

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan



TABLE OF CONTENTS

*Message from Sherry Riley, Acting Bureau Chief, Bureau of HIV/AIDS
Patient Care Planning Group Letter of Concurrence
Executive Summary*

Section 1: Where Are We Now?

Introduction.....	2
1A: Description of Local HIV/AIDS Epidemic	3
1B: Current Continuum of Care, Including Overlaps in Care.....	10
1C: Description of Need.....	13
1D: Description of Priorities for the Allocation of Funds.....	15
1E: Description of Gaps in Care.....	17
1F: Description of Prevention Service Needs.....	19
1G: Description of Barriers to Care.....	20
1H: Evaluation of 2009 Comprehensive Plan.....	28
1I: Process for Creating the 2012-15 SCSN.....	29
Summary.....	30

Section 2: Where Do We Need To Go?

Introduction.....	33
2A: Plan to Meet 2009 Challenges Identified in the Evaluation of the 2009 Comprehensive Plan.....	33
2B: 2012-2015 Proposed Care Goals.....	35
2C: Goals Regarding Individuals Who Are Aware of Their HIV Status but Are Not in Care.....	36
2D: Goals Regarding Individuals Unaware of Their HIV Status.....	38
2E: Proposed Solutions for Closing Gaps in Care.....	39
2F: Proposed Solutions for Addressing Overlaps in Care.....	44
2G: Proposed Coordinating Efforts to Ensure Optimal Access to Care.....	45
2H: Role of the Ryan White Program in Collaborating with the Enhanced Comprehensive HIV Prevention Planning and Implementation Initiative.....	48
Summary.....	49

Section 3: How Will We Get There?

Introduction.....	52
3A: Strategy, Plan, Activities, Timeline, and Responsible Entity(ies) to Close Gaps in Care ...	52
3B: Strategy, Plan, Activities, Timeline, and Responsible Entity(ies) to Address the Needs of Individuals Aware of Their HIV Status, but Are Not in Care.....	59
3C: Strategy, Plan, Activities, Timeline, and Responsible Entity(ies) to Address the Needs of Individuals Unaware of Their HIV Status (with an Emphasis on Identifying, Informing, Referring, and Linkage to Care Needs).....	65
3D: Strategy, Plan, Activities, Timeline, and Responsible Entity(ies) to Address the Needs of Special Populations Including but Not Limited to; Adolescents, Injection Drug Users, Homeless, and Transgender.....	69
3E: Activities to Implement the Proposed Coordinating Efforts to Ensure Optimal Access to Care.....	73
3F: Healthy People 2020 Objectives.....	74
3G: Reflection of the Statewide Coordinated Statement of Need.....	74
3H: Coordination and Adaption with Changes That Will Occur with the Implementation of the Patient Protection and Affordable Care Act.....	75
3I: National HIV/AIDS Strategy.....	76
3J: Strategy to Respond to Any Additional or Unanticipated Changes in the Continuum of Care as a Result of Budget Cuts.....	77
Summary.....	78

Section 4: How Will We Monitor Progress?

Introduction.....	80
4A: Monitoring and Evaluation of the 2012-15 Plan.....	80
4B: Improved Use of Ryan White Client Level Data.....	81
4C: Use of Data in Monitoring of Service Utilization.....	81
4D: Measuring Clinical Outcomes.....	81
4E: Assessing the Impact of the Early Identification of Individuals with HIV/AIDS Initiative..	82
Summary.....	82

Appendices

A: Acronym List.....	i
B: Goal Alignment Key.....	iv

A Message From...

Sherry Riley

Acting Bureau Chief, Bureau of HIV/AIDS

Why the Plan?

As of 2010, over 1.5 million people nationwide have been infected with HIV, with an additional 48,100 new infections estimated to occur each year. The epidemic remains a major public health challenge in Florida, as the number of persons infected each year continues to grow and the state must continue to find the resources to provide ongoing systems of care to meet the needs of people living with HIV/AIDS. Florida's Statewide Coordinated Statement of Need and Comprehensive Plan will assist us in meeting our goals and ensuring that we meet these challenges by providing quality services and care for people living with HIV/AIDS.

The Florida Department of Health, Bureau of HIV/AIDS and Patient Care Planning Group (PCPG) developed this plan in cooperation with our community planning partners throughout the state who have contributed their leadership, dedication, and expertise toward making it a meaningful and successful endeavor. It is a vital tool in assisting the HIV/AIDS program in meeting our goal of providing a high quality, community-based continuum of care for people living with HIV/AIDS throughout Florida. Achieving positive outcomes related to the goals and strategies delineated in the plan will ensure that the people affected by this epidemic will receive services that allow them to lead more productive and healthy lives. Florida adopted the three primary goals of the National HIV/AIDS Strategy as evidence of its commitment to stop the HIV epidemic; support all infected individuals with dignity; access to high-quality care and improved health outcomes; and, reduce HIV-related health disparities.

A Message

As this plan indicates, the impact of HIV/AIDS is far reaching and continues to affect more people in every community in Florida. As the epidemic grows, it is important for all HIV/AIDS service organizations, public and private, to coordinate and plan cooperatively, identify gaps in service needs, link persons to healthcare, and work together to maximize our limited resources. Comprehensive planning is a key component in reaching those objectives, and the Bureau of HIV/AIDS is committed to ongoing refinement and improvement of the planning process.

Special Thanks

I would like to thank the Bureau of HIV/AIDS, patient care staff, the Patient Care Planning Group, the Statewide Coordinated Statement of Need and Comprehensive Plan writing workgroup members, and our community partners for their hard work, expertise, and leadership in working together to create a plan to improve the comprehensive system for HIV/AIDS care and treatment in Florida. Through this planning process, you have demonstrated a commitment to cooperation and excellence that will make a significant difference in the lives of Florida's men, women and children who are infected and affected with HIV/AIDS. I would also like to acknowledge the vision and leadership of Tom Liberti, Chief of the Bureau of HIV/AIDS, who retired in March 2012. Tom has been involved in HIV since the beginning and he actually built many of the programs we take for granted today.

PATIENT CARE PLANNING GROUP LETTER OF CONCURRENCE

March 21, 2012

Frances Hodge, Project Officer
Health Resources and Services Administration
5600 Fishers Lane
Parklawn Building
Room 7A-54
Rockville, Maryland 20857

Dear Ms. Frances Hodge:

On behalf of the statewide Patient Care Planning Group (PCPG), we are confirming our concurrence with Florida's 2012-15 Statewide Coordinated Statement of Need (SCSN) and Comprehensive Plan. Part B of Title XXVI of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires the State to engage in a public advisory planning process to develop the comprehensive plan and comment on the implementation of the plan. We believe this document addresses the patient care planning needs of priority populations supported through the funding commitments of the Florida Department of Health's Bureau of HIV/AIDS (Part B grantee). Throughout the duration of the plan, the PCPG will monitor and evaluate the progress towards achieving the goals and meeting the challenges identified within the document. We consider the 2012-15 SCSN and Comprehensive Plan to be representative of the collaborative effort among the various components of Florida's HIV/AIDS Comprehensive Planning Network (FCPN), which includes the PCPG, the Prevention Planning Group (PPG), the Hepatitis Planning Group, the statewide Consumer Advisory Group (CAG), the 14 regional Consortia, the five Eligible Metropolitan Areas (EMAs), and one Transitional Grant Area (TGA). We can confirm that the PCPG was actively engaged in the development of this document and applied a thorough review process to ensure concurrence.

In developing the plan the SCSN and Comprehensive Plan writing workgroup adopted, as its guiding framework, the three primary goals of the National HIV/AIDS Strategy (NHAS). As Florida strives to meet its own proposed goals, it will also be contributing to the national coordinated effort to achieve the NHAS' vision of a nation committed to stopping the HIV epidemic and supporting all infected persons with dignity, and access to high-quality care.

Florida's 2012-15 SCSN and Comprehensive Plan has been an incredibly successful collaboration between the Part B grantee; the PCPG; Ryan White Parts A, C, D, and F;

and various other stakeholders. The Part B grantee invited the grantees from all of Florida's Ryan White programs, Lead Agency staff, contract managers, HIV/AIDS Program Coordinators (HAPC), PCPG members, providers, and consumers to participate in a SCSN web conference in February 2011 to allow as many stakeholders to offer input as possible. A face-to-face meeting for this SCSN took place in March of 2011 in Tampa, Florida. The PCPG, an advisory work group specifically charged with assisting the Part B grantee in the development of the Comprehensive Plan for Patient Care services, attended, as well representatives from other Ryan White parts, Lead Agency staff, contract managers, HAPC, providers, and consumers. A SCSN writing group was created at that meeting and this document is the product of their efforts and those of the Comprehensive Plan writing workgroup formed at the October 2011 PCPG meeting. The Comprehensive Plan writing workgroup met in Orlando for three days in January 2012 to draft Sections 2 and 3 of this document. Then, a synthesis of the SCSN and Comprehensive Plan writing workgroups reviewed a draft of the entire plan in March 2012 and suggested further revision. Prior to the March 2012 PCPG meeting, the Part B grantee provided members with the opportunity to review the final iteration of Florida's 2012-15 SCSN and Comprehensive Plan and establish concurrence. The two Patient Care Planning Group co-chairs are designated as signatories to this letter of concurrence.

Sincerely,



Debra J. Tucci
Department of Health Co-Chair



Shirley Boughton
Community Co-Chair

Executive Summary

Joseph P. May

Program Administrator, Bureau of HIV/AIDS

Where Are We Now?

The Bureau of HIV/AIDS, Patient Care Section, is the operational unit within the Department of Health entrusted with ensuring that People Living with HIV/AIDS (PLWHA) throughout the state of Florida receive needed medical and support services. The federal Ryan White Program and state General Revenue fund these services, which are managed and provided through a statewide network of public and private service providers, in 14 geographical areas of the state.

The 2012-15 State of Florida HIV/AIDS Patient Care Statewide Coordinated Statement of Need and Comprehensive Plan includes a significant amount of information concerning the status of HIV/AIDS in Florida. This information has meaningful implications for statewide planning, allocation of resources, and the delivery method for HIV health and support services across Florida. The Surveillance Section of the Bureau of HIV/AIDS has been instrumental in providing data and reports concerning demographic trends and emerging population issues in Florida. This is vital in ensuring that service gaps or additional needs are identified so the state may adjust service delivery appropriately. The Statewide Coordinated Statement of Need (SCSN) has been incorporated into this plan. The SCSN was developed in cooperation with the comprehensive plan as there is common ground in the available data and identification of service needs.

Where Do We Need to Go?

The Bureau of HIV/AIDS has collaborated with the Patient Care Planning Group (PCPG), a statewide planning body tasked with the development of the Comprehensive Plan. The PCPG is comprised of a diverse group of individuals, representing all 14 regional consortia; Part A, C, D, & F funded entities; HIV/AIDS Program Coordinators (HAPC); public health employees; clinicians; PLWHA; persons of color; gay and/or bisexual men; and, the transgender community. Florida is wholly committed to aligning its statewide response to HIV/AIDS with the National HIV/AIDS Strategy (NHAS) and has adopted, as its guiding framework, the NHAS primary goals:

Goal #1: Reducing the number of people who become infected with HIV; Goal #2: Increasing access to care and optimizing health outcomes for PLWHA; and Goal #3: Reducing HIV-related health disparities. Florida designed its specific statewide HIV/AIDS care, within that NHAS framework, to target the unique barriers, challenges, resources, and circumstances currently affecting Florida's ability to maximize its HIV/AIDS response.

How Will We Get There?

The Comprehensive Plan identifies multiple issues and challenges confronting the delivery of HIV-related services in Florida and addresses the components deemed most critical to cultivate a high quality, comprehensive continuum of care for all PLWHA in the state. This document presents a framework for the continued development and improvement of Florida's comprehensive service delivery model over the next three years. The Comprehensive Plan will ensure effective implementation, yet allow flexibility to accommodate emerging issues and trends in each of the 14 areas. Recommended strategies seek to build upon the existing spectrum of HIV care and treatment.

We have continued to align our personnel system, information systems, planning processes, programs, and contracts with the Comprehensive Plan. We are committed to making necessary organizational and operational changes based on the needs of our clients, our staff, and our customers to ensure HIV/AIDS service delivery in Florida is the best. We are committed to making these changes through a fair, equitable, and transparent process. We will continue to work closely with other organizations, planning bodies, and funding sources to ensure these needs are met.

How Will We Monitor Progress?

The current plan describes the process to monitor and evaluate progress in achieving the proposed goals. The monitoring and evaluation plan communicates the procedure for tracking change throughout the duration of the plan. The Part B grantee will improve in the following areas: use of Ryan White client level data; monitoring service utilization through data; and, measuring clinical outcomes statewide. The Bureau of HIV/AIDS will communicate statewide progress updates bi-annually at the PCPG meetings and will use the updates to monitor and evaluate the challenges and successes in order to refine, revise, and adjust the current plan as needed.

SECTION 1: WHERE ARE WE NOW?

*“Do not dwell in the past, do not
dream of the future, concentrate the
mind on the present moment.”*

Buddha

Introduction

Florida has one of the largest Ryan White Part B funded programs in the country. There are 14 regional consortia and funds are administered by the Florida Department of Health's Bureau of HIV/AIDS (Part B grantee) in Tallahassee. The majority of the grant received from Health Resources and Services Administration (HRSA) goes towards funding the AIDS Drug Assistance Program (ADAP), the largest and most costly of the programs, largely due to the size and scope of the epidemic in the state. Florida also has six directly funded Part A programs, including five Eligible Metropolitan Areas (EMAs) and one Transitional Grant Area (TGA), as well as 21 organizations funded through Part C and six Part D grantees. The Part B grantee contracts with the lead agency of each consortium and provides oversight through local contract managers and community programs personnel. The Part B grantee allocates the funds to the local consortia, who then prioritize service categories. There is a statewide standardized eligibility criteria and determination process for all programs administered through the Part B grantee: Consortia, General Revenue, Patient Care Network, ADAP, AIDS Insurance Continuation Program (AICP) and Housing Opportunities for Persons with AIDS (HOPWA). The current income cap for all Part B grantee programs is 400% of Federal Poverty Level (FPL), with the exception of HOPWA, which is 80% of local median income as directed by the U.S. Department of Housing and Urban Development (HUD). All other programmatic requirements are enforced, including documentation of HIV disease and prescriptions for medications on the ADAP formulary.

Florida's first Statewide Coordinated Statement of Need (SCSN) was developed in 1996, as a direct response to the initial Ryan White Care Act requirement. Over the years, its scope has broadened to include more representation and reflect the changing needs of People Living with HIV/AIDS (PLWHA) within the state's boundaries. The SCSN has been an ongoing, collaborative, and representative process to identify significant issues and gaps in services and to recommend strategies to enhance further quality of life issues and outcomes for PLWHA.

Florida's 2012-15 SCSN and Comprehensive Plan has been an incredibly successful collaboration between the Part B grantee; the Patient Care Planning Group (PCPG); Ryan White Parts A, C, D, and F; and various other stakeholders. The Part B grantee invited the grantees from all of Florida's Ryan White programs, lead agency staff, contract managers, HIV/AIDS Program Coordinators (HAPC), PCPG members, providers, and consumers to participate in a SCSN web conference in February 2011 to allow as many stakeholders to offer input as possible. A face-to-face meeting for this SCSN took place in March 2011 in Tampa, Florida. The PCPG, an advisory work group specifically charged with assisting the Part B grantee in the development of the Comprehensive Plan for patient care services, attended, as well representatives from other Ryan White parts, lead agency staff, contract managers, HAPC, providers, and consumers. The PCPG is a diverse group of individuals, representing all 14 regional consortia; Part A, C, D, & F funded entities; HAPC; public health employees; clinicians; PLWHA; persons of color; gay and/or bisexual men; and, the transgender community. A SCSN writing group was created at that meeting and this document is the product of their efforts and those of the Comprehensive Plan writing workgroup formed at the October 2011 PCPG meeting. The Comprehensive Plan writing workgroup met in Orlando for three days in January 2012 to draft the following sections

of this document. A synthesis of the SCSN and Comprehensive Plan writing workgroups reviewed a draft of the entire plan in March 2012 and suggested further revision.

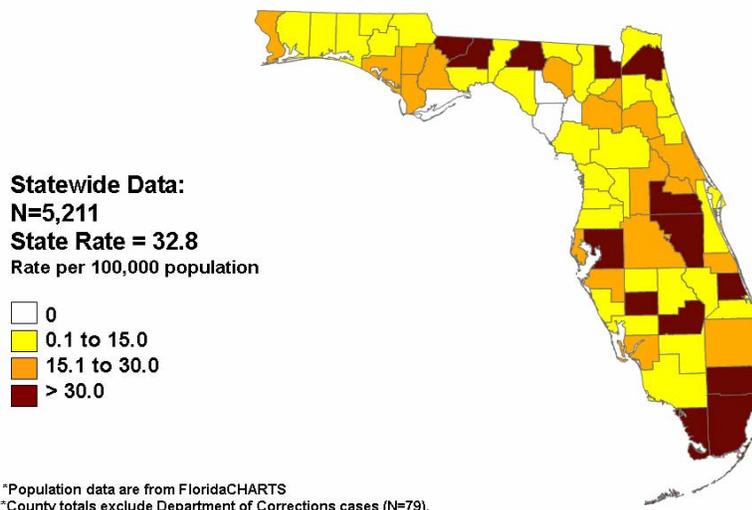
1A: Description of Local HIV/AIDS Epidemic

Florida ranked first among states in the number of Human Immunodeficiency Virus (HIV) cases reported in 2009 (most recent year available for U.S. data). That year 13% of all U.S. HIV cases were reported in Florida, followed by 11% in California and 10% in New York. Florida ranked second among states in the estimated number of Acquired Immune Deficiency Syndrome (AIDS) cases diagnosed in 2009 (most recent year available for U.S. data) and third cumulatively behind New York and California.

In 2010, at least one HIV case was reported in 63 of the 67 counties in Florida (Figure 1.A.1.). The majority of cases were reported from Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, Pinellas, and Polk. They reported a combined 75% of Florida's total reported cases in 2010. The greatest numbers of HIV cases were reported from Miami-Dade, Broward, and Orange. These three counties reported a combined 50% of the statewide total. The 5,211 HIV cases depicted in Figure 1.A.1. capture the first time that someone was diagnosed/reported with HIV disease, regardless if the individual had AIDS at that time of first diagnosis/report. When Florida reports HIV and AIDS cases by year, they are NOT mutually exclusive. Only when data are presented as snapshots in time, like all living cases, does Florida divide them into separate groups of HIV (not AIDS) and AIDS.

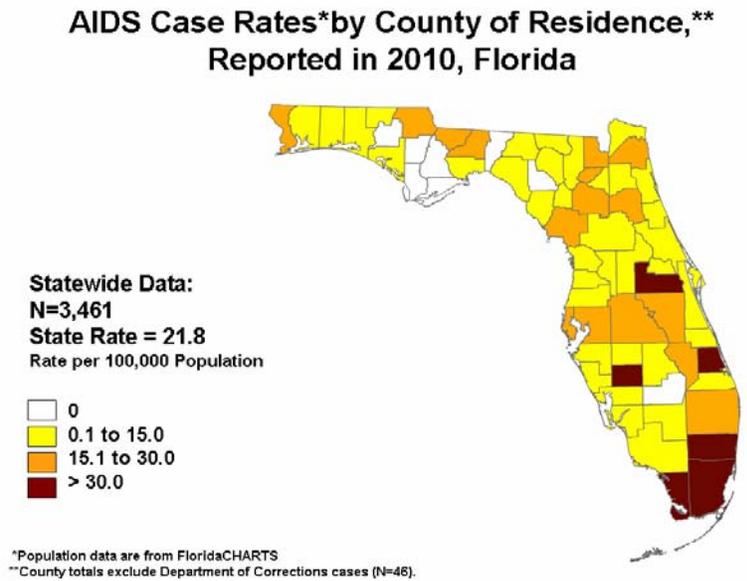
Figure 1.A.1. HIV cases, by county of residence, Florida, 2009 (excluding Department of Corrections).

HIV Case Rates* by County of Residence, Reported in 2010, Florida**



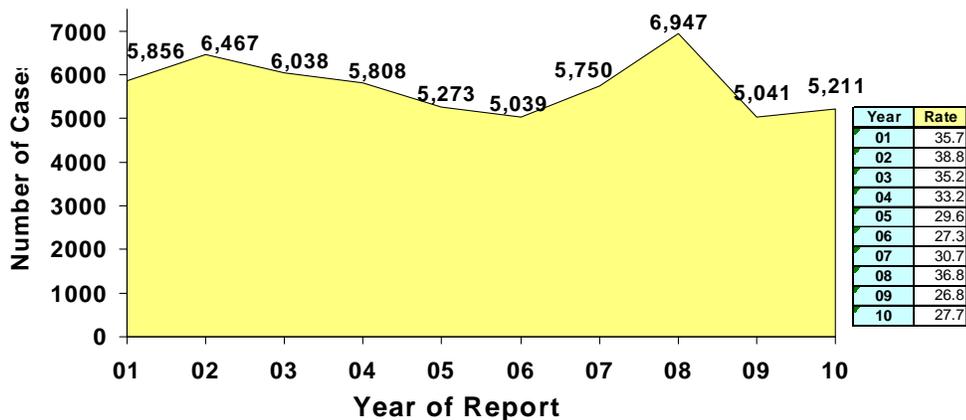
Although the AIDS epidemic is widespread throughout Florida, the majority of cases were reported from eight counties: Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach, Pinellas, and St. Lucie (Figure 1.A.2.). These counties reported a combined 74% of Florida's total reported cases in 2010. The greatest numbers of AIDS cases were reported from two counties located in the southeastern part of the state: Miami-Dade and Broward. These two counties reported a combined 39% of the statewide total.

