



# PCHAP

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Partnership for **C**omprehensive  
**HIV/AIDS P**lanning



# Priorities and Allocations Committee

## Purpose

- **Priorities** - Rank eligible CARE Act service categories in order of priority, based on documented needs of persons within Area 12 that are living with HIV/AIDS;
- **Allocations** - Develop a recommendation for how Ryan White Part B and Florida General Revenue funds should be divided between service categories (by percentage of total grant award) in order to best meet the needs of the local community through quality, cost-effective services.



## Guidance for Decision Making

- Decisions must be based on documented needs
- Services must be responsive to the epidemiology of HIV/AIDS in Area 12
- Prioritized services must support the provision of basic health care, limiting duplication of services, and minimizing hospitalizations among clients
- Decisions must address the overall service needs in the area, and not focus on individuals



## Guidance for Decision Making

- Services should be culturally appropriate
- Services should focus on the needs of low-income, underserved, and severe needs populations
- Services must meet established standards of care and quality
- Services must be cost-effective



## Criteria for Service Selection

- Documentation of need:
  - Epidemiology of local epidemic
  - Information from consumers and providers
  - Other structured sources of information
- Quality and cost-effectiveness of services:
  - Client surveys
  - Other evaluation methods
- Service responsiveness to cultural norms of target populations, especially those with most severe need



## Criteria for Service Selection

- Consistent with existing continuum of care and overall goals to:
  - Ensure access to basic healthcare
  - Minimize the need for hospitalization
  - Eliminate duplication of services
- Address ongoing and emerging needs
- Reflect changing local Epidemiology of HIV



# National HIV/AIDS Strategy

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## **NHAS Patient Care Highlights**

Updated to 2020

*July 2015*



## Goals, Steps and Actions

- **4 Goals**

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- **11 Steps**

- **37 Recommended Actions**

- ❖ *and dozens more sub-actions*





## Recurring Ideas

- Linkage to Care
  - Retention in Care
  - Support in Care
  - Relationships of Trust / Stigma
- 
- Peer Programs
  - Patient (Person) Centered Holistic Care
  - Prioritized Interventions (e.g. 32114, black females, young MSMs)
  - Trauma Informed Care
  - Mental Health & Substance Use Services
  - Affordable Care Act
  - HIV care from Primary Care Health Professionals
  - Improving Outcomes



## Goal/Action Highlights

- **Goal I - Reducing New HIV Infections**

- Care as Prevention**

- Care programs should help people access and navigate complex insurance and medication assistance programs that help pay for services. (I.B.2)
    - Supportive services and assistance such as nutrition, transportation, childcare & housing. (I.B.2)
    - Ongoing services to support retention in care and access to interventions that address reductions in sexual and substance use risks. (I.B.4)

## Goal/Action Highlights

- **Goal 2 – Increasing Access to Care & Improving Outcomes**
  - People Living with HIV should be supported to select the health care coverage that best meets their care and treatment needs. (2.A.1)
  - Encourage healthcare delivery strategies that extend the capacity of the existing workforce of HIV specialists. (e.g. Interdisciplinary teams, Peers, task shifting) - (2.B.1)
  - Engage clinical providers on the importance of routine HIV screening. (2.B.2)



## Goal/Action Highlights

- Integrate HIV services into health centers and other primary care settings thru screenings, basic HIV care/treatment, referral for complex cases and coordination of care across settings & providers. (2.B.2)
- Increased collaboration between care providers and substance use and mental health services to ensure identification of and treatment for these conditions, including increased use of brief screening tools. (2.B.3)
- Consider support services – such as housing assistance, transportation, and nutrition – that enable PLHIV to obtain and adhere to HIV treatment. (2.C.1)



## Goal/Action Highlights

- **Goal 3 – Reducing Disparities & Inequities**
  - Ensure that groups at the highest risk receive testing and are linked to and retained in care... (3.A.1)
  - Communities should engage all sectors to ensure consumers and providers are aware of opportunities available in health care delivery and financing to address HIV risk and improve health outcomes. (3.A.2)
  - Scale-up programs that address social determinates of health. (e.g. lack of education, poverty, unemployment) (3.B.1)

# Goal/Action Highlights

## Stigma

- Coordinate efforts to dismantle discrimination in clinical settings. (3.C.1)
- RWV consortia should work to actively promote public leadership by people living with HIV. (3.C.4)

*“Many people feel shame and embarrassment when they are diagnosed with HIV infection. ... Creating safe spaces where all individuals feel accepted and respected will enable more individuals to get tested for HIV, enter and stay in care when diagnosed, adhere to medication regimens, and adopt prevention measures, including disclosing their HIV status.”*



## Goal/Action Highlights

- **Goal 4 - More Coordinated Fed. Response**
  - Federal encourage of leadership at state and local levels to coordinate planning, prioritizing and implementation of HIV prevention/care services (4.A.3)
  - Governments should hold them selves and recipients of public funds accountable for achieving results. (4.B.2)
  - Funding announcements should clearly state performance goals... (4.B.3)
  - Progress reports should be available to the public. (4.B.3)



# Needs Survey Data

## Spring 2013

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- ❖ **45** - Questions
- ❖ **174** - Respondents
- ❖ **20** - Flagler Residents
- ❖ **154** - Volusia Residents





# Acronyms

**MSM** - Men who have sex with men (includes homosexual and bisexual)

**IDU** - Injecting drug user (category assumes that needle-sharing has taken place)

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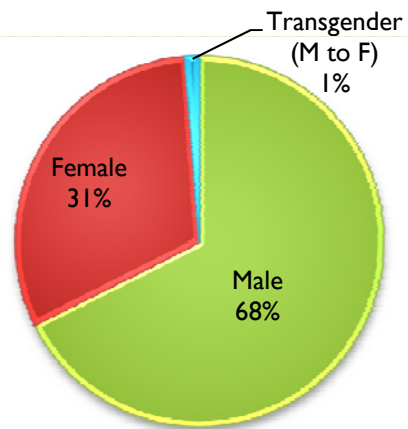
**Hetero** - Persons infected by a partner of the opposite sex

**Blood** - Persons exposed through receipt of contaminated: blood/blood products, transplanted tissue/organs or artificial insemination (includes both confirmed and suspect cases pending investigation)

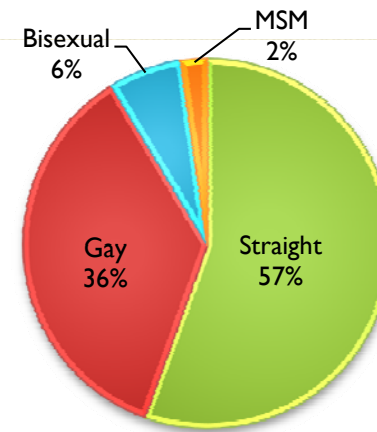
**Other/Unknown** - Confirmer other risks

