.

Whenever possible, jail staffers try to alert the provider representative when an inmate identified as one needing care is about to be released. In addition, funded programs in all four counties of the EMA send staff to the jails to provide assistance with linking released PLWHA to care. In Area 7, when a prisoner with HIV is released, personnel at the prison will contact the Area 7 (Part B) Linkage staff member to schedule the client's appointment prior to their release. The Linkage staff member maintains contact with the prisoner upon release and provides follow-up to ensure that appointments are kept. When appointments are not kept, the staff member determines the barrier(s) that prevented the missed appointment and works with the client to remove/reduce the barrier in order to facilitate linkage.

Mental health problems usually predate substance use activity which can interfere with HIV/AIDS treatment adherence. In the Orlando Service Area, the rate of PLWHA with chronic mental illness is 1,868.4/100,000 (16.7%) which is significantly higher when compared to the general population at 4.1 percent.

Substance abuse (including binge drinking and illicit drug use) is also more prevalent among PLWHA than the general population. Data from eHARS indicate the rate of substance abuse among the PLWHA population at 13,239.83/100,000 is more than 1.5 times the rate in the general population at 8,200/100,000. Active substance abusers are more likely to engage in risky behaviors that can have a negative effect on overall health. The interaction of illegal substances and HIV medications can diminish an individual's ability to adhere to proper HIV treatment. IDU is the second most common exposure category for both male and female PLWHA in the Orlando Service Area. eHARS data indicate that in the Service Area, the rate of IDU for PLWHA is 14,357.2/100,000. According to the 2013 National Survey on Drug Use and Health (NSDUH) report, the IDU rate for the general population is 2,600/100,000.

To reach high risk women of child-bearing age (WCBA), the Targeted Outreach for Pregnant Women Act (TOPWA) was implemented in Orange County (the county bearing the burden of the epidemic). The mission of TOPWA is to reach high-risk women or HIV-infected pregnant women not receiving services. Since 1999, TOPWA has maintained the goal of assisting under-served women in accessing prenatal care and other services that lower their risk for HIV infection or substance abuse.

Women encountered by a TOPWA outreach worker can receive:

- HIV testing
- Pregnancy testing
- Referrals for substance abuse testing and treatment
- HIV prevention education and condoms

Pregnant women enrolled in TOPWA can receive:

- Assistance getting Medicaid coverage
- Assistance getting prenatal care
- HIV testing
- Referrals for substance abuse testing and treatment
- HIV prevention education and condoms
- Referrals for family planning services

- Referrals for other services in the community,

Many women are encountered by TOPWA through street outreach in housing projects, laundromats, bars, or public places. TOPWA has served thousands of women over the past 10 years, and many pregnant women are brought to TOPWA by previous clients, who are their sisters, neighbors, or friends. TOPWA works closely with high-risk obstetrical clinics to locate and assist women who miss scheduled prenatal appointments. Pregnant women living with HIV receive added support, encouraging them to keep taking medications to prevent transmission of the virus to their baby. Due to medical advances, if a woman follows all medically directed protocols; the baby will be free of HIV over 98% of the time. The number of babies born healthy as a result of TOPWA will never be known, but we know the number of babies born with HIV has dropped dramatically. We look forward to the next 10 years as we continue to reach out to women who may fall through the cracks of our system of care.

Provider Survey: The Ryan White Part A Provider Survey was commissioned as part of the Needs Assessment for the 2015 Data Presentation for the Orlando Eligible Metropolitan Area HIV Health Services Planning bodies (the Planning bodies). The Ryan White Part A 2015 Needs Assessment Provider Survey was administered to Ryan White Part A providers.

This survey results provided data regarding where services were being provided, how client and provider needs are being met and what services are of core importance. The data were gathered in an effort to gain a better understanding of the capacity and delivery of services provided by all participating agencies.

The 2015 Provider Survey was administered to 12 Ryan White Part A providers as a link to an online version of the survey sent via email in May 2015. The survey was also provided as an attachment in the email to allow providers the option of completing a hard copy instead of the online version. Eleven (11) surveys were completed and returned, resulting in a 92 percent response rate. Clarification was obtained via telephone or email as needed.

Similar to the 2014 survey, non-medical case management remained the most frequently reported service provided, approximately two-thirds of respondents provide HIV/AIDS care-related services as a component of a larger services program, one-third are solely HIV/AIDS care-related service providers, and most providers have offered services for 15 years or more. According to 2015 responses, service categories with the most employees and volunteers were medical professionals (13 full-time and 11 part-time) and mental health/substance abuse counselors (15 full-time, 1 part-time and 3 volunteers). The service categories with the greatest reported capacity were non-medical case management, OAHS, and HIV education.

As in the previous survey, over 80 percent of providers offer HIV counseling and testing; most providers that conducted HIV testing utilized rapid testing, followed closely by OraSure; all providers offer walk-in or same-day appointments and over half provide 24-hour coverage.

All 2015 respondents reported that they hire multi-lingual staff, compared to 92% in 2014. The percentage of providers that translate patient materials increased from 33% in 2014 to 54.5% in 2015 and the percentage of agencies that ensure translators or interpreters are available decreased from 75% in 2014 to 63.6 percent in 2015. As in the previous survey, most providers reported that they did not have problems meeting any language needs of their clients. The only languages

presenting challenges to providers were Creole (27.3%) and sign language (9.1%); Creole was also noted in the previous year's survey. Hiring staff of different cultures and basic diversity/cultural competency training continue to be the most frequently reported methods of addressing cultural diversity in both the 2014 and 2015 surveys. The percentage of providers who hire peer educators/counselors of different cultures decreased from 33% in 2014 to 18.2% in 2015. Programs targeting specific populations include Extended Testing Initiative ETI's (Targeted MSM as well as African-American men and women), Willow (HIV+ women), Mpowerment Prevention Program (MSM and transgender, ages 14-29 years), ARTAS Project testing and education (incarcerated individuals), substance abuse and mental health (homeless, injection drugs users and individuals in recovery), and programs for MSM population.

While Part B did not conduct a formal Provider survey, the Part B providers within the Tri-County area of Orange, Osceola and Seminole Counties, who were also Part A providers were respondents of the Part A Survey, thus the above responses also reflects the Part B provider system.

Similar to the 2014 Provider Survey, the most frequently cited funding sources in 2015 were Part A, Part B in Brevard County, Medicaid, and state funding.

When asked about barriers to service provision, the most frequently reported challenges were similarly distributed in the 2014 and 2015 surveys. Consumer distrust/suspicion as a barrier increased from 42% (2014) to 64% (2015). The most frequently requested capacity building trainings were motivational training for staff/clients (45%) and HIV/AIDS general training (45%). In 2014, the most frequent responses were staff and volunteer recruitment training, which decreased from 50% in 2014 to 36% in 2015 and program evaluation, which decreased from 42% in 2014 to 36% in 2015.

Additionally, anecdotal information from the Brevard County providers indicates that they are experiencing similar challenges as the Part A providers. Brevard providers however are experiencing challenges in meeting the needs of their creole-speaking clients and due to the length of the county, transportation also present a challenge for clients as the public transportation system in Brevard is inadequate.

Out-of-Care Survey: The survey instrument used for this assessment was designed by members of the Ryan White Planning bodies. The survey was translated from English into Spanish and Creole in an effort to capture specific at-risk population groups. Surveys were distributed on May 1, 2015 to all Ryan White providers in the Part A Service Area. On July 27, 2015, the survey was available to be administered in the Orange County Jail.

The survey process was expanded in October 2015, which included training fifteen individuals representing several Ryan White agencies, to administer the survey at locations outside of the provider network. Surveys were also sent to the Health Care Center for the Homeless in Orange County.

A total of 172 completed surveys were collected from May 1, 2015 to December 7, 2015. Only 17 respondents met the out-of-care definition of not having had medical care for the past 12 months. Although individuals received training to administer the survey, no completed surveys were collected.

The most important services for the out-of-care population were access to care, medications, housing and mental health services. This aligns with the results of the most recent consumer survey

conducted in 2013. HIV stigma is still a very big barrier for those currently diagnosed and not in care. Efforts should be made to incorporate inquiries via the primary or chronic disease care assessment processes to help bring people into care or return clients who have dropped out of the health care system.

Focus Group: On January 19, 2016, the Health Council of East Central Florida conducted a focus group to identify potential strategies to increase access to and retention in HIV care. The group focused on three questions during the discussion period. They were as follows:

- How can the Orlando Service Area increase the number of individuals seeking and actually being tested for HIV?
- For those individuals who learn that they test positive for HIV, how can the Orlando Service Area improve the ability to link them to care?
- What would improve the likelihood that once diagnosed as HIV positive, an individual linked to care will follow-through and continue to receive that care?

In an effort to increase the number of individuals seeking and actually being tested, the group defined ten possible strategies. These ranged from engaging the faith-based community to reducing the length of surveys. It was felt that increasing access to testing at locations frequented by gay populations, engaging peers, and offering an incentive would help to accomplish this goal. Stigma still remains a big issue as well as misconceptions regarding risk and treatment protocols. Addressing these through marketing and education were suggestions made by the group.

Once individuals learn their status and need to seek care, the linkages within the system may not be fully integrated. To improve these linkages, the group focused on education. It is important that the messages are clear, consistent, and available to everyone, from RW providers to private physicians, and locations where social services are accessed. It was felt that peers can play an important role by engaging the client before the daunting task of completing the required paperwork.

Retention in care has always been challenging due to a myriad of factors. The focus group members felt that the client should be empowered by making them part of the process, teaching them to be their own advocate, and encouraging them to get involved in community organizations where policy change can happen to benefit those diagnosed with HIV disease. The group suggested using current technology to streamline the processing time for clients. Using IT technology would also be helpful with the younger population who rely on social media for most of their information. Education was also cited as an integral component for conveying knowledge that will help the client understand the importance aspects of the disease and treatment adherence. The group suggested bringing all services under one roof in a 'one-stop shop' model would be effective for those accessing multiple services and could help alleviate some of the transportation issues within the community.

B. HIV Care Continuum

a. Descriptive Narrative of HIV Care Continuum

The HIV Care Continuum is a model that is used by federal, state, and local agencies to identify issues and opportunities related to improving the delivery of services to PLWH across the entire HIV Continuum of Care. The HIV Care Continuum has five main "steps" or stages including: HIV

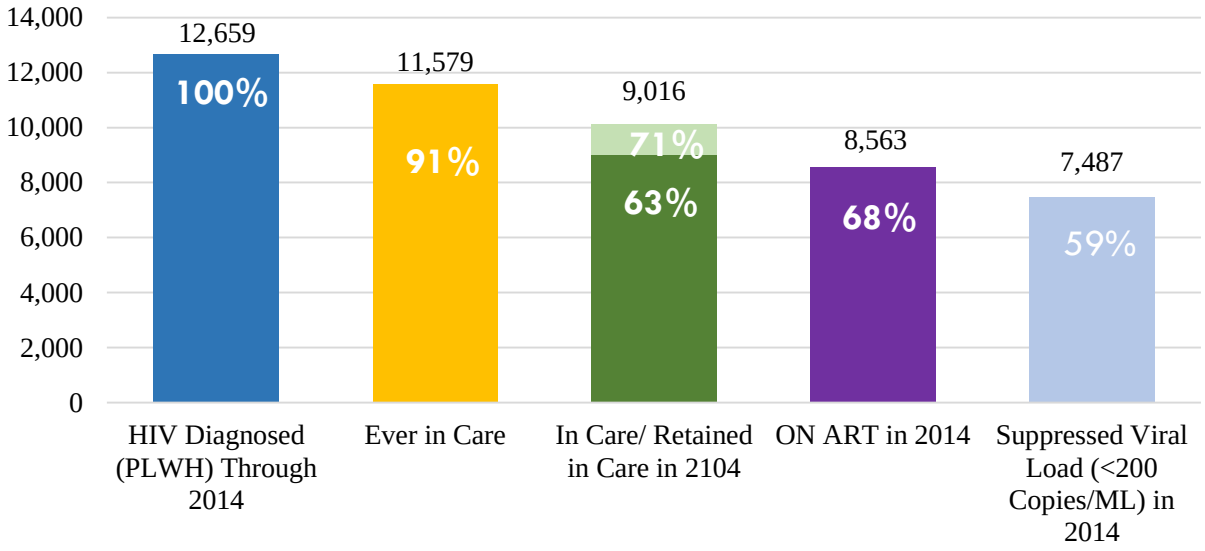
diagnosis, linkage to care, retention in care, antiretroviral use, and viral suppression. The State of Florida has developed a diagnosis-based model to identify issues and opportunities related to improving the delivery of services to high-risk, uninfected individuals. Since the Orlando Service Area's HIV Continuum of Care chart is developed by the Florida Department of Health, it uses a diagnosis-based model.