Figure 1.A.2. AIDS cases and rates per 100,000 population, by county of residence, Florida, 2009, (excluding Department of Corrections).



Generally, there was an increase in HIV cases starting in 2002 due to increased HIV testing statewide as part of the “Get to Know Your Status” campaign (Figure 1.A.3.). Since that time, newly reported HIV cases have decreased each year until 2007. Enhanced reporting laws were implemented in November 2006, leading to an artificial peak in HIV cases in 2007 and 2008, followed by an artificial decrease in 2009 with an expected approach to leveling in 2010.

Figure 1.A.3. HIV case rates per 100,000 population, by year of report, Florida, 2001-2010.



HIV/AIDS Cases by Age, Sex, and Race

The greatest proportion of AIDS cases reported in 2010 was among persons 40-49 years old at 33%, followed by the 50+ age group with 28%, followed by the 30-39 age group with 24%. Compared with AIDS cases, a greater proportion of HIV cases in 2010 were reported among those aged 40-49 at 27% followed by those aged 20-29 at 25% and aged 30-39 at 23%.

Over the past ten years, the proportion of AIDS cases among men and women declined slightly from 2.4:1 (male to female ratio) in 2001 to 2.1:1 in 2010. In 2010, the AIDS case rate per 100,000 population was 30.6 among adult males and 13.5 among adult females, indicating that AIDS cases in this period were still more likely to be reported among males than females in Florida.

The trend for HIV cases by sex is the opposite of that for AIDS cases. Recent trends in HIV transmission are best described by the HIV case data. The relative increase in male HIV cases might be attributed to proportional increases in HIV transmission among Men who have Sex with Men (MSM), which may influence future AIDS trends. In 2001, 35% of the HIV cases reported in Florida were female. Over the past ten years, the proportion of HIV cases among men has increased while the proportion among women has decreased. The result is an increase in the male-to-female ratio, from 1.9:1 in 2001 to 3.0:1 in 2010. This pattern differs from that seen for AIDS cases during the same time. In 2010, the HIV case rate per 100,000 population was 50.2 among adult males and 16.2 among adult females, higher than the rates seen among AIDS cases.

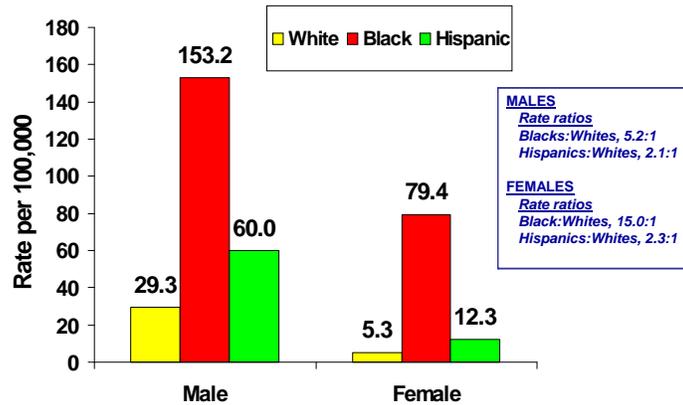
In 2010, adult males represented 68% of reported AIDS cases and adult females represented 32%. Also in 2010, adult males represented 75% of HIV infections and adult females accounted for 25% of cases. Florida's adult population is 49% male and 51% female; therefore, male cases are disproportionately impacted.

Historically, blacks account for over 50% of the reported AIDS cases; however, they represent only 15% of the adult population over the past 10 years. The proportion of AIDS cases among blacks has remained fairly constant. The proportion of AIDS cases has decreased among whites by 12% while increasing by 20% among Hispanics.

In 2010, blacks were over-represented in the AIDS and HIV cases, accounting for 54% of adult AIDS cases and 48% of adult HIV cases, but only 15% of the adult population. Hispanics represent 21% of the adult population and account for 19% of the adult AIDS cases and 22% of the adult HIV cases.

Black men and, to an even greater extent, black women are over-represented in the HIV epidemic (Figure 1.A.4.). The HIV case rate for 2010 is 5 times higher among black men than among white men. Among black women, the HIV case rate is 15 times higher than among white women. Hispanic male and Hispanic female rates are 2 times higher than the rates among their white counterparts.

Figure 1.A.4. Adult HIV cases and case rates per 100,000 population by sex and race/ethnicity, Florida, 2010.

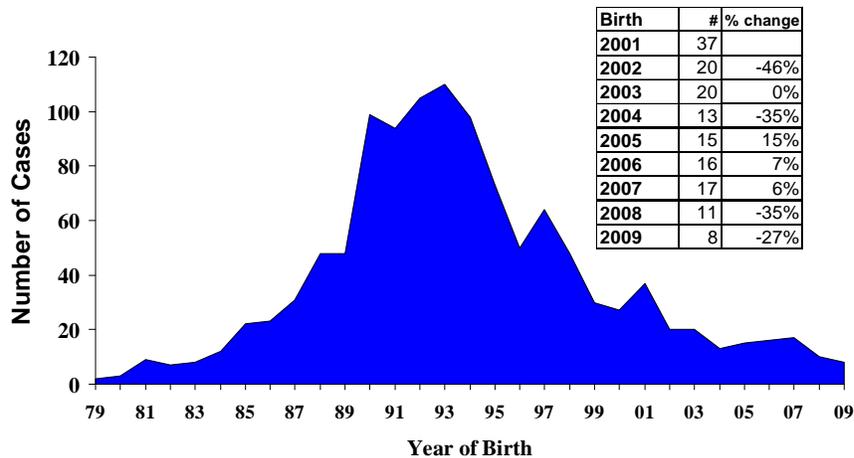


Perinatal HIV/AIDS Cases

Strategies to reduce the rate of mother-to-child HIV transmission continue to evolve and the number of infants born to HIV-infected mothers in Florida has declined from a high of 183 in 1992 to 6 in 2010 – a decrease of 96% (Figure 1.A.5). Since HIV-exposed newborn reporting became mandatory in 2006, there has been an average of 620 babies born to HIV-infected women per year. As of this writing, 2010 is the first year Florida has achieved the goal to keep the rate of HIV transmissions in newborns below 1%. Among the 68 HIV-infected babies born in Florida from 2005-2009,

- 27% of all mothers who delivered an infected infant did not know they were HIV positive prior to delivery, and
- 20% of all mothers who delivered an infected infant contracted HIV during the pregnancy.

Figure 1.A.5. Perinatal HIV/AIDS Cases by Year of Birth, born in Florida, 1979-2009 (N=1,167).



In 2006, the Part B grantee promulgated Florida Administrative Code 64D-3.042 regarding HIV testing of pregnant women, which eliminated the requirement of a separate consent (opt-out testing) and requires that pregnant women be tested at the initial prenatal care visit and at 28-32 weeks gestation. Women who present to the ER in labor and without documentation of prenatal care or an HIV test after 27 weeks gestation are tested for HIV and Sexually Transmitted Disease (STD) with rapid testing methods.

A woman in labor who is identified as HIV-infected will begin the zidovudine (ZDV) protocol, including IV ZDV given as a 1-hour loading dose followed by a continuous infusion until delivery to prevent mother-to-child transmission. The infant is started on a 6-week treatment course within 12 hours of birth. The Part B grantee has a Baby Rxpress Program to provide Retrovir (AZT) for HIV-exposed newborns at no cost to the family when they have no other means to pay for the medication. The Part B grantee has a credit account at identified Walgreens stores throughout Florida. The perinatal nurse, their designee, or the family can present the prescription and the payment voucher to a participating Walgreens store and the drug is dispensed in exchange for the voucher. The goal of this effort is for the mother to leave the hospital with the medicine in hand. There are currently different solutions in different areas of the state - many of which work very well. Some use home delivery pharmacies, and some hospitals dispense the medicine to the mother from the hospital pharmacy. If a local area has an existing system in place, the Part B grantee advises partners to continue to use it and utilize Baby Rxpress when there seems to be no other option. Baby Rxpress is the payer of last resort to provide AZT for the babies quickly, when families do not have insurance, money to pay for the medicine, and/or a ride to the drug store.

The decline can also be attributed to the aggressive efforts of Florida's Ryan White Part D programs and the Targeted Outreach for Pregnant Women Act Program (TOPWA), which has served to link HIV-infected pregnant women to care. The perinatal HIV programs in Fort Lauderdale, Jacksonville, Miami, Tampa, and Orlando have received funding from the Ryan White Part D program since 1994 to coordinate or provide family-centered care and treatment for HIV-infected women. They also have been successful in assisting patients in accessing clinical trials to evaluate treatment and to develop safe and effective approaches to prevent mother-to-infant transmission of HIV. While great strides to reduce perinatal HIV transmission have been made in Florida, the goal continues to be zero transmission and efforts must continue to focus on the missed opportunities. Even with this success we continue to repeat the mantra that, "One is too many." The stated goal of the perinatal program is to keep the rate of HIV transmissions in newborns below 1%.

Adult (age 13+) HIV/AIDS Cases by Transmission Category

Among the male AIDS and HIV cases reported for 2010, MSM was the most common risk factor (61% and 74% respectively) followed by cases with a heterosexual risk (28% for AIDS and 21% for HIV). The recent increase among MSM is indicated by the higher percent of MSM among HIV cases compared to AIDS cases, as HIV cases tend to represent a more recent picture of the epidemic. Among the female AIDS and HIV cases reported for 2010, heterosexual contact was the highest risk (87% and 89% respectively).

Prevalence Estimate of HIV Infection in the U.S. and Florida

Assessment of the extent of the HIV epidemic is an important step in community planning for HIV prevention and HIV/AIDS patient care. The HIV prevalence estimate—the estimated number of persons living with HIV infection—includes those living with a diagnosis of HIV or AIDS and those who may be infected but are unaware of their serostatus. Approximately 1,039,000-1,185,000 persons are currently living with HIV infection in the U.S. Florida has consistently reported 10-12% of the national AIDS morbidity and currently accounts for 11% of all persons living with AIDS in the U.S (Figure 1.A.6.). The Part B grantee now estimates that approximately 135,000 persons, or roughly 11.7% of the national total, are currently living with HIV infection in Florida as of the end of 2009. Of that amount, the Part B grantee estimates that 27,000 are unaware of their status, based on the Early Identification of Individuals with HIV/AIDS (EIIHA) formula.

Figure 1.A.6. Persons Living with HIV Infection in the U.S. (2008) and Florida (2009).

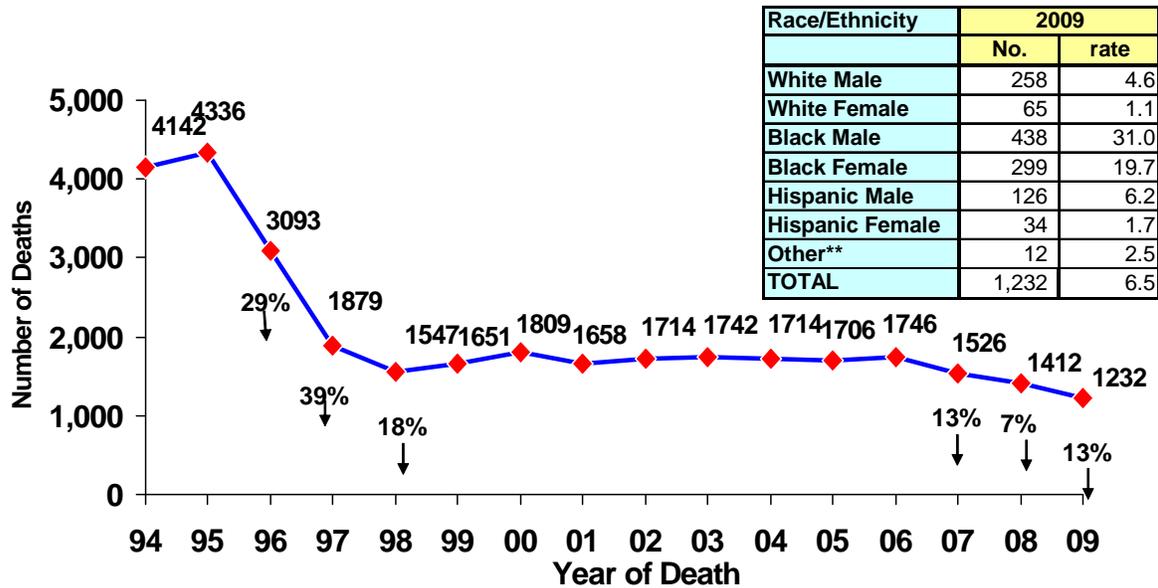
Subgroup N=	U.S. 663,084	Florida 93,053
Male	73%	70%
Female	27%	30%
White	33%	30%
Black	48%	49%
Hispanic	17%	19%
Other	3%	2%
MSM	46%	44%
IDU	19%	11%
MSM/IDU	5%	4%
Heterosexual	28%	39%
Other	2%	2%

Impact of HIV Related Deaths

Since Florida began tracking AIDS cases in 1981, a cumulative total of 121,161 AIDS cases have been reported through December 31, 2010. Of these cumulative cases, 66,848 (55%) are known to have died. HIV/AIDS deaths decreased markedly from 1996-1998, associated with the advent of Anti-Retroviral Therapy (ART) in 1996 (Figure 1.A.7.). A leveling of the trend during 2000-2006 may reflect factors such as viral resistance, late diagnosis of HIV, adherence problems, and lack of access to or acceptance of care. Yearly declines of 13% in 2007, 7% in 2008, and another 13% in 2009 appear to be promising. Racial/ethnic disparities are evident in the death rate data. Decreases among males and females were observed in all racial/ethnic

groups, except white females (where there was no change at all). The peak year for resident HIV deaths was 1995. In 2008 and 2009, HIV was the sixth leading cause of death among persons aged 25-44 as recorded by Florida's Office of Vital Statistics.

Figure 1.A.7. Resident HIV deaths, by year of death, Florida, 1994–2009.



Unmet Need Estimate

To provide an accurate unmet need estimate, the Surveillance Section began by assuring that they had the most accurate statistics on living status. To do so, the Part B grantee has set up ongoing matches with the death certificate database in the Office of Vital Statistics and with reports of death certificates on cases with a known HIV-related death. Additionally, the Part B grantee routinely matches this data with the death certificate database to receive notification on deaths to cases with unrelated causes. Furthermore, the Part B grantee annually matches their data against the five most recent years of deaths from the Social Security Death Master File and updates deaths accordingly. For this past year, the Part B grantee also matched their AIDS cases with the National Death Index, which identified over 700 new deaths not previously recorded.

To generate the statewide number of clients in service, the Enhanced HIV/AIDS Reporting System (eHARS) case data of HIV/AIDS cases still presumed living in Florida through 2010 were matched with Medicaid, ADAP, the Health Management System, CAREWare and the Electronic Laboratory Reporting and paper labs databases. A database was created from results of these matches that contain any HIV/AIDS case from the eHARS with at least one CD4, Viral HIV test or HIV prescription recorded in 2010, indicating that they received the specified HIV primary medical care service within a 12-month period as defined by HRSA and therefore are in care. Cases reported from the Department of Corrections (DOC) were included in the match in the “special population” category.

Using the above input data and estimates, we were able to generate the following statewide figures for unmet needs:

Living AIDS Cases (PLWA) through 2010: 52,522
Living HIV (not AIDS) Cases (PLWH) through 2010: 42,666
PLWHA through 2010: 95, 188
Number of PLWA who received medical care in the period1: 36,1082
Number of PLWH who received medical care in the period1: 20,7032
Number of PLWHA who received medical care in the period1: 56,8112
Number of PLWA who DID NOT receive medical care in the period1: 16,4142
Number of PLWH who DID NOT receive medical care in the period1: 21,9632
Total of PLWHA who DID NOT receive medical care in the period1: 38,3772

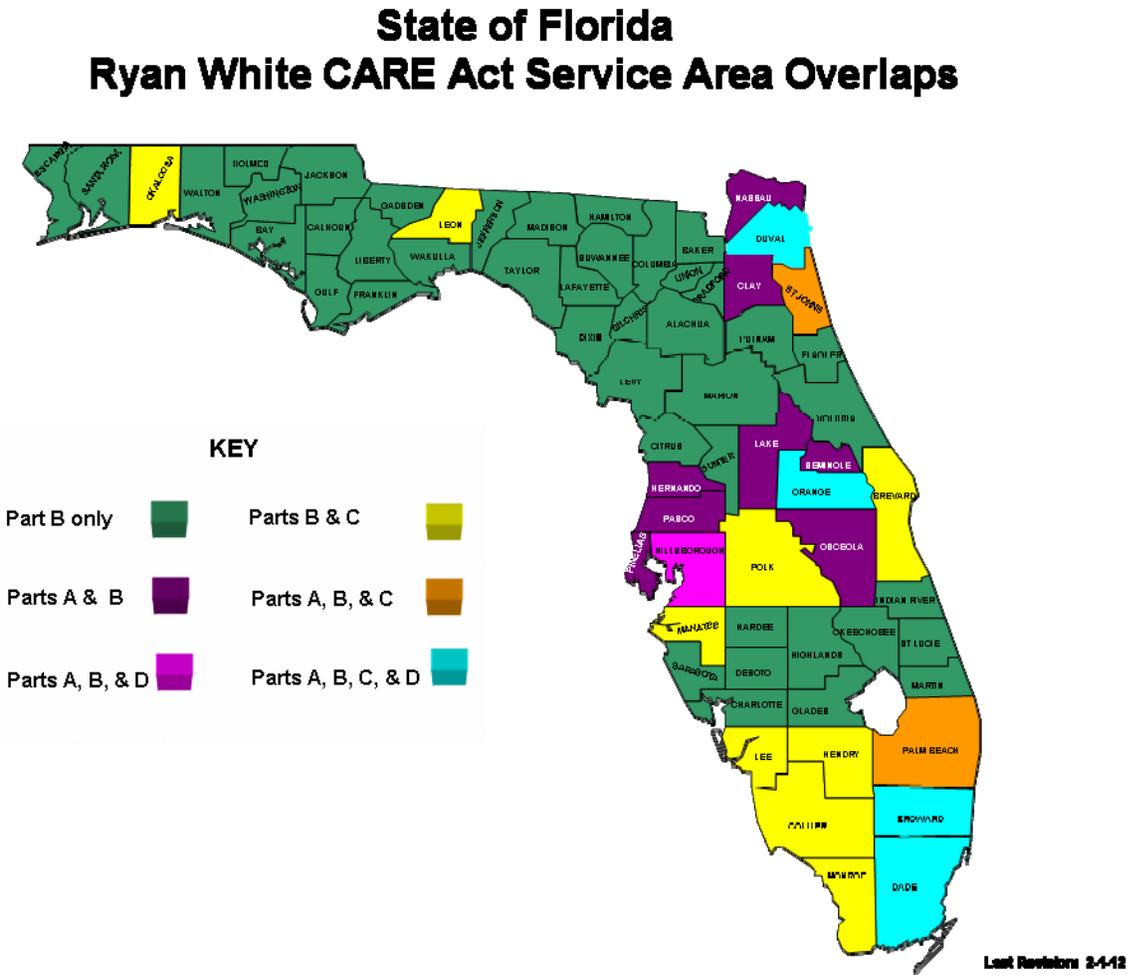
1B: Current Continuum of Care, Including Overlaps in Care

Whether a person is newly diagnosed or presents at a service provider as a PLWHA, Florida has always made it a priority to link everyone to care through Florida's standardized, statewide eligibility process as soon as possible. Eligibility staff serves as the entry point for Part B case management and also links clients to medications, health insurance, and housing assistance through the ADAP, AICP, and HOPWA programs. Specialists in those programs further assist clients with enrollment.

Florida clients are re-determined for eligibility every six months. This creates an opportunity to keep clients in care, while re-assessing their needs and changes in financial status. Eligibility specialists are trained to identify alternate funding sources such as Medicaid, Medicare, or private health insurance. Indigent care services are available in many local tax districts, and case managers can facilitate enrollment. Case managers work with each client to identify all possible sources of assistance, thereby ensuring that Ryan White is payer of last resort.

PLWHA in Florida receive medical and support services through several funding streams in a myriad of provider settings. Availability and level of care are influenced by geography, population density (urban vs. rural), and the number and type of Ryan White-funded programs. Florida has one of the largest Ryan White-funded programs in the United States (Figure 1.B.1). The Part B grantee funds 14 regional consortia that coordinate service provision in all of the state's 67 counties. Urban areas most severely affected by the HIV/AIDS epidemic are home to six Part A programs (five EMAs and one TGA). In addition, many service areas enjoy support through Ryan White Parts C, D, and F. Twenty-one public and private organizations are funded through Part C, which provide direct services in 17 counties in Florida. The state's six Part D grantees target special populations: specifically, children, youth, and women living with HIV and their families in five counties. Seven Part B areas receive state HIV/AIDS matching funds (General Revenue Patient Care Network) and non-categorical general revenue dollars. Thirty of Florida's counties, mostly rural, receive only Part B funds.

Figure 1.B.1. Ryan White CARE Act Service Area Overlaps, Florida, Fiscal Year (FY) 2011-12.