# Survey Demographics

## Gender

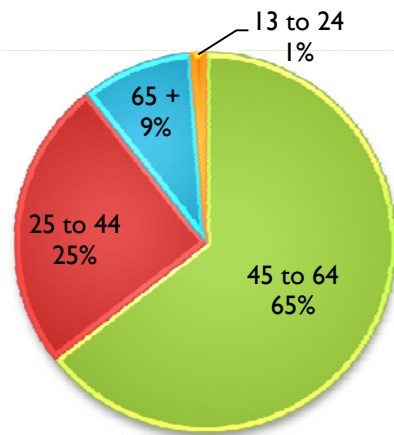


## Identity

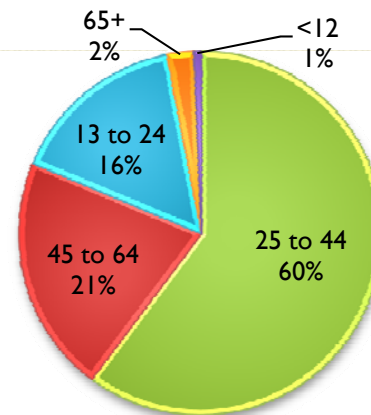


# Survey Demographics

## Age Group

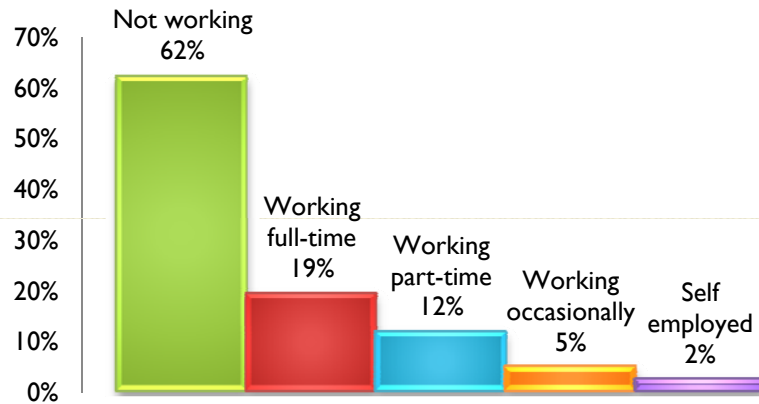


## Age First Tested Positive

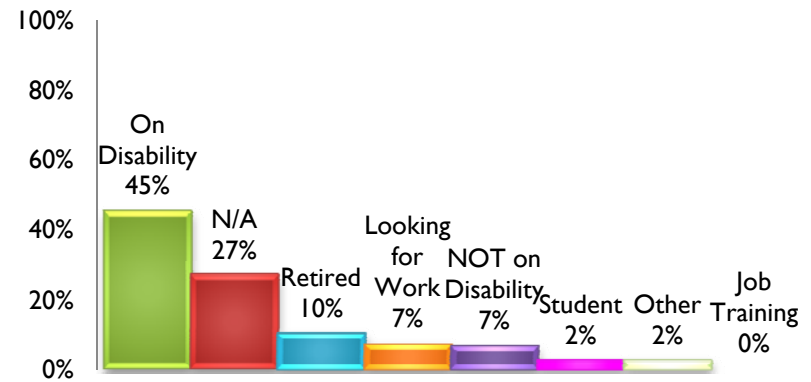


# Survey Demographics

## Work Situation

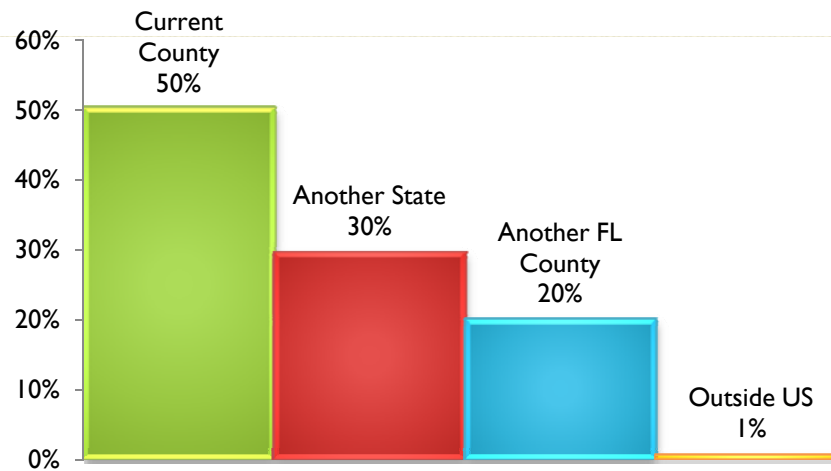


## Why not Working



# Survey Demographics

## Where Tested Positive

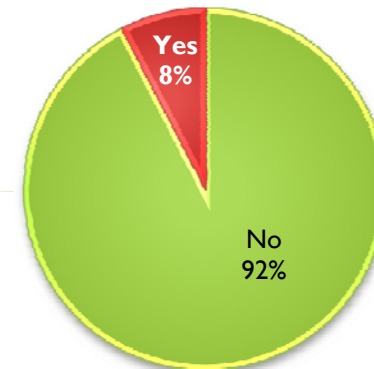


# HIV Care Information

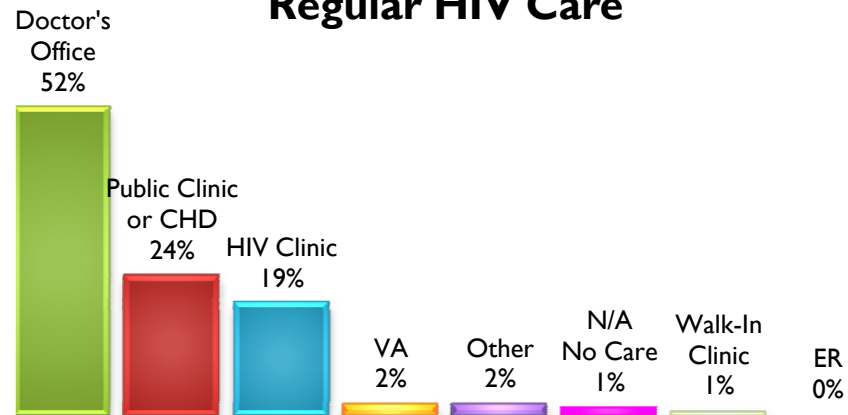
## Received HIV Care in Last Year



## HIV Related Hospitalization



## Location of Regular HIV Care

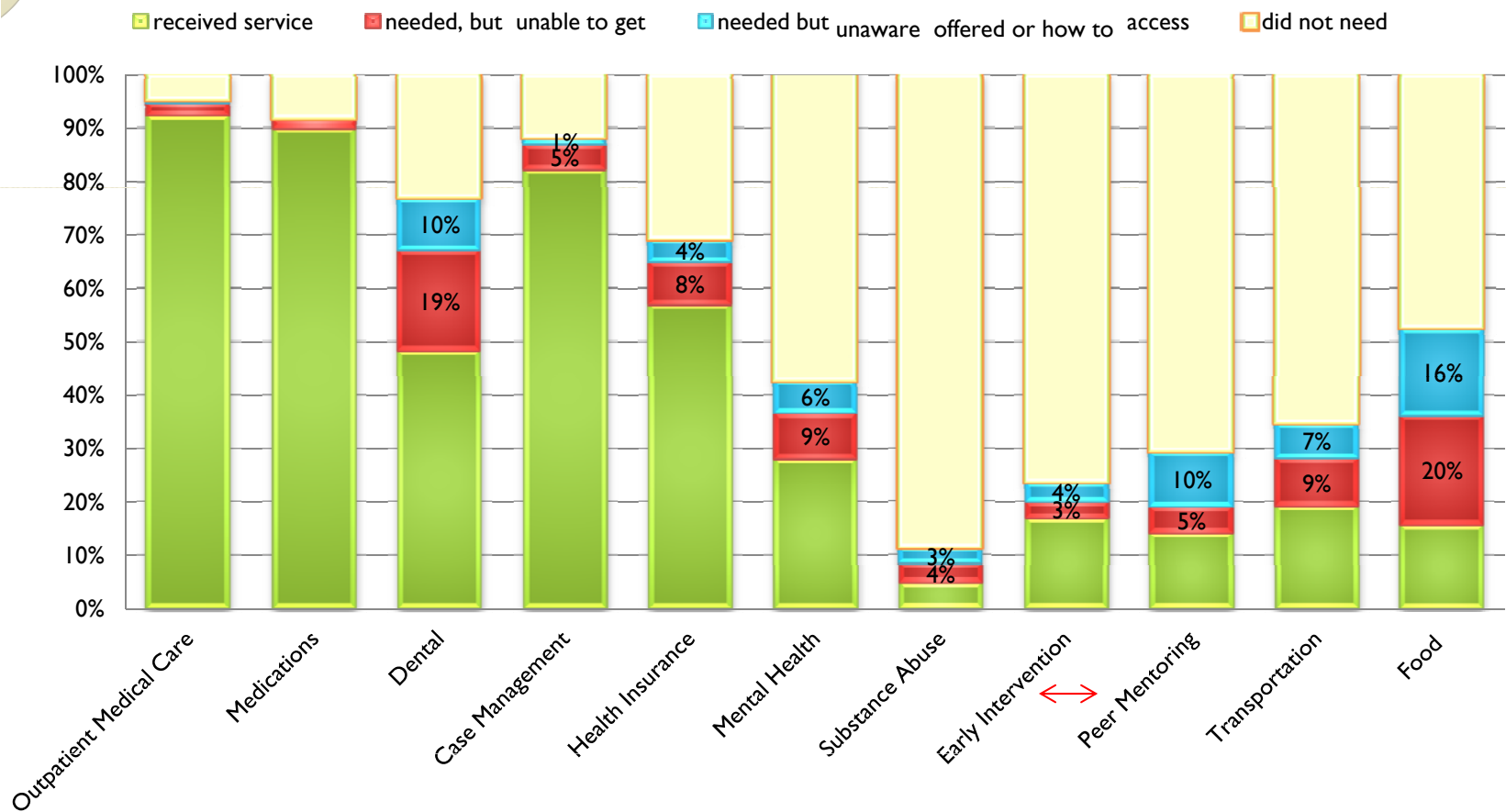


# Identified Needs

## Top 10 Important Services



# Service Availability







# HIV/AIDS Epidemiology

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## **Area 12:** Volusia and Flagler Counties

# HIV and AIDS Case Data

- ⦿ AIDS Cases became reportable in Florida in 1981.
- ⦿ HIV (not AIDS) became reportable in Florida on July 1, 1997.
- ⦿ HIV Infection reporting represents newly Adult HIV Infection Cases, regardless of AIDS status at time of report, that were previously reported.
- ⦿ AIDS cases and HIV infection cases by year of report are NOT mutually exclusive and CANNOT be added together.
- ⦿ Frozen databases of year-end data are generated at the end of each calendar year. These are the same data used for Florida CHARTS and all grant-related data where annual data are included.
- ⦿ HIV prevalence data are generated later in the year, usually in July, when most of the “expected” death data are complete.

# HIV and AIDS Case Data (con't)

- Ⓡ **Adult cases represent ages 13 and older, pediatric cases are those under the age of 13. For data by year, the age is by age of diagnosis. For living data, the age is by current age at the end of the most recent calendar year, regardless of age at diagnosis.**
- Ⓡ **Unless otherwise noted, whites are non-Hispanic and blacks are non-Hispanic.**
- Ⓡ **Unless otherwise noted. Area and county data will exclude DOC cases.**

# Snapshot of Persons Reported with HIV Disease, 2014, Partnership 12

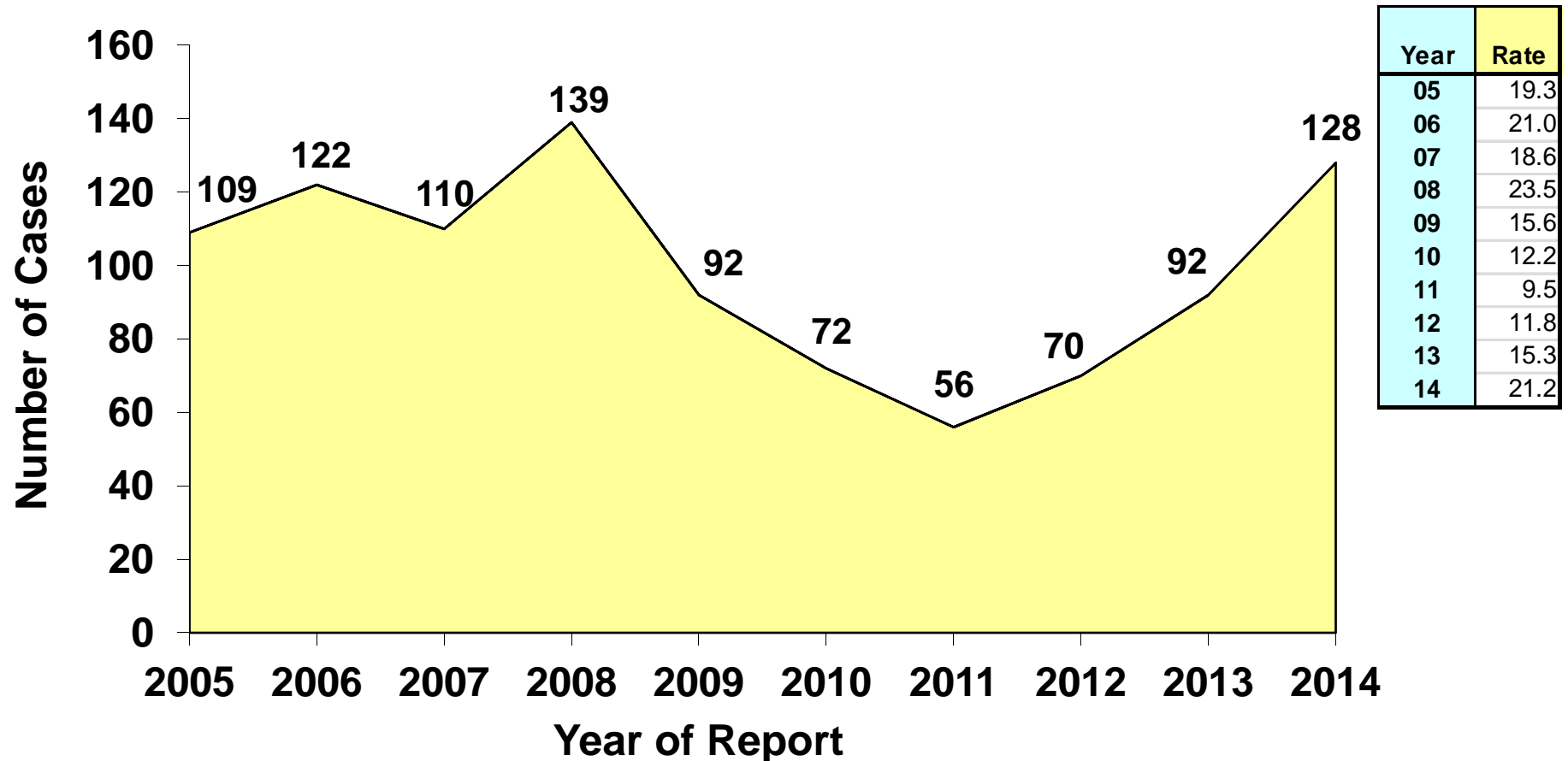
|   | HIV Infection and AIDS Cases Reported in 2014* |                         |       |       |
|---|--|-------------------------|-------|-------|
|   | Adults<br>(Age 13+)                            | Pediatrics<br>(Age <13) | TOTAL |       |
|   | <b>HIV Infection Cases</b>                     | 128                     | -     | 128   |
| <b>AIDS Cases</b>   | 58   | 1                       | 59    |       |
| *HIV infection cases and AIDS cases by year of report are NOT mutually exclusive and CANNOT be added together.            |  |                         |       |       |
| <b>Total Population, 2014*</b><br><br><div style="text-align: center; font-size: 1.2em; font-weight: bold;">604,859</div> | Cumulative HIV/AIDS Cases Reported 1981-2014   |                         |       |       |
|   | Adults<br>(Age 13+)                            | Pediatrics<br>(Age <13) | TOTAL |       |
|   | <b>HIV (not AIDS) Cases**</b>                  | 749                     | 11    | 760   |
|   | <b>AIDS Cases</b>                              | 1,992                   | 19    | 2,011 |
|   | <b>Total</b>                                   | 2,741                   | 30    | 2,771 |
| **HIV (not AIDS) cases were NOT reportable until 07/1997  |  |                         |       |       |
| Persons Living with HIV Disease through 2014, as of 06/30/2015:   |  |                         | 1,784 |       |