The diagnosis-based model of the HIV Care Continuum allows the service area to display each step of the continuum as a percentage of the number of PLWH who were only diagnosed. The diagnoses-based continuum directs steps that can be taken to get individuals with HIV into care and virally suppressed (<200 copies/ml).

The HIV Care Continuum depicted below illustrates the HIV epidemic for the Orlando Service Area.

Please note that in order to be considered "Retained in Care," an individual must have gone to two medical visits at least three months apart during 2014.

Figure 14: 2014 HIV Care Continuum of the Orlando Service Area



- 82% of those diagnosed with HIV in 2014 had documented HIV-related care within 3 months of diagnosis
- 83% of PLWHA in care had a suppressed viral load in 2014

An individual does not need to be "Retained in Care" in order to be prescribed ART, thereby showing a higher number of people prescribed ART than those considered to be "Retained in Care." Definitions for numerators and denominators are as follows:

I. HIV Diagnosed: Number of reported cases of HIV Infection regardless of AIDS

II. Ever in Care: PLWHA with at least 1 documented viral load (VL) or CD4 lab, medical visit or prescription since HIV diagnosis.

Linkage to Care: Numerator is the number of clients who have received at least one medical visit during 2014; Denominator is the total number of reported HIV cases

III. Retained in Care: Numerator is the number of clients who have received two or more visits three months apart during 2014; Denominator is total number of reported HIV cases

IV. Antiretroviral Use: Numerator is the number of clients with access to prescribed HIV medications according the PHS treatment guidelines; Denominator is the total number of reported HIV cases for 2014.

V. Viral Load Suppression: Numerator is clients with viral load <200; Denominator is total reported HIV cases for 2014.

The data used by the State to develop the diagnosis-based HIV Care Continuum stems from the merging of the following databases:

- HIV/AIDS Reporting System (eHARS) database
- Florida's CAREWare database
- Miami's SDIS database (Miami's CAREWare)
- ADAP database

The analysis of data from the latter databases depends on:

- the completeness of laboratory reporting in eHARS,
- the maintenance of timely death reporting, and
- the accurate maintenance of current PLWH addresses, accommodating for in and out migration

All of the bars in the HIV Care Continuum reflect actual data, analyzed from the matched databases with the exception of the ART bar. The data for ART was estimated based on Florida's Medical Monitoring Project (MMP) data.

As previously mentioned, the merging of the latter databases facilitated the data necessary to develop a diagnosis-based HIV Care Continuum in alignment with any data policies protecting the identity of PLWH living in the service area of Florida. At the present time, since there are no formal policies and procedures serving as barriers for developing the HIV Continuum of Care model, the significant limitation results in assuming that persons not in care (based on the listed data matches above) are truly not in care. The upcoming challenges will be to develop policies and procedures, with available staff at the state health office and in the Orlando Service Area,

- to evaluate those cases not in care,
- specify who will be responsible for trying to locate those persons not in care and
- ascertain how staff will carry out this process.

Legal agreements may need to be drawn up if non-DOH staff needs to be contracted to perform some of these duties.

Additionally, continued efforts will be made to further improve the completeness of state and local data elements. Moreover, facilitating data agreements with local IT departments will allow for greater development of the HIV Care Continuum.

b. Description of Disparities in Engagement

The Orlando EMA's sub-recipients utilize Minority AIDS Initiative (MAI) funding to enhance the quality of care and health outcomes in minority communities disproportionately impacted by HIV/AIDS in the Orlando Service Area. Brevard County does not have MAI funds. MAI funds support OAHS and specialty care, as well as associated laboratory services, and will begin funding four linkage coordinators through MAI dollars beginning in FY 2016. The Orlando Service Area continues to experience a disproportionate amount of African American and Hispanic populations living with HIV. The Orlando Service Area identified Blacks, Hispanics, and those with more than one race as the target populations. Blacks represented 18.6% of the population; however, they represented 33% of the new HIV cases and 45% AIDS cases in the Orlando Service Area. Hispanics represented 27% of the general population and comprised 31% of the new HIV cases and 24% of new AIDS cases. The most significant increases were among new AIDS and HIV cases in the Hispanic population when comparing eHARS data from 2012 to 2014. They are as follows: among Hispanic MSM new AIDS cases increased 52% and new HIV cases 106.2%; HIV cases among Hispanic male IDU increased 141.7%; HIV case among Hispanic male youth (13-24 years) increased 45%; HIV cases among Hispanic female youth increased from 1 case in 2012, to 5 cases in 2014 (400%); and new AIDS cases among Hispanic WCBA were up 85.7% while new HIV cases for this population increased 181.8%. Therefore, it is critical that MAI support these and other vulnerable populations.

Trended data support the need to continue the allocation of MAI funds in the Orlando Service Area for critical core medical services, especially to African Americans and Hispanic/Latino Americans.

The plan to address disparities focused on developing and implementing individualized treatment plans that include strategies for medication and treatment adherence for disproportionately impacted/underserved communities. The goal of this plan is to reduce the disparity in access to care for HIV+ minority consumers in the rural counties of the Orlando Service Area, by increasing access to culturally appropriate medical services. Primary care services also include the provision of specialty care services through Memoranda of Understanding (MOU) with specialty care providers.

In addition, medical case managers from eleven (11) diverse racial and ethnic cultures are located at all clinics that provide OAHS through Part A and Part A MAI funds. When consumers representing minority groups access medical care at these clinics, they have access to medical case management and are linked to all other available Part A services. The activities described in this MAI plan provide increased access to the HIV continuum of care for minority communities.

c. HIV Care Continuum Planning

The measures utilized in the HIV Care Continuum table underscore the most vital components in HIV care. OAHS, Pharmaceutical services, the Insurance Services Program, as well as Medical Case Management, are four service categories directly impacted by the measures included within the Care Continuum table. The Planning bodies consistently prioritizes these categories for funding, understanding the importance of ensuring individuals are obtaining access to and receiving critical medical care and medications, oftentimes coordinated through the medical case managers operating within the Orlando Service Area. In addition, several performance measures tied in to these service categories are tracked within the Clinical Quality Management program among Part A/Part B funded providers and reported back to them to identify possible service improvement activities. These HIV HAB measures have been measured and benchmarks are in development to strengthen PLWHA care. Several providers within the Orlando Service Area also receive Part B and/or

General Revenue funds, thereby eliminating possible gaps in patient care. In addition, several of the Part A funded case management providers are also counseling and testing sites, allowing for a smooth transition between prevention and patient care in the event an individual tests positive.

The Orlando Service Area has engaged in several activities to ensure PLWHA are linked into care in addition to retaining them in care. Beginning in FY 2016, the Orlando Service Area and CFAP will begin funding Early Intervention Services in the form of linkage coordinators to help link newly diagnosed individuals into medical care. The intent is to decrease the number of people not receiving medical care, which will in turn increase the number of people prescribed ART and hopefully add to the number of people with a suppressed viral load. The Part A and Part B Recipients will begin revising its quality management plan in early 2016 in order to reconfigure the data that is currently collected to identify and address possible gaps in care with providers, particularly retained in medical care, prescription of ART, and viral load suppression. Thirdly, the Orlando Service Area continues to engage representatives from Prevention, Part B, Part C, and Part D to identify strategies to remove barriers to care and ensure a seamless system for all individuals regardless of their status.

C. Financial and Human Resources Inventory

a. Funding Sources

Funding Source	Anticipated 2016 Budget	Core Medical-related Services	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Ins. Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Supportive Services	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered Meals	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Ref. for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence Counseling	HIV Testing
	Dollar Amount																																
Part A	$10,183,023*		x		x	x		x				x	x	x	x		x		x	x		x			x		x						
Part B	$1,714,310												x				x																
ADAP	$103,443,567**			x																													
Part C	$1,456,803		x		x	x						x	x	x			x				x						x	x				x	
Part D	$868,073		x									x		x			x				x				x		x	x				x	
Part F	$1,199,325		x				x																			x							
CDC	-																																
P4C	$546,143		x									x		x																			
SAMHSA	$3,832,025														x																x		
HOPWA	$3,481,165																					x											
STATE	$4,805,650		x		x									x																			x
Medicaid Waiver (PAC)	$1,162,454													x																			

* Includes Program Income; **Indicates funding for all 67 counties.

SECTION I: Statewide Coordinated Statement of Need/Need Assessment

NOTE: Data based on CAREWare and Health Management Services via the Florida Department of Health.

Stages of the HIV Care Continuum	Goal	Outcome		Service Category (One or more may apply)
I. Diagnosed	Maintain the percentage of people who know their HIV+ status.	HIV Positivity* Late HIV Diagnosis*		Counseling and Testing (Part B and General Revenue) not funded by Part A Early Intervention Services
		Baseline: Numerator/Dominator, % 11,186/11,186, 100%	Target: Numerator/Dominator, % 11,745/11,745, 100%	
II. Linked to Care	Increase the percentage of people who go to at least one medical visit.	Linkage to HIV Medical Care*		Outpatient Medical Care Medical Case Management Medical Transportation
		Baseline: Numerator/Dominator, % 7,841/11,186, 70%	Target: Numerator/Dominator, % 8,809/11,745, 75%	
III. Retained in Care	Increase the percentage of people who receive medical care twice a year at least three months apart.	Retention in HIV Medical Care* HIV Medical Visit Frequency**		Outpatient Medical Care Medical Case Management Medical Transportation Treatment Adherence Health Insurance Premium
		Baseline: Numerator/Dominator, % 6,852/11,186, 61%	Target: Numerator/Dominator, % 7,634/11,745, 65%	
IV. Prescribed ART	Increase the percentage of clients with access to prescribed HIV/AIDS medications consistent with PHS Treatment Guidelines.	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care* Prescription of HIV Antiretroviral Therapy **		Outpatient Medical Care Medical Case Management Medical Transportation Local Pharm. Assistance Program
		Baseline: Numerator/Dominator, % 7,449/11,186, 67%	Target: Numerator/Dominator, % 8,456/11,745, 72%	
V. Virally Suppressed	Increase in the percentage of clients with a viral load of <200	Viral Load Suppression Among Persons in HIV Medical Care* HIV Viral Load Suppression**		Outpatient Medical Care Medical Case Management Local Pharm. Assistance Program
		Baseline: Numerator/Dominator, % 6,495/11,186, 58%	Target: Numerator/Dominator, % 7,399/11,745, 63%	

* HHS Measures can be found at http://www.aids.gov/pdf/hhs-common-hiv-indicators.pdf
** HAB Core performance measures can be found at: http://hab.hrsa.gov/deliverhivaidscare/coremeasures.pdf

b. HIV Workforce

The HIV prevention and care service delivery systems must share a firm foundation to maximize the impact of the Orlando Service Area response to the HIV/AIDS epidemic. Coordination of these efforts is necessary to accomplish the goals as set by planning bodies.