Funding overlaps result in a disparity in service. In metropolitan areas, more HRSA-defined core medical services are funded and readily available, including outpatient, substance abuse and legal services. Though a PLWHA may have to wait to see an eligibility specialist or to be assigned a case manager for referrals, a wider range of medical and support services are available. Clients in rural service areas of the state overall receive less per-capita funding, and find fewer safety-net community providers for unfunded services.

PLWHA in Florida receive the bulk of their medical care through Medicaid and Medicare, the top two payer sources. The relatively older population is mirrored in a higher Medicare enrollment. As many former veterans choose to retire here, Florida has a fairly significant number of PLWHA who access their medical care through the Veteran's Administration. Currently, Florida has a mandated Medicaid managed-care program in five counties of the state, Baker, Broward, Clay, Duval, and Nassau and legislation was passed in the 2012 session to expand the program statewide.

Due to the downturn in the economy, the system of care has been put under serious strain, beginning in 2008. Florida's unemployment rate exceeds the national average by 1.4 percentage points (December 2011, Bureau of Labor Statistics). It reached 11% in 2009 and remained above that point through 2010, only recently dropping below 10% in December 2011.

Joblessness and economic hardship have both reduced available resources and caused more PLWHA to seek assistance. The financial situation has been further aggravated by a lack of increased financial resources from federal or state governments. County Health Departments (CHDs), many who are the sole providers of HIV medical services in some of Florida's 30 'Part-B-only' counties, have seen a 7-25% reduction in General Revenue funding.

Florida's Ryan White service delivery system's client caseloads are steadily increasing. One of the factors driving this is Florida's aggressive testing initiative. This effort has produced over 400,000 HIV tests in 2011 and over 300,000 each of the previous 4 years. Meeting the needs of the thousands of newly diagnosed in Florida each year is becoming more and more challenging. Many existing PLWHA now seek Ryan White assistance as they have lost jobs or benefits. ADAP enrollment increased by 25% beginning in 2008 up to the moment the wait list was instituted.

In January of 2010, the ADAP program experienced a shortfall in funding necessary to meet the needs of all clients through the end of the 2010-11 program year. Agreements with Welvista, the Fair Pricing Coalition, and strategies such as the bridge program allowed ADAP to remain viable. In August of 2010, Florida announced its first reduction in its formulary, the number of medications available as part of the ADAP. Florida instituted the first wait list for ADAP services in approximately 15 years in June 2010 with 500 clients statewide, which grew to 3,680 through March 2011, while 10,405 clients were maintained on ADAP. Approximately 35% of currently eligible ADAP clients were affected.

The Part B grantee has sought and received some additional funding for the ADAP in the 2011-12 grant year. Clients received medications through Pharmaceutical Assistance Programs, compassionate use programs, local Part A and Part B programs, and through use of drug discount cards. With communication and training, ADAP and Case Management staff kept clients enrolled, informed, and worked identify new sources for HIV/AIDS medications. Local areas assisted with coverage for insurance premiums, co-pays, and other insurance-related pharmaceutical expenses for wait list clients. There was a great strain placed upon the local service delivery system, due to the response almost all of the need was met. The strain on the local service delivery system was great, but the response covered almost all of the need. The local and state planning bodies came up with data requests and worked with the state to build a check and balance system to avoid this type of scenario from happening again.

Addressing the ADAP crisis and shortfalls in the AICP, which has had a wait list for almost three years, has required sacrifice. The Part B grantee instituted restrictions on the use of Part B funds. Three non-core services are no longer funded: Health Education/Risk Reduction (HERR), Treatment Adherence, and Outreach Services. In addition, the Part B grantee reviewed the use of core and non-core services in each area of the state.

In communities that had them, HERR workers provided critical lifelines to individuals in getting them in to care, keeping them in care, finding them when they are lost to care, or simply helping them adhere to complex medical regimens. Another vital role is in the Prevention for Positives programs, teaching clients how to be responsible living with HIV. Peer Navigator programs are forming in greater numbers across the state to meet this need. Peers are in a unique position to perform the important functions the HERR workers perform for some and provide a valuable new asset in communities where this role has been missing.

Food assistance has been capped. A client may receive up to \$35 per month in vouchers or food bank visits. Food is important to have to take with some medications and many rural areas do not have access to the food banks often found in more urban areas. Even in those areas, there is less to go around due to the downturn in the economy.

The Ryan White planning consortia are the vital link between communities and the Part B grantee. Consortia incorporate lead agencies, health departments, providers, consumers, and advocates into planning and service delivery. Consumers and providers participate in satisfaction surveys, focus groups, operate support groups, and work to reduce stigma through public awareness. Some local AIDS Service Organizations and Community-based Organizations hold local fundraisers, obtain small grants, and accept donations to meet potential shortfalls. Some examples include: Broadway Cares, Equity Fights AIDS, the M.A.C. AIDS fund, and the Elton John AIDS Foundation. Due to economic conditions, private donations are low.

One of the greatest accomplishments of Floridians working in the field of HIV is to work together collaboratively to help find solutions. As funding has become scarcer, Florida's system of care has become more reliant upon integration and finding better, more cost-effective ways to provide services. Part B consortia, Part A planning councils, and planning groups have combined to provide better oversight and efficiencies, ensuring that Florida does its best to provide top quality services to PLWHA.

1C: Description of Need

The Part B grantee conducts Florida's Statewide Anonymous Ryan White Needs Assessment Survey every three years to help identify service needs, gaps in service, and barriers to care from a consumer perspective. The 2010 Statewide Needs Assessment was designed to take respondents between 10 and 15 minutes to complete and was conducted between January 1 and September 30, 2010. The results were used to provide baseline data for evaluation and were combined with the results of the Provider Needs Assessment and actual service delivery data to help identify statewide needs.

Based on the survey responses, the largest care need identified by respondents overall was Outpatient Ambulatory Medical Care (OAMC) at 95%, followed by Medications at 95%, Case Management at 89%, Treatment Adherence at 88%, Early Intervention Services at 80%, HERR at 80%, Mental Health Services at 73%, Substance Abuse Treatment at 69%, Dental/Oral Health at 69%, Nutritional Counseling at 68%, Health Insurance at 66%, Food Bank at 63%, and Transportation at 60%.

When responses from persons in special populations are evaluated on their own, the results tend to demonstrate a need for the more basic services such as direct medical care, food, and transportation. For example, respondents to the survey that stated they were either currently homeless or homeless at any point in the 6 months immediately preceding the survey identified their priority of care needs as follows: Case Management (91%), OAMC (88%), Medications (82%), Dental/Oral Health (82%), Food Bank (77%), Health Insurance (73%), Transportation (71%), and Mental Health Services (60%). Indirect services such as Treatment Adherence were listed as needed by 30% less of the respondents in the homeless special population, Early Intervention Services by 23% less, HERR by 26% less, Substance Abuse Treatment by 29% less, while direct services like Food Bank saw an increase of 14%, Dental/Oral Health increased 13%, and Transportation increased by 11%.

For the adolescent (< 17) special population, the need for basic services is once again higher than indirect services. Adolescent respondents to the survey stated that their most needed services were OAMC (96%), Case Management (96%), Medications (96%), Dental/Oral Health (69%), and Health Insurance (59%). Indirect services were listed as not needed at much higher rates when compared to the response group. For example, Substance Abuse Treatment saw a reduction of 58%, Treatment Adherence reduced 47%, HERR reduced 47%, Early Intervention Services reduced 39%, and Mental Health Services reduced 32%.

In the fall of 2010, the Part B grantee convened a stakeholders meeting of 25 consumers, medical providers, activists and sub-grantees to discuss how the National HIV/AIDS Strategy (NHAS) should be operationalized in Florida. The group focused on the second goal of the strategy, "Increasing access to care and optimizing health outcomes for people living with HIV." To meet this goal, it is essential that HIV positive individuals that have been lost to follow up and are no longer adherent to their medical protocols are connected to linkage services. Linkage services in Florida include providing technical assistance to medical providers and HIV clinics on best practices in identifying those who miss their appointments and need to be rescheduled and contacting ADAP clients who do not pick up their medications and are closed to the program to reengage them in treatment. An additional need that was identified by the group was the need for utilizing HIV-infected persons to act as peer navigators to assist individuals in accessing and maintaining medical care.

In addition to basic linkage and peer education programs, the success of the Antiretroviral Treatment Access Study (ARTAS) program has shown that there is a growing need for evidence-based Prevention for Positives programs. The need is even greater for PLWHA that are incarcerated in Florida. To ensure that incarcerated persons do not fall out of care, the Part B grantee has set up testing and linkage programs in 16 of the largest jails in Florida as well as a Pre-Release Planning Program through the DOC.

Another very specific need is for linking pregnant women to care. The TOPWA program goes into the community to screen women in housing projects, laundromats, beaches, bars, homeless shelters; essentially anywhere low-income women congregate. They work to assist women with getting HIV and pregnancy testing. If an HIV-positive woman is found to be pregnant, she is provided extra support with an emphasis on adherence and attention to her specific needs.

The greatest need for PLWHA that are unaware of their status is to learn their HIV status. For more than 25 years, the Florida Department of Health (DOH) has worked towards this end by providing HIV screening in public healthcare settings such as health department clinics, jails, community health centers, mobile medical units, Tuberculosis clinics, student health centers, and family planning clinics. HIV testing is available free of charge, through conventional blood-draw, OraSure, or rapid HIV testing. The Part B grantee continues to expand testing venues in drug treatment facilities, jails, correctional facilities, university health centers, community health centers, free clinics, and health department clinics.

Most of the Community Health Centers (CHC) in Florida are registered HIV test sites and the Part B grantee has an active partnership with 12 of the 41 CHC throughout the state. Prevention program staff will continue to enhance existing relationships and seek to collaborate with the remaining CHCs in the state, including training sites to implement rapid HIV testing and encourage universal screening of all of the centers' clients. Part B grantee staff will continue to strengthen its relationship with the Florida Association of CHC to promote further routine testing among member health centers. While most of the state's testing partners offer testing in their agencies, they also conduct community outreach in an effort to reach high-risk populations. Florida's partners conduct testing in a wide variety of venues, including street outreach locations. Additionally, many CHD and community partners utilize mobile testing units to make testing more accessible for those who may not otherwise access testing services, offering testing in neighborhoods identified as having a high number of HIV-positive individuals and venues that cater specifically to high-risk populations.

Upon receiving an HIV diagnosis, clients are offered enrollment in case management services and linkage to medical care. The Part B grantee modeled its linkage program based in part on ARTAS, an evidence-based program that addresses Prevention for Positives. Enrolled clients have a minimum of two, and maximum of five, face-to-face contacts with the care coordinator. The second face-to-face contact includes an educational component focusing on HIV/AIDS transmission, medical care, and treatment adherence. The care coordinator utilizes a short-term case management system that emphasizes the client's strengths and past successes to assist them in enrolling in medical care. The ultimate goal of ARTAS is for clients to become independent enough to navigate the medical care system without the need for on-going case management services.

1D: Description of Priorities for the Allocation of Funds

Throughout fiscal years 2009-2012, the Part B grantee made several changes to the method for allocating funds to each area in Florida mainly due to a continued increase in demand for services. In past fiscal years, Ryan White Part B funding was allocated to each area based on the number of PLWHA in an area in proportion to the statewide total of PLWHA and the total funding from all sources in the area to produce the amount allocated per PLWHA. The goal of

this methodology was to achieve funding “parity” among areas (i.e. having similar amount of funding per PLWHA in each area). For those areas with multiple funding sources and a higher amount per PLWHA, a hold harmless provision was used to ensure funding was not reduced in an area, even if the formula called for a reduction. This system was in effect for a number of budget cycles and was functional when funding increases were the norm. It brought the funding levels for many rural areas up to move them closer to the levels in the higher funded areas. When areas received their funds, they allocated them to services based on several factors, each of which was identified locally. These included the SCSN, epidemiological data, local Quality Management (QM) plans, programming models such as the linear programming model, and the availability of services by other providers/funding sources in their respective areas. As service delivery data became more readily available, local areas began using that information to eliminate redundant services, prioritize core services over support services, and for adjusting funding from less utilized services to those with wait lists or those where demand was exceeding supply.

Prior to FY 2009, each area submitted a funding request based on their estimated needs for the year. The method for determining the estimated need was varied by area. After the implementation of CAREWare, utilization was determined for each area by a combination of unit cost and the final rate of expenditure for the prior fiscal year. The implementation of CAREWare allowed the Part B grantee to begin identifying each area's spending patterns. Historic spending trends provide an insight into the organization's ability to effectively manage and expend allocated funding. These factors could then be evaluated in a linear programming model that seeks to optimize the distribution of funding across multiple providers. The linear programming model could be used to determine the maximum allocation for each area, or the minimum allocation required for the consortia to function within the constraints listed above.

As funding for the overall Part B program reached a plateau, it was determined, that some adjustments were needed to allow for level or decreased funding. An Allocation Methodology Workgroup was formed with representatives from various areas and they proposed a new methodology that would be based on whether there were waiting lists for core services, resource utilization (spending patterns), and cost per client for services (where data was available).

This was deemed to be a more supportable methodology and one that would allow for addressing wait lists if they should occur. In addition, using PLWHA estimates was not necessarily a good representation of the number of clients that were being served. This methodology has not been fully implemented as of this date.

During FY 2009 and 2010, some core services developed waiting lists, including AICP and ADAP. As such, a plan to increase revenue and shift funding from other patient care services was developed. This resulted in a management decision to reduce funding for the 2011-12 lead agency programs along with elimination of funding for some support services. The allocation methodology developed did not lend itself to this situation and was not used to determine program funding shifts and reductions. At present, the data on client numbers and costs has improved and increased to the point that it may be reliably used for future allocation methodologies.

1E: Description of Gaps in Care

The Part B grantee utilizes the Statewide Anonymous Ryan White Needs Assessment Survey in addition to service delivery information received from providers statewide to identify gaps in service. 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.

In Florida, the level of services offered, aside from ADAP and AICP, is decided at a local level. As such, the only statewide gaps in care were seen in ADAP and AICP. The AICP wait list was implemented August 1, 2009 and the ADAP wait list was implemented June 1, 2010. Currently, the wait list for AICP has been eliminated and as of March 9, 2012, the number of individuals, waiting to receive services for ADAP was 775.

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 needs assessment 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 Needs Assessment. In 2011, 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 needs assessment, 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. One area noted that the Part A grantee had 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.

Description of Shortfalls in Healthcare Workforce

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 grantee has been successful in working creatively with the legislature, the governor's office, and providers 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 (although no client has 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 for FY 2011-2012, many local regions 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, 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. Ryan White, whose reimbursement rates should be no more than Medicaid rates, is also unattractive to these private providers.

Clients have indicated statewide 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 Florida'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.

1F: Description of Prevention Service Needs

The Prevention Planning Group assessed prevention and service needs through implementation of a community needs assessment survey between April and May 2010. The survey consisted of 26 questions and offered HIV prevention service providers an opportunity to describe prevention and service needs in their community. Questions assessed a range of variables, including respondent demographics, agency information, delivery of prevention services, and community and agency needs. There were 158 agencies who responded to the survey; approximately half (51%) of agencies reported providing HIV prevention services (e.g., interventions, HIV testing, outreach) to an estimated 1,000 people in the last 12 months; approximately one-fourth estimated serving 250-999 clients (25%); and, another one-fourth estimated serving less than 250 clients (23%). The majority of agencies reported providing clients with HIV prevention walk-in services or same-day appointments (85%) and offering services during weekends or evening hours (67%).

Respondents were asked to select from a list any significant barriers or difficulties their agencies have faced when providing HIV prevention services. Insufficient funding (71%) represents the most reported barrier. The two other most prevalent barriers reported include increasing workloads (44%) and inadequate transportation (43%). Respondents selected from a list the three most important unmet needs for HIV prevention services in their area. The top three prevention needs selected were media campaigns (30%), community mobilization (26%), and

group support (25%). Other services needs include community-level interventions (23%), Internet-based outreach, interventions, or campaigns (23%), rapid HIV testing (20%), HIV/STD education (19%), linkage to care (18%), STD testing (17%), individual- and group-level interventions (16%), and cell phone-based interventions or campaigns (16%).

Findings suggest that most providers have expertise and capacity for providing HIV prevention services to Florida's at-risk populations. While most agencies reported a services program in which HIV/AIDS is not the sole focus, the majority had an established history (≥ 10 years) of providing HIV/AIDS services. Respondents reported diverse funding sources for HIV prevention, which support the sustainability of programs. The vast majority of agencies ensure prevention staff receive important trainings on HIV/AIDS, cultural competency, and confidentiality. Less than one-third of agencies reported needing Technical Assistance (TA). However, these agencies reported a wide range of TA needs. Free trainings and TA available to providers (e.g., via the contracted providers, CDC-funded capacity building assistance providers, and DOH staff) should be further promoted by DOH and further utilized by providers.

Responses suggest broad implementation and reach of HIV prevention services, including HIV testing, behavioral interventions, and condom distribution. Agencies appear to target a vast range of populations and to implement practices that help increase access to and use of services (e.g., walk-in services, non-traditional hours). Reported barriers to services underscore the need to explore further ways of addressing issues such as transportation, mental health issues, substance abuse, and homelessness. Such barriers may be lessened by linking clients to psychosocial and health services, as well as local efforts to implement structural interventions (e.g., new public transportation routes, policies limiting alcohol advertising).

Responses suggest that providers desire more far-reaching initiatives in their areas (e.g., media campaigns, community mobilization initiatives, community-level interventions). A variety of other prevention service needs were reported (e.g., group support, rapid HIV testing, linkage to care, and individual- and group-level interventions), including an interest in the use of new technologies for HIV prevention (e.g., Internet- and cell phone-based initiatives). Provider responses suggest that numerous populations, particularly blacks and MSM, have unmet service needs. Areas use these findings with other data (e.g., epidemiologic and funding data) to help assess and meet the service needs of Florida's at-risk populations.

1G: Description of Barriers to Care

Over the past 20 years of providing vital patient care services to the PLWHA communities throughout Florida, consumer surveys and focus groups indicate barriers still exist that can limit or prevent PLWHA from receiving available services that are essential to improving or maintaining their health. Addressing and overcoming these barriers to care is an ongoing challenge. Identified barriers include:

Routine Testing (including any state or local legislation barriers)

Currently Florida statute 381.004(4)(c) states that “each CHD shall provide a program of counseling and testing” for all HIV tests. The required counseling shall “include informing the patient of the availability of partner-notification services, the benefits of such services, and the confidentiality protections available as part of such services.” In addition, Florida statute 381.004(5)(e) states that all HIV testing sites registered through the Department “must provide the opportunity for pretest counseling on the meaning of a test for HIV, including medical indications for the test; the possibility of false positive or false negative results; the potential need for confirmatory testing; the potential social, medical, and economic consequences of a positive test result; and the need to eliminate high-risk behavior.” The registered testing site is then also required by 381.004(5) (g), F.S. to “provide the opportunity for face-to-face post-test counseling on the meaning of the test results; the possible need for additional testing; the social, medical, and economic consequences of a positive test result; and the need to eliminate behavior which might spread the disease to others.”

Florida statute requires opt-out STD and HIV testing for all pregnant women at their initial prenatal care visit, again at 28-32 weeks gestation, and at labor and delivery for women with an undocumented HIV status. For all other populations, Florida statute requires that informed consent is obtained prior to performing an HIV test. In medical settings, the provider can obtain verbal consent and must document this in the client's medical record. The Part B grantee's staff assisted the Florida Senate Healthcare Committee in reviewing Florida statutes regarding HIV testing and informed consent. It was determined that Florida statute allows for verbal or other types of informed consent for HIV testing and that the current law is not a barrier to routine HIV testing.

Program Related Barriers in Rural Communities:

Health Professional Shortage Area (HPSA) and Medically Underserved Areas/Populations (MUA/MUP) designations exist throughout the state in both rural and urban communities. The following are a list of barriers identified that specifically affect consumers living in rural communities.

- Eligibility Requirements

Florida established Rule 64D-4, Florida Administrative Code, and created the Ryan White Part B Eligibility Manual in 2007 in an effort to streamline eligibility requirements to access all programs funded through Ryan White Part B to include: patient care, ADAP, AICP, and state HOPWA. This barrier was identified only for areas of the state where access to eligibility specialists and/or case managers is limited, making it difficult to establish a client's eligibility in a timely manner so that they can access care.

- Limited or lack of public transportation (buses, taxis, etc.)

In areas where some public transportation exists, bus passes are given to consumers, but bus stops are limited and often far from consumers residence

- Limited or lack of Medicaid transportation

In some areas of the state, Medicaid rides have been limited to disease specific consumers, i.e., cancer patients receiving chemotherapy; dialysis patients; etc.

- Limited or lack of access to Obstetrics/Gynecology services

Consumers have to travel to larger county for this service

- Limited or lack of access to Outpatient Ambulatory Medical Care

Consumers have to travel to larger county to access this service

- Limited or lack of access to Specialty Medical Care

- Limited or lack of access to Dental/Oral Health Care

Even in areas of moderate population, service providers may be too expensive, or may not be able to meet business practice standards required of Medicaid providers

- Limited or lack of Medicaid Providers

Consumers have to travel to larger county to access this service

- Limited funds to increase capacity to enroll new consumers into available services

Insufficient funding to support existing caseload

- Federally Qualified Health Centers (FQHC) making demands on current providers typically accessed by Ryan White consumers

Competing with FQHC reimbursement rates

Program Related Barriers in Urban Communities:

HPSA and MUA/MUP designations exist throughout the state in both rural and urban communities. The following are a list of barriers that the workgroup identified that specifically affect consumers living in urban communities.