\*2014 estimate is provisional

\*\*HIV (not AIDS) cases were NOT reportable until 07/1997



# HIV Infection Cases and Rates\*, by Year of Report, 2005-2014, Partnership 12



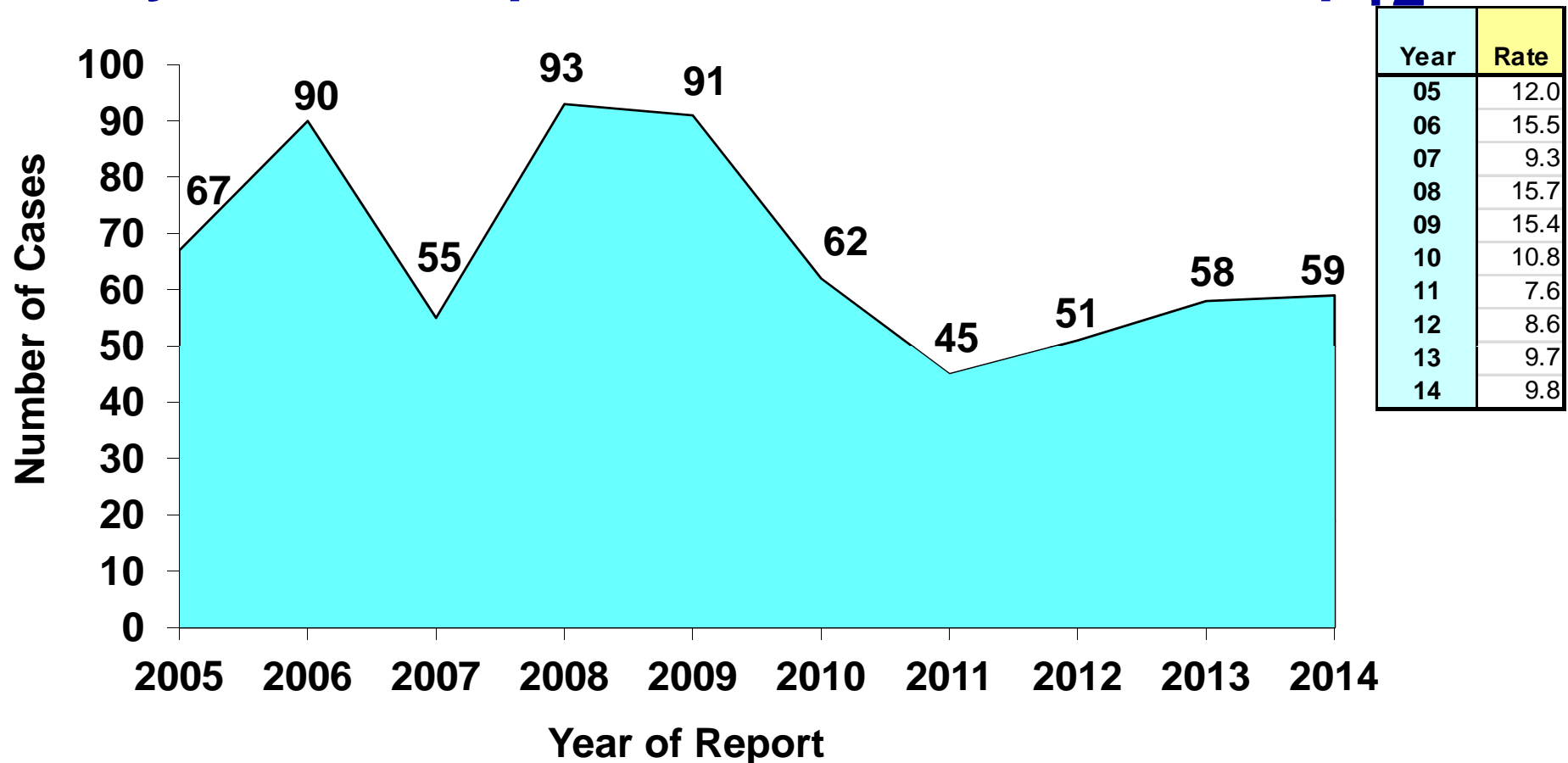
**Note:** Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of HIV infection in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of HIV infection in 2013. An additional 31% increase was observed in 2014 compared to the previous year. This is higher than the 12% incline observed by the state during the same time period.

\*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015. Rates are expressed as per 100,000 population.



# AIDS Cases and Rates\*

## By Year of Report, 2005-2014, Partnership<sup>12</sup>

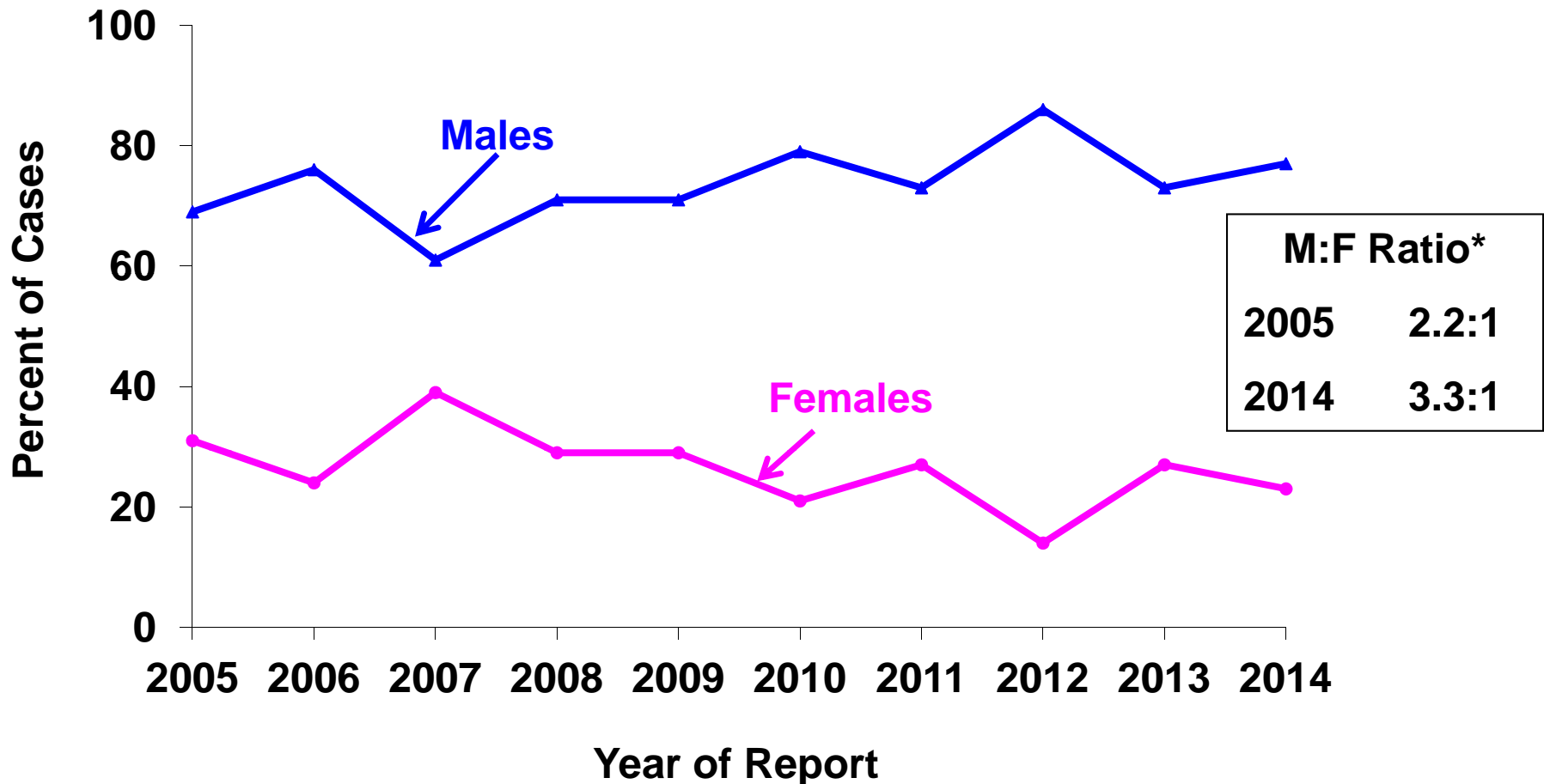


Enhanced laboratory reporting (ELR) laws in 2006 and the expansion of ELR in 2007 led to an artificial peak in newly reported cases of AIDS in 2008. This was followed by a general decline in reported cases through 2012. Another surge in the expansion of ELR in 2012 was followed by another increase in newly reported cases of AIDS in 2013. In 2014, AIDS cases increased slightly by 2% from the previous year. In contrast, the state observed a 15% decline in AIDS cases during the same time period.

\*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015. Rates are expressed as per 100,000 population.