The Orlando Service Area has a responsibility to administer public health activities and to oversee the coordinated efforts of all agencies receiving Ryan White funding. We are also charged with a responsibility of bringing all stakeholders to the table regardless of funding, for the benefit of the consumers. This process strengthens our efforts to develop a coordinated HIV prevention and care program.

The Orlando Service Area workforce is comprised of many facets of care. This includes prevention, linkage, treatment, education and support services. HIV services are accessed through different means. Consumers may enter care via key points of entry, health fairs, clinics, private practice and community linkage programs to name just a few.

A high quality HIV/AIDS continuum of care is maintained through collaboration among all Ryan White Parts and non-Ryan White service providers to ensure seamless delivery of essential services. The continuum of care incorporates the core services of primary medical care (including outpatient ambulatory medical care), medical case management, pharmacy services, substance abuse and mental health services (outpatient), medical nutrition therapy, oral health care services, housing services, the payment of health insurance premiums and the addition of early intervention services. This jurisdiction's primary focus is getting people into care, ensuring that they remain in treatment and reducing disparities in health care.

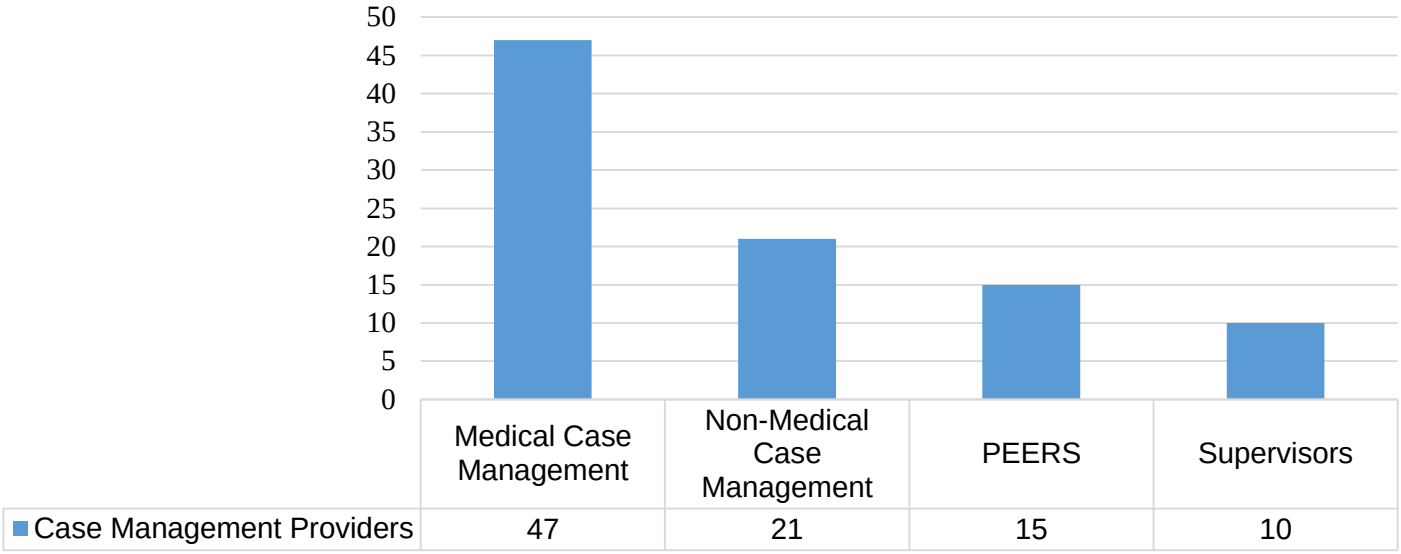
Our jurisdictional workforce includes agencies supporting the above core and support services. Prevention and educational programs are available as are testing initiatives. Linkage programs are in place to allow for crossover between the differently funded programs. This allows the consumer to access a broader continuum of care for their individual health needs.

Care and support is provided by physicians, nurse practitioners (ARNP), Physician Assistant's, licensed social workers, licensed mental health workers, and staff with experience in their field of expertise. Nearly all positions require a Baccalaureate degree and/or experience. Supervisory levels and above require an advanced degree.

By establishing high educational and work experience standards, this jurisdiction is able to provide consumers with the highest standards in care. Ongoing education relating to job performance is a requirement of all funded agencies.

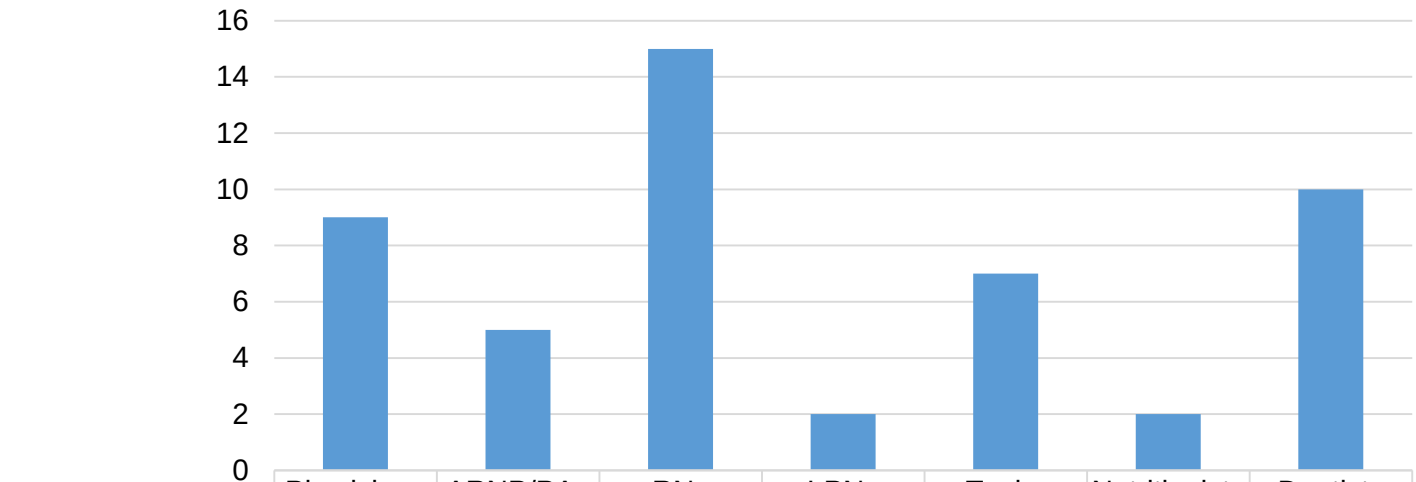
A firm foundation is built with the needs of the consumer being placed first. Oversight and management expertise guide our agencies as they support and provide services to consumers, reaching not only those in care but reaching out to those that have fallen out of care or have never accessed care.

Figure 15: Orlando Service Area Case Management Providers



	Medical Case Management	Non-Medical Case Management	PEERS	Supervisors
Case Management Providers	47	21	15	10

Figure 16: Orlando Service Area Medical Providers



	Physicians	ARNP/PAs	RNs	LPNs	Techs	Nutritionists	Dentists
Medical Providers	9	5	15	2	7	2	10

Figure 17: Orlando Service Area Mental Health and Substance Abuse Providers

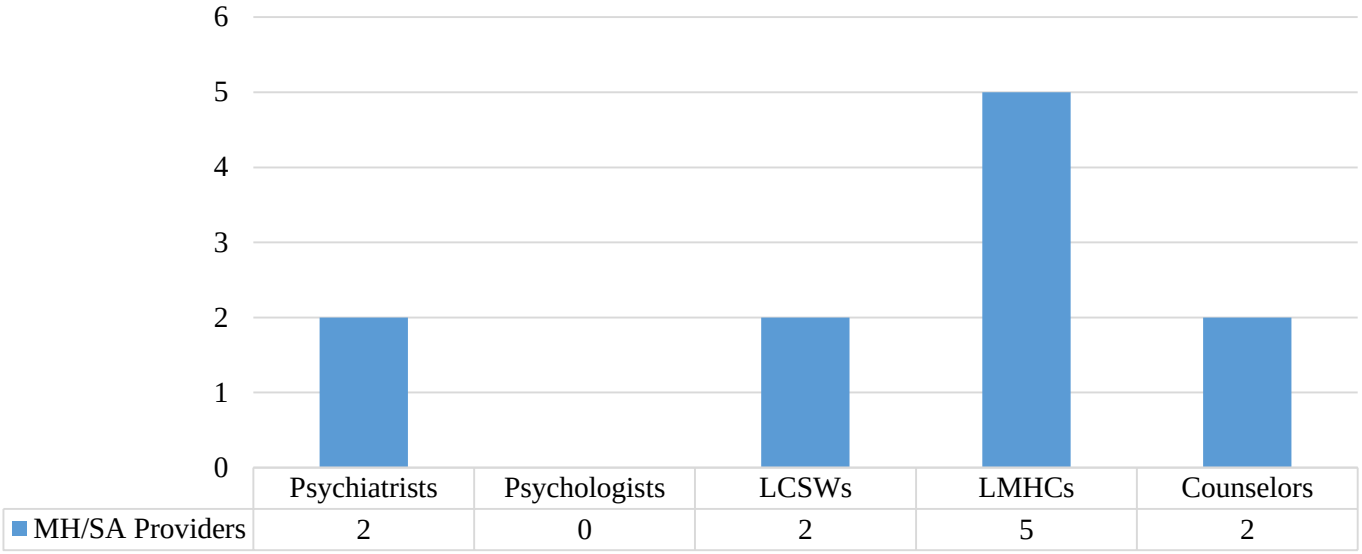
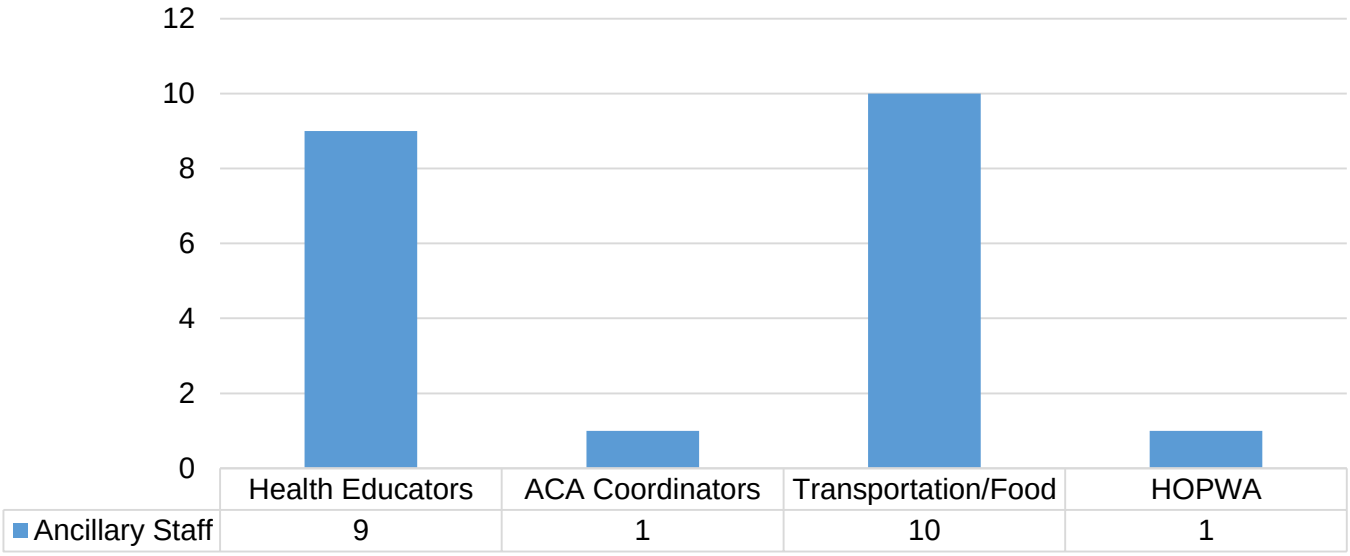


Figure 18: Orlando Service Area Ancillary Staff



c. Funding Sources to Ensure Continuity of Care

The Orlando Service Area consists of five counties in which the state managed health department is a provider. The health departments are the medical homes for individuals living within their respective jurisdiction and various service providers are co-located to provide parity in access to care and support services through geographic location and comprehensiveness of services. Services are provided using a client centered holistic approach to addressing the wellbeing of the consumers. The Orlando Service Area provides services that are culturally and linguistically relevant to the population served, including sign language, and the use of providers that reflect the dominant culture of that specific geographic location. Quality of services is maintained by the use of national monitoring standards, adherence to Public Health Service guidelines, local Standards of Care and HAB Outcome Measures.