- Eligibility Requirements

Florida established Rule 64D-4, F.A.C., and created the Ryan White Part B Eligibility Manual in 2007 in an effort to streamline eligibility requirements to access all programs funded through Ryan White Part B to include patient care, ADAP, AICP and state HOPWA. In most urban areas of the state, these requirements have not posed any barriers, but in some urban areas of the state, they have for similar reasons, such as:

- Unable to get an appointment with eligibility staff to complete paperwork
- Multiple eligibility applications for different funding sources, i.e. Ryan White Part A, Ryan White Part B, Medicaid, etc.
- No centralized eligibility

- Shortage of OAMC Providers

With the ever-increasing number of PLWHA in need of OAMC services throughout the state, the need to identify and support additional providers is vital. Some of the challenges that are faced when recruiting new providers are:

- Contracting and reporting requirements set forth by local, state and/or federal government
- Reimbursement rates
- Not accepting Medicaid
- In some areas, the competitive bidding process

- Shortage of Specialty Care Providers

OAMC providers reference an increased complexity of care associated with both new and established clients. Many new patients are admitted to the Ryan White system of care directly after discharge from a hospital where they were diagnosed with HIV/AIDS and one or more opportunistic infections. These patients are frequently severely ill with AIDS-related acute and chronic conditions. In these instances, clinical care providers have expressed a need for the expertise of specialist consultation due to the complexity of many of the co-morbid conditions within the PLWHA population. In addition, in some of the areas that do have specialists, many of them are not accepting Medicaid.

- Patient Care Access Network (PCAN) and FQHC

With the Patient Protection and Affordable Care Act (PPACA) and the NHAS supporting increased funding for these entities, existing and established service providers will be in direct competition for providing care to PLWHA. In some urban areas, the current

providers of care are already FQHC or PCAN so they should be able to continue without too much interruption in service provision. However, in other urban areas, where the primary provider of care is not currently either of these entities, there is the potential for an interruption of service provision.

Provider Related Barriers

- Delayed Notice of Grant Award (NGA)

Due to delays in the approval of the FY 2011/2012 federal budget, the Health Resources Services Administration (HRSA) was unable to release the NGA for all Ryan White funding (Part A, Part B, Part C, Part D, and Part F) until late August 2011. This resulted in grantees issuing contracts based on prior year funding. This created barriers to providers in several ways. The one most commonly referenced was their inability to meet increased demand due to lack of capacity if they were relying on funds to hire new or replace staff. They were hesitant to hire new or replace staff not knowing what their final award would be. The inability to expand capacity was a common barrier voiced across the state.

- Uncertainty of the future of Ryan White Treatment Authorization Act

Many of the major provisions of the PPACA will be fully implemented in 2014, making the future of Ryan White funding uncertain. Many providers have expressed concern over what to expect after 2014, what to expect with Medicaid reform, the possibility of future of expansion funds for Ryan White Part C clinics going to fund FQHCs, and the lack knowledge of HIV/AIDS-specific care at FQHCs and how that will affect the overall care and treatment of PLWHA.

Other Issues

- Stigma and Fear

Thirty years into the treatment of HIV/AIDS, fear and stigma significantly limit or prevent the successful diagnosis and treatment of PLWHA and those at great risk. Communities still have a great opportunity for becoming better informed and more willing to accommodate PLWHA. Recent inroads are made through World AIDS Day, National Week of Prayer and named recognition days, such as National Women and Girls Day. Ryan White consortia present opportunities to increase awareness, expand Florida's assertive testing goals, and involve PLWHA in meaningful efforts. Much remains to be done.

- Prevalence of homelessness

In some areas of the state, the percentage of homelessness among those living with HIV/AIDS is almost twice the rate observed in the general population. Bringing

homeless PLWHA into care and keeping them in care continues to be a challenge, regardless of rural or urban locations. Being adequately housed is a major determinant for a PLWHA being able to adhere to a medical plan of care. Affordable housing is essential to stabilize those clients who are the lowest income and the most fragile.

“Affordable” is defined as households having to spend no more than 30% of their gross income on their housing costs, including utilities. Changes in the state’s housing market make it more difficult for those living below the poverty level to secure independent housing of any kind as low rent housing gives way to condominiums and residential communities. Some of the current housing trends affecting the state are summarized below.

- Foreclosures in Florida
 - The enactment of the American Recovery and Reinvestment Act of 2009 included a tax credit for first-time homebuyers. Despite this incentive, Florida ended 2010 with 5.51% of all properties in the state in foreclosure, a decrease of 6.08% from the previous year.
 - Florida’s foreclosure rate ranked third highest among all states. One in every 18 Florida housing units received a foreclosure filing in 2010 — twice the national average.
 - Declining property values have resulted in a further decrease in property taxes.

It is necessary to the health and wellbeing of all PLWHA that state and local grantees of all Ryan White funded programs (RW A, B, C and D), state and city HOPWA, as well as prevention and patient care providers work collaboratively to strive to meet the unique needs of this growing population.

- Persons without insurance coverage

In July 2010, the Obama administration released its NHAS. One of the three primary goals of the plan is to increase access to care and improve health outcomes. President Obama stated that it is important to get people with HIV into care early after infection to protect their health and reduce their potential of transmitting the virus to others. According to data submitted through CAREWare, in 2011 at least 46% of PLWHA accessing RW Part B services are uninsured. This is an increase from 18% in 2010. It should be noted that 44% of CAREWare clients identified did not report insurance status. Additionally, the 2010 number may actually be higher as full implementation of CAREWare for eligibility was not achieved until 2011. As documented in multiple studies nationwide, the uninsured typically do not seek preventive or maintenance medical care because of cost and often delay needed care. These delays adversely influence outcomes and increase the complexity and cost of care to be delivered. A lack of health insurance can exacerbate many treatable illnesses including HIV disease.

- Persons living at or below 300% of the poverty level

The poor have difficulty accessing needed health services, whether they are uninsured or underinsured. Hardships such as paying co-pays as well as maintaining safe housing and purchasing healthy foods are all barriers that prevent the poor from staying in care and adhering to a medical regimen. RW Part B CAREWare utilization data for 2010 indicates that 84% of RW Part B clients are living at or below 300% of FPL. The number of RW Part B clients living at or below 300% of FPL is expected to increase based on the current economic condition.

- Substance Abuse

Substance abuse, which includes binge drinking and illicit drug use, is also more prevalent among PLWHA than it is among the general population. Data indicates that a significant percentage of PLWHA have reported a history of substance abuse. 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. The relationship between injection drug use (IDU) and HIV/AIDS transmission is well known. IDU is the second most common exposure category for female PLWHA and third most common for male PLWHA in the state.

- Mental Health

According to the American Psychiatric Association, people with HIV are more likely to experience a range of mental health issues, which can often accompany adverse life-events. Additionally, mental health problems usually predate substance use activity, which can interfere with HIV/AIDS treatment adherence. Limited or lack of mental health providers in general, and specifically providers with knowledge of HIV/AIDS, causes additional barriers for clients needing this vital service.

- Trends in services and fiscal resources

During the 2010 legislative session, the Florida legislature passed a bill with a provision directing each state agency to review contract renewals and re-procurements, and attempt to reduce costs by 3%. It is the statewide goal to achieve substantial savings; however, it is the intent of the Legislature that the level and quality of services not be affected. Each agency shall renegotiate and re-procure contracts consistent with this directive.

- Cost of Care

Determining the cost of care per patient per service is difficult and many primary care providers have indicated that they do not have a mechanism in place to track the cost of care by patient and/or co-morbidity or to track services by specialists. Many providers have multiple funding sources reimbursing at various rates while the considerable variation in lab and testing costs make an average cost determination difficult.

Expenditures associated with treating and managing PLWHA continues to increase in most core service categories, while other categories have shown a decrease in expenditure.

- Co-morbidities

Providers have indicated that clients have increasingly complex medical needs including the co-morbidities and co-factors identified above. Co-morbidities require more complex medical and psychosocial interventions than standard HIV care. The care provider must be vigilant regarding medication interactions when treating multiple conditions, nutritional needs, housing circumstances, side effects management, and other quality of life issues. In addition, the aging population will continue to pose new challenges as medical providers must account for the additional concerns of older adults and the aging process. As a result, in many areas across the state, rural and urban alike, consortia and planning councils have worked with the state and EMA leadership to implement key cost containment measures for specialty care referrals in an effort to reduce the likelihood of these additional factors driving up the cost of care per client.

- Formerly incarcerated

According to the DOC, 35,925 offenders were released in 2010. Of these, 1,151 were HIV-positive. This was a decrease from the 1,287 of HIV-positive offenders released in 2009. Jail Linkage Providers around the state have indicated that there are times where post-incarcerated individuals who learned of their HIV status while incarcerated were released from local jails and/or prisons before they were linked to care. A further complication is the release date for inmates is usually unknown resulting in no prior notification of an impending release. Providers in each county have developed processes to address the issue in their county. All have one or more staff located at the jails and work with jail clinical staff to identify HIV-positive inmates through testing or self-disclosure and counsel them on how to access needed care and services upon their release. Whenever possible, jail staff 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 EMA counties send staff to the jails to provide assistance with linking released PLWHA to care.

- Changes in Florida statute and local laws

This concern specifically refers to the possible change in FPL from the current 400% for consumers accessing services through the RW Part B Program to anything lower. Currently, it will remain at 400%, but several public hearings took place across the state to gather input from the public to present to the Governor and the Legislature. The vast majority of attendees and respondents expressed opposition to reducing the current FPL. In addition, services that were supported in part with property taxes experienced significant budget cuts at the local level. Health and social service agencies' funding was reduced and in some cases eliminated, driving many PLWHA to RW services. The loss

of these resources will continue to have a significant impact on the system of care within the state.

1H: Evaluation of 2009 Comprehensive Plan

In preparation for the creation of the 2012-15 Comprehensive Plan, seven members of the PCPG met to evaluate the 2009-12 SCSN and Comprehensive Plan. The group reviewed the entire SCSN and Comprehensive Plan page by page and returned some areas where the SCSN and Comprehensive Plan fell short and could be improved upon for 2012-15. The evaluation from the group is summarized below.

- The 2009-12 SCSN was not a strong enough summary statement of Florida's need. It tended to be just a description of the previous and current SCSN determination processes and multiple lists/charts/graphs of collected data with little narrative.
- The 2009-12 SCSN did not have the "dots connected for the reader" in that there was not a distinct page or set of pages that made a concise statement of need.
- The 2009-12 SCSN had too many charts and graphs, which left it up to the reader to try to figure out what the big issues, trends, and messages are. The "big picture" was not drawn for the reader succinctly in the narrative.
- Florida is a diverse state with large metropolitan centers as well as many rural regions with many separate and distinct differences in barriers, needs, interventions, funding levels/sources/disparities, and resources. There was no cohesive discussion of the urban versus rural disparities in the 2009-12 SCSN narrative, and only episodic mention of rural-related disparities and barriers in the individual area reports.
- The 2009-2012 Comprehensive Plan does not have any true recommendations.
- The 2009-2012 Comprehensive Plan does not have a true summary or conclusions.
- The 2009-2012 Comprehensive Plan Section 1 (Where are we now?) leaves out any description/discussion of the most highly funded (by Part B and GR) program – ADAP. ADAP was not perceived to be in trouble when this plan was submitted in November 2008, but neither was AICP – and AICP received a half page of narrative. ADAP is merely mentioned as a funding source for several of the core services in the tables.
- The 2009-2012 Comprehensive Plan Section 2 (Where do we need to go?) never does address that question – other than listing the funding priorities for the combined 14 consortia.

- The 2009-2012 Comprehensive Plan Section 3 (How will we get there?) clearly states that it includes a “sample of initiatives...to provide a glimpse of different challenges...” and “offers a relatively small compilation of tactical initiatives directly from the local plans, which in turn represented only a fraction of the activities undertaken to provide the highest quality continuum of care...” While this served to show individualization, it does not discuss the implication statewide. There was also no mention of how the state’s goals (HRSA themes) would be met or measured.
- The 2009-2012 Comprehensive Plan Section 4 (How will we measure progress) of the 2009-2012 document describes in detail the Sterling Criteria, yet does not address any real-life implementation of a QM program. The Part B grantee or the PCPG did not request that each area submit updates of progress towards implementing and achieving the goals to which they committed in the previous comprehensive plan, including successes, challenges, delays, what was not successful, and what was successful.

II: Process for Creating the 2012-15 SCSN

The development of the 2012-15 SCSN was a coordinated, statewide effort on the part of representatives from all RW Parts in Florida. The process officially began with a SCSN web conference in February 2011, which included representation from all of Florida’s Ryan White parts, lead agency staff, contract managers, HAPC, PCPG members, providers, and consumers. At the face-to-face SCSN/PCPG meeting in March 2011, participants formed an ad-hoc writing group to write the SCSN. The writing group met several times over the following months via conference call and web conferencing. The PCPG approved the SCSN draft at the October 2011 statewide meeting for inclusion in the Comprehensive Plan. The representation from the different RW Parts as well as the list of meeting times is listed below.

- The first writing group web conference took place May 25, 2011. Representatives from Part A grantees, Part A planning councils, the Part B grantee, Part B direct care providers, Part B consortia, Part C grantees, and Part D grantees participated on the call.
- The writing group had three more web conferences, which were held in June 2011, August 2011, and February 2012.
- The writing process was divided amongst participants of the writing group and many of those participants involved other local RW partners in the development of their respective sections. For example, the Part B grantee representative for Orange County obtained participation from the Part A grantee, Part B grantee staff, and Part B direct care providers.

Summary

As home to the second largest population of PLWHA, Florida strives to meet the medical, pharmaceutical and psychosocial needs of its clients amid tough economic conditions and unexpectedly greater demand for services. The Part B grantee has worked to accommodate uniqueness in its PLWHA population, including the aging of PLWHA, in-migration of persons from other states, and a growing bi-lingual Hispanic population, including non-residents. The most imminent challenge appears to be overall adequacy of funding and the challenge to distribute that funding between ADAP and Part B services to meet the needs for most PLWHA.

Florida shares successes from the 2009-2012 planning cycle, including the continued commitment to testing; the significant reduction and prevention of mother to child HIV transmission; marked increase in the use of informatics to quantify the epidemic and the progress being made; and, the continued dedication and involvement found within lead agencies, advocates and consortia.

Still, challenges remain as Florida evaluates its current position, funding notwithstanding. Disparities in HIV/AIDS incidence are found now in greater numbers within people of color. Great regional differences exist between urban and rural areas, both in terms of service availability, per-capita funds available, and safety-net support systems to cover under-funded persons and services.

Clients' needs now focus more on basic core services, as economic conditions bring more PLWHA into Ryan White Part B care. Meeting clients' pharmaceutical needs has been an absolute commitment from the ADAP program and the Part B grantee. Funding that commitment through multiple means and communicating with clients and local staff is an ongoing challenge. Clients and providers recognize the increased need for core services and still require non-core services, but strive to meet them in other ways. They have also identified medical care, transportation, food, housing, and case management as priorities.

Barriers to care are more linked to and are a result of increased needs, many of those aggravated by economic conditions. Stable housing and proper nourishment are determining factors for client outcomes and the success of treatment. Psychosocial needs and substance abuse issues appear in greater numbers; however, they go unaddressed when the more basic needs take priority. Barriers are being addressed through increased cooperation between local planning consortia for Parts A and B, local caregivers, community leaders and faith leaders.

With the growing HIV population in Florida, Ryan White stakeholders need to improve the:

- Capacity for providers to test targeted local communities, especially the Hispanic community;
- Linkage to care, particularly for persons aware of their status, but not in care;
- Eligibility and information sharing process for the HIV service delivery system;

- Consistent delivery of high quality care; and,
- Ability to reduce, and ultimately eliminate, the ADAP wait list.

Section 2 - Where Do We Need to Go?

“It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, ...we had everything before us, we had nothing before us,... - in short, the period was so far like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only.”

Charles Dickens (1812 - 1870), A Tale of Two Cities

Introduction

Florida is fortunate to receive incredible commitment and dedication from the countless advocates, healthcare service providers and other partners within the HIV-positive community who promote, protect, and improve the health and lives of People Living with HIV/AIDS (PLWHA). Florida has faced incredible challenges and unfortunately, at times, has not taken advantage of opportunities for change.

Access to health care remains an area needing greater emphasis as it relates to reducing disparities among population groups most at risk. The availability of health and support services, as well as the social and economic barriers that many PLWHA face cannot be overlooked.

It appears that the vastness of our diverse community and the unforeseen scarcity of some resources require a higher sense of accountability for all in leadership. Leadership in the HIV/AIDS response can only be achieved through accepting change, being visionary and involving the HIV-community in the decision making process. Such a collaborative strategy ensures that goals are accomplished with an understanding and agreement on responsibilities and maximizing those available resources.

Florida's plan for a system of care that provides the highest possible standards of care for its HIV-positive community is consistent with the National HIV/AIDS Strategy (NHAS). The significant issues, critical concerns, areas of focus from the NHAS - including proposed care goals, the identification and linkage of diagnosed and high-risk undiagnosed individuals, solutions for closing gaps in care, proposed solutions for addressing overlaps in care, and proposed coordinating efforts to ensure optimal access to care and to improve health outcomes of HIV positive individuals - are described below.

Solutions for tomorrow's emerging community health needs require us to adopt new practices and approaches. Section 2 is Florida's vision for a high quality, comprehensive continuum of care and the elements that shape this system. The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative supports all three of the NHAS goals.

2A: Plan to Meet 2009 Challenges Identified in the Evaluation of the 2009 Comprehensive Plan

The evaluation of the 2009 Comprehensive Plan revealed numerous deficiencies, which the Florida Department of Health's Bureau of HIV/AIDS (Part B grantee) and the Patient Care Planning Group (PCPG) will continue to address throughout the next planning period. Florida has devised strategies to undertake the shortcomings below.

- The format, structure, and overall organization of the previous plan did not provide a concise, coherent explanation of Florida's current state of HIV healthcare service delivery.
- The 2009 plan contained a collection of seemingly disconnected regional goals, which offered a relatively small compilation of tactical initiatives.
- The previous plan failed to provide an adequate, cohesive discussion of the urban and rural disparities.
- Section 4 of the 2009 plan included a description of data collection methods, rather than a plan with a system of evaluation and monitoring.
- The Part B grantee and the PCPG did not approach the previous plan as a living document and consequently did not continually review nor update the previous plan.

The current plan provides a cogent summary of the state's current critical needs and service gaps; recommendations from the Part B grantee and the PCPG to address those needs and gaps; as well as key goals and strategies to carry out those recommendations. The writing group formatted, structured, and organized each section of the plan with the following components: an introduction of what that section contains, a response to the minimum requirements set forth in the guidance, and a summary of key findings and recommendations. All sections after Section 1 directly address the Statewide Coordinated Statement of Need (SCSN), which includes a concise statement of need.

The goals in the current plan originate from the needs identified in Florida's SCSN, reflect statewide themes and support the goals of the NHAS. Goals, strategies, outcomes, and quality measurements align with spending priorities and allocations.

Florida is a diverse state, with large metropolitan centers as well as many rural regions – and many separate and distinct differences in barriers, needs, interventions, funding levels, funding sources, disparities, and resources. The current plan recognizes those differences and formulates strategies to fill the disparate gaps and meet the identified needs.

The current plan describes the process to monitor and evaluate progress in achieving the proposed goals. The monitoring and evaluation plan communicates the procedure for tracking change throughout the duration of the plan. The Part B grantee will improve in the following areas: use of Ryan White client level data, monitoring service utilization through data, and measuring clinical outcomes statewide.

Each area will submit updates of progress towards implementing and achieving the goals in current local comprehensive plans, including successes, challenges, and delays. The Part B grantee will communicate statewide progress updates bi-annually at the PCPG meetings. The

Part B grantee and the PCPG will use the progress updates to monitor and evaluate the challenges and successes in order to refine, revise, and adjust the current plan as needed.

2B: 2012-2015 Proposed Care Goals

Florida is wholly committed to aligning its statewide response to HIV/AIDS with the NHAS. In doing so, Florida adopts, as its guiding framework, the NHAS primary goals:

- Reducing the number of people who become infected with HIV;
- Increasing access to care and optimizing health outcomes for people living with HIV; and
- Reducing HIV-related health disparities.

Florida's specific statewide HIV/AIDS care goals are designed, within that NHAS framework, to target the unique barriers, challenges, resources, and circumstances currently affecting Florida's ability to maximize its HIV/AIDS response. Among the most prominent of these factors are:

- Need for stabilization of Florida's AIDS Drug Assistance Program (ADAP);
- Continued insufficient and/or delayed funding at both the state and federal levels to provide care to an ever-increasing HIV/AIDS population;
- Outdated allocation methodologies used by the Part B grantee to distribute federal and state HIV-dedicated monies across the state;
- Rural versus urban inequities in funding, services, access to care (transportation issues, and access to oral health care and medical specialty services), and provider HIV-competence and availability;
- Florida's need to shift from an acute disease management model to a chronic disease management model to more accurately and appropriately respond to the changing needs of HIV-positive persons, who living with a chronic, manageable disease can now anticipate near-normal life expectancies;
- Continuing population disparities in the epidemic, especially Men who have Sex with Men and women of color;
- Far-reaching stigma across all HIV-positive subpopulations; and
- Florida's need to develop a statewide program for its HIV care network.