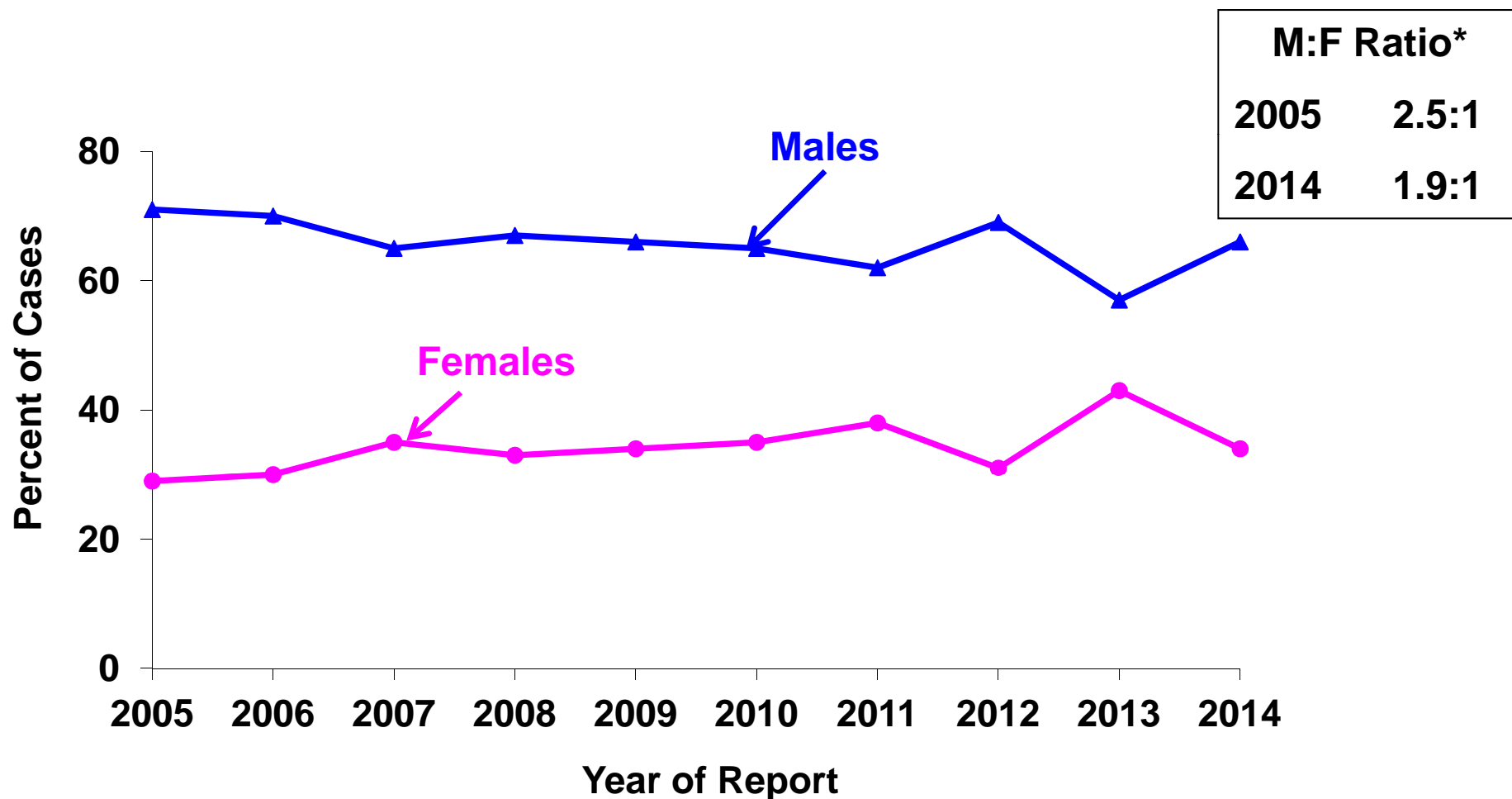
# Adult HIV Infection Cases, by Sex and Year of Report, 2005-2014, Partnership 12



**Note:** Recent trends in HIV transmission are best described by the HIV case data. The relative increases in male HIV infection cases might be attributed to proportional increases in HIV transmission among men who have sex with men (MSM), which may influence future AIDS trends. \*The male-to-female ratio is the number of cases among males divided by the number of cases among females.



# Adult AIDS Cases, by Sex and Year of Report, 2005-2014, Partnershi p 12



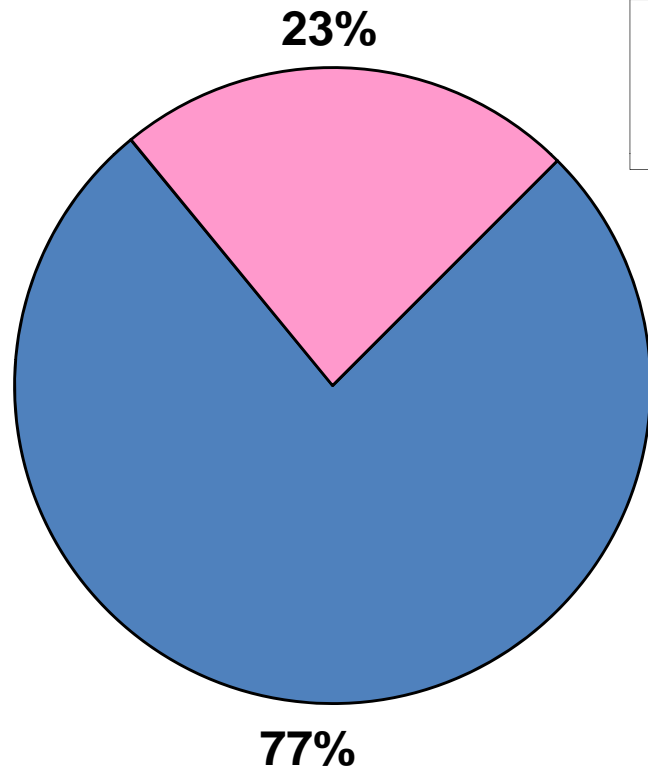
Note: AIDS cases tend to represent HIV transmission that occurred many years ago. The relative increases in males cases reflect the changing face of the AIDS epidemic over time. \*The male-to-female ratio is the number of cases among males divided by the number of cases among females.



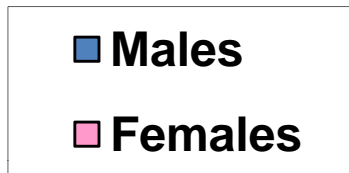
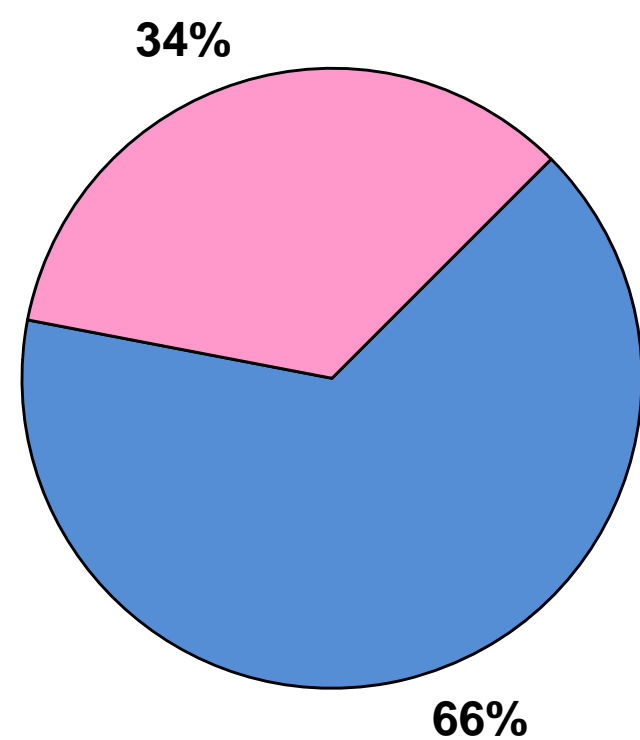