Service providers are required to participate in diversity training on an annual basis, as well as to have culturally reflective staff of the target population. The majority of sub-recipients/service providers in the Orlando Service Area hire people from various ethnic and racial backgrounds, mirroring the PLWHA population, ensuring that the entities offering services can meet the unique cultural and linguistic needs of historically underserved populations. The Orlando Service Area contracts with providers in communities where PLWHA who have been historically disadvantaged can obtain services to increase access to care and health outcomes.

The State of Florida Legislation opted not to expand Medicaid, however the Orlando Service Area, through Case Management services, constantly review the consumer's eligibility for Medicaid services and enroll all those who meet the qualifications. Also, the Orlando Service Area increased the number of consumers that enrolled in ACA plans in 2015 and is working on the enrollment for 2016; these strategies have reduced the need in funding for OAHS compared with previous years. The Orlando Service Area changed the pharmacy provider and brought it in house to a County operated pharmacy. The pharmacy, a 340B entity, is able to bill insurance companies and generate revenue, including rebates, that is utilized as program income. Program income generated reduces the amount of funding needed from the grant for the Local AIDS Pharmaceutical Assistance program.

The Orlando Service Area requires that service providers expend funds and provide services in proportion to the epidemic; also the providers are required to submit monthly reports of their compliance with same and if necessary make the appropriate adjustments by targeting populations and engaging in outreach activities.

The needs assessments are related to the HIV Care Continuum as it reflects consumers' ability to link to care, their retention in care, as well as their compliance with ART resulting in suppressed viral loads. Based on the unmet need data there are 4,334 consumers within the service that are aware of their status but not in care. The Orlando Service Area encouraged service providers to engage in outreach activities and to establish appropriate relationships & coordination with the established Key Points of Entry as part their contractual requirements. In addition, the Orlando Service Area is working on increasing the awareness of the availability of services provided by engaging consumer to be ambassadors to those unaware though education of case managers, peers and other network service providers in collaboration with other local and state programs. The Orlando Service Area is working on the comprehensive plan in collaboration with prevention and patient care programs. The comprehensive plans goals are overarching and related to access to and retention in-care. The relevant performance measures are recommended by HAB/HRSA as part of the HHS Core Metrics which are recommended for HHS funded HIV programs and services. Performance measures are also related to service categories funded as reflected in the compressive plan to monitor service delivery. The action items are reviewed collaboratively by the Planning bodies and Recipients to determine if specifically assigned goals and objectives have been met or are pending.

d. Identify Needed Resources

The need for early intervention specialists (EIS)/Linkage Coordinators were identified last year and from that need both Part A and Part B funded a total of eight positions starting in March and April 2016, respectively.

With the five service counties that sprawl from the space coast to below Disney and into the rural counties to the west a continued need is a better mass transit system. It is difficult for the consumers to get to their primary care physicians, Infectious disease and specialty providers.

Affordable housing is a continued need in all of the service counties. With the restrictions and waiting lists for Housing Opportunities for Persons with AIDS (HOPWA), Section 8 and other government housing programs it limits our consumers who do not have the funds, the credit or other hindrances to obtaining suitable housing.

D. Assessing Needs, Gaps and Barriers

a. Process to Identify HIV Prevention and Care Service Needs

Health care providers indicate that their consumers have increasingly complex medical needs including the co-morbidities and co-factors identified previously. Co-morbidities require more complex medical and psychosocial interventions than standard HIV care. Providers must be vigilant regarding medication interactions when treating multiple conditions, nutritional needs, housing situation, side effects management and other quality of life issues. The aging population will continue to pose new challenges as medical providers account for the additional concerns of older adults and the aging process. As a result, the Recipients have implemented key cost containment measures for specialty care referrals to reduce the likelihood of these additional factors driving up the cost-of-care per client.

The Orlando Service Area community input process is structured to afford an opportunity for consumers to provide written feedback on their level of satisfaction with services and/or the system in general at all funded sites. As outcome data is generated from the implementation of the HIV Care Continuum it is shared with the Planning bodies and community members. The Planning bodies' methods through the use of contracted agencies include: focus groups; in-depth interviews; surveys; monthly Ryan White Community Meetings; newsletters; and the Orlando Service Area websites. These data collection methods are designed to gather input from the consumer in the HIV Care Continuum of Care to provide direction on future planning considerations for the Orlando Service Area. The results of all methods are used to guide future planning considerations.

The Planning bodies utilizes established principles and criteria based on the Ryan White HIV/AIDS Program Part A and B Manual http://hab.hrsa.gov/manageyourgrant/files/happartamanual2013.pdf and http://hab.hrsa.gov/manageyourgrant/files/habpartbmanual2013.pdf throughout the entire priority setting and resource allocation process, as agreed upon by its members and in accordance with the existing and emerging needs of PLWHA, as identified by the comprehensive needs assessment. The process is data driven by examining the epidemiological profile of PLWHA; assessing service utilization; reviewing available funding streams by service category; and evaluating survey data gathered from consumers and providers within the Orlando Service Area.

The Planning bodies focus efforts on addressing the HIV Care Continuum outcomes by evaluating and coordinating with other Ryan White-funded Parts (C and D) and local, state, and federal resources. This is an ongoing practice that includes the priority setting and resource allocation processes.

The Planning Committee of the Planning Council (EMA) developed the process, with input from consumers during PLWHA Caucus and committee meetings and through the newsletter, website and focus groups, to ascertain consumer needs and concerns with the existing system of care. In open community meetings, the Planning bodies approved the priority setting and resource allocation processes prior to implementation and adhered to the process throughout. The priority setting and resource allocation process was conducted during several public meetings spanning one month. First, a data presentation was conducted over the course of one day, providing epidemiological data, funding streams, expenditures and utilization, resources maps, provider survey data, consumer survey data, barriers to care surveys, and unmet need data to all Planning bodies and community members attending. A priority setting meeting was conducted one week later and a slate of service category priorities was developed and approved by the Planning bodies. A resource allocation meeting was conducted one week later where actual funding amounts were assigned and approved by the planning bodies. An evaluation assessment for each component of the process was completed by members of the planning

bodies. Finally, a debriefing meeting was added to gather additional information on how the process went and what changes were needed to improve it.

The Lead Agency for the Ryan White Part B recipient conducts the data presentation, priority setting and resource allocation for Tri-County (Osceola, Orange and Seminole) in one setting and the Brevard County process in a separate setting in Brevard. The Lead Agency provides the same data to the CFAP members as their Part A counterparts. Brevard County receives 72% of the RW Part B dollars with the remaining used to fill any gaps in services in the combined Part A and Part B service counties.

b. HIV Prevention and Care Service Needs of Persons at Risk for HIV and PLWH

According to the HRSA/HAB Unmet Need Framework, the Florida HIV/AIDS and Hepatitis Program estimated for CY 2014 there were 4,334 (39%) PLWHA who were not in-care. EIIHA efforts focus on post-test counseling, referrals and linkage into appropriate services for individuals. Activities related to those who are HIV+ but not in care are similar, although the key difference is that these individuals know their status. The overall goal is the same though, which is to identify people who are HIV+ and bring them and/or retain them in care.

The Orlando Service Area will begin funding linkage coordinators in FY 2016 to assist with linking newly diagnosed individuals into primary medical care, designed to decrease the number of people who know their status but are not in care. The Recipients will begin allocating dollars into Early Intervention Specialist (EIS) in FY 2016 in order to fund eight (8) linkage coordinators, four (4) each from Ryan White Part A and B respectively.

In an effort to address unmet need, the Orlando Service Area moved to a case management model four years ago, in order to more aggressively bring people into care and keep them in care. The Planning bodies continue to dedicate funding to both medical and non-medical case management for this purpose. They use data made available to them from the EIIHA workgroup to dedicate funding to assist in bringing newly diagnosed positives into medical care. The Planning bodies considered the needs of historically underserved populations during the priority setting and resource allocation meetings and continues to support the proactive stance taken by the Recipient's to test and link people into care. Many of the testing and counseling sites are also Ryan White Part A and Part B patient care providers. The Planning bodies considered the funding of services located near or in disproportionately impacted communities in order to meet the HRSA goals of increasing access to quality primary medical care and other services and decreasing HIV health disparities among infected and affected subpopulations in historically underserved communities. In addition, the Planning bodies implemented an "Out-Of-Care" survey to determine why individuals drop out of care. The goal was to determine the barriers that cause individuals to fall out of care and address and decrease those barriers.

The Anti-Retroviral Treatment and Access to Services (ARTAS) funded through the Ryan White Part B MAI program actively re-links people who have fallen out of medical care back into care. This program, along with other outreach efforts, are aggressively implemented to successfully link HIV+ individual to the system of care and case managers regularly interact with site staff. Several Counseling and Testing sites engage in aggressive marketing campaigns to encourage people to get tested to learn their status.

A primary care facility providing services for the homeless (Health Care Center for the Homeless - HCCH) was awarded a Bureau of Primary Care grant Partnership 4 Care grant to expand and integrate medical care with the PLWHA population. The EMA provides them with detailed information on resources available and the process to link individuals testing positive to the system of care. HCCH is also an Expanded Testing Initiative site and

has implemented routine HIV testing into their primary medical care which identifies homeless HIV-infected individuals and links them to care within their facility.

Planning body members and consumers participate throughout the year as information concerning the service delivery system, unmet needs and gaps in care as well as any real or perceived barriers is collected and reviewed. Participation is facilitated through the monthly PLWHA Caucus meeting, CFAP general membership meetings, representation at various Consumer Advisory Board (CAB) meetings held by providers, special focus groups and interview sessions, and participation with support groups by Planning Council and Consortia members. Information from each of these sources is brought back monthly to the Council for review and action as needed.

The Planning bodies continue to adhere to the HRSA mandate that 75% of service dollars be used to fund core medical services. The Part A and B planning bodies considered the Unmet Need Framework in the planning and decision making processes for setting priorities, resource allocations, and the system of care. The needs of those not in care and unaware of their status were considered based on barriers to care and unmet need data. It is estimated that 39% of PLWHA in the Orlando Service Area were not currently receiving primary medical care services in CY 2014. As such, approximately 85% of service dollars have been allotted to core medical services for the FY 2015.