Future dynamics which have yet to be fully defined and implemented, but which will factor heavily into Florida's statewide response to the HIV/AIDS epidemic, include (but are not limited to):

- Full execution of the Patient Protection and Affordable Care Act (PPACA) or not, depending on the political climate after the 2012 elections and Supreme Court decision;
- Long-term economic recovery of both the nation and Florida;
- Uncertainty of the future of the Ryan White Act's reauthorization;
- Adoption of "Treatment is Prevention" HPTN (HIV Prevention Trials Network) 052 protocol as standard HIV treatment;
- Florida's proposed statewide Medicaid Reform package;
- The Florida Department of Health's expected re-organization, which will most certainly change the landscape of the current Part B grantee's configuration and resources;
- Florida's legislative attempts to privatize and/or outsource many currently government-provided services; and
- The Part B grantee's current focus on competitive procurement for all Part B sub-contracts, which will also most certainly change the statewide landscape of lead agencies, providers, and ultimately patient care.

While these factors are still moving targets and are not yet fully realized nor implemented, Florida must attempt to accommodate them in the commitment to its statewide HIV/AIDS response plan. No matter what the economic, political, and organizational backdrops are, there will still remain Florida's HIV-positive community with its critically unique and pressing needs for care and support. It is to this community that Florida pledges its strategic focus with this plan.

Florida's proposed HIV/AIDS care goals, described fully in Section 3 of this document, flow from the NHAS primary goals. As Florida strives to meet its own proposed goals, it will also be contributing to the national coordinated effort to achieve the NHAS's vision of a nation committed to stopping the HIV epidemic and supporting all infected persons with dignity and access to high-quality care.

2C: Goals Regarding Individuals Who Are Aware of Their HIV Status but Are

Not in Care

The Part B grantee will take an active, leadership role in identifying the appropriate methods to report aggregate data and implement a strategic plan for reducing unmet need numbers in Florida beginning in 2012. Given that Florida intends to use the three primary goals of the NHAS as statewide goals, the unmet care goals for persons aware of their HIV-positive status but not currently in care would align as follows:

- Decrease the number of individuals aware of their status but not in care and decrease the overall infectivity of this group of individuals by decreasing their in-care and/or monitored viral load.
- Reduce the time from HIV diagnosis until entry into care by addressing the barriers for persons aware of their HIV diagnosis and not in care.
- Reduce HIV-related health disparities specific to persons who are not in care.

Before the Part B grantee can formulate a plan to reduce unmet need numbers in Florida, all paper labs need to be imported into the Enhanced HIV/AIDS Reporting System (eHARS) in order to establish a true baseline of unmet need. Electronic Laboratory Reporting (ELR) has been promoted as a public health priority for the past several years. ELR planning and management in Florida has been and remains, a joint venture between the bureaus of the Division of Disease Control (Epidemiology, HIV/AIDS, TB, STD); the Division of Environmental Health, Bureau of Environmental Epidemiology; the Division of Information Technology; and the Office of Planning, Evaluation, and Data Analysis. Managers of those programs recognize that implementation of ELR is vital to enhancing disease intervention in Florida.

At the Part B grantee level, ELR results and hard-copy results end up in a Structured Query Language (SQL) table and then are appended to the corresponding case report records in the eHARS. Currently, the only method of determining whether a laboratory is not reporting results, as required by Ch. 64D-3.042, F.A.C., is if a field surveillance person receives a completed case report from a physician and does not have the corresponding lab to attach. In this scenario, the field surveillance person alerts the Part B grantee's surveillance staff, who, in turn, contacts the lab to make the lab aware of their reporting responsibilities. The Surveillance Section will issue an internet-based survey in 2012 to all laboratories licensed by the Agency for Health Care Administration to process tests in Florida. The survey will ask what HIV tests they currently perform and which are referenced to another facility.

The Surveillance Section has hired two short term contract positions to 1) match known HIV clients to the vital statistics database so that the Part B grantee will have a more comprehensive view of who is currently living, and 2) data entry staff to back enter paper labs received for the past couple of years. This should be completed by Summer/Fall 2012, at which point the Part B grantee can convene a meeting with representation from the Patient Care, Prevention, and Surveillance sections of the Bureau of HIV/AIDS. The participants will work to develop a

strategic plan, which will outline the process to alert the 16 statewide HIV/AIDS Program Coordinators (HAPC) of those individuals within their geographical area who are aware of their HIV-status and not in care.

Community-level efforts are now being organized to appropriately access test results and client-level information, to bring HIV-positive persons into care or assist them in returning to care. Personal circumstance, family situations, and psychosocial factors contribute to PLWHA unfortunately not remaining in care consistently. In addition, stigma and incorrect public beliefs about HIV/AIDS are known barriers that inhibit PLWHA from seeking treatment once they are diagnosed. Public Health Disease Intervention Specialists and Peer Navigators, working with local agencies and prevention programs will identify persons to approach with the option of obtaining care for HIV/AIDS. The results of local efforts will be useful as the Part B grantee develops strategies and processes on a statewide level to bring persons into care.

2D: Goals Regarding Individuals Unaware of Their HIV Status

The identification and linkage of diagnosed and high-risk undiagnosed individuals to appropriate services, contributes to all three goals of the NHAS. The EIIHA initiative is an integral component of a high quality, comprehensive continuum of care. Individuals who delay knowing their status through testing are likely to have damaged immune systems that will be difficult to reconstitute upon entry into care, due to the rapid replication of the virus in their bodies. Undiagnosed individuals are also more likely to infect others. The lower the viral load, the less likely transmission will occur. Ensuring that individuals have access to anti-retroviral therapy can reduce viral load often to undetectable levels thus reducing transmission rates. Additionally, untreated co-infections can cause spikes in viral load. Therefore, it is paramount that Florida focuses on early diagnosis, early entry into care, and early access to anti-retrovirals, and other HIV/AIDS medications.

Florida's testing data for publically funded HIV tests, illustrate the imperative for the state to improve data integration and data sharing in order to have an accurate picture of the number of individuals unaware of their HIV status. For example, the Part B grantee expects test sites to document at the local level whether they have done post-test counseling for HIV negative results from conventional tests. However, due to dwindling resources, the Part B grantee no longer requires that local sites report information on negative results. As a result, Florida's 2010 testing data indicated that 51.5% of HIV negative individuals were not informed of their status. The Part B grantee cannot currently capture the number of HIV negative individuals referred to services statewide.

Integrating and sharing data among the disparate databases will allow local areas as well as the Part B grantee to determine the following: a categorical breakdown of the overall unaware population into subgroups; a true estimate of the HIV negative individuals informed post-test of their appropriate HIV screening result; the diagnosed and undiagnosed individuals who receive

referrals for services; and, the newly diagnosed HIV positive individuals who are successfully linked to care. Once Florida acquires complete, accurate, and verifiable baseline data, it will generate a plan to increase the number of people who know their status, who are referred to appropriate services, and for those who test HIV positive are linked to medical care and ultimately retained in care. To accomplish this integration, Florida will:

- Create a public health information network (or participate in an existing one) to actualize a mechanism to identify those clients who have a positive HIV test result, ascertain if they are in other systems of HIV care and, if not, contact them to offer Ryan White services.
- Encourage funding for Early Intervention Services to improve the referral mechanism between HIV testing functions in prevention and the Ryan White HIV service delivery systems across the state as well as actual linkage from testing through care by implementing peer programs.

Rapid tests account for approximately half of the HIV tests in Florida's public sector. For rapid testing, Florida possesses excellent documentation for the positive (reactive) and negative test results, with the post-test counseling rate for both nearly 99%. While documentation is excellent statewide for the results of all the rapid tests, it is admirable only on the reactive results for the conventional HIV tests. The Part B grantee will investigate opportunities to convert conventional test sites to rapid test sites and geographic expansion of current rapid test sites. Once Florida begins to track data for all HIV tests statewide, the Part B grantee will assess the capacity of Diffusion of Effective Behavioral Interventions (DEBI) and Evidence-based Behavioral Interventions (EBIs) that target high-risk HIV negative individuals and expand the DEBI and EBIs to meet the need of individuals referred for services. Florida will therefore:

- Increase coordination with existing HIV testing initiatives, as well as increase types and frequency of new rapid testing resources.
- Support the expansion of rapid testing throughout the HIV testing system, including traditional counseling and testing sites, as well as DEBI and EBIs.

2E: Proposed Solutions for Closing Gaps in Care

Gaps in care identified in Section 1 include:

- Funding deficits;
- ADAP solvency fragility and wait list (potential gap);
- Chronic disease management training deficit (for medical case managers); and

- Access to care issues:
 - Lack of transportation
 - Shortage of HIV-competent providers and lack of capacity

Funding Deficits

Florida's largest challenge to closing gaps in care is directly related to the level of funding allocated at both the federal and state levels. For the past ten years, Florida has been essentially flat funded (with the exception of some emergency ADAP and supplemental funding) by the Ryan White Program. Florida, like many other states, has struggled with multi-billion dollar deficits for the past five years. There has been erosion of state general revenue funding for HIV programs as well.

In 2010 alone, 4,560 new persons infected with HIV were identified in Florida. Yet only 3,470 of those persons were linked to appropriate HIV care. The ability of Florida's HIV care network to absorb that many new cases and their related care is critically challenged, especially without additional funds coming into the system.

More urgently, nearly 1,100 of those newly identified HIV-positive persons never even entered our system of care. Ironically, these not-in-care individuals saved the care system from experiencing even greater gaps in care. Those "savings", however, pale dramatically when one considers the true economic, public health, and personal costs of delayed entry into pertinent and life-saving HIV care.

The state Medical Director for the HIV/AIDS program, Dr. Jeffrey Beal, working with The AIDS Institute, former state epidemiologist Spencer Lieb, 19 research organizations and 116 HIV researchers have formed the Florida Consortium for HIV/AIDS Research (FCHAR). This effort is complemented and supported by the fact that Florida has the only nationally accredited Public Health Institutional Review Board (IRB) in the country and efforts are underway to establish a formal liaison between this IRB and FCHAR. Presently, all HIV/AIDS research performed through a state agency, or funded by state monies, and research utilizing clients of state programs is reviewed through this IRB, so that inter-cooperation will enhance the effectiveness of HIV/AIDS research efforts in Florida. Helping facilitate the enrollment and participation of PLWHA in clinical trials and other research projects paid for by outside funding streams, is a possible solution to stretching limited funds

One of the solutions Florida is currently exploring is the use of the Pre-Existing Condition Insurance Plan (PCIP). Florida is one of the states that has the federal government operating their PCIP. When the requirements for proof of pre-existing conditions were relaxed and the premiums were reduced in July 2011, a test project was begun to examine cost efficiencies. Florida will examine if PCIP utilization for HIV-positive persons will save money in the ADAP program as well as in Outpatient Ambulatory Medical Care (OAMC), pharmaceutical, oral

health, and specialty physician services. The Part B grantee will further explore this as an option to advance solvency in the ADAP program and in HIV care in general.

As the PPACA is more fully implemented by 2014 and primary medical care is being provided under other resources such as Medicaid or private insurance, it is anticipated that there will be more funds to “wrap around” for support services as fewer of our resources will need to be used for core medical services. This would provide further resources to address some of the gaps noted above.

The Part B grantee will also revisit its resource allocation methodology to ensure fair and equitable distribution of funds based on static or increases in HIV and AIDS cases who are actually engaged in Ryan White-funded care. With the full implementation of CAREWare for Part B reporting, there is much improved access to client-level data, which can be used as an input in the allocation process.

Additionally, the Part B grantee will continue to refine and monitor the statewide HIV program eligibility screening process. This might include the use of “secret shoppers” to “test” those agencies providing eligibility services and provision of technical assistance when discrepancies are discovered. This will help further facilitate the proper appropriation of resources and prevent the spending of Ryan White funds when other payer sources are available.

ADAP Solvency Fragility and Wait List

The ADAP situation in Florida does not meet the Health Resources and Services Administration (HRSA) definition of “gap in care” because persons on the ADAP wait list are currently able to access their HIV medications through a negotiated arrangement with Welvista and the pharmaceutical companies. However, that arrangement holds no guarantees for the future that the same benefits will continue to be extended if Florida’s ADAP wait list continues to expand.

The ADAP wait list, while comparatively low right now, will continue to exist and may expand for the future. Should the PAP/Welvista support remain at current levels, or dissolve entirely, there is the potential for a huge gap in care for all persons affected. Therefore, Florida is identifying the stability and solvency of the ADAP as one of its most important gaps, albeit a potential gap as of the date of this document.

The wait list was reduced in 2011-2012 over 75%, from about 4,000 to 775 individuals as of March 9, 2012 with potential for additional reductions. A variety of factors allowed the Part B grantee to accomplish this reduction:

- Additional Ryan White/ADAP funding extended to Florida from HRSA;
- Further implementation of the PPACA, which now allows ADAP assistance to be counted toward meeting Medicare Part D recipients’ true-out-of-pocket “donut hole” costs. As a result, Medicare Part D (instead of ADAP) can now be utilized for medication coverage once Part D’s catastrophic coverage is reached;

- Securing a Pharmacy Benefit Manager (PBM) to manage the data interface between ADAP's Medicare Part D clients and the federal Centers for Medicare and Medicaid Services (CMS);
- ADAP's reduced formulary, which covers only HIV and some Opportunistic Infection medications;
- Ongoing ADAP data matches with Florida's Medicaid & Medicare programs, to ensure that ADAP is always the payer of last resort for eligible persons;
- Access to 340b negotiated prices for ADAP; and
- Enhanced tracking and trending of available ADAP data.

Chronic Disease Management Training Deficit

The Part B grantee, its Part B lead agencies, the statewide PCPG, and the Florida/Caribbean AIDS Education and Training Center (F/C AETC) have identified another critical gap in Florida's service delivery system. Medical case management is one of the most highly funded core services made available statewide to persons living with HIV. As HIV infection moves from being defined as an acute illness to a chronic illness, the need for updated medical case management widens. Persons infected with HIV today can expect to have nearly normal life expectancies – a very different prognosis from even ten years ago. Of course, that expectancy has two important caveats: persons infected with HIV must link early to lifetime care and adhere faithfully to their medication regimens.

Chronic disease management, as opposed to acute disease management, is the future of controlling and navigating HIV infection. Florida's medical case managers, skilled at assisting clients to negotiate the hurdles of an acute care setting, must make the philosophical and educational shift to helping their clients establish lifetime proficiencies at managing their own health and HIV-related issues. This will be particularly important as our clients move into the new systems of healthcare that are on the federal government's horizon.

Currently, Florida is in its infancy of establishing a training program for all Ryan White-funded medical case managers. The F/C AETC has created and produced a series of basic online training modules, with statewide input from case managers, medical providers, clients, lead agencies, and Part B grantee staff. A concerted statewide effort must be mounted to make the paradigm shift to chronic disease management in order for our clients to move in tandem with the expected changes in the healthcare system.

Access to Care Issues

While it is impractical to try to address each access gap identified in Section 1 of this document, we will highlight several important gaps and offer some solutions.

Although the majority of Florida's PLWHA live in the largest metropolitan areas, where there are often a myriad of services available, much of rural Florida lacks the infrastructure and resources to fill the gaps in care.

Transportation

Transportation remains the biggest challenge in rural areas of the state, due to the lack of car ownership (or funds to afford the cost of maintaining, insuring, and fueling an automobile), lack of public transportation, and the long distances people must travel from where they live to available services. Access to life-saving medical care and treatment is dependent upon being able to successfully link with the service delivery network. The reality of no viable means of obtaining transportation creates a terrible gap in our care system.

Although transportation is identified as a "non-core" service, it is a critical service when measuring a state's ability to provide "core" services. With poor access to transportation, clients will have no access to even the most state-of-the-art core services and treatment. No treatment access equates to higher transmission rates, delayed entry into care, and higher mortality rates. Yet transportation continues to be classified as non-core, and of lower importance, with regard to funding priorities, than many services that can only be accessed if appropriate transportation is available.

One very rural region of the state has had particular success with using gas vouchers/cards to reimburse clients for travel (or rides from others) to their medical appointments. This use of these reimbursements has demonstrated a significant increase in clinic show rates to 84.5%. Expansion of this cost effective strategy, especially across the rural areas of the state, would do much to close this gap.

Shortage of HIV-Competent Providers and Lack of Capacity

Most parts of the state struggle with lack of HIV-competent providers and lack of capacity to meet the growing medical needs and numbers of their clients. The long term economic effects of the current recession have negatively affected even the most stable of health departments, forcing many of them to curtail or close the clinics attended by HIV-positive individuals. Health departments have long been part of the backbone of clinical HIV care in Florida, especially for those who have no other payer for their care. Many private and university-based infectious disease physicians will not admit persons funded only by Medicaid or with no health insurance.

General funding increases might mitigate this gap eventually. However, in the current healthcare and political climate, that remains a remote possibility.

Utilizing current resources could possibly create a mid-to-long term solution. Initially, the Part B grantee will identify two or three areas within the state, which have inadequate capacity to meet the needs of their existing client base. Part A and Part B will work jointly to assess the needs in these areas and then put an education plan in place to address the capacity issues.

Florida envisions collaborating with the F/C AETC to provide the necessary technical assistance to meet the identified needs.

The Part B grantee will work within the confines of what they are permitted with regard to preparing our clients for the transitions that could be coming if the PPACA is finally fully implemented. This will require the combined efforts of the Part B grantee's medical director, legal advisors, F/C AETC, and all levels of stakeholders in the statewide care network.

Most other gaps identified in consumer and provider surveys used to update and drive this document tend to be in wrap-around or non-core services: legal services, food vouchers or food banks, and emergency financial assistance. Local entities must seek out and work with other community partners to establish those services. One area of the state was successful in collaborating with a faith-based organization to create what is now one of the larger food bank operations in the state. Unfortunately, with gaps in core services (ADAP, case management, medical care), these non-core gaps will not be met with Part B dollars. It will be up to regional planners and motivators to attempt to close these gaps, which are clearly also important to our clients.

2F: Proposed Solutions for Addressing Overlaps in Care

As discussed in Section 1B, all 67 Florida counties receive Part B funding. The state contains 6 directly funded Part A programs, including 5 Eligible Metropolitan Areas (EMAs) and one Transitional Grant Area (TGA), which serve 15 of Florida's 67 counties. Many service areas also enjoy support through Ryan White Parts C, D, and F. Figure 1.B.1. depicts the various service area overlaps. Given that the geographic areas with high levels of unmet need among the PLWHA population tend to be the larger urban counties, Florida's service area overlaps provides critical additional access.

Florida has experienced increased demands on each of the Ryan White parts as a result of the recent economic conditions. The state endeavors to utilize its limited federal grant dollars efficiently and effectively to provide access to high quality services to as many eligible PLWHA as feasible. The Part B grantee requires the 14 lead agencies to complete a coordinated service plan annually, which delineates the dollars allocated by line item for each funding source. While some areas fund disparate service categories among the different Ryan White parts, many clients receive services from multiple parts of Ryan White. Geographic service areas must integrate their data systems or improve data sharing when a single data system proves unattainable. Likewise, the Part B grantee must work towards solutions to upload client level data into the state's CAREWare database. This will help to minimize the potential for unnecessary duplication and/or overlap in services.

- The Part B grantee will encourage each consortium to have one comprehensive client level dataset capable of reporting data for services utilized in their geographic area with the payer sources identified.
- The Part B grantee will work towards a statewide reporting format that allows external providers to submit their service utilization data in a format that will ensure compatibility with Florida's CAREWare system.

Florida encourages transparency, coordination, and collaboration among all Ryan White parts, inter-related programs, and providers to maximize the strengths of all involved to fulfill the overall health care needs of the state's PLWHA population. Geographic areas stretch the limited resources and increase access to care through the creation of a community-wide service delivery system. Continued collaboration among providers will serve to insure that organizations are cognizant of and seek to maximize the benefits of, existing or potential overlaps in care.

- The Part B grantee will encourage Part A and Part B to use the same database to capture client level data within their service area.
- The Part B grantee will perform a Medicaid cross match between the Florida Medicaid Management System (FLMMIS), ADAP, and CAREWare databases on a monthly basis and send results to lead agencies.

2G: Proposed Coordinating Efforts to Ensure Optimal Access to Care

The Part B grantee will continue to seek approval for a statewide All Parts meeting. In the past, this was an annual forum, which brought all Ryan White funded entities in the state together in a face-to-face meeting to discuss challenges and opportunities faced by providers offering services across the various geographic areas of the state. The All Parts meeting provided a wonderful opportunity for networking, sharing of best practices and support for those working in the HIV arena in Florida.

Many of the areas that receive both Parts A and B have consolidated planning and allocation of resources. The Part B grantee will encourage that this consolidation be taken even further with the inclusion of Parts C, D, and F in the planning of services, in order to coordinate and facilitate the thorough utilization of resources. The Part B grantee will investigate the potential for expansion within the statewide PCPG membership, which already embraces Part A, to include specific representation of Part C, D, F, ADAP, AIDS Insurance Continuation Program, and Housing Opportunities for Persons with AIDS programs. The Part B grantee will also encourage local areas to combine planning processes for patient care and prevention services.

As illustrated throughout this section, one of the greatest opportunities in the area of coordination would be the creation and maintenance of a more accessible and inclusive statewide database.