# Adult HIV Infection and AIDS Cases by Sex, Reported in 2014, Partnership 12

**HIV Infection**  
**N=128**



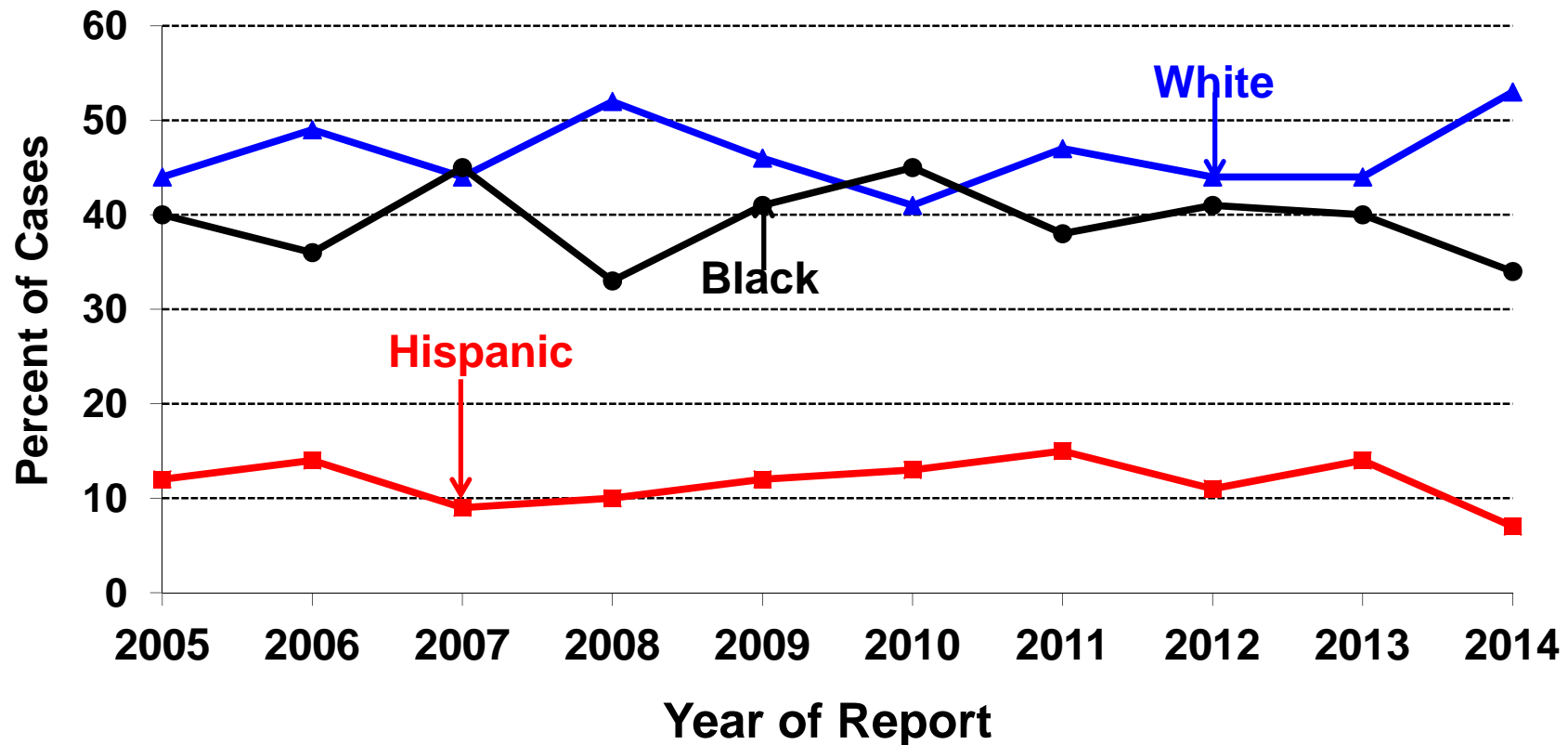
**AIDS**  
**N=58**



Note: Partnership 12's Adult Population is: 48% Male and 52% Female



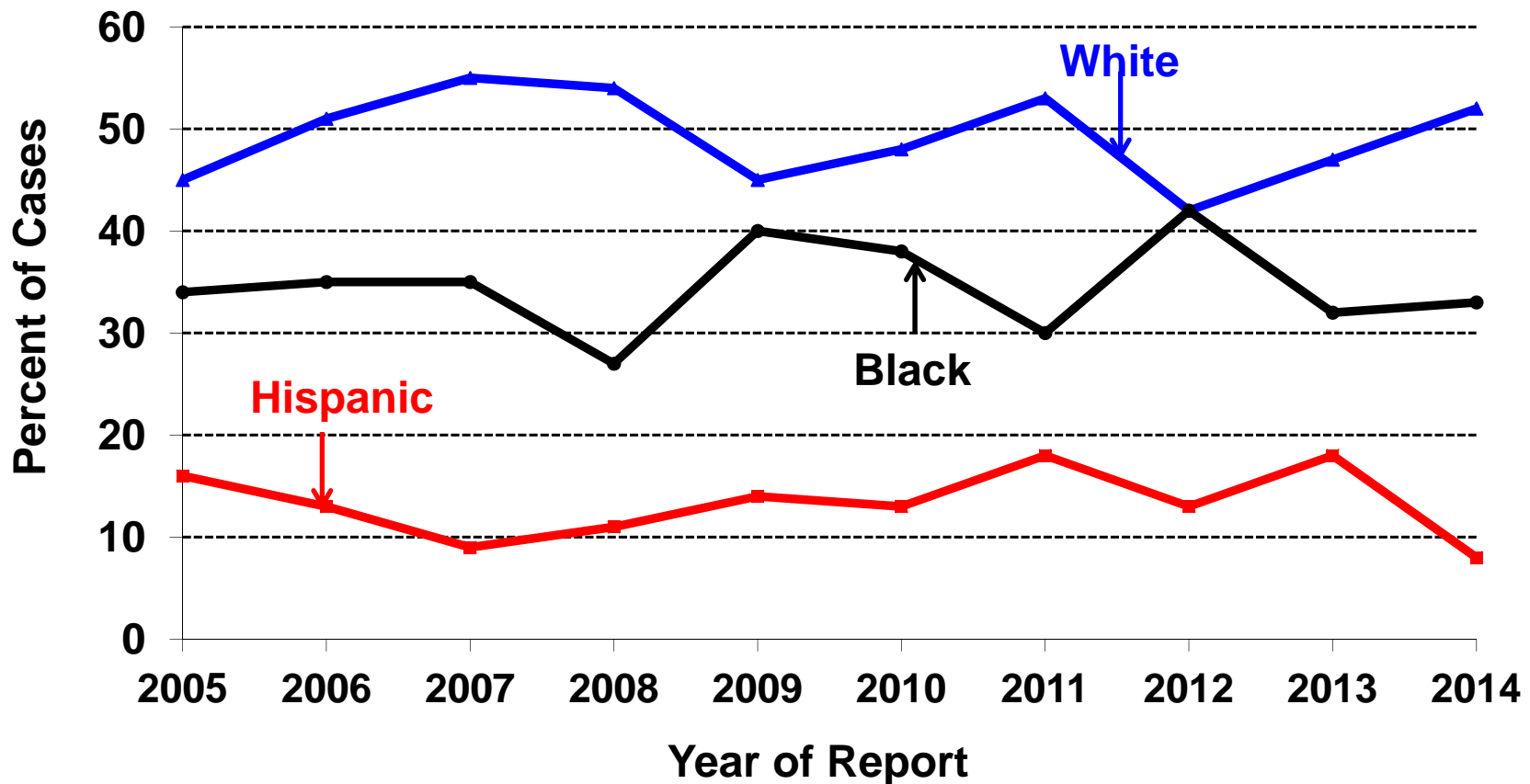
# Adult HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 12



**Note:** HIV case reporting reflects more recent trends in the epidemic with respect to the distribution of cases by race/ethnicity. From 2005 to 2014, the proportion of HIV infection cases among blacks and Hispanics decreased by 6 and 5 percentage points, respectively. In contrast, the proportion of HIV infection cases among whites increased by 9 percentage points over the same time period. Other races represent less than 3% of the cases and are not included.



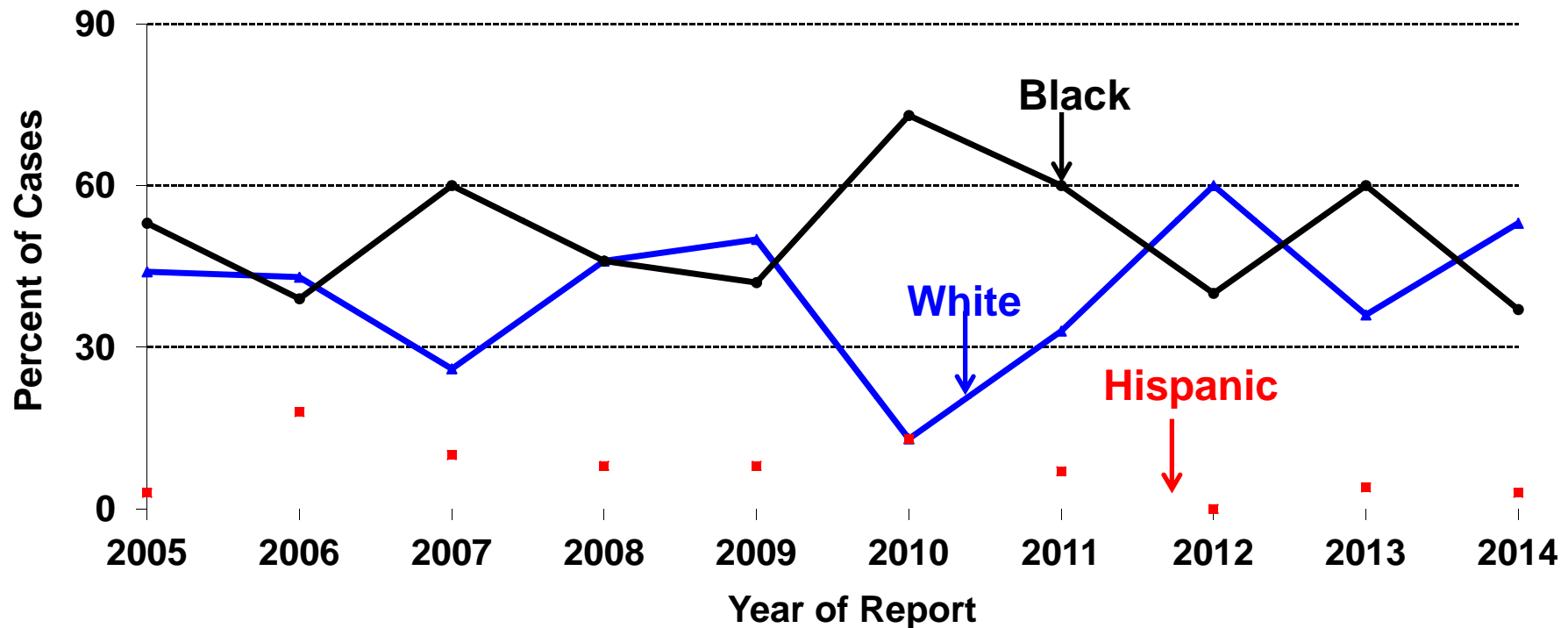
# Adult Male HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 12



Note: From 2005 to 2014, the proportion of HIV infection cases among white males increased by 7 percentage points. In contrast, the proportion of HIV infection cases among black and Hispanic males decreased by 1 and 8 percentage points, respectively, during the same time period. Other races represent less than 7% of the cases and are not included.



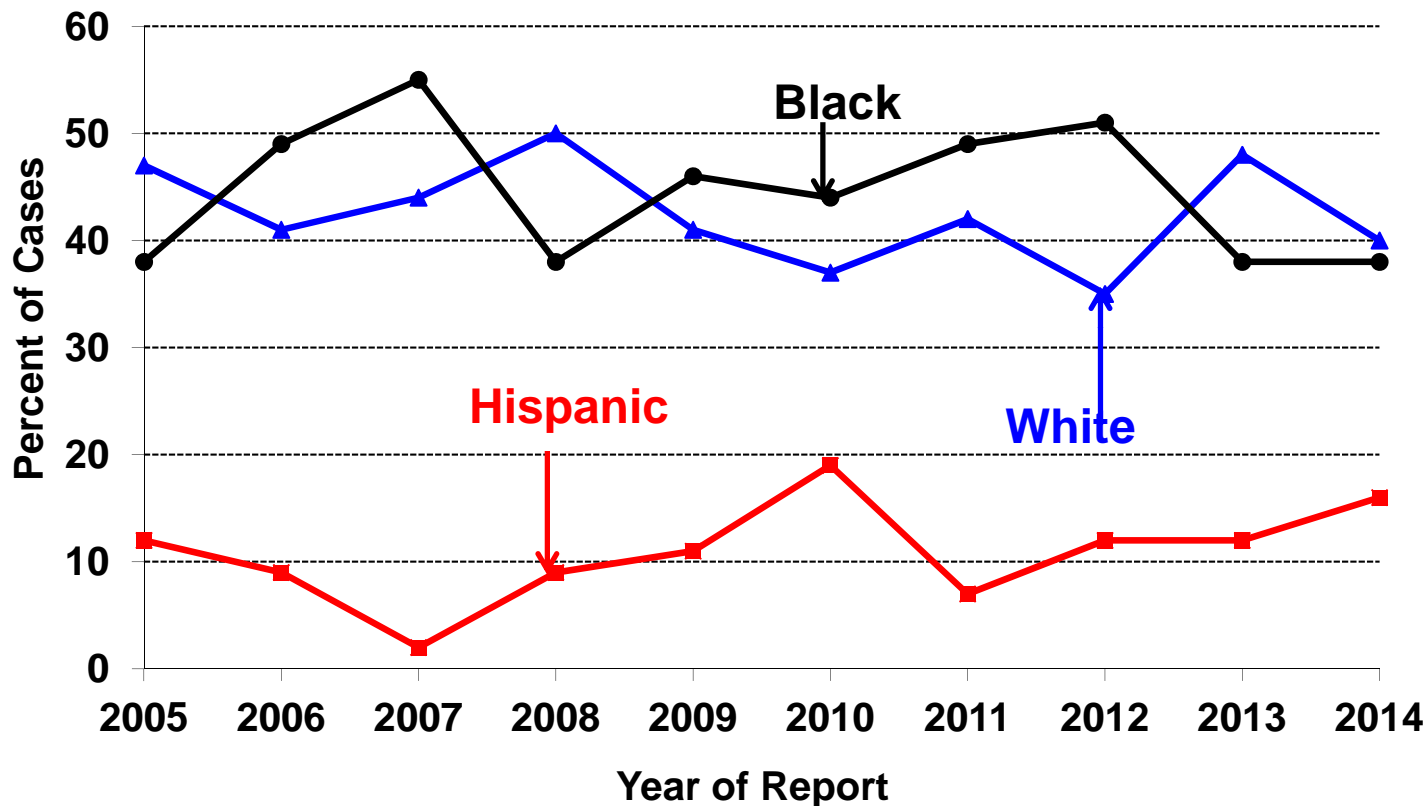
# Adult Female HIV Infection Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 12



**Note:** The proportion of black and white adult female HIV infection cases shifted up and down over the years, oftentimes, crossing paths. From 2005 to 2014, the proportion of adult female HIV infection cases among blacks decreased by 16 percentage points. In contrast, the proportion of adult female HIV cases among whites increased by 9 percentage points, whereas adult female HIV cases among Hispanics remained unchanged during the same time period. Other races represent less than 5% of the cases and are not included.