MAI funds have historically been utilized to provide OAHS to racial and ethnic minorities. Trended epidemiological data support the need to continue allocating MAI funds in the Orlando Service Area for critical core medical services to Black, non-Hispanic, and Hispanic populations who are disproportionately impacted by HIV. Part A MAI funds are used to support OAHS, including the development and implementation of individualized plans of care that include strategies for adherence in the continuation of medical care for disproportionately impacted or underserved communities. For 2016, the planning bodies have allocated part of the MAI Funding to create and strengthen linkage to care for minorities who test positive. The linkage coordinators will work closely with the testing agencies to ensure the linkage. Part B MAI funds are used solely to identify consumers who have dropped out of care and re-link them to care via the ARTAS program.

The planning bodies examined epidemiological and utilization data to access the needs of the community for priority setting and resource allocation. The group aligned the top five service categories to coincide with the top five needs identified in the Consumer Survey. As a result, the top five services in order of priority are as follows:

1. OAHS
2. AIDS Pharmaceutical Assistance (Local)
3. AIDS Drug Assistance Program
4. Oral Health
5. Medical Case Management.

Epidemiological data for the Orlando Service Area continues to show that new cases of HIV and AIDS are a disproportionate burden among the Black, non-Hispanic populations. There has also been a rise in new cases in the Hispanic population. Community input is continually sought through caucus meetings, health fairs, community gatherings, newsletters, website, focus groups and in-depth interviews in an effort to address the reasons for the continued spread of the disease among these populations. The information gathered is analyzed and presented to the Planning bodies and community members to aid in setting priorities and resource allocations and will be used to support the effectiveness of the HIV Care Continuum.

The planning bodies utilized a trend analysis of expenditures and utilization to identify how and where funds were spent over the past five years along with epidemiology and unmet need data to determine the best methods for fund allocation. This data was shared with the Planning bodies and community members at the annual data presentation and proved instrumental in crafting funding slates for the upcoming fiscal year.

This planning effort requires an in-depth understanding of services as well as other publicly funded HIV services that are available to PLWHA. The Coordination of Services and Funding report includes funding source access details, broken out by service category, on the following programs: Part A, Part A MAI, Part B, Part B MAI, Part C, Part D, Part F, Substance Abuse and Mental Health Services Administration (SAMHSA) and Housing Opportunities for People with AIDS (HOPWA). All the recipients closely coordinate with other available programs and funding streams within the Orlando Service Area to enhance the HIV Care Continuum. This integration and coordination is achieved by regularly scheduled strategic planning meetings across all Ryan White Parts funded within the Orlando Service Area (Parts A, B, C and D). In addition, collaborative sessions are scheduled with prevention, housing, mental health and substance abuse to improve the current system of linkages and to strengthen the referral process. These efforts assure that Ryan White funds will always be utilized as the "Payer of Last Resort."

A visual of the HIV Care Continuum was shared during the annual priority setting and resource allocation process as part of the Unmet Need presentation to assist in recognizing the possibility of health insurance coverage options and uncertain changes and how it would affect the most important needs of consumers. The planning bodies examined epidemiological and utilization data and reviewed the Orlando Service Area efforts to collaborate with other entities during the Affordable Care Act enrollment period to include the number of new and estimated enrollees. The planning bodies recognizes the importance of prioritizing and funding critical core medical services to ensure PLWHA receive appropriate care to ensure the quality of life.

Several strategies were considered during the priority setting and resource allocation process to make unaware consumers aware of their status and link them to care, including increased testing by reducing real and perceived barriers to HIV testing; ensuring that counseling, testing, and linkage services are provided to at-risk populations through our collaborations with Prevention, Counseling and Testing initiatives with other Ryan White entities and the Department of Health; increasing the percentage of persons who receive results after testing for HIV; linking all newly infected individuals to appropriate medical and support services; providing pre-release planning and linkage services in local jail facilities; ensuring newly identified HIV+ incarcerated persons are linked to appropriate community services prior to release; maintaining and expanding the network of providers willing and able to serve ex-offenders; and ensuring baseline data is collected and trends are monitored on an ongoing basis.

In support of our case management driven system, case managers are located in all clinics that provide OAHS and services funded through Part A and B and Part A and B MAI funds. It is anticipated that as outcome data is generated from the implementation of the HIV Care Continuum it will be shared with the planning bodies and community to help guide future planning considerations.

c. Describe Service Gaps

Florida, like many other states, has faced severe general revenue shortfalls since the economic downturn in 2006. Each year, as the legislature is forced to continue making funding cuts to balance an ever-demanding budget, services across the state have been curtailed and sometimes even eliminated. The Part B recipient has been successful in working creatively with the legislature, the governor's office, and sub-recipients to ensure that the continuously shrinking allocation to HIV/AIDS care has been absorbed first at the administrative levels, before affecting direct client care. However, with ever deeper cuts in annual funding, eventually the effect is

being felt at the client level, as evidenced by the ADAP wait list in 2010 (although no client had gone without life-saving medications), and diversion of federal Ryan White Part B allocations from local consortia areas to help keep ADAP afloat.

Florida has experienced nearly flat funding of its Ryan White Part B program for many years, despite growing incidence and prevalence of HIV. With reductions in local Ryan White Part B allocations across the state beginning in FY 2011-2012, many local regions including East Central Florida, have had to reduce funding for services from eligibility determination to medical case management to ambulatory care. These reductions have translated to a shrinking healthcare workforce, and in some areas, wait lists for newly HIV-diagnosed and identified individuals to enter care.

Besides HIV-specific funding cuts, local health departments have also experienced deep erosions in their state General Revenue funding and Medicaid reimbursement rates for the past four years. In many areas across the state, like in East Central Florida, local health departments are the medical homes for HIV ambulatory care, particularly for persons with no other funding sources besides Ryan White. Many health departments are now closing their primary care clinics and curtailing their HIV specialty activities. They simply cannot afford to continue to pay for the staff necessary to provide this complex and expensive care anymore. Private clinicians, for the most part, are not particularly interested in packing their practices with clients who have no insurance payers or who have only Medicaid.

Clients have indicated statewide as well as locally, a need for more HIV-competent and more culturally competent medical providers. The perfect storm of an economic downturn, with its resultant slashes in budgets and thus, reimbursements, has driven providers to reduce their workforces. New medical providers recognize the warning sign, and look elsewhere to establish their practices. Persons most in need of culturally competent providers are many times also persons who have no payer resources – they must rely on the governmentally funded networks of care, which right now are in funding turmoil. Many HIV-competent providers are beginning to age out of the care network. They have been the backbone of the area's network for many years. Some continue to practice beyond their anticipated retirements simply because there are few replacements for them. Others wearied by what seems an endless battle to fit more and more people into their already crowded practices, finally just move on to the private side or to an early retirement.

The simple math of an ever-increasing HIV-positive population trying to be served in a healthcare system whose funding cannot keep pace with the need and with rising costs yields an unfortunate product: shortfalls in care to a critically fragile community.

In the Orlando Service Area, a gap in service is defined when 30% or more consumers are unable to access a particular service. The Ryan White Orlando EMA Part A and Area 7 Ryan White Part B Recipient offices' in East Central Florida, utilized the Statewide Anonymous Ryan White Consumer Needs Survey in addition to service delivery information received from providers statewide to identify gaps in service. The survey consisted of 59 questions and offered HIV service providers an opportunity to describe service needs in their community. Questions assessed a range of variables, including respondent demographics, HIV/AIDS Medical Care, RW services that they may or may not have been able to receive, Jail/Prison Release services and Housing. They also had the opportunity to provide additional comments. There were 572 consumers that responded to the survey which included 266 from Brevard. The survey asks clients what services they needed but were unable to obtain from their service providers because they were not offered at all, were no longer being offered, or because of a wait list.

On a local level, the gaps vary by area based on several factors, including availability of other funding sources, transportation issues, and availability of providers to deliver services. Overall, 72% of respondents to the consumer needs survey indicated they received all needed services that were listed in this survey tool. The majority of respondents indicated that they received specific services that they needed. Of the 18 services listed on the survey, more than 57% (4,000 respondents) needed each of six specific services (service gaps in parentheses): Food Bank (37%), Health Insurance (34%), Dental/Oral Health (31%), Case Management (11%), OAMC (5%), and Medications (5%). The latter two services are core services and fortunately, these needs are met for 95% of respondents.

The responses from the area providers were very similar to those of the clients in the Consumer Needs Survey. Each area was surveyed and asked to rank services in order by largest to smallest gaps. The gaps in services identified by the providers were then given a score based on the rank given by the provider. The largest gaps in services, in order from largest gap to smallest gap, according to the providers surveyed were as follows: Legal Services, Food Bank, Medical Transportation, Health Insurance, Rehabilitation Services, Dental/Oral Health, Substance Abuse Treatment, Mental Health Services, Home Health Care, Nutritional Counseling, Hospice, Outreach, Local AIDS Pharmaceutical Assistance, Housing Services, Early Intervention Services, OAMC, Medical Case Management, Emergency Financial Assistance, and Case Management (Non-Medical).

In addition to the consumer needs survey, ongoing focus group research as well as recent reports from the Centers for Disease Control and Prevention (CDC) has revealed that MSM are experiencing gaps in both patient care and prevention services. Some areas report these gaps for care are directly related to the client not receiving medical case management. This could be caused by lack of capacity to meet the growing demand, as well as simple lack of knowledge of the existence of the service by the consumer. In rural areas, support services such as transportation or other issues such as lack of proximate providers were identified as one of the causes for clients' not being connected. In urban communities, where access was not as prevalent an issue and more funding was available to support non-core services, MSM indicated that they relied heavily on peer networking for navigating through the healthcare system when difficulties engaging or obtaining medical case management were an issue.

Additionally, in both rural and urban communities, there were MSM who lacked awareness of the planning bodies, consortia and/or planning councils that could have served as a voice for this group. Contact with planning body members would have increased awareness of services and funding sources to needed health services for MSM. Service gaps for Women of Child Bearing Age include limited family-centered resources such as childcare, transportation, and treatment protocols. In some areas of the state, Minority AIDS Initiative resources are specifically targeted to this group in an effort to increase services for women and the RW Part A grantee office provides medications for pregnant infected women and their exposed newborn infants whenever there are barriers to accessing this service. The Part A grantee in the Orlando EMA/Area 7 has entered into an agreement with a local pharmacy to keep a supply of appropriate medications on hand for the following scenarios: a pregnant woman's Medicaid coverage is delayed approval or suspended and she is unable to obtain her medications; an infant is born and needs medications; mother and newborn are discharged over the weekend and unable to secure needed medications.

The service gaps were prioritized in accordance with the top five services identified in the 2013 Consumer Needs Survey as the most important for those with HIV/AIDS. For this reason, oral health and mental health were in the top seven prioritized core medical service categories.