While each of the programs has their own data collection and grant reporting requirements, current data systems that exist cannot always share and integrate the data. The Part B grantee will continue work to coordinate efforts in data sharing and integration.

The Part B grantee will work to address the movement of individuals from the Ryan White system of care into insurance and Medicaid programs as the PPACA components become effective. As Florida moves closer to full implementation, the Part B grantee will continue to work with the F/C AETC on standardized case management trainings, to make the transition for clients as seamless as possible.

Below are some of Florida's proposed coordinating efforts with specific programs to ensure optimal access to care.

Part A Services

- The Part B grantee will work further to streamline eligibility activities so clients only have to do eligibility once within each six month determination period, regardless of payer part. The Part B grantee provides training to eligibility staff from any funding source and will encourage Part A grantees to participate in the workgroup to update the eligibility manual.
- The Part B grantee will coordinate with Part A to update the case management manual and streamline these activities statewide.
- The Part B grantee will encourage that funding from Part A is allocated to state ADAP.
- The Part B grantee will continue to seek approval for a statewide All Parts meeting.

Part C Services

- The Part B grantee will work further to streamline eligibility activities so clients only have to do eligibility once, regardless of payer part.
- Part B grantee will encourage continued collaboration at the local level in order to coordinate access to care and ensure unduplicated services for OAMC.
- The Part B grantee will continue to seek approval for a statewide All Parts meeting.

Part D Services

- The Part B grantee will work further to streamline eligibility activities so clients only have to do eligibility once, regardless of payer part.

- The Part B grantee will encourage the inclusion of Part D in local and statewide planning of services to coordinate and facilitate the thorough utilization of resources.
- The Part B grantee will continue to seek approval for a statewide All Parts meeting.

Part F Services

- The Part A and Part B grantees will continue to work collaboratively with F/C AETC on case management modules for training all case managers.
- The Part B grantee will continue to seek approval for a statewide All Parts meeting.

Private Providers (Non-Ryan White Funded)

- The Part B grantee will continue to require local areas to establish written referral relationships with specified points of entry (including emergency rooms, detention facilities, etc.) to ensure appropriate referrals.

Prevention Programs Including: Partner Notification Initiatives and Prevention with Positives Initiatives

- The Part B grantee will continue to encourage local areas to combine planning processes for patient care and prevention services.

Substance Abuse Treatment Programs/Facilities

- The Part B grantee will encourage representation on local consortia/planning bodies.

Sexually Transmitted Disease (STD) Programs

- The Part B grantee will continue to coordinate with the STD program by making available results from PRISM (STD database) as proof of HIV, which eliminates retesting and allows easier and faster access to services.

Medicare

- ADAP will continue to do a Medicare match against ADAP clients through CMS.
- ADAP will continue its premium plus program, which allows Medicare Part D clients to access their Part D plans as primary payers before ADAP can assist as secondary payer.

- Local consortia will continue coordination to assist eligible clients to receive assistance with Medicare co-pays for doctors, etc., using Part A and B funding.

Medicaid

- Part B grantee will continue a Medicaid match using FLMMIS against clients in CAREWare and ADAP Database monthly to ensure Ryan White is the payer of last resort. Local areas will continue to screen clients during eligibility recertification using the Medicaid database.
- Part B grantee staff will stay actively involved with Project AIDS Care (PAC) Medicaid Waiver staff and coordinate activities to align services accordingly. In addition, Part B grantee staff will work with the local consortia to ensure that PAC enrollment and services are maximized, as appropriate, to make the most of Part B funding and services.
- Part B grantee will continue to encourage Medicaid representation on local consortia/planning bodies.
- Part B grantee will continue participation on monthly reform calls/meetings.

Children's Health Insurance Program

- Local agencies will continue to work with KidCare by referral and through Children's Medical Services.

Community Health Centers (CHC), Federally Qualified Health Centers (FQHC), and FQHC "look-alikes"

- The Part B grantee will continue to encourage collaboration and coordination at the local level where clients are referred for medical care.

2H: Role of the Ryan White Program in Collaborating with the Enhanced Comprehensive HIV Prevention Planning and Implementation Initiative

The importance of integrating Ryan White planning efforts with those of other entities providing services to persons with HIV infection cannot be emphasized enough since such integration will only lead to more integrated, effective, non-duplicative services for persons living with HIV. One example of such an integrated effort is clearly apparent in the Miami Dade planning area.

The Miami-Dade Enhanced Comprehensive HIV Prevention Plan (ECHPP) was developed by the Part B grantee in collaboration with the Miami-Dade County Health Department, Office of HIV/AIDS (MDCHD) and the Health Council of South Florida (Council). The goals of the Miami-Dade County ECHPP are consistent with the NHAS: to reduce new HIV infections, increase access to care, improve health outcomes for people living with HIV/AIDS, reduce HIV related disparities, and provide a more coordinated response to the HIV/AIDS epidemic in Miami-Dade County. Funding for ECHPP was granted to the Part B grantee who then contracted with the Council to write the plan. The Part B grantee also provided funding to the MDCHD to implement the plan.

The MDCHD ECHPP addresses the goal to increase access to care and optimize health outcomes for PLWHA by creating a linkage model to bridge the gap to care when a client is awaiting a confirmatory HIV positive test. This is accomplished through a partnership with the Miami-Dade Part A/Minority AIDS Initiative (MAI) and the Part B grantee. Under this partnership, the Miami-Dade Part A/MAI provides the technical support and services of a linkage specialist to Part B Take Control (community health fairs) events. The linkage specialist is present at each Take Control event, immediately connecting all clients diagnosed with HIV to appropriate health and social service benefits.

There is general agreement in the Miami-Dade County HIV/AIDS local community that collaboration and coordination of Ryan White Part A and B Program services is beneficial to clients as well as service providers. However, this approach had not been standard practice in Miami-Dade County until the implementation of the ECHPP. Through ECHPP, the Part B grantee has worked collaboratively with the Miami-Dade County Part A/MAI to help reduce barriers to HIV prevention and patient care services. The MDCHD and Miami-Dade County Part A/MAI partnership has focused on implementing the following activities between September 2011 and September 2013:

- Assessing the feasibility of having the Ryan White Part A Service Delivery Information System (SDIS) and CAREWare interface for improved coordination of services and resources for Ryan White Part A and Part B clients.
- Assessing feasibility of offering centralized intake across all programs for HIV and other health and social services.

Summary

HIV/AIDS affects us all. As the epidemic continues to grow and as more people learn their HIV status, it is vital that we are able to link increasing numbers of positive individuals with quality health care. We can only achieve this by working together to coordinate and plan programs;

identify and eliminate gaps in services; and avoid duplication of services to maximize our resources.

We want to be a place where communities are healthy and persons in the HIV-community can easily access needed health services. Our knowledge, involvement and activities with EIIHA efforts demonstrate our commitment and passion to help those with HIV live longer and healthier lives while also reducing transmission of the virus to others.

Florida is constantly evolving in its journey to go beyond the needs and expectations of its clients, advocates and healthcare service providers. Accountability can only be achieved by continuous improvement, performance measurement, setting clear expectations and goals, and focusing on health outcomes. Leadership forms the basis for success in facing and dealing with one's past challenges.

Barriers in Florida's progress in ultimately achieving an ideal, high quality, comprehensive continuum of care is regrettably caught up in the budget climate at the state and federal level. Florida's ADAP remains in crisis and the urgent situation is constantly being addressed. Florida's Medicaid program continues to be strained.

However, when all is said and done, Florida will surpass expectations to get the job done, make the best of the resources available, and strive to remain on the cutting edge of the ever-changing HIV/AIDS epidemic. Our actions will reflect taking full responsibility for our performance. Actively collaborating with all our community partners and working with all stakeholders and partners within the HIV-positive community, Florida will build relationships, solve problems, make decisions and deliver services to achieve our 2012-2015 proposed care goals. In so doing, Florida is committed and dedicated towards planning and achieving a better and healthier community and embracing the role as the visionary leader in the nation's HIV/AIDS response.

SECTION 3: HOW WILL WE GET THERE?

“Any intelligent fool can make things bigger, more complex, and more violent. It takes a touch of genius -- and a lot of courage -- to move in the opposite direction.”

Albert Einstein

Introduction

Florida’s 2012-15 Statewide Coordinated Statement of Need (SCSN) and Comprehensive Plan addresses the components deemed most critical to cultivate a high quality, comprehensive continuum of care for all People Living with HIV/AIDS (PLWHA) in the state. The goals and corresponding strategies, activities, and timelines delineated in this section demonstrate collaboration between the Florida Department of Health’s Bureau of HIV/AIDS (Part B grantee), Comprehensive Plan writing workgroup, and Part A grantees. The Patient Care Planning Group (PCPG) reviewed the plan to substantiate that the proposed methods responded to Florida’s crucial needs and identified challenges. The Part B grantee and PCPG will revise, amend, and/or include additional goals, objectives, and activities throughout the implementation period to improve the health outcomes and quality of life for Florida’s PLWHA. For Sections 3A through 3D, the timeline/due dates correspond to the numbered activities. However, the “responsible entity(ies)” listed in the last column may apply to any or all of the activities and related timelines delineated in the preceding columns. Please refer to Appendix B for the corresponding National HIV/AIDS Strategy (NHAS) goals, Healthy People 2020 (HP2020) objectives, and Patient Protection and Affordable Care Act (PPACA) goals referenced in the following tables containing strategies, plan, activities, timeline, and responsible entity(ies).

3A: Strategy, Plan, Activities, Timeline, and Responsible Entity(ies) to Close Gaps in Care

<i>Goal 1.1 Stretch limited resources to help close gaps in care.</i>			
Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(ies)
Assess cost benefit of Pre-Existing Condition Insurance Plan (PCIP) and determine plan to expand if PCIP proves a	1. Continue Monroe County pilot of providing PCIP to small group of AIDS Insurance Continuation Program (AICP) clients (PCIP coverage remains administered by the Health Council of South Florida, Inc. with participating	1. July 2012 2. July 2012 and continued annual cost benefit analysis 3. December 2012	* Health Council of South Florida, Inc. * Part B grantee * Part B lead agencies

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

<p>cost effective option</p>	<p>clients opting for the PCIP Extended Option Plan) 2. Review Health Council of South Florida's analysis of cost-effectiveness from trending of insurance expenses for the PCIP through the end of each June, beginning in July 2012 3. Determine feasibility of opening PCIP coverage to more AICP clients 4. Create strategic plan for PCIP expansion 5. Lead agencies shall implement the approved strategic plan for statewide PCIP expansion as required</p>	<p>4. June 2013 5. Ongoing, from development of plan until implementation of PPACA in 2014</p>	
<p>Continue to refine and monitor eligibility screening process</p>	<p>1. Continue to monitor client eligibility for Medicaid through monthly Medicaid matches in Florida Medicaid Management System (FLMMIS) against CAREWare 2. Update the current Bureau of HIV/AIDS Eligibility Procedures Manual with statewide input from eligibility workers, case managers, and Part B grantee and disseminate to eligibility workers statewide inclusive of all Ryan White parts 3. Continue to provide monthly eligibility training to new staff via WebEx monthly 4. Lead agencies shall complete quarterly reviews of eligibility files in accordance with Health Resources and Services Administration (HRSA) and Department of Health (DOH) requirements</p>	<p>1. July 2012 and ongoing monthly 2. December 2012 3. July 2012 and ongoing monthly 4. July 2012 and ongoing quarterly</p>	<p>* Part B grantee * Ryan White funded eligibility staff * Part B lead agencies</p>
<p>Require consortia to have</p>	<p>1. Lead agencies must utilize CAREWare or have</p>	<p>1. July 2012</p>	<p>* Part B lead agencies</p>

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

<p>one comprehensive client level dataset capable of reporting data for services utilized in their geographic area with the payer sources identified</p>	<p>a working interface or upload to capture required client level service delivery information</p> <ol style="list-style-type: none"> 2. Each lead agency will have representation on the statewide meetings 3. Incorporate additional program data into CAREWare: Counseling Testing Referral System (CTRS), AIDS Drug Assistance Program (ADAP), Enterprise Master Person Index (EMPI) 4. Expand Health Management System (HMS) upload 5. Continue to perform a Medicaid cross match between the FLMMIS, ADAP, and CAREWare Databases on a monthly basis and send results to lead agencies 6. Lead agencies shall review and ensure the accuracy of client Medicaid/Medicare information in CAREWare by utilizing all available information including the monthly Medicaid/Medicare Match Report 7. Expand access to report portal 8. Convene user advisory workgroups 	<ol style="list-style-type: none"> 2. August 2012 3. August 2012 4. December 2012 5. July 2012 and ongoing monthly 6. July 2012 and ongoing quarterly 7. August 2012 8. December 2012 	<ul style="list-style-type: none"> * Part B grantee * Part B consortia * PCPG
<p>Work towards a statewide reporting format that allows external providers to submit their service utilization data in a format that will ensure compatibility with Florida's CAREWare system</p>	<ol style="list-style-type: none"> 1. Lead agencies not utilizing CAREWare must have a working interface or upload that provides sufficient data to comply with grant requirements per Administrative Guidelines 2. Lead agencies shall perform uploads monthly into CAREWare 3. Set aside development funding for jProg (software firm that develops and maintains CAREWare under contract for HRSA) 4. Work with jProg to determine next steps 	<ol style="list-style-type: none"> 1. October 2012 2. October 2012 and ongoing monthly 3. July 2012 4. December 2012 	<ul style="list-style-type: none"> * Part B lead agencies * Part B grantee * jProg

Encourage Part A and Part B to use the same database to capture client level data within their service area	<ol style="list-style-type: none"> 1. Work with HRSA Project Officer to determine Part B role to capture data needs for all Ryan White Parts 2. Formulate plan delineating next steps 	<ol style="list-style-type: none"> 1. December 2012 2. April 2013 	<ul style="list-style-type: none"> * Part B grantee * Part A grantees
Adjust resource allocation methodology to ensure fair and equitable distribution of funds based on Part B service utilization data	<ol style="list-style-type: none"> 1. Review current funding allocations 2. Include expanded financial metrics in allocation methodology 3. Reconvene allocation methodology workgroup 	<ol style="list-style-type: none"> 1. July 2012 2. December 2012 3. March 2013 	<ul style="list-style-type: none"> * Part B grantee * PCPG * Allocation Methodology Workgroup
Facilitate the enrollment and participation of PLWHA in clinical trials and other research projects, paid for by outside funding streams	<ol style="list-style-type: none"> 1. Florida Consortium for HIV/AIDS Research (FCHAR) will provide regular progress updates to Part B grantee (quarterly) and PCPG (bi-annually) regarding research projects and clinical trials 2. Educate local areas regarding potential benefits, eligibility, and impact of investigative research and clinical trials 	<ol style="list-style-type: none"> 1. October 2012 and ongoing 2. December 2013 	<ul style="list-style-type: none"> * FCHAR * Part B grantee * PCPG * Part B consortia/ lead agencies
<i>Aligns with Following: NHAS - 2,3; HP2020 - 10; PPACA - 1,2</i>			

<i>Goal 1.2 Decrease or eliminate the ADAP wait list.</i>			
Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
Closer tracking and	1. ADAP technical assistance request from the	1. Ongoing	* Part B grantee

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

trending of available ADAP data	grantee, National Association of State and Territorial Apprenticeship Directors, and other sources 2. Obtain additional training and program enhancements to address this issue	2. July 2012 through March 2013 and ongoing as needed	
Increase timely dissemination of information with Part A grantees and Part B consortia/lead agencies	1. Expand access to report portal 2. Link and incorporate the ADAP database into HMS 3. Enable upload of ADAP data into CAREWare 4. Create reports that Part A grantees and Part B consortia/lead agencies can access through report portal	1. August 2012 2. July 2012 through March 2013 3. July 2012 through March 2013 4. December 2013	* Part B grantee * Part A grantees * Part B consortia//lead agencies
Consolidate all ADAP supported insurance services under a single provider contract to ensure continuity and appropriate rebate recovery	1. Collect rebates under initial Pharmacy Benefit Manager (PBM) contract 2. Require insurance services to be more closely coordinated with ADAP and enhance rebate recovery in the Intent to Negotiate for ADAP services	1. July 2012 2. Ongoing rebate enhancement through 2015	* Part B grantee * PBM
Streamline ADAP eligibility and enrollment processes	1. Explore and research feasibility of selecting an entity to coordinate all eligibility processes 2. Issue bidding instrument to solicit proposals	1. June 2013 2. June 2014	* Part B grantee * PCPG
Create a system to obtain real time information that will provide information for all ADAP clients through selection of a comprehensive PBM	1. Prepare bidding instrument and process proposals 2. Initiate contract for comprehensive PBM services 3. Evaluate PBM performance	1. July 2012 2. July 2012 3. October 2012 and ongoing	* Part B grantee * PBM

Perform a Medicaid cross match on a monthly basis to ensure that ADAP is always the payer of last resort for eligible persons	1. Continue to monitor client eligibility for Medicaid through monthly Medicaid matches in FLMMIS against the ADAP database	1. July 2012 and ongoing	* Part B grantee
<i>Aligns with the Following: NHAS - 1,2,3; HP2020 - 1,2,3,4,5,6,7,10,11,12; PPACA - 1,2,3,4</i>			

<i>Goal 1.3 Address chronic disease management training deficit.</i>			
Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
Shift the medical case management paradigm from acute disease management to chronic disease management	<ol style="list-style-type: none"> 1. Continue creation and production of a series of basic online training modules with statewide input from case managers, medical providers, clients, lead agencies, and Part B grantee staff 2. Part A and Part B case managers shall access and use trainings 3. Part A and Part B case managers shall complete trainings 4. Providers shall maintain documentation of case management training in personnel file 	<ol style="list-style-type: none"> 1. September 2012 2. December 2012 3. March 2013 4. March 2013 	<ul style="list-style-type: none"> * Florida/ Caribbean AIDS Education and Training Center (F/C AETC) * Part B grantee * Part A and Part B case managers * Providers
<i>Aligns with the Following: NHAS - 1,2,3; HP2020 - 10,11,12,17,18; PPACA - 1,2,3</i>			

<i>Goal 1.4: Improve access to care issues.</i>			
Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
Increase HIV-competent providers and improve their capacity to meet growing medical needs of clients	<ol style="list-style-type: none"> 1. Identify two or three areas within the state, which have inadequate capacity to meet the needs of their existing client base 2. Assess the needs in these areas 3. Put an education plan in place to address the capacity issues 4. Collaborate with the F/C AETC to provide the necessary technical assistance to meet the identified needs 	<ol style="list-style-type: none"> 1. December 2012 2. December 2013 3. March 2014 4. December 2014 	<ul style="list-style-type: none"> * Part B grantee * Part A grantees * F/C AETC
Assess gap in transportation service	<ol style="list-style-type: none"> 1. Research the impact transportation issues have on accessing medical care 2. Examine potential allocation for transportation considering prioritization of core medical services 3. Lead agencies shall utilize standardized statewide comprehensive needs assessment survey 4. Evaluate gap in transportation service from client and provider perspective 	<ol style="list-style-type: none"> 1. December 2012 2. January 2013 3. December 2013 4. March 2014 	<ul style="list-style-type: none"> * Part B grantee * PCPG * Part B consortia/ lead agencies
Prepare clients for transitions that will come with implementation of the PPACA	<ol style="list-style-type: none"> 1. Part B grantee shall continue to monitor proposed legislation regarding PPACA 2. Part B grantee shall continue to participate on monthly Medicaid reform calls/meetings 3. Part B grantee will evaluate on bi-annual basis 4. Part B grantee shall present an PPACA evaluation report to the PCPG bi-annually 	<ol style="list-style-type: none"> 1. July 2012 2. July 2012 and ongoing monthly 3. July 2012 and ongoing 4. July 2012 and ongoing 5. July 2013 and ongoing until fully implemented 	<ul style="list-style-type: none"> * Part B grantee * PCPG * Part B lead agencies

	<p>5. Maintain an up-to-date plan for transitioning clients once Part B grantee has enough information to understand the impact of implementation of PPACA</p> <p>6. Lead agencies shall implement the approved strategic plan for transitioning clients as required</p>	<p>6. 2013-2014</p>	
<p><i>Aligns with the Following: NHAS - 2,3; HP2020 - 10,11,12,16; PPACA - 1,2,3</i></p>			

3B: Strategy, Plan, Activities, Timeline, and Responsible Entity(ies) to Address the Needs of Individuals Aware of Their HIV Status, but Are Not in Care

<p><i>Goal 2.1: Decrease the number of individuals aware of their status but not in care and decrease the overall infectivity of this group of individuals by decreasing their in-care and/or monitored viral load.</i></p>			
Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
<p>Establish a true baseline number of individuals aware of status but not in</p>	<p>1. Import all paper labs into the Enhanced HIV/AIDS Reporting System (eHARS)</p> <p>2. Manually input cases in Out of State database</p>	<p>1. July 2012</p> <p>2. July 2012</p> <p>3. December 2012</p>	<p>* Part B grantee</p>