# Adult AIDS Cases by Race/Ethnicity and Year of Report, 2005-2014, Partnership 12

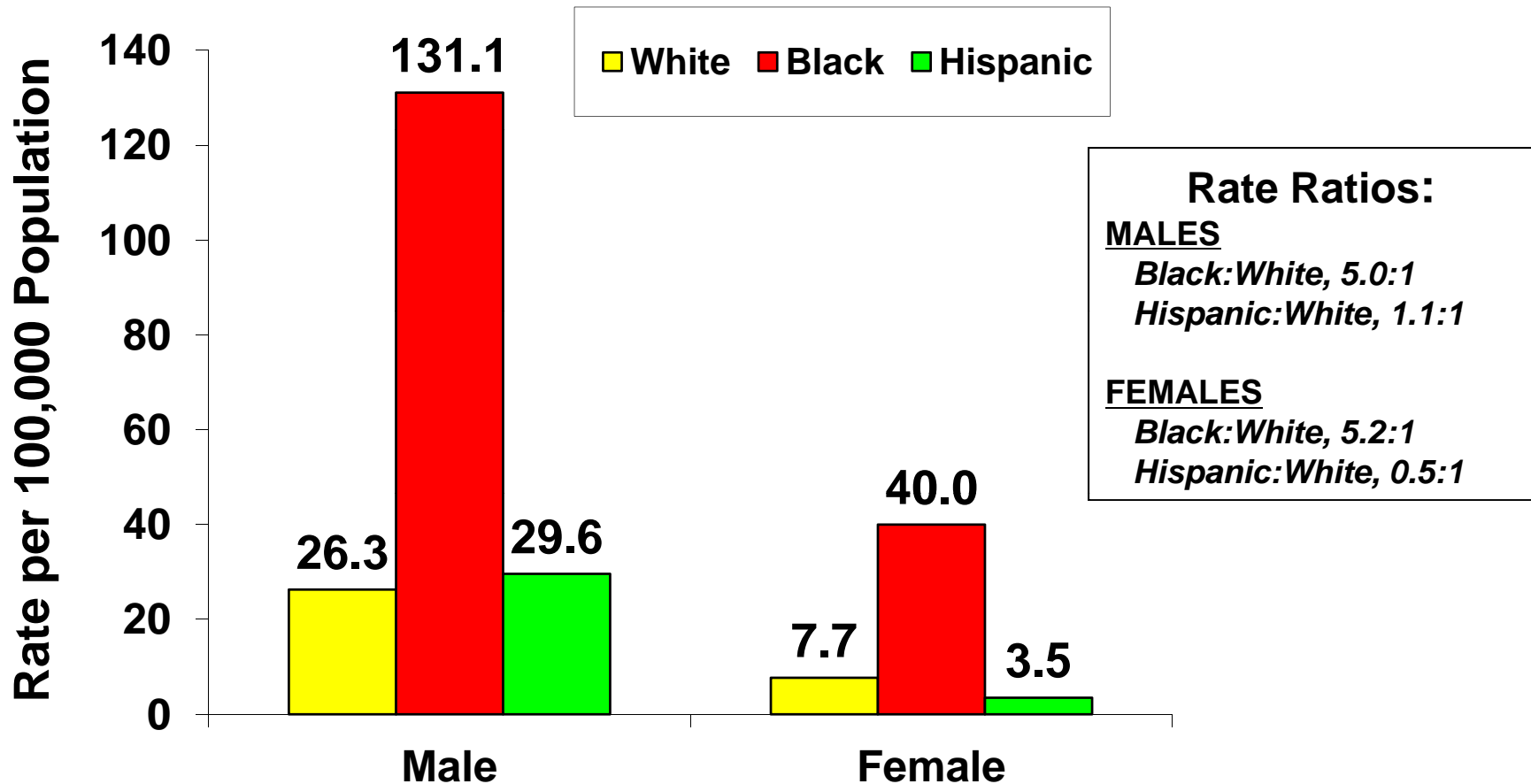


- Factors Affecting Disparities**
- Late diagnosis of HIV.
  - Access to/ acceptance of care.
  - Delayed prevention messages.
  - Stigma.
  - Non-HIV STD's in the community.
  - Prevalence of injection drug use.
  - Complex matrix of factors related to socioeconomic status

Note: In 2014, blacks accounted for 38% of adult AIDS cases, but only 10% of the population. Over the past ten years, the proportion of AIDS cases among blacks and whites fluctuated over time, oftentimes, crossing paths. From 2005 to 2014, the proportion of adult AIDS cases among Hispanics increased by 4 percentage points. In contrast, the proportion of adult AIDS cases among whites decreased by 7 percentage points, whereas the proportion of AIDS cases among blacks remained unchanged during the same time period. Numerous disparities can affect the increases of HIV disease in a given population. Other races represent less than 3% of the cases and are not included.



## Adult HIV Infection Case Rates\* by Sex and Race/Ethnicity, Reported in 2014, Partnership 12

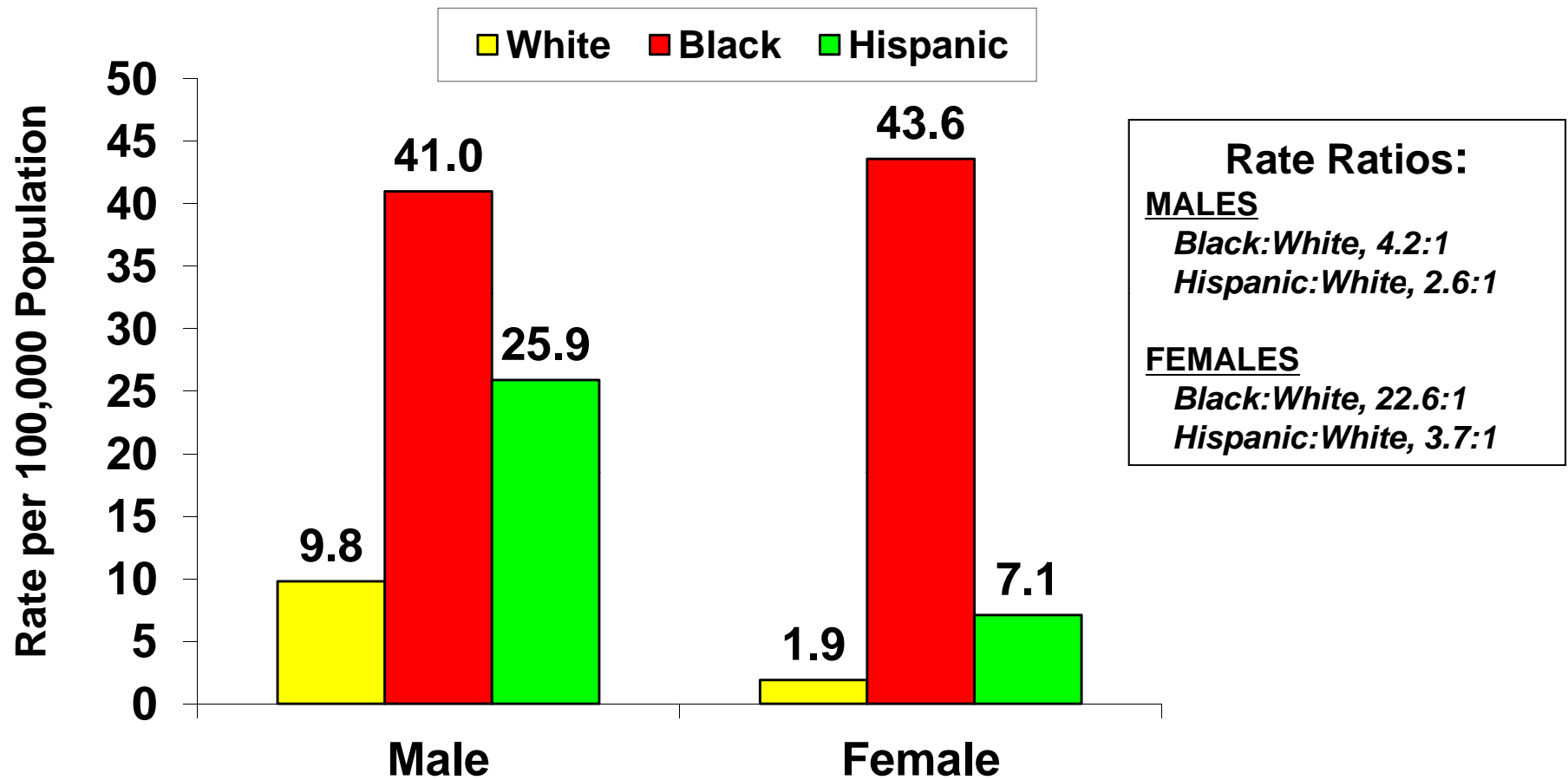


**Note:** Among black males, the HIV case rate is 5 times higher than the rate among white males. Likewise among black females, the HIV case rate is 5 times than the rate among white females. Among Hispanic males, the HIV case rate is slightly higher than the rate among white males. In contrast, among Hispanic females the HIV case rate is lower than the rate among white females.

\*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.



# Adult AIDS Case Rates\* by Sex and Race/Ethnicity, Reported in 2014, Partnership 12



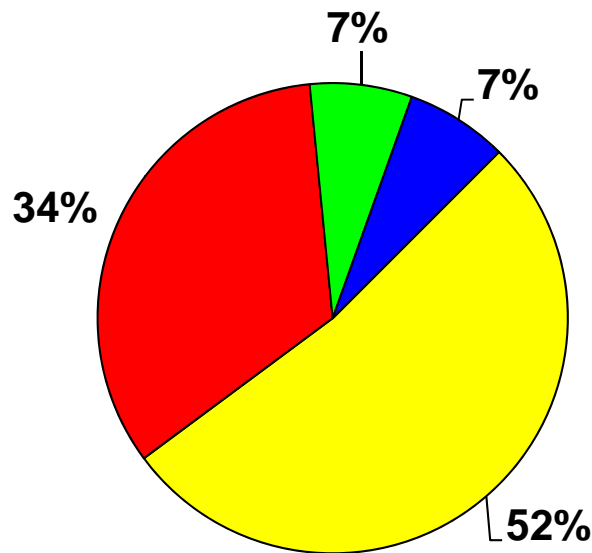
**Note:** Among black males, the AIDS case rate is 4 times higher than the rate among white males. Among black females, the AIDS case rate is nearly 23-fold greater than the rate among white females. Hispanic male and female rates are higher than the rates among their white counterparts.

\*Source: Partnership 12 population estimates are provided by Florida CHARTS as of 7/9/2015.