Service gaps will be addressed through increased funding to case managers who will coordinate consumer's transportation and dental health service needs. Addition funding assistance will be provided to help consumers with enrollment into ACA programs. The Recipients' will continue to expand partnerships with local food

banks, disburse copies of the Resource Directory to consumers which identifies local food programs respectively and eligibility criteria, and educate case managers to increase awareness of food resources for consumers. Increased funding was also provided to mental health services to cover the newly added psychiatric care services.

d. Describe Barriers to HIV Prevention and Care

Figure 19: Barriers to HIV Care

Barriers to Care	Social & Structural Barriers	Legislative Barriers	Health Department Barriers	Program Barriers	Service Provider Barriers	Client Barriers
Policy implementation (e.g. Medicaid expansion, clean needle exchange programs, abstinence-based curriculum, etc.)	X	X		X	X	X
Significant budget cuts across the State – decreased funding at the local level			X	X	X	X
Federal, State and County contracting and procurement processes		X	X	X	X	X
Insufficient integration of cost data and service provision data to improve service delivery process.	X	X		X	X	
Limitations and delay on state epidemiological data				X	X	X
Delay in migration data (e.g. impact of consumers relocated from other states)		X		X	X	X
Insufficient communication protocols between prevention and patient care.	X	X	X	X	X	
Lack of integrated software system to share pertinent client information.	X	X	X	X	X	
Inadequate local public transportations systems	X	X				
Lack of dental providers in rural counties	X			X		X
Inadequate specialty care and primary care providers	X	X				X
Insufficient staff to client ratio					X	X
Lack of community partnerships/linkages		X	X	X	X	X
Lack of affordable housing	X	X		X		X
Lack of knowledge of the Ryan White service system by potential key points of entry	X		X	X	X	X
Low rate of health insurance coverage and declining coverage	X	X				
Lack of a functional, real time information system				X	X	X
Language and cultural barriers	X				X	X

Figure 19A: Barriers to HIV Prevention – Service Gaps

Barriers to Prevention	Social & Structural Barriers	Legislative Barriers	Health Department Barriers	Program Barriers	Service Provider Barriers	Client Barriers
Lack of Funding		X	X	X		
Federal Guidelines restricting bridging of programs		X	X	X		
Federal, State and Local policies not in alliance with community needs		X	X	X	X	
Agency turnover and lack of continuity of leadership			X		X	
Community Needs based on State Epidemiological data not necessarily on service area		X	X	X		
Weak or non-existent partnership and/or communication between agencies			X	X	X	
Community unaware of programs unavailability	X				X	X
Lack of community education leading to continued stigma			X	X	X	X
Inability to publicly educate due to local and state mandates	X	X				
Lack of staff training to understand cultural barriers			X	X	X	
Inadequate public transportation	X	X				

E. Data: Access, Source, and Systems

a. Describe Main Data Sources

The Orlando Service Area received epidemiological data from the Florida Department of Health, Bureau of Communicable Disease, HIV/AIDS section. Data is primarily gleaned from Enhanced HIV/AIDS Reporting System. Population data was gathered from the Florida Department of Health, Office of Health Statistics. Data regarding health behaviors for adolescents and adults was provided by the Youth Risk Behavioral Surveillance System (YRBSS) and Behavioral Rick Factor Surveillance System, respectively. Additionally, qualitative data was gathered from focus groups and provider and client surveys.

b. Describe Data Policies that Served as Barriers

The merging of the databases discussed above facilitated the data necessary to develop the Orlando Service Area diagnosis-based HIV Care Continuum in alignment with any data policies protecting the identity of PLWHA living in the area. At the present time, since the State Health Office generates the Service Area's HIV Continuum of Care Model and there are no formal policies and procedures serving as barriers for developing model, the significant limitation results in assuming that persons not in care (based on the listed data matches

above) are truly not in care. The upcoming challenges will be to develop policies and procedures, with available staff at the state health office and locally,

- to evaluate those cases not in care,
- specify who will be responsible for trying to locate those persons not in care and
- ascertain how staff will carry out this process.

Legal agreements may need to be drawn up if non-DOH staff needs to be contracted to perform some of these duties.

Additionally, continued efforts will be made to further improve the completeness of state and local data elements. Moreover, facilitating data agreements with local IT departments will allow for greater development of the HIV Care Continuum for the state, as demonstrated by the data agreement with Miami. Data sharing with the Ryan White Part A's around the state will be assessed to coordinate programs that target the care continuum.

c. Describe Any Data That Was Needed but Not Available

The data that the planning group would like to have used in conducting the needs assessment and in developing the HIV Care Continuum and the plan, but was not available were:

- Information from Medicaid regarding the amount of funds spent on providing HIV care and treatment
- Information from ADAP regarding the number and demographics of clients accessing medications
- Information from ADAP regarding the number of clients enrolled in ACA plans
- Actual information, not estimates, on the number of clients prescribed ART
- System wide unduplicated RSR data
- Community Health Center program data
- Vital statistics data

SECTION II

Integrated HIV Prevention and Care Plan

SECTION II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

a-d Sections

Goal 1: Reduce New HIV Infections

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

Strategy 1: Implement routine testing in applicable medical facilities.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of September 2017	Distribute the routine testing guidelines developed by the HIV/AIDS Section of the Florida Department of Health headquartered in Tallahassee to applicable medical facilities.	Ryan White Part A Planning bodies; Ryan White Part B/ Prevention Consortium (CFAP) and the local Part B grant recipient office.	Medical Facilities such as primary care providers, emergency rooms, urgent care centers, etc.	• Number of medical facilities in receipt of guidelines.
By the end of November 2018	Ensure training on implementation of the guidelines is provided to all medical facilities.	AETC (AIDS Education and Training Center)	Medical Facilities such as primary care providers, emergency rooms, urgent care centers, etc.	• Number of training sessions completed. • Number of facilities completing the training. • Number of facilities implementing routine testing.

Strategy 2: Increase outreach and targeted testing.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of December 2020	Deliver intensified outreach and testing to MSMs including young MSMs and heterosexuals of color.	Expanded Testing Initiative (ETI) sub-recipients, CBOs and ASOs.	MSMs (including young MSMs), heterosexuals of color.	• Number HIV tests performed. • HIV Positivity Rate. • Number of positives linked to care.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2018	Designate individuals at testing sites to coordinate daily/weekly follow-up with DIS.	ETI sub-recipients, CBOs, ASOs, DIS/Linkage Coordinators, Medical Facilities.	MSMs (including young MSMs), heterosexuals of color.	• Number of positives referred and linked to DIS for Partner Services. • Number of positives linked to Case Management and/or Primary Medical Care.
By the end of March 2018	Determine a model to increase collaboration with DIS.	ETI sub-recipients, CBOs, ASOs, DIS/ Linkage Coordinators, Medical Facilities.	MSMs (including young MSMs), heterosexuals of color.	• Identification of a best practice model. • Implementation of the best practice model. • Number of Memorandum of Agreements (MOAs) with Health Departments, DIS and Medical Facilities.
By the end of December 2020	Develop jurisdiction wide couples' counseling and testing protocols to include partner elicitation and notification.	CDC-funded Health Department.	ETI sub-recipients, CBOs, ASOs, DIS/ Linkage Coordinators, Medical Facilities.	• Protocols developed. • Number of trainings. • Number of couples' counseling/testing sessions.

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

Strategy 1: Increase Prevention for Positives Initiatives.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2021	Implement Effective Behavioral Interventions (EBIs) for Prevention for Positives/Treatment as Prevention (TaP).	Local Ryan White Part B recipients, Ryan White recipients.	Ryan White sub-recipients.	• Number of clients enrolled in interventions. • Number of clients completing interventions.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of June 2019	Identify medical facilities and CBOs predisposed to implementing PrEP and nPEP.	Ryan White Part A Planning bodies, Ryan White Part B/ Prevention Consortium, local Part B recipient, AETC.	Medical facilities, CBOs and ASOs.	• Number of MOAs with Medical Facilities.
By the end of September 2020	Provide training on the implementation of PrEP and nPEP.	AETC	Medical facilities, CBOs and ASOs.	• Number of CBOs and Medical Facilities that receive trainings.
By the end of March 2021	Implement PrEP and nPEP.	Medical Facilities, CBOs and ASOs.	High-risk HIV negative individuals, sexual assault victims, accidental exposures.	• Number of individuals receiving PrEP and nPEP.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2017	Identify and apply for alternative funding sources for EBIs for target populations.	Ryan White recipients and sub-recipients, Prevention sub-recipients.	MSMs (including young MSMs), heterosexuals of color.	• Number of funding sources, other than Ryan White and CDC, identified. • Number of successful applications submitted.
By the end of June 2017	Implement training to CBOs, ASOs, medical facilities, etc. on EBIs for target population.	CDC-funded health departments.	MSMs (including young MSMs), heterosexuals of color.	• Number of training sessions completed. • Number of individuals receiving training.
By the end of December 2017	Implement appropriate EBIs.	Prevention sub-recipients.	MSMs (including young MSMs), heterosexuals of color.	• Number of individuals from target population enrolled and completed EBIs. • Number of individuals reporting reduced risk factors.

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

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

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of September 2020	Identify funding resources to support expansion of: Early Intervention Services (EIS), linkage, peer support and case management services.	Ryan White recipients, planning bodies, and Prevention recipients.	CBOs and ASOs	• Number of newly identified funding resources.
By the end of December 2021	Expand the aforementioned services.	Ryan White recipients, CBOs and ASOs.	MSMs (including young MSMs), heterosexuals of color.	• Number of EIS, linkage, peer, and case management services provided.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of September 2018	Identify/develop standardized training for the provision of the aforementioned services.	Ryan White recipients and planning bodies.	EIS, peer, case management, linkage service providers.	• Standardized training developed or identified.
By the end of February 2019	Implement the standardized training to CBOs, ASOs, etc.	Ryan White recipients.	EIS, peer, case management, linkage service providers.	• Number of standardized training sessions completed. • Number of service providers receiving training.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of December 2018	Identify the models/best practices of aforementioned services that work in the private	Ryan White recipients and planning bodies.	Private sector ASOs.	• Models/best practices identified.

	sector.			
By the end of March 2021	Implement identified models/best practices.	Ryan White recipients and private sector ASOs.	HIV positive individuals receiving care in the private sector.	• Number of models/best practices implemented in the private sector. • Number of individuals receiving services in the private sector.

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

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
Annually, by end of December	Educate clinical providers on the most current Public Health Service (PHS) Guidelines annually (within 90 days of update).	Ryan White recipients and planning bodies.	Clinical providers.	• Number of update sessions provided. • Number of clinical providers trained. • Number of individuals on ARV.
Annually, by end of December	Provide treatment updates in a Continued Medical Education/Continued Educational Units (CME/CEU) setting for clinical providers.	Ryan White recipients and planning bodies.	Clinical providers.	• Number of sessions receiving CME/CEUs. • Number of individuals on ARV.
By the end of August 2017	Identify and strengthen partnerships with key points of entry.	Ryan White sub-recipients, other CBOs and ASOs.	Key points of entry	• Number of MOAs established.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of May 2017	Provide system-wide standardized customer service training.	Ryan White and Prevention recipients and planning bodies.	Ryan White sub-recipients, other CBOs and ASOs.	• Number of training sessions completed. • Number of staff trained.
By the end of August 2018	Provide comprehensive cultural competency training reflective of consumers served.	Ryan White and Prevention recipients and planning bodies.	Ryan White sub-recipients, other CBOs and ASOs.	• Number of training sessions completed. • Number of staff trained.

By the end of October 2018	Provide activities to decrease compassion fatigue across agencies and providers.	Ryan White and Prevention recipients and planning bodies.	Ryan White sub-recipients, other CBOs and ASOs.	• Number of activities provided. • Number and type of participants.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of February 2019	Provide information, resources and technical assistance to strengthen and increase delivery of EBIs that address treatment adherence.	Ryan White recipients and AETC.	Ryan White sub-recipients, other CBOs and ASOs.	• Number of EBIs that address treatment adherence implemented. • Number of virally suppressed individuals.

Goal 3: Reduce HIV-Related Disparities and Health Inequities

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

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of November 2017	Establish relationships/ partnerships with Homeless Service Network (HSN), Housing Opportunities for Persons with AIDS (HOPWA) and other homeless service providers.	Ryan White recipients and planning bodies.	Ryan White sub-recipients and homeless service providers.	• Number of MOAs established with homeless service providers. • Number of HSN meetings attended.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of May 2018	Educate the Ryan White system of care on the "Housing First" initiative.	Ryan White recipients and HSN.	Ryan White sub-recipients.	• Number of Ryan White service providers receiving training.
By the end of December 2021	Identify the number of homeless HIV positive individuals in medical care.	Medical providers.	Homeless HIV positive individuals.	• Number of homeless HIV positive individuals who received medical care.
By the end of	Link homeless HIV positive individuals to	Ryan White recipients and HSN.	Homeless HIV positive	• Number of homeless HIV positive

December 2021	housing.		individuals.	individuals who received housing.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of October 2019	Identify current and potential providers of needed services.	Ryan White recipients and planning bodies.	Ryan White sub-recipients, other CBOs and ASOs.	• Number of providers identified.
By the end of December 2021	Implement "out-call"/non-traditional services.	Ryan White sub-recipients, other CBOs and ASOs.	HIV positive homeless individuals.	• Number of services provided. • Number of individuals receiving services.