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

<p>care, utilizing available data systems (Gold Standard)</p>	<p>3. Ensure the most complete possible matching by analyzing redundancies between the eHARS and the following supplemental databases: Medicaid, CAREWare, ADAP, and HMS 4. Eliminate estimations through completeness of data</p>	<p>4. June 2013</p>	
<p>Develop a process for continuous improvement in ascertaining those individuals aware of status but not in care based on available data</p>	<p>1. Continue to enhance the process of importing paper labs into the eHARS 2. Improve the calculation of in and out migration in the eHARS and incorporate them with the population and estimates of who is in care 3. Identify other available databases that may be beneficial for matching with the eHARS in order to identify additional sources of care, not captured elsewhere 4. Analyze redundancies between the eHARS and the following supplemental databases: Medicaid, CAREWare, ADAP, and HMS 5. Continue to re-evaluate the entire step-by-step process of calculating the unmet need in order to provide the most accurate area-specific data</p>	<p>1. July 2012 and ongoing annually 2. July 2012 3. Upon creation of new patient care database 4. December 2012 5. Annually, in May/June</p>	<p>* Part B grantee</p>
<p>Capture in-care and/or monitored viral load</p>	<p>1. Use the eHARS, eLabs, ADAP, and CAREWare viral load data to see how comprehensive Florida's viral load data is. 2. Assess reliability of estimate based on proportion of cases with known viral load 3. Lead agencies that fund Outpatient Ambulatory Medical Care (OAMC) and/or Medical Case Management shall ensure that the Viral Load and CD4 are captured at least every six months</p>	<p>1. July 2012 2. July 2012 3. July 2012 and ongoing 4. Ongoing at bi-annual PCPG meetings 5. December 2012 6. March 2013</p>	<p>* Part B grantee * Part B lead agencies * PCPG * F/C AETC</p>

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

	<p>4. Provide in-care and/or monitored viral load update to PCPG</p> <p>5. Assess local relevance, meaning anything below the state level, based on data completeness and quality standards (will vary by location and some jurisdictions may not be able to have local estimates)</p> <p>6. Develop plan for improvement in data completeness</p>		
Develop a referral and linkage system between HIV prevention and the HIV patient care system	<p>1. Providers shall ensure proper client consent documentation</p> <p>2. Make prevention data available for reporting</p> <p>3. Expand HMS upload</p> <p>4. Incorporate additional program data into CAREWare: CTRS, ADAP, EMPI</p>	<p>1. July 2012 and ongoing</p> <p>2. July 2012</p> <p>3. July 2012 and ongoing monthly</p> <p>4. August 2012</p>	<p>* Providers</p> <p>* Part B grantee</p>
Develop and implement contact protocols for individuals aware of status and not in care	<p>1. Import all paper labs into the eHARS</p> <p>2. Part B grantee shall conduct inquiry, which includes prevention, surveillance, and patient care representation</p> <p>3. Formulate plan to let Part B consortia know who is aware of their status and not in care within their local area</p> <p>4. Lead agencies shall implement the approved strategic plan to bring identified individuals into care as required</p>	<p>1. July 2012</p> <p>2. October 2012</p> <p>3. March 2013</p> <p>4. March 2013 and ongoing</p>	<p>* Part B grantee</p> <p>* Part B lead agencies</p>
Develop jail linkage projects that encompass all of Florida's counties willing to participate	<p>1. Communicate with local county sheriff's offices or county governments to assess their willingness to incorporate HIV linkage activities in their jails</p>	<p>1. December 2013</p> <p>2. March 2015</p>	<p>* Part B grantee</p> <p>* Sheriff's offices</p> <p>* County governments</p>

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

	2. Disseminate the Jail Linkage Guidelines and Standards to assist administrators in implementing new programs		
Develop a linkage project for undocumented immigrants	<p>1. "Palabras Sabias" (words of wisdom) is a Latino HIV/AIDS social marketing campaign designed to increase HIV/AIDS awareness (posters and vintage cards promote HIV prevention, testing, and linkage to care)</p> <p>2. Used at community events and outdoor print media (posters are designed to reach heterosexual Latinos and Latinas, while the vintage card series targets Latino Gay Men)</p>	<p>1. 2012-2015</p> <p>2. 2012-2015</p>	<p>* Part B grantee</p> <p>* Part B consortia</p> <p>* County Health Department staff</p>
Build and strengthen linkage-to-care systems statewide	<p>1. Continuation of nine Minority AIDS Initiative (MAI) linkage projects around the state to assist clients who are newly diagnosed or who have fallen out of care with initiating medical care, improving adherence, and remaining in care</p> <p>2. Use funds received via Substance Abuse and Mental Health Services Administration (SAMHSA), the MAI-TCE grant increased linkage for HIV-infected clients with co-occurring mental health and/or substance abuse issues in Miami-Dade</p> <p>3. Alachua and Broward counties are currently implementing strong linkage programs within their County Health Departments</p> <p>4. Assess the effectiveness of current local linkage-to-care programs</p> <p>5. Develop best practice document and share statewide</p>	<p>1. 2012-2015</p> <p>2. 2012-2015</p> <p>3. 2012-2015</p> <p>4. December 2013</p> <p>5. June 2014</p> <p>6. March 2015</p>	<p>* Part B grantee</p> <p>* MAI providers</p> <p>* SAMHSA</p> <p>* Part B consortia/lead agencies</p>

	6. Part B consortia/lead agencies shall review best practice document and implement linkage program as funding allows		
<i>Aligns with the Following: NHAS - 1,2,3; HP2020 - 1,2,3,4,5,6,7,10,11,12; PPACA - 2,3,4</i>			

Goal 2.2: Reduce the time from HIV diagnosis until entry into care by addressing the barriers for persons aware of their HIV diagnosis and not in care.

Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
Identify barriers and obstacles to engaging in care for persons aware of their HIV-positive status who are not in care	<ol style="list-style-type: none"> 1. Analyze data from 2010 Client Needs Assessment survey regarding barriers for those aware of their status, but not in care 2. Collaborate with needs assessment workgroup to determine how to assess barriers for persons aware of their HIV-positive status, but not in care 3. Lead agencies shall utilize standardized statewide comprehensive needs assessment survey 4. Evaluate barriers for persons aware of their HIV-positive status, but not in care from client and provider perspective 	<ol style="list-style-type: none"> 1. December 2012 2. January 2013 3. December 2013 4. March 2014 	<ul style="list-style-type: none"> * Part B grantee * PCPG * Part B consortia/ lead agencies
Prioritize and reduce identified barriers and obstacles	<ol style="list-style-type: none"> 1. Evaluate barriers for persons aware of their HIV-positive status, but not in care from client and provider perspectives 2. Prioritize identified barriers 3. Formulate plan to reduce barriers identified as highest priority 	<ol style="list-style-type: none"> 1. March 2014 2. July 2014 3. December 2014 4. December 2014 and ongoing 	<ul style="list-style-type: none"> * Part B grantee * PCPG * Part B lead agencies

	4. Lead agencies shall implement the approved strategic plan to reduce identified barriers as required		
<i>Aligns with the Following: NHAS - 2,3; HP2020 - 10,11,12; PPACA - 1,2</i>			

Goal 2.3: Reduce HIV-related health disparities specific to persons who are not in care.

Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
Increase peer linkage and navigation efforts	1. Assess effectiveness of four recently established peer programs in Alachua, Duval, Orange, and Palm Beach counties 2. Determine best practice for peers providing advocacy and guidance to help overcome barriers to obtaining and remaining in care 3. Determine best practice for peers assisting clients in navigating the medical care system in their areas 4. Evaluate how to overcome barriers and obstacles to get peer programs into place 5. Formulate plan to increase peer linkage and navigation efforts statewide 6. Lead agencies shall implement the plan to increase peer linkage and navigation efforts as resources permit	1. 2012-2014 2. 2012-2014 3. 2012-2014 4. Summer 2014 5. December 2014 6. December 2014 and ongoing	* Part B grantee * Part B consortia/ lead agencies

Aligns with the Following: NHAS - 2,3; HP2020 - 10; PPACA - 1,2

3C: Strategy, Plan, Activities, Timeline, and Responsible Entity(ies) to Address the Needs of Individuals Unaware of Their HIV Status (with an Emphasis on Identifying, Informing, Referring, and Linkage to Care Needs)

<i>Goal 3.1 Decrease the number of individuals Unaware of their HIV status.</i>			
Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
Expand overall number of tests throughout the state	<ol style="list-style-type: none"> 1. Early Intervention Consultants and Minority AIDS Coordinators will work with community organizations and healthcare facilities 2. Early Intervention Consultants and Minority AIDS Coordinators will identify and recruit potential test sites 	<ol style="list-style-type: none"> 1. Ongoing 2012-2015 2. Ongoing 2012-2015 	* Part B grantee
Increase test site capacity in the testing system	<ol style="list-style-type: none"> 1. Apply for additional Centers for Disease Control and Prevention funding 2. Apply for additional HRSA funding 3. Apply for additional SAMHSA funding 	<ol style="list-style-type: none"> 1. Ongoing 2012-2015 2. Ongoing 2012-2015 3. Ongoing 2012-2015 	* Part B grantee

<p>Improve post-test counseling rates by converting more traditional test sites to rapid test sites.</p>	<p>1. Counseling and Testing Team will continue to strive to convert eligible traditional testing sites to rapid testing sites 2. Early Intervention Consultants and Minority AIDS Coordinators will assist existing sites in targeting testing activities to become eligible for rapid testing</p>	<p>1. Ongoing 2012-2015 2. Ongoing 2012-2015</p>	<p>* Part B grantee * Traditional testing sites</p>
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Aligns with Following: NHAS - 1,2; HP2020 - 13,14,15; PPACA - 2

<p><i>Goal 3.2 Reduce the number of people who become infected with HIV/AIDS.</i></p>			
<p>Strategy/Plan</p>	<p>Activities</p>	<p>Timeline/ Due Date</p>	<p>Responsible Entity(s)</p>
<p>Expand overall number of tests throughout the state</p>	<p>1. Counseling and Testing Team will work with Early Intervention Consultants and Minority AIDS Coordinators to assist new entities in becoming test sites 2. Maintain the network of registered test sites 3. Continue to support testing with the purchase of test devices and laboratory services that are distributed from the Bureau of HIV/AIDS</p>	<p>1. Ongoing 2012-2015 2. Ongoing 2012-2015 3. Ongoing 2012-2015</p>	<p>* Part B grantee * Test sites</p>
<p>Expand the number of Diffusion of Effective Behavioral Interventions (DEBI) and Evidence-based Behavioral Interventions (EBIs), and Social Networking</p>	<p>1. Conduct a competitive process to solicit proposals for conducting DEBI, EBIs, and SNS statewide with new programs to begin 1/1/13 2. Assess the current capacity of DEBI, EBIs, and SNS that target high-risk HIV negative individuals</p>	<p>1. December 2012 2. October 2013</p>	<p>* Part B grantee</p>

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

Strategies (SNS) that target high risk communities			
Refer high-risk negative individuals into services that help keep them negative	<ol style="list-style-type: none"> 1. Keep negative result data locally 2. Work with Reporting Unit to determine plan to upload data from local provider sites to statewide data system 	<ol style="list-style-type: none"> 1. Ongoing 2012-2015 2. December 2013 	<ul style="list-style-type: none"> * Part B grantee * Local County Health Department staff * Community based organization staff
<p><i>Aligns with the Following: NHAS - 1; HP2020 - 1,2,3,4,5,6,7,9,13,14,15,17,18; PPACA - 2,4</i></p>			

Goal 3.3 Increase the number of individuals aware of their HIV positive status who are linked to medical care.

Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
Expand rapid testing services statewide	<ol style="list-style-type: none"> 1. Counseling and Testing Team will strive to convert eligible traditional testing sites to rapid testing sites 2. Early Intervention Consultants and Minority AIDS Coordinators will assist existing sites in targeting testing activities to become eligible for rapid testing 	<ol style="list-style-type: none"> 1. Ongoing 2012-2015 2. Ongoing 2012-2015 	<ul style="list-style-type: none"> * Part B grantee
Compute the OAMC visit rates in the OAMC engagement period (three months following HIV	<ol style="list-style-type: none"> 1. Expand access to Quality Management (QM) metrics 2. Lead agencies that fund OAMC and/or Medical Case Management shall ensure that 	<ol style="list-style-type: none"> 1. August 2012 2. October 2012 3. December 2012 4. Ongoing, on a biannual 	<ul style="list-style-type: none"> * Part B grantee * Part B lead agencies * PCPG

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

<p>seropositive test), and long-term retention period</p>	<p>medical visits are captured 3. Convene QM workgroup 4. Provide QM workgroup update at PCPG meetings 5. Create Quality Improvement project</p>	<p>basis beginning in 2013 5. December 2013</p>	
<p>Participate in a public health information network to create a mechanism to identify those clients that have positive HIV test results to ascertain if they are in other systems of HIV care, and if not, contact them to offer Ryan White services</p>	<p>1. Determine the legal steps necessary to move forward with this effort 2. Incorporate additional program data into CAREWare: CTRS, ADAP, EMPI 3. Expand HMS upload 4. Expand access to report portal</p>	<p>1. August 2012 2. August 2012 3. December 2012 4. December 2012</p>	<p>* Part B grantee</p>
<p>Incorporate counseling/testing data into care reporting data systems to track referrals/linkages</p>	<p>1. Continue to examine minimum data set with data from ADAP, CAREWare, HMS, counseling and testing, and electronic lab reporting 2. Track linkages and referrals for HIV-infected persons from counseling and testing data 3. Redesign CTRS database to facilitate integration</p>	<p>1. Ongoing, on a monthly basis 2. Ongoing, on a monthly basis 3. December 2012</p>	<p>* Part B grantee</p>
<p><i>Aligns with the Following: NHAS - 2,3; HP2020 - 10,13; PPACA - 1,2,4</i></p>			

3D: Strategy, Plan, Activities, Timeline, and Responsible Entity(ies) to Address the Needs of Special Populations Including but Not Limited to; Adolescents, Injection Drug Users, Homeless, and Transgender

<i>Goal 4.1: Improve ability to meet the needs of special populations.</i>			
Strategy/Plan	Activities	Timeline/ Due Date	Responsible Entity(s)
Address the needs of HIV-positive adolescents	1. Encourage Part B consortia/lead agencies to engage in activities that will reach HIV-positive adolescents 2. Potential activities for Part B consortia/ lead agencies include: Local Speakers Bureau- recruiting and training youth as public speakers Increase HIV-positive youth participation in RW consortium Involve HIV-positive youth in outreach services to locate and identify out of care youth Connect with youth groups / teen centers/ high schools/community centers Identify ways to include HIV-positive youth in	1. December 2012 2. December 2013	* Part B grantee * Part B consortia/ lead agencies * Providers * F/C AETC

	<p>designing services, choosing venues in which outreach can be undertaken, and determining ways to best identify youth and engage and retain them in care Design client surveys that are as youth-sensitive as possible Recruit and train Youth Peer Educators</p>		
<p>Address the needs of HIV-positive Injection Drug Users (IDUs)</p>	<p>1. Encourage Part B consortia/lead agencies to engage in activities that will reach HIV-positive IDUs 2. Potential activities for Part B consortia/ lead agencies include: Enter into Memorandum of Agreement / Memorandum of Understanding with drug treatment facilities within the service area to refer clients to needed services Keep a current listing of treatment facilities available in the service area Establish a representative at the local consortia or planning body from a local drug treatment facility Ensure referrals to drug treatment are up-to-date, and include referrals to buprenorphine and methadone maintenance therapy where available Ensure that staff is educated in the effects of incarceration on IDU health and is able to provide services which reduce its negative impacts</p>	<p>1. December 2012 2. December 2013</p>	<p>* Part B grantee * Part B consortia/ lead agencies * Providers</p>

Florida's 2012-15 Statewide Coordinated Statement of Need and Comprehensive Plan

<p>Address the needs of HIV-positive homeless individuals</p>	<p>1. Develop coordinated planning models, including coordinated prevention and patient care planning and resource allocation activities 2. Combine patient care and Housing Opportunities for Persons with AIDS (HOPWA) program guidance to enhance the state's response to housing and care needs for HIV-positive consumers</p>	<p>1. June 2013 2. June 2013</p>	<p>* HOPWA grantee * Part B grantee * PCPG</p>
<p>Address the needs of HIV-positive transgendered persons</p>	<p>1. Work in collaboration with appropriate entities to update data collection methods of transgender individuals (MTF, FTM, etc.) in order to accurately capture sex and gender demographics for all people, by including two-question system, as recommended by The University of California at San Francisco's Center for AIDS Prevention Studies Center of Excellence for Transgender Health Current gender Gender assigned at birth 2. Work in collaboration with the Prevention Section and the F/C AETC to combat stigma and discrimination of transgender individuals through promoting trainings that helps health professionals provide non-judgmental care and ask questions about gender identity correctly and consistently; such as: the Best Practices for HIV prevention Among Trans People and the Trans Cultural Competency courses, provided by UCSF/CAPS Center of Excellence 3. Part B consortia/lead agencies shall partner</p>	<p>1. December 2012 2. Ongoing 2012-2015 3. Ongoing 2012-2015 4. Ongoing 2012-2015 5. December 2012 6. December 2013</p>	<p>* Part B grantee * PCPG * Part B consortia * Department of Disability Determination * F/C AETC</p>

	<p>with the Prevention Section to request technical assistance as needed from the Center of Excellence and the F/C AETC to coordinate trainings and policy recommendations for clinicians and healthcare providers</p> <p>4. Work in collaboration with the Prevention Section to promote Transgender Professional Medical Provider Conference (Broward County) and other trans-focused statewide meetings</p> <p>5. Develop guidelines/best-practice recommendations on holistic provision of services for transgender HIV-positive people, including housing, insurance access and disability determination</p> <p>6. Compile and disseminate resource inventory of transgender-friendly housing services to Florida transgender community</p>		
<p>Improve the ability to capture and report data on Florida's HIV-positive transgendered population</p>	<p>1. Develop a unified method for documenting transgender information and utilization</p> <p>2. Educate providers (clinicians, case managers, ADAP staff, etc.) regarding the correct way to capture transgender information</p>	<p>1. April 2013</p> <p>2. December 2014</p>	<p>* Part B grantee</p> <p>* PCPG</p> <p>* Part B consortia</p> <p>* Providers</p> <p>* F/C AETC</p>
<p>Improve the ability to capture and report data on Florida's HIV-positive transgendered population</p>	<p>1. Develop a unified method for documenting transgender information and utilization</p> <p>2. Educate providers (clinicians, case managers, ADAP staff, etc.) regarding the correct way to capture transgender information</p>	<p>1. April 2013</p> <p>2. December 2014</p>	<p>* Part B grantee</p> <p>* PCPG</p> <p>* Part B consortia</p> <p>* Providers</p> <p>* F/C AETC</p>
<p><i>Aligns with the Following: NHAS - 2,3; HP2020 - 10; PPACA - 1,2</i></p>			

3E: Activities to Implement the Proposed Coordinating Efforts to Ensure Optimal Access to Care

Coordination and collaboration among Ryan White parts, providers, programs for prevention, substance abuse, and Sexually Transmitted Disease (STD), as well as Medicaid, Medicare, KidCare, and Community Health Centers remain essential to comply with the requirements of the Ryan White Treatment Extension Act of 2009. Florida provides services in a coordinated and cost-effective manner to increase their accessibility and availability, reduce duplication of effort, and ensure the Ryan White program continues as the payer of last resort. Section 2G describes some specific activities the Part B grantee will undertake to implement the proposed coordinating efforts to ensure optimal access to care for PLWHA in the state.

When setting priorities and allocating funding, the Part B grantee evaluates the available resources for HIV care services and coordinates with other local, state, and federal entities, which requires an in-depth understanding of services provided by all Ryan White parts, as well as other publicly funded HIV services. This iteration of Florida's SCSN and Comprehensive Plan involved an increased cooperative partnership among the various Ryan White parts in order to coordinate service provision better in future years. The Part B grantee will investigate the potential for expansion within the statewide PCPG membership, which already embraces Part A, to include specific representation of Part C, D, F, ADAP, AICP, and the HOPWA program.

The Patient Care Section of the Bureau of HIV/AIDS coordinates with the Prevention Section to inform persons unaware of their HIV status, keep referral lists updated, link persons to care, and assist clients on the ADAP waiting list to access Patient Assistance Programs. The reporting units within each section share a programmer to ensure integration and communication between data systems. The implementation and assessment of the impact of the EIIHA initiative obliges increased communication and collaboration between patient care and prevention at the state and local level.

The Ryan White Part B program conscientiously and consistently screens all potential consumers at initial intake and current clients during their recertification every six-months for Medicaid, KidCare, private health insurance eligibility, and other programs to ensure Ryan White remains the payer of last resort. The Part B grantee enforces eligibility policies that do not preclude a veteran living with HIV from receiving Ryan White Services due to qualification for health care benefits through the Department of Veteran Affairs, thus exempting veterans from the payer of last resort requirement.

The Part B grantee integrates and coordinates Ryan White funded services with other available programs and services within the state through strategic planning to enhance the continuum of HIV care. Increased collaboration with prevention, housing, mental health, and substance abuse providers will ensue to strengthen referral processes and improve the current system of linkages.

3F: HP 2020 Objectives

Florida's 2012-2015 SCSN and Comprehensive Plan addresses the two major goals of the Healthy People 2020 initiative: (1) to increase the quality and years of a healthy life; and (2) eliminate health disparities. Florida created this plan with the intent to strengthen the delivery of critical medical care to newly diagnosed individuals, as well as those currently out of care. Through enhancement, expansion, and continued HIV education of the medical provider network, the state strives to deliver increasingly sensitive and timely care for its consumers and improve health outcomes for PLWHA. The Part B grantee will enhance collaboration with prevention to support efforts to educate the community about HIV, refer high-risk HIV-negative individuals to appropriate interventions to help them remain negative, as well as link HIV-positive individuals to medical care, and as important, retain them in care.