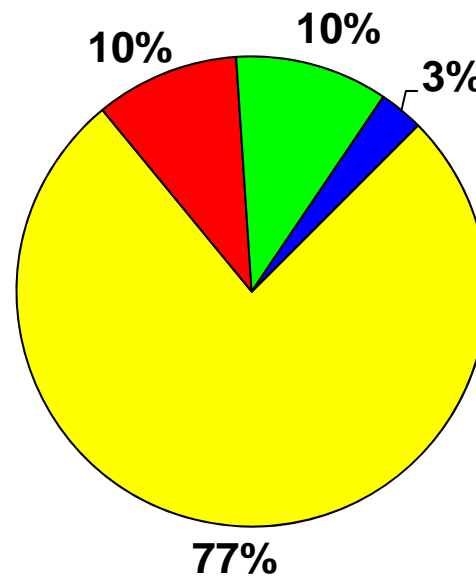


# Adult HIV and AIDS Cases Reported in 2014 and Population Data, by Race/Ethnicity, Partnership 12

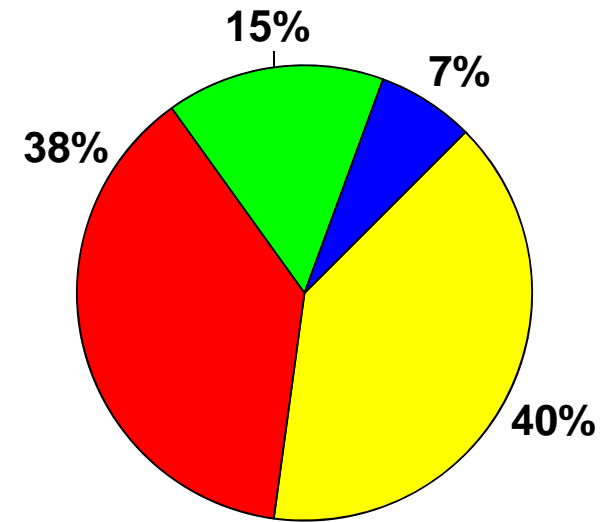
**HIV Infection**  
N=128



**2014 Partnership 12  
Population Estimates\***  
N=524,576



**AIDS**  
N=58



■ White 
 ■ Black 
 ■ Hispanic 
 ■ Other\*\*

Note: In this snapshot for 2014, blacks are over-represented among the HIV and AIDS cases, accounting for 34% of adult HIV cases and 38% of adult AIDS cases, but only 10% of the adult population. Similarly, Hispanics are over-represented among AIDS cases, accounting for 15% of adult AIDS cases, but only 10% of the adult population. A group is disproportionately impacted to the extent that the percentage of cases exceeds the percentage of the population.

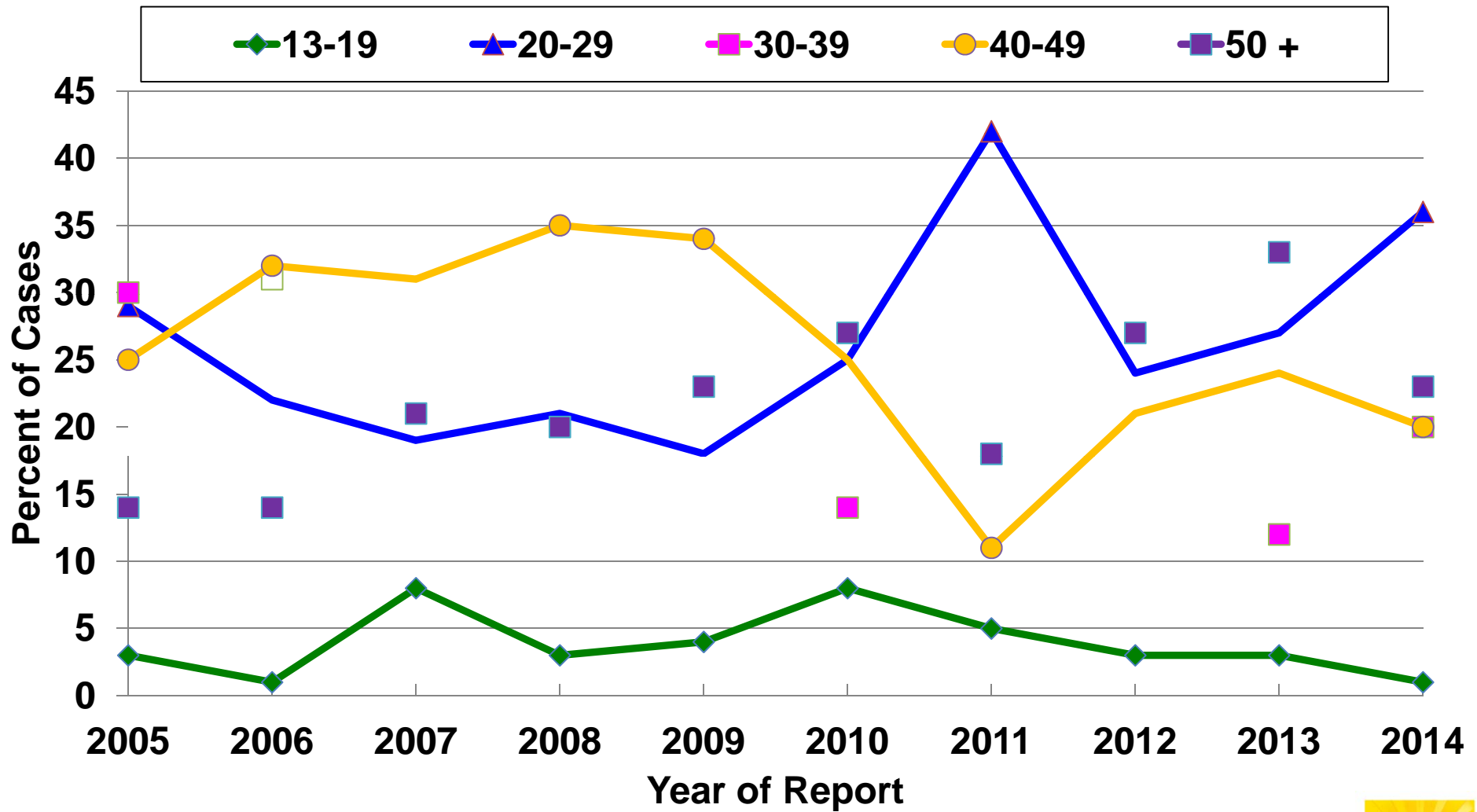
\*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.

\*\*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.





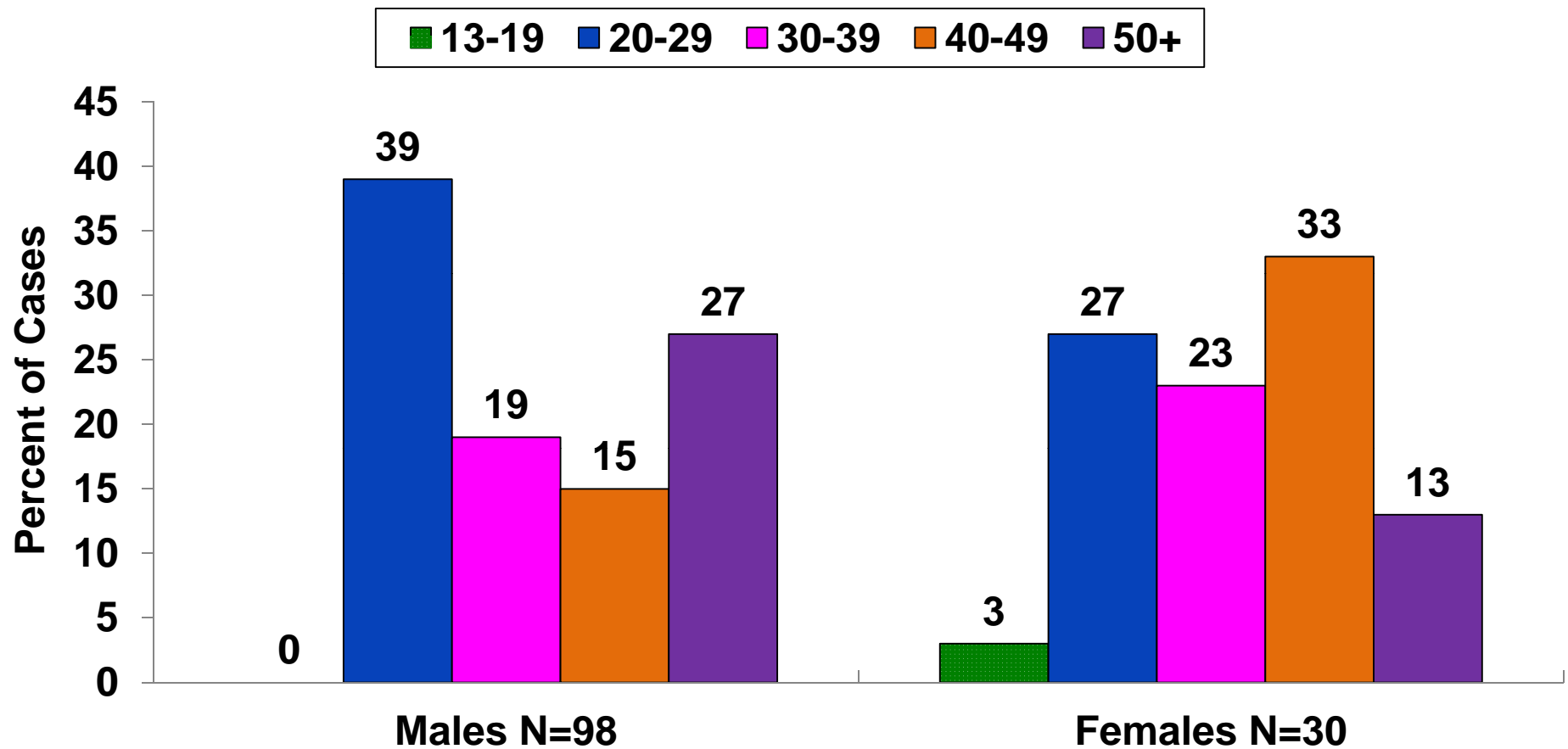
# Adult HIV Infection Cases, by Age Group at Diagnosis, and Year of Report, 2005–2014, Partnershi p 12



Note: From 2005 to 2014, the proportion of adult HIV infection cases among those aged 20-29 and among those aged 50 or older, increased by 7 and 9 percentage points, respectively.