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

Strategy 1: Expand available services to the aforementioned populations.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2017	Identify and strengthen relationships with key stakeholders in the aforementioned populations.	Ryan White recipients and planning bodies; Ryan White sub-recipients.	Key stakeholders of the sub-populations.	• Number of MOAs established with key stakeholders.
By the end of November 2019	Increase mobile testing to address disproportionately affected populations as identified in epidemiological profile.	Ryan White recipients and planning bodies; Ryan White sub-recipients, and Prevention providers.	Gay and bisexual men, young Black gay and bisexual men, Black females.	• Number of mobile testing sessions conducted. • Number of individuals from the sub-populations tested.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of September 2018	Continue and improve education among clinical providers regarding current and updated modalities of treatment for the aforementioned populations.	Ryan White recipients and planning bodies; AETC.	Ryan White sub-recipients, other CBOs and ASOs.	• Number of training sessions provided. • Number and type of service providers trained.

By the end of July of each year	Continue and improve cultural competency training for Provider staff.	Ryan White recipients and sub-recipients; AETC.	Ryan White sub-recipients, other CBOs and ASOs.	• Number of training sessions provided. • Number and type of service providers trained.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of March 2017	Identify best practices and successful techniques in existing EBIs.	Ryan White recipients and sub-recipients; Prevention service providers.	Gay and bisexual men, young Black gay and bisexual men, Black females.	• Best practices identified.
By the end of March 2019	Standardize implementation of identified best practices and successful techniques for all EBIs.	Ryan White recipients and sub-recipients; Prevention service providers.	Gay and bisexual men, young Black gay and bisexual men, Black females.	• Number of individuals successfully completing EBIs. • Number of individuals reporting reduced risk behaviors.

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

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

Strategy 1: Investigate the feasibility of combining planning bodies.

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of June 2019	Improve education regarding coordination of effort and system of care.	Ryan White recipients and planning bodies.	Planning bodies.	• Number of educational sessions provided.
By the end of December 2019	Convene with all planning body stakeholders.	Ryan White recipients and planning bodies.	Planning bodies.	• Number of meetings held.
By the end of June 2020	Update 2005 feasibility study.	Ryan White recipients and planning bodies.	Planning bodies.	• Feasibility study updated.

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

Timeframe	Activity	Responsible Parties	Target Population	Data Indicators
By the end of December 2020	Develop and implement communication protocols between the planning bodies.	Ryan White recipients and planning bodies.	Planning bodies.	• Communication protocols developed. • Implement communication protocols.
By the end of December 2021	Implement the results of the feasibility study.	Ryan White recipients and planning bodies.	Planning bodies.	• A more coordinated local response to the epidemic.

e. Challenges/Barriers in Implementing the Plan

The jurisdiction anticipates the following challenges/barriers in implementing the plan:

- The collection of data from the private sector, VA, Medicaid and Medicare
- The availability of housing units for homeless HIV positive individuals

B. Collaborations, Partnerships, and Stakeholder Involvement

a. Describe Specific Contributions

Both Planning bodies, the Planning Council (PC) and the Area 7 Consortium (CFAP) agreed to establish a collaborative Integrated Plan Writing Team which consisted of members of the Planning Committee of the PC, members of the CFAP Comprehensive Plan Committee, the Area 7 HIV/AIDS Program Coordinator (HAPC), the Part B Recipient Area Representative, representatives from the Part A Recipient's office, Ryan White Parts C and D representatives, Housing Opportunities for People with AIDS (HOPWA) representative, mental health and substance abuse providers and prevention providers as well as consumers. The composition of the Writing Team is reflective of the Central Florida epidemiology and is responsible for drafting the Plan. The Writing Team met monthly from June through November of 2015 and twice per month from December through February to draft the Plan.

To ensure that all members of both the PC and CFAP planning bodies were involved in the process both bodies included a report on the Progress of the Integrated Plan as a standing Agenda Item for their monthly meetings from the release of the Guidance in June 2015, to the completion and approval of the Plan in April 2016. During each report, Writing Team members presented the most recent draft of the Goals, Objectives, Strategies and Activities, obtained feedback from the membership, and revised the draft as necessary.

In addition to the monthly discussion and feedback sessions during the planning bodies meetings, Stakeholder meetings were held in each of the five (5) Orlando Service Area counties (Brevard, Lake, Orange, Osceola, and Seminole) to be impacted by the Plan. During these Stakeholder meetings representatives from the private sector, the clergy, law enforcement, education, public officials, and the general public were invited to discuss the draft goals, objectives, strategies and activities and provide feedback to the writing team for inclusion in the Plan.

The final draft of the Plan was posted on each planning body's website for a two (2) week period during the month of March 2016 and emailed to all participants as well as invitees of the Stakeholder meetings to garner additional feedback from the wider community. All feedback was reviewed by the writing team and incorporated as applicable. The final document was then presented to both the PC and CFAP during the March meeting for a 30-day review per their Bylaws and approved during the April meeting. Once approved the letter of concurrence from the Chairs of both planning bodies were obtained (see Appendix A). The completed Orlando Service Area Integrated HIV Prevention and Care Plan was then submitted to the Department of Health's Headquarters in Tallahassee for inclusion into the Statewide Plan.

b. Describe Stakeholders and Partners Who Are Needed

Stakeholders from the private medical sector, public officials from each impacted County, representatives from the education sector and clergy were invited to participate in the planning process either as a member of the writing team or as a participant at the Stakeholder meetings. Since we were unable to attract their participation in the development process, the writing team decided and the planning bodies concurred to include these Stakeholders in the final solicitation for feedback. Both planning bodies also plan to continue to solicit participation from these Stakeholders as their input will be needed to more effectively improve the outcomes progress along the HIV Care Continuum.

c. Provide Letter of Concurrence

Please see the letter of concurrence from the PC Chairperson, and the CFAP Prevention and Patient Care Chairpersons in Appendix A.

C. People Living With HIV (PLWH) and Community Engagement

a. How Are People Involved in Plan Development

The Central Florida area, consisting of Brevard, Lake, Orange, Osceola and Seminole Counties, has a long history of both PLWHA and Community Engagement in developing plans for Prevention and Patient Care. This has been accomplished primarily through consumer representation on the Central Florida AIDS Planning Consortium (CFAP) and the Orlando Eligible Metropolitan Area HIV Health Services Planning Council (PC). Planning Council membership consists of approximately 50% individuals living with HIV and 45% being un-conflicted consumers. CFAP membership consists of 50% PLWHA with 27% un-conflicted. Additionally, the PC hosts a PLWHA Caucus a/k/a the Ryan White Community Meeting that attracts a larger number of consumers, including CFAP and PC members as well as non-members of both planning bodies. The purpose of the Ryan White Community Meeting is to serve as a venue for the HIV community to express feedback prior to decisions being made which impact both the prevention and patient care components of the service delivery system. Meetings of all three (3) groups are held monthly. Both the PC Support and the Lead Agency for CFAP are responsible for the group composition, ensuring that they are representative of the epidemic within the various geographic regions, Lake, Orange, Osceola and Seminole Counties for the PC and Brevard, Orange, Osceola and Seminole Counties for CFAP, utilizing the principles of Parity, Inclusion and Representation (PIR). The PC and CFAP, along with the Ryan White HIV/AIDS Program (RWHAP) Part A Recipient, PC Support, Lead Agency, and the HIV/AIDS Program Coordinator (HAPC), who is the RWHAP Part B Recipient Representative, are responsible for the development and implementation of this plan.

b. Describe the Inclusion of PLWHA with Plan Development

PLWHAs were well represented in the development of this Integrated HIV Prevention and Care Plan, as 25% of the members of the writing team self-identify as HIV Positive. PLWHAs have also contributed by participating

in the Statewide Needs Assessment, on focus groups, serving on Consumer Advisory Boards, as well as participating at the Stakeholder meetings held in each of the five (5) Counties that will be affected by the plan. There are several robust peer-driven navigation and prevention programs as well as focus groups that contribute greatly to PLWH involvement on many different levels. These PLWHAs have helped us identify what is working well, areas for improvement, barriers to accessing prevention and patient care services, as well as helping to develop our Unmet Need matrix. Further, they have participated widely in providing feedback to the planning bodies by attending various "town hall" or Stakeholder meetings that have helped us develop goals and improve service delivery around Eligibility, Case Management, High-Impact Prevention, Pre-Exposure Prophylaxis (PrEP), ADAP and many of the other services that comprises the service delivery system. 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. Proposed changes in local policies are reviewed and feedback is provided by each of the planning bodies as well as the Caucus.

c. Describe Methods to Engage Communities

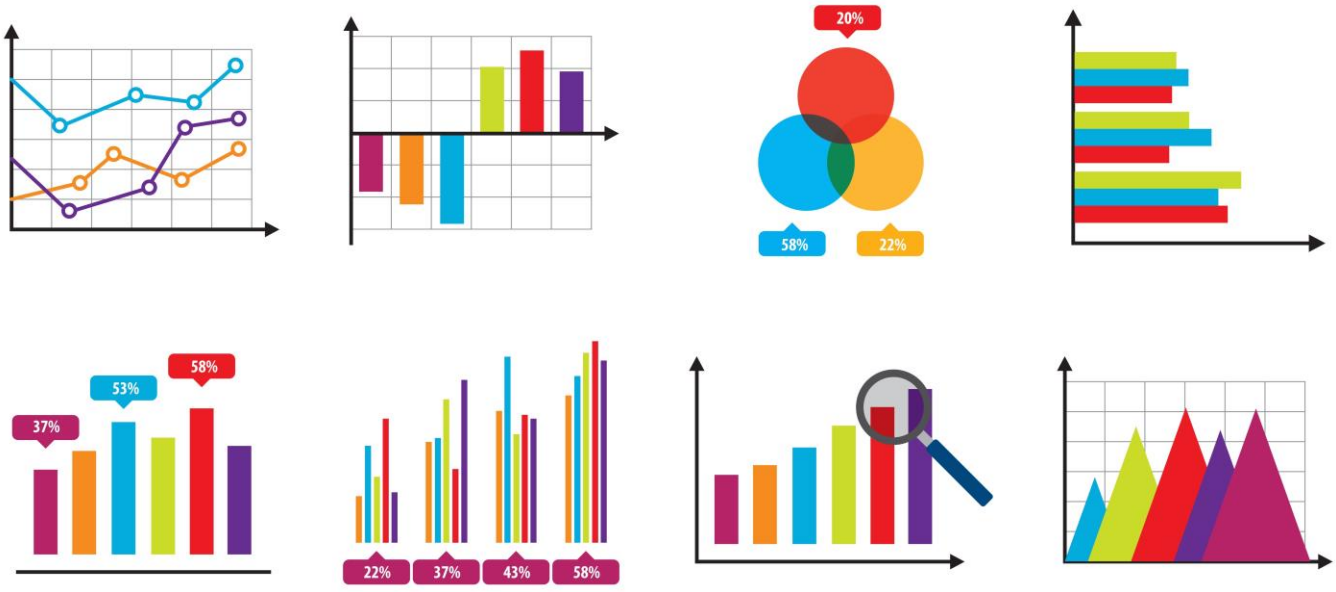
The development of a Workgroup/writing team that reflected the epidemic, the use of Stakeholder meetings in each of the five Counties as well as focus groups were different methods employed by the Orlando Service Area to engage all communities in the development of the Plan. The biggest challenge has been to engage PLWHA who are not in care or to find those who have tested positive but not entered care; but that is not unique to this area. Many areas of the state have dedicated staff to find those lost to care and we work closely with our surveillance specialists to identify and re-engage those individuals.

d. Describe How Impacted Communities Are Engaged in the Planning Process

The Orlando Service Area is a diverse area where we strive to reach even the most marginalized and underserved. A "one size fits all" approach is not very effective, due to the language and cultural challenges presented by such diversity; therefore, much effort and resources have been put forth to engage all PLWHA, those most at-risk for becoming infected, as well as their families and support systems. There have been a number of focus groups conducted across the area to identify the needs of specific populations, such as the MSM, Youth, and Transgender communities.