Numerous studies emphasize the importance of adherence to decrease the likelihood of HIV-transmission and improve the health outcomes of PLWHA. Florida will continue efforts to determine an in-care and/or monitored viral load baseline at the state and local level where possible. After achieving a valid, verifiable, and reliable baseline, Florida will formulate a strategy to reduce the in-care and/or monitored viral load by increasing the proportion of consumers with undetectable levels, which will mean retaining people in care and educating them about the importance of adhering to their medical regimen. The Part B grantee will continue to work towards increased data sharing and integration to decrease the delay in service and accelerate the provision of a high-quality, coordinated service delivery system. By July 2013, the Part B grantee in conjunction with the PCPG will evaluate the 18 HIV-related objectives and develop a strategic plan to prioritize and measure them throughout the remainder of this comprehensive plan.

3G: Reflection of the SCSN

Florida incorporated the SCSN within the Comprehensive Plan to evidence its commitment to address the identified, needs, gaps, barriers, and challenges. As resources constrict and demand for services expand, Florida's Comprehensive Plan recognizes and advances the importance of coordination and collaboration between patient care and prevention, maximizing the collective effort and streamlining care, while serving more people with less. Florida's combined SCSN and Comprehensive Plan prioritizes core medical services, including OAMC and medications, as the foundation for optimal care. The strategy to expand medical care networks and increase their capacity to reach more people and retain them in care advanced an access to care gap identified as a core issue in the SCSN. Florida intends to address this issue by identifying areas with inadequate capacity, assessing the needs, creating an education plan, and collaborating with Part A grantees and the F/C AETC to implement the plan.

3H: Coordination and Adaption with Changes That Will Occur with the Implementation of the Patient Protection and Affordable Care Act (PPACA)

Florida's 2012-2015 SCSN and Comprehensive Plan embraces the intent of the PPACA: to improve quality of care, reduce barriers, and improve health outcomes for all individuals. Florida plans to enhance and expand its current medical provider network in an effort to increase capacity and provide more Ryan White consumers with exceptional care. Florida will maintain an up-to-date plan to prepare clients for transitions, which will result from full implementation of the PPACA. The Part B grantee, in conjunction with the F/C AETC and Part A and Part B case managers, will continue its efforts to address the training deficit in chronic disease management. In addition, Florida will continue to screen all eligible consumers for Medicaid and Medicare in anticipation of the transition with the implementation of the major provisions of PPACA in 2014.

Currently, fewer than one in five (13%) PLWHA have private insurance and nearly 24% do not have any coverage at all. Government programs provide HIV-related services for those who do not have enough health care coverage or the financial resources to cope with their HIV. The PPACA helps address coverage issues and provides new protections for patients and consumers. Many important features of the law went into effect in 2010 and have already begun to help PLWHA find and keep health insurance. Insurance companies can no longer deny coverage to children because of HIV/AIDS or any other pre-existing condition. Insurers cannot rescind coverage except in cases of fraud or intentional misrepresentation of a material fact. Insurers can no longer impose a lifetime dollar limit on essential health benefits. ADAP benefits now count as contributions toward a Medicare beneficiary's True out of Pocket (Troop) spending limit for drug coverage. This will continue to provide considerable savings to Florida's ADAP. Beginning in 2011, Medicare beneficiaries who reached the "donut hole" began to receive a 50% discount on covered brand name drugs while in the "donut hole." Discounts for brand name and generic drugs will grow over the course of the decade until the donut hole is closed.

When the PPACA achieves full implementation, additional changes in health insurance options will make it more accessible. In 2014, the PPACA will ensure that Medicaid coverage is available to all low-income Americans (less than 133% of the FPL), including adults with no children. As a result, low-income adults living with HIV will no longer have to wait for an AIDS diagnosis to become eligible for coverage. Insurers will not be able to deny coverage or charge more for anyone who has a pre-existing condition or impose annual dollar limits on essential health benefits. People without access to employer-sponsored insurance or Medicaid will be able to buy private coverage from insurance exchanges, designed to make buying health

insurance easier and more affordable. People with low and middle incomes will have access to federal premium tax credits, which will ensure that this coverage is affordable for them.

The PPACA seeks to ensure that people with public or private coverage can find high-quality health care. Health insurance plans will need to provide information in a user-friendly way, clearly explaining covered and non-covered services. Individuals and small business that purchase insurance, including people who buy coverage in the insurance exchanges, will have access to a benefit package that equals the scope of a typical employer plan. The package will offer coverage to meet the health care needs, including prescription drugs, preventive care, chronic disease management, and substance abuse and mental health treatment. Medicare and many private insurance plans are now required to cover many recommended preventive services, including screening for HIV, mammograms and other cancer screenings, with absolutely no cost sharing for patients, which will help PLWHA stay healthy. The PPACA calls for new investments to help providers manage chronic disease. The law also recognizes the value of patient-centered medical homes to strengthen the quality of care, especially for people with complex chronic conditions such as HIV. Medical homes provide a way to offer coordinated, integrated, and comprehensive care that has proven to be particularly effective for treating people living with HIV.

While health care coverage is a key issue for PLWHA, other economic, social, and physical factors influence their overall health. The PPACA acknowledges the importance of these other factors. The law makes critical investments in prevention, wellness, and public health activities to improve public health surveillance, community. It expands initiatives to strengthen cultural competency training for all health care providers to ensure the equitable treatment of all populations. The PPACA also bolsters the federal commitment to reducing health disparities. The law helps improve access to comprehensive quality health care, thereby improving the health and well-being of all PLWHA.

The Part B grantee intends to monitor proposed legislation closely and adapt its plan to ensure compliance with the PPACA. Florida will continue its commitment to a high quality, comprehensive continuum of care regardless of the ultimate configuration of the PPACA.

3I: National HIV/AIDS Strategy (NHAS)

The NHAS concentrates its efforts on reducing new infections, increasing access to care, and reducing health disparities. Likewise, Florida's 2012-15 SCSN and Comprehensive extends a statewide strategy to ensure the implementation of community-level approaches to reduce HIV infection, increase access to care, and reduce HIV-related health disparities, particularly in high-risk communities. Ryan White providers will continue to encourage risk reduction strategies and treatment adherence, as well as provide education to consumers and those affected by HIV about the threat of infection. By expanding medical care provider networks and increasing their capacity Florida will simultaneously increase access to care and reduce health disparities

throughout the state. Since this strategy will provide consumers increased options for medical care, it will also encourage their retention in care. Florida's 2012-2015 SCSN and Comprehensive Plan includes strategies tailored to the unique needs of special populations.

The Part B grantee recognizes the importance of rapid testing, an effective method of engaging people to identify and inform them of their status and refer and/or link them to appropriate services. The Part B grantee will encourage consortia to fund Early Intervention Services to improve the referral mechanism between HIV testing functions in prevention and the Ryan White HIV service delivery systems across the state as well as actual linkage from testing through care by implementing peer programs. Florida will improve coordination and collaboration between the patient care and prevention sections at the Bureau of HIV/AIDS to improve data sharing and integration to reduce barriers to care by facilitating a client's transition from prevention to patient care services. By adopting the three primary goals of the NHAS as the 2012-15 proposed care goals, Florida emphasizes the commitment to align its statewide response to HIV/AIDS with the NHAS. As Florida strives to meet its own proposed goals, it will also be contributing to the national coordinated effort to achieve the NHAS' vision of a nation committed to stopping the HIV epidemic and supporting all infected persons with dignity, and access to high-quality care.

3J: Strategy to Respond to Any Additional or Unanticipated Changes in the Continuum of Care as a Result of Budget Cuts

The Part B grantee and PCPG both appreciate the uncertainty with respect to federal funding for Ryan White services, as well the potential for erosion of state general revenue funding for HIV programs. As noted in Section 2E, Florida's largest challenge to closing gaps in care directly relates to the level of funding allocated at both the federal and state levels. Florida, as many other states, has struggled with multi-billion dollar deficits for the past five years.

The Part B grantee will reconvene the allocation methodology workgroup to ensure fair and equitable distribution of funds based on static or increases in HIV and AIDS cases who are actually engaged in Ryan White-funded care. With the full implementation of CAREWare for Part B reporting, there is much improved access to client-level data, and the possibility to apply utilization data as an input in the allocation process. The Part B grantee's strategy to respond to future budget cuts will be to focus primarily on critical core medical services.

Summary

Florida's 2012-15 SCSN and Comprehensive Plan highlights various issues that make the delivery of quality HIV-related services within the state vulnerable. Barriers and gaps in care, due to sustained funding deficits and political challenges, will be met head-on, and delivery of vital care for all diagnosed individuals, whether currently in or out of care, will be strengthened through proactive coordination and collaboration between Ryan White parts, HIV/AIDS program areas, and other allied health service entities throughout the state. This plan sets forth the basis for continued growth and improvement of Florida's comprehensive service delivery system throughout the next three years. The Comprehensive Plan will function as a tool to facilitate the effective implementation of planned strategies that will strengthen the existing system of HIV care and treatment in Florida.

Florida will work towards increasing access to care while decreasing HIV infection and related health disparities. Despite funding challenges, Florida will decrease or eliminate service gaps by maintaining an efficient, streamlined process for coordinating services, ensuring that the payer of last resort requirement is fully met, and adjusting resource allocation methodology to ensure balanced distribution of Part B funding throughout the state.

The Comprehensive Plan assures that vital information will be disseminated effectively to all partners in care and relevant programs. The outlined goals and strategies will underline and address priority areas of focus, ultimately bringing the state into alignment with the NHAS's structure of HIV care, resulting in an updated and practical approach to promoting quality care while maintaining efficiencies.

Regardless of funding and political difficulties, Florida will rise to meet the challenges by staying abreast of health policy changes and the ever-increasing demand for services. Florida will remain on the forefront of information and cutting edge practices to improve health outcomes for all eligible PLWHA in the state.

SECTION 4: HOW WILL WE MONITOR PROGRESS?

*“Our greatest glory is not in never
falling, but in rising every
time we fall.”
Confucius*

Introduction

The Florida Department of Health's Bureau of HIV/AIDS (Part B grantee) employs a multi-pronged approach in evaluating its progress towards achieving the goals set forth in the Comprehensive Plan: Goal # 1: Reducing the number of people who become infected with HIV; Goal #2: Increasing access to care and optimizing health outcomes for People Living With HIV; and Goal #3: Reducing HIV-related health disparities. In addition to these over-arching goals, the Part B grantee will be assessing the impact of the Early Identification of Individuals with HIV/AIDS (EIIHA) strategy, improving the usage of Ryan White client level data, using data to monitor service utilization, as well as providing an outline of the Quality Management program within the Part B grantee's Reporting Unit.

4A: Monitoring and Evaluation of the 2012-15 Plan

The Part B grantee relies on a collaborative effort among the Florida HIV/AIDS Comprehensive Planning Network (FCPN) that includes the Patient Care Planning Group (PCPG), the Prevention Planning Group (PPG), the Hepatitis Planning Group (HPG), the statewide Consumer Advisory Group (CAG), the 14 regional consortia, the 5 Eligible Metropolitan Areas (EMAs) and 1 Transitional Grant Area (TGA) to monitor the 2012-2015 Comprehensive Plan. Data drives the process from which to evaluate progress made towards goals and will inform adjusting the plan to meet the needs of People Living with HIV/AIDS (PLWHA) in Florida.

The Part B grantee's Reporting Unit maintains a statewide information technology infrastructure for providers to report client level data that can be used to evaluate financial, clinical, and utilization metrics. The AIDS Information Management System (AIMS), the Health Management System (HMS) and CAREWare are the main data sources utilized for generating reports. However, it should be noted that the Reporting Unit has access to and monitors all other databases including: the AIDS Drug Assistance Program (ADAP) database, the Counseling Testing Referral System (CTRS) database and the Enhanced HIV/AIDS Reporting System (eHARS) database and the Patient Reporting, Investigation and Surveillance Manager (PRISM) database. The Part B grantee's Reporting Unit reviews these systems and generates a variety of reports. These reports are used to trend data that are used by the Part B grantee, statewide planning groups, consortia, as well as EMAs and TGA to make service and/or fiscal related decisions. These collaborations will continue throughout the course of the 2012-2015 Comprehensive Plan.

The statewide PCPG is tasked with monitoring the goals set forth in the Comprehensive Plan throughout the year. Due to budget and travel restrictions, the PCPG is only able to meet face-to-face twice per year. However, the group voted to meet via web-conferences between the face-to-face meetings to monitor and evaluate progress towards achieving the goals and meeting the challenges identified in the Comprehensive Plan. In addition, the PCPG encourages its consortia

representatives to include review of the Comprehensive Plan at all regular scheduled consortia meetings, keeping it a true living document.

4B: Improved Use of Ryan White Client Level Data

The Part B grantee's Reporting Unit is expanding its utilization of client level data to identify gaps in services and to develop and implement strategies to close those gaps. The Ryan White Services Report, which captures client level data on a yearly basis, will be used by the Part B grantee and its stakeholders to ensure data completeness, consistency, and quality. The data elements required for this report will provide the Part B grantee and the PCPG access to reliable and verifiable information, which can be utilized to make recommendations to relevant programs within Florida's service delivery system. The Part B grantee also uses this data in determining Part B patient care and General Revenue funding distribution throughout the state.

4C: Use of Data in Monitoring of Service Utilization

The Part B grantee's Reporting Unit provides service reports to consortia through each area's lead agency to inform them of utilization trends. These reports are used in conjunction with financial and utilization data to determine whether local funding should be reallocated to another service category to meet identified emerging needs better, fulfilling one of the major legislative requirements. The reports are used to predict current and future trends and make changes when needed. Financial and service utilization data are used in all areas of the state during their annual priority setting and resource allocation processes to determine the most effective and efficient use of Part B funds to meet the needs of the local PLWHA community.

4D: Measuring Clinical Outcomes

The Part B grantee will establish a Quality Management Committee that will be responsible for monitoring the quality of core medical and support services available to eligible PLWHA to achieve improved medical outcomes throughout the state. This Committee will be comprised of individuals from the Part B grantee, including the Senior Epidemiologist, Medical Team, Reporting Unit, Community Programs Unit, as well as PCPG members and other relevant stakeholders. The Committee will incorporate measures from HRSA's HIV/AIDS Bureau HIV Performance Measures that will track and trend data to monitor the quality of care provided thus providing a baseline on which to expand and improve the established seamless access to HIV/AIDS services.

4E: Assessing the Impact of the Early Identification of Individuals with HIV/AIDS Initiative

It is anticipated that with the full implementation of EIIHA activities that the state will see a decrease in the overall unmet need. According to the most recent data, it is estimated that the unmet need for Florida currently stands at 40%. The goal of all stakeholders will be to significantly reduce the unmet need over the next five years.

Identifying and linking newly diagnosed people into care, and bringing people who were out of care back into care, will require additional providers. Achieving this goal will result in a simultaneous increase in the number of people receiving primary medical care services that will need to be measured and monitored through reports generated via CAREWare, HMS and all other data sources. In order to meet this increased demand for services, the Part B grantee will look to enhance and expand the current network of providers throughout the state by March 2015. The Part B grantee's patient care and prevention Programs will continue to find ways to improve and increase the number of Minority AIDS Initiative Antiretroviral Treatment Access Study programs around the state. These programs will continue to improve their efforts to bring people back into care and encourage them to remain on their treatment regimen.

Data are crucial to the successful implementation of EIIHA. In order to improve data sharing among all areas of the state, the Part B grantee's Reporting Unit will continue to offer technical assistance to those areas that are not currently utilizing the state CAREWare system, whether EMAs, TGA, or Part B consortia areas, so that their data is included in all of the statewide data reports.

By increasing access to care and optimizing health outcomes for PLWHA, Florida can reduce the number of people who become infected with HIV and reduce HIV-related disparities.

Summary

The mission of the Part B grantee is to provide access to quality care for HIV-positive individuals in Florida. To accomplish this, the Part B grantee, the service provider network and a variety of stakeholders engage in a three-year planning cycle. The resulting comprehensive plan sets goals and priorities that are put into practice and a variety of outputs and outcomes are monitored to ensure progress. The Part B grantee manages a technology infrastructure that allows data to be collected and analyzed for the various HIV programs, and which provides feedback for management. Despite a high level of sophistication, this technology infrastructure is low cost since it leverages already existing IT resources at the Department of Health. Deficiencies are quickly identified and corrective actions can be taken based on findings. The

Part B grantee strives to allocate resources based on proportionality (trends in the epidemic), to allocate resources equitably, and to insure our service network is fully utilized. In doing so, the Part B grantee believes clients will achieve healthy outcomes and funding will be used efficiently.

APPENDIX A: ACRONYM LIST

ADAP	AIDS Drug Assistance Program
AICP	AIDS Insurance Continuation Program
AIDS	Acquired Immune Deficiency Syndrome
AIMS	AIDS Information Management System
ARTAS	Antiretroviral Treatment Access Study
CAG	Consumer Advisory Group
CDC	Centers for Disease Control and Prevention
CHC	Community Health Centers
CHD	County Health Departments
CMS	Centers for Medicare and Medicaid Services
CTRS	Counseling Testing Referral System
DEBI	Diffusion of Effective Behavioral Interventions
DOC	Department of Corrections
DOH	Department of Health
EBIs	Evidence-based Behavioral Interventions
EC	Emerging Communities
ECHPP	Enhanced Comprehensive HIV Prevention Plan
eHARS	Enhanced HIV/AIDS Reporting System
EIHA	Early Identification of Individuals with HIV/AIDS
ELR	Electronic Laboratory Reporting
EMAs	Eligible Metropolitan Areas

EMPI	Enterprise Master Person Index
F/C AETC	Florida/Caribbean AIDS Education and Training Center
FCHAR	Florida Consortium for HIV/AIDS Research
FCPN	Florida HIV/AIDS Comprehensive Planning Network
FLMMIS	Florida Medicaid Management System
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FY	Fiscal Year
HAPC	HIV/AIDS Program Coordinators
HERR	Health Education/ Risk Reduction
HIV	Human Immunodeficiency Virus
HMS	Health Management System
HOPWA	Housing Opportunities for persons with AIDS
HP2020	Healthy People 2020
HPG	Hepatitis Planning Group
HPSA	Health Professional Shortage Area
HPTN	HIV Prevention Trials Network
HRSA	Health Resources and Services Administration
HUD	Housing and Urban Development
IDUs	Injection drug users
jProg	Software firm that develops and maintains CAREWare under contract for HRSA
LIS	Low Income Subsidy
MAI	Minority AIDS Initiative
MDCHD	Miami-Dade County Health Department, Office of HIV/AIDS
MSM	Men who have Sex with Men
MUA/MUP	Medically Underserved Areas/Populations
NGA	Notice of Grant Award
NHAS	National HIV/AIDS Strategy

OAMC	Outpatient Ambulatory Medical Care
PAC	Project AIDS Care
PAPs	Pharmaceutical Assistance Programs
PBM	Pharmacy Benefit Manager
PCAN	Patient Care Access Network
PCIP	Pre-Existing Condition Insurance Plan
PCPG	Patient Care Planning Group
PLWHA	People Living with HIV/AIDS
PPACA	Patient Protection and Affordable Care Act
PPG	Prevention Planning Group
PRISM	Patient Reporting, Investigation and Surveillance Manager
QM	Quality Management
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSN	Statewide Coordinated Statement of Need
SNS	Social Networking Strategies
STD	Sexually transmitted disease
TA	Technical Assistance
TGA	Transitional Grant Area
TOPWA	Targeted Outreach for Pregnant Women Act Program
TrooP	True out of Pocket
ZDV	zidovudine

APPENDIX B: GOAL ALIGNMENT KEY

National HIV/AIDS Strategy (NHAS) Goals

NHAS 1 - Reduce number of people who become infected with HIV.

NHAS 2 - Increase access to care and optimizing health outcomes for people living with HIV.

NHAS 3 - Reduce HIV-related health disparities.

Healthy People 2020 (HP 2020) HIV Objectives

HP2020 1 - Reduce the number of new HIV diagnoses among adolescents and adults.

HP2020 2 - Reduce new (incident) HIV infections among adolescents and adults.

HP2020 3 - Reduce the rate of HIV transmission among adolescents and adults.

HP2020 4 - Reduce the number of new AIDS cases among adolescents and adults.

HP2020 5 - Reduce the number of new AIDS cases among adolescent and adult heterosexuals.

HP2020 6 - Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.

HP2020 7 - Reduce the number of new AIDS cases among adolescents and adults who inject drugs.

HP2020 8 - Reduce the number of perinatally acquired HIV and AIDS cases.

HP2020 9 - Increase the proportion of new HIV infections diagnosed before progression to AIDS.

HP2020 10 - Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.

HP2020 11 - Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS.

HP2020 12 - Reduce deaths from HIV infection.

HP2020 13 - Increase the proportion of people living with HIV who know their serostatus.

HP2020 14 - Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.

HP2020 15 - Increase the proportion of adults with tuberculosis (TB) who have been tested for HIV.

HP2020 16 - Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support.

HP2020 17 - Increase the proportion of sexually active persons who use condoms.

HP2020 18 - Decrease the proportion of men who have sex with men who reported unprotected anal sex in the past 12 months.

Patient Protection and Affordable Care Act (PPACA) Goals

PPACA 1 - Eliminate disparities in health care.

PPACA 2 - Strengthen public health and health care access.

PPACA 3 - Invest in the expansion and improvement of the health care workforce.

PPACA 4 - Encourage consumer and patient wellness in both the community and the workplace.