SECTION III

Monitoring and Improvement



SECTION III: Monitoring and Improvement

a. Describe the Process for Reporting on the Progress of the Plan Implementation

The Orlando Service Area employs a multi-pronged approach in evaluating its progress towards achieving its goals in the Comprehensive Plan, assessing the impact of EIIHA, improving the usage of Ryan White client level data, using data to monitor service utilization, as well as an outline of the Clinical Quality Management program.

The Evaluation and Comprehensive Plan Committees of the Planning bodies monitor the Comprehensive Plan goals during their regularly scheduled meetings. Both Committees meet every month of the year, and both make review of the Comprehensive Plan a part of their regularly conducted business. Both request data from the Recipients on a frequent basis to ensure it has the most current information possible to assist them in their duties.

In addition, the Planning bodies utilize Ryan White HIV/AIDS Program Services Report (RSR) data in Priority Setting and Resource Allocation. The Planning bodies will be able to incorporate this data, along with the rest of the data used during this process, to paint a more complete picture of service utilization on a more detailed level to improve the process.

The Recipients and Planning bodies will continue to authorize special studies, in addition to the yearly needs assessment process, to identify gaps and barriers in care, assess service delivery, and offer recommendations on improving care. These activities commence on a yearly basis by the middle of the year, and this year will be no different. Data from these special studies is presented to the committees and the Planning bodies on a yearly basis during the Priority Setting and Resource Allocation processes.

b. Describe the Plan to Monitor and Evaluate the Implementation of Goals and SMART Objectives

Specific activities are monitored within each strategy for the specific object tied to each goal. The outcomes of these are reflected in the data indicators which measures the progress being made toward addressing the overall objectives. These indicators are analyzed through data collection from various sources. Specific numerators and denominators for each indicator have been developed and distributed to providers to ensure consistency in methodology. Performance data is obtained from Provide and CAREWare reported by each network provider. Provider data is aggregated into a summary report by the Recipients. This aggregate data is shared with the Planning bodies and the CQM Steering Committee, Network Providers and other stakeholders on a quarterly basis. Corrective action plans are required by the Recipients from providers whose quarterly performance did not meet or exceed the established targets. A follow-up session is scheduled with the provider to monitor implementation and anticipated improvement. Providers who meet the outcome measures are encouraged to identify and sustain the practices that produce positive results.

SECTION III: Monitoring and Improvement

Key Performance Indicators

	Goal 1: Reduce New HIV Infections.		Goal 2: Increase Access to Care and Improve Health Outcomes for People Living with HIV.		Goal 3: Reduce HIV-Related Disparities and Health Inequities.		Goal 4: Determine and develop mechanisms to improve coordination across all planning bodies by 2021.
Strategic Goal	Indicator 1: Increase the percentage of people living with HIV who know their serostatus to at least 90% from the baseline of 84%.	Indicator 2: Reduce the number of new diagnoses by at least 10% from 845 at baseline to 760.	Indicator 4: Increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 80%.	Indicator 6: Increase the percentage of persons with diagnosed HIV infection who are virally suppressed to at least 65% from the baseline of 59%.	Indicator 7: Reduce the percentage of persons in HIV medical care who are homeless to no more than 5%.	Indicator 9: Reduce disparities in the rate of new diagnoses by at least 10% in the following groups: gay and bisexual men, young Black gay and bisexual men, Black females, and persons living in the Southern United States.	
Audience	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts	PC, All RW Parts
Key Performance Question	How effective is our screening process?	How effective is our prevention effort?	How effective are we in getting HIV+ individuals into care?	How effective are we in suppressing VL?	How effective are we in housing HIV+ individuals?	How effective are we in serving populations experiencing disparities?	How effective are we in coordinating our services?
How will this indicator be used?	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the Continuum of Care. Will be used to measure progress across all RW Parts.	Aligns with the National HIV Goals. Will be used to measure progress across all RW Parts.	Aligns with the National HIV Goals. Will be used to measure progress across all RW Parts.
Indicator Name	Know Status	Newly Diagnosed	Linked	Virally Suppressed	Homeless	Disparities	Coordination
Data Collection Method	Provider reporting statistics to	Provider reporting statistics to	Provider reporting statistics to	Provider reporting statistics to	Commission on Homelessness	Provider reporting statistics to	Coordination activities

	FL DOH	FL DOH	FL DOH	FL DOH	surveys	FL DOH	
Assessment / Formula / Scale	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 0 – 100% scale.	Uses 1-6 scale.
Targets and Performance Thresholds	From 84% to 90% by 2021	From 845 to 760 by 2021	80% by 2021	From 59% to 65% by 2021	To no more than 5% by 2021	By at least 10% by 2021.	By at least 3 points achieved by 2021.
Source of Data	FL DOH data reports	FL DOH data reports	FL DOH data reports	FL DOH data reports	Commission on Homelessness	FL DOH data reports	Workgroup meeting minutes
Data Collection Frequency	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly
Reporting Frequency	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly	Quarterly
Data Entry	Work group	Work group	Work group	Work group	Work group	Work group	Work group
Revision Date	Annual	Annual	Annual	Annual	Annual	Annual	Annual

c. Describe the Strategy to Utilize Data and Improve Health Outcomes

To improve the HIV-related clinical quality health outcomes of PLWHA in the Orlando Service Area, the Recipients work with staff to ensure that the outcome data is coded correctly and that it accurately reflects the improvement trends in the data. In addition to the HAB core metrics, the Orlando Service Area will work with Recipient staff to customize outcome measurement reports so that aggregate reports can be obtained directly from the Provide ENTERPRISE and CAREWare databases. The QM team works to champion outreach coordination, increasing the visibility and access to care of hard to reach populations in our Orlando Service Area by developing and implementing specific targeted strategies.

The mission of the Clinical Quality Management (CQM) Program is to provide core medical and support services for eligible individuals with HIV/AIDS to achieve their medical outcomes as defined by Orlando Service Area. The program seeks to further develop and expand systems of care to meet the needs of PLWHA. The vision of the CQM Program is to be progressive, maximizing collaboration, efficiency and innovation in improving health outcomes to meet the needs of Persons Living with HIV/AIDS (PLWHA) within the Orlando Service Area with seamless access to quality care while reducing HIV infection, stigma and discrimination in high-risk communities against PLWHA. The goal of the CQM program is to provide the best care possible, for every consumer at every site, every day. Overall, the processes ensure that Primary Medical Care services are provided in accordance with the Department of Health and Human Services (DHHS) treatment guidelines and standards of care so that we may 1) reduce the number of people who become infected with HIV, 2) increase access to care and optimize health outcomes for people living with HIV, and 3) reduce HIV-related health disparities.

The overall responsibility for oversight and management of quality management (QM) activities rests with the Recipient's CQM team. This team is responsible for planning, directing, coordinating and improving healthcare services in the EMA. This CQM Team facilitates the implementation of the work plan associated with the QM Plan and relevant activities described in the Comprehensive Plan. This team is responsible for the development and deployment of system-wide quality initiatives and is responsible for conducting ongoing clinical quality

assurance activities including programmatic and administrative reviews of service providers to ensure service delivery quality.

The Part A Recipient Administrator is the chairperson of the CQM Steering Committee, an advisory board directing and providing an oversight role in the implementation, monitoring and evaluation of the CQM Program and the development of the QM Plan. The Quality Management Steering Committee (QMSC) meets quarterly. The Recipient Administrator authorizes the Steering Committee to oversee the development of data-driven plans and measures prior to implementing performance improvement strategies throughout the provider network. The Recipient Administrator reports quality management findings, utilization data reports, special studies, evaluation of outcomes and indicators from all service categories, emerging issues and progress to the Planning bodies.

The internal process that assesses the Clinical Quality Management (CQM) Program is the "Quality Council" or Evaluation Committee of the Planning bodies and the CQM Steering Committee. Each of these committees consist of stakeholders and expert volunteers that provide oversight of the CQM Program by reviewing clinical outcome data and making recommendations and providing feedback during periodic scheduled reporting and update forums.

In addition, the QM team participates in a Regional Quality Management Meeting and facilitates the service coordination with emphasis on coordination with prevention, given new EIIHA requirements, with an EIIHA Strategy Meeting. The QM team participates in the Resource Allocation Process by providing outcome and utilization data for decision making.

SECTION IV

Submission and Review Process

SECTION IV: Submission and Review Process

The Integrated HIV Prevention and Care Plan for the Orlando Service Area will be submitted to Tallahassee by May 16, 2016 to be included as a Chapter in the State Plan. Once the State Plan is completed then the Orlando EMA will submit the State Plan to HRSA for review.

APPENDIX A

Letter of Concurrence

LCDR Anderson A. Tesfazion, US Public Health Service
Public Health Analyst, Division of Metropolitan HIV/AIDS Programs
HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane, 09W-13D
Rockville, Maryland 20857

Dear Mr. Tesfazion:

The HIV Health Services Planning Council and the Central Florida AIDS Planning (CFAP) Consortium ***concurs*** with the following submission by the Orlando Service Area (Brevard, Lake, Orange, Osceola, and Seminole Counties) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Planning Council and Consortium have reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Planning Council and Consortium ***concurs*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

The Consortium for Area 7 and the HIV Health Services Planning Council for the Orlando Eligible Metropolitan Area (EMA) established a collaborative Integrated Plan Writing Team which consisted of members of the Planning Council, CFAP members, the Area 7 HIV/AIDS Program Coordinator (HAPC) - the Ryan White Part B Recipient's Area 7 Representative, representatives from the Area 7 Lead Agency, representatives from the Ryan White Part A Recipient's office, Ryan White Parts C and D representatives, Housing Opportunities for People with AIDS (HOPWA) representative, mental health and substance abuse providers and prevention providers as well as consumers. The composition of the Writing Team was reflective of the East Central Florida epidemiology and was responsible for drafting the Integrated Plan. The Draft Plan was presented to the full Planning Council and Consortium membership monthly for discussion and feedback. Feedback received was incorporated into the Plan and the final draft of the Plan was presented to each body for a 30-day review at their respective March meeting and posted on each body's website. The 2017-2021 HIV Integrated Prevention and Care Plan for the Orlando Service Area was adopted on April 14, 2016 by the CFAP Consortium and by the Planning Council on April 27, 2016.

The signatures below confirm the ***concurrence*** of the planning bodies with the Integrated HIV Prevention and Care Plan.

Shirley Lanier, HIV Health Services Planning Council Chair — 5/9/2016 — Date

Karen Jaeger, CFAP Consortium Patient Care Chair — 4-26-16 — Date

John Curry, CFAP Consortium Prevention Chair — 4-26-16 — Date