# Adult HIV Infection Cases, by Sex and Age Group at Diagnosis, Reported in 2014, Partnership 12



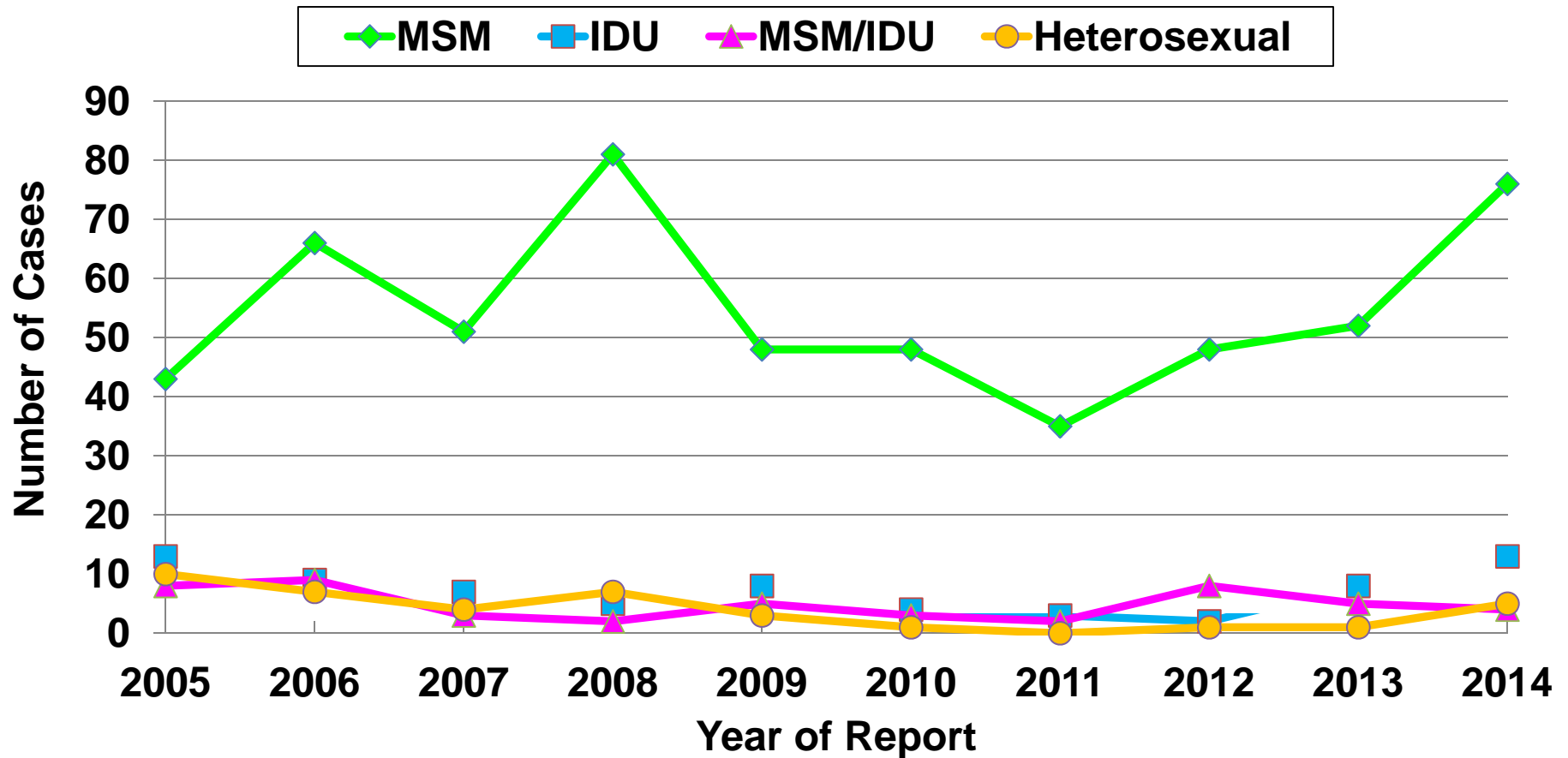
Note: HIV infection cases tend to reflect more recent transmission than AIDS cases, and thus present a more current picture of the epidemic. With regard to the age group with the highest percent of HIV infection cases, recent estimates show that among males, 39% of HIV infection cases occur among those aged 20-29, whereas among females, 33% of HIV infection cases occur among those in the 40-49 age group.



# Definitions of Mode of Exposure Categories

- ◆ **MSM** = Men who have sex with men or Male-to-male sexual contact with person with HIV/AIDS or known HIV risk
- ◆ **IDU** = Injection Drug User
- ◆ **MSM/IDU** = Men who have sex with men or Male-to-male sexual contact & Injection Drug User
- ◆ **Heterosexual** = Heterosexual contact with person with HIV/AIDS or known HIV risk
- ◆ **OTHER** = includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.
- ◆ **NIR** = Cases reported with No Identified Risk
- ◆ **Redistribution of NIRs** = This illustrates the effect of statistically assigning (redistributing) the NIRs to recognized exposure (risk) categories by applying the proportions of historically reclassified NIRs to the unresolved NIRs.

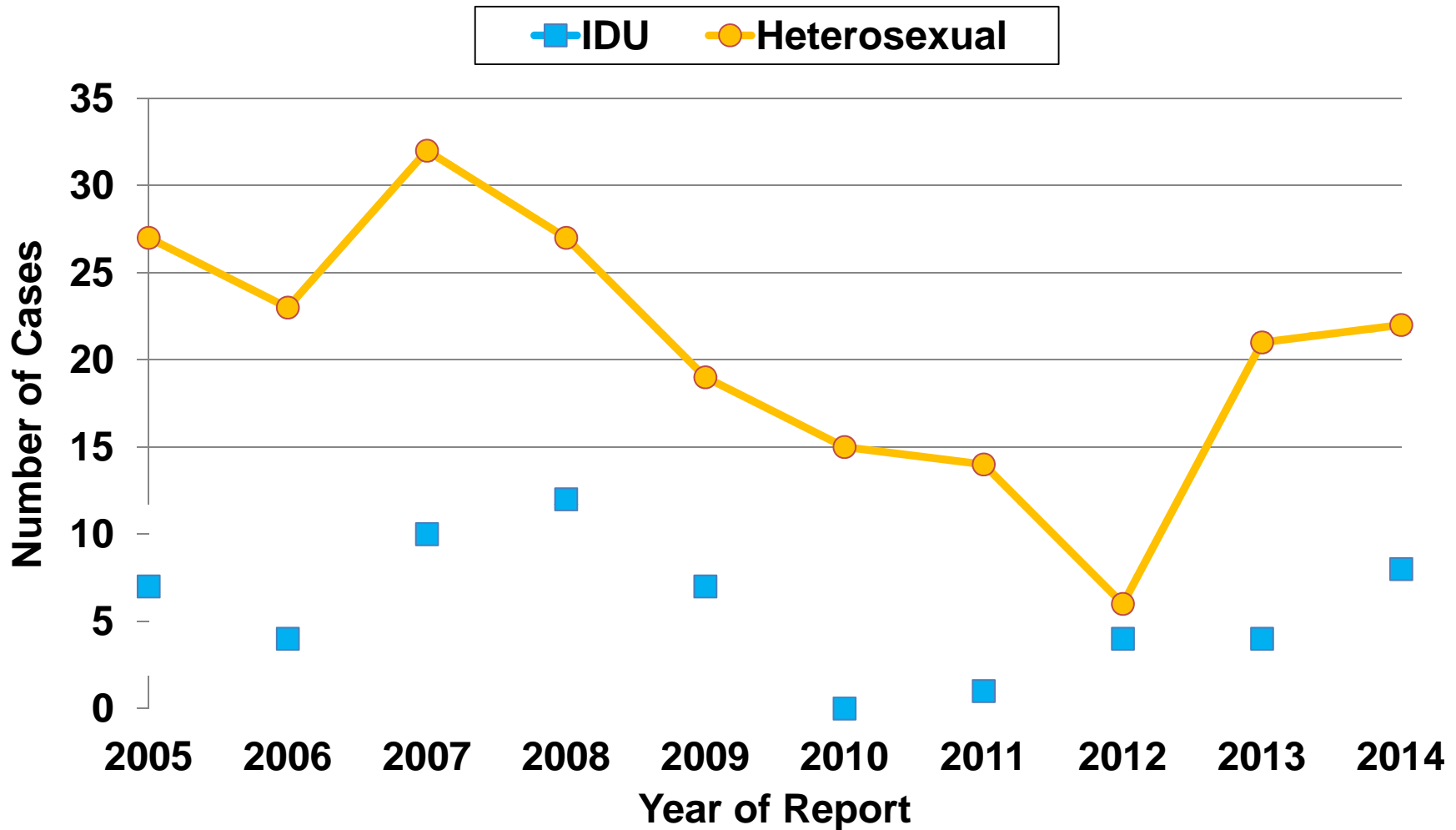
# Adult Male HIV Infection Cases, by Mode of Exposure and Year of Report, 2005–2014, Partnership 12



Note: NIRs redistributed. For most years, male-to-male sexual contact (MSM) remains as the primary mode of exposure among male HIV cases in Partnership 12.



# Adult Female HIV Infection Cases by Exposure Category and Year of Report, 2005-2014, Partnership 12

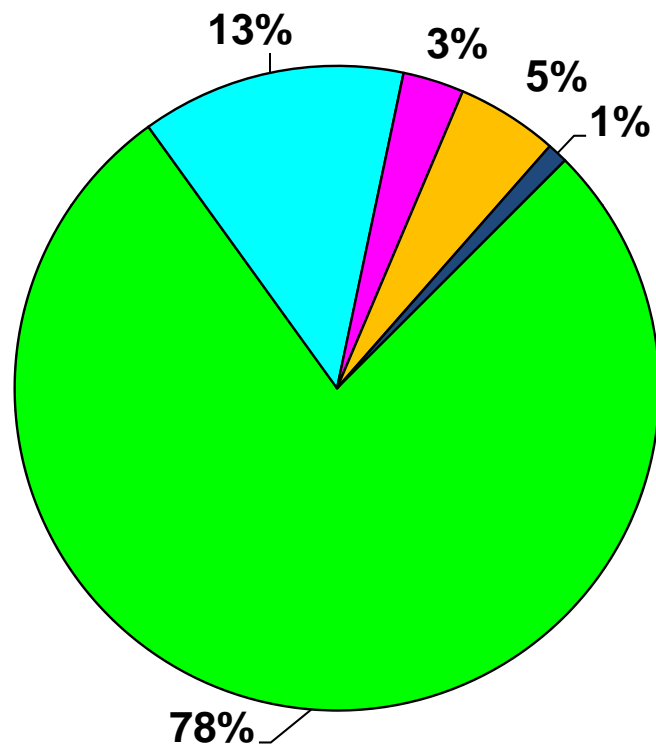


Note: NIRs redistributed. The heterosexual risk continues to be the dominant mode of exposure among females.

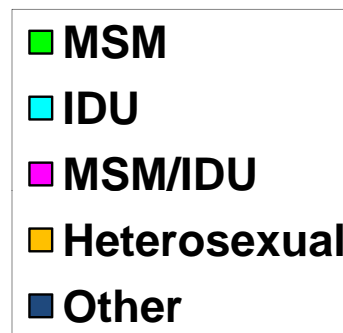
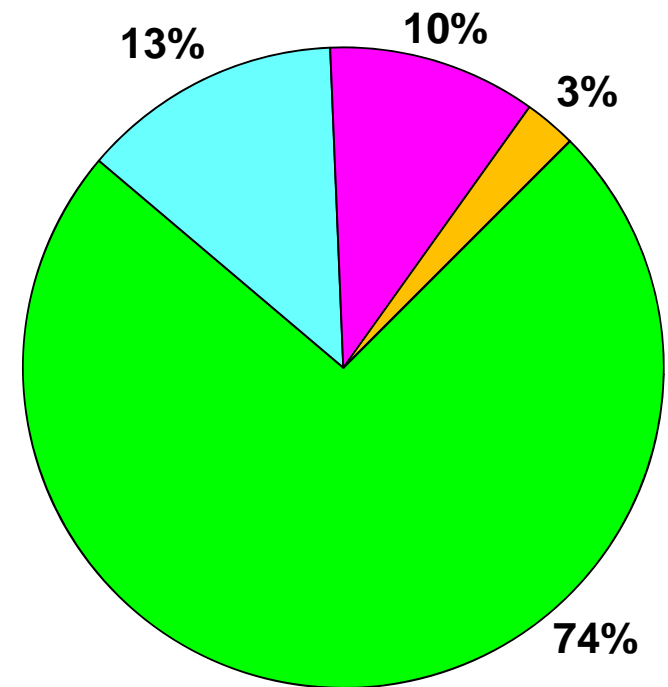


# Adult Male HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 12

## HIV Infection N=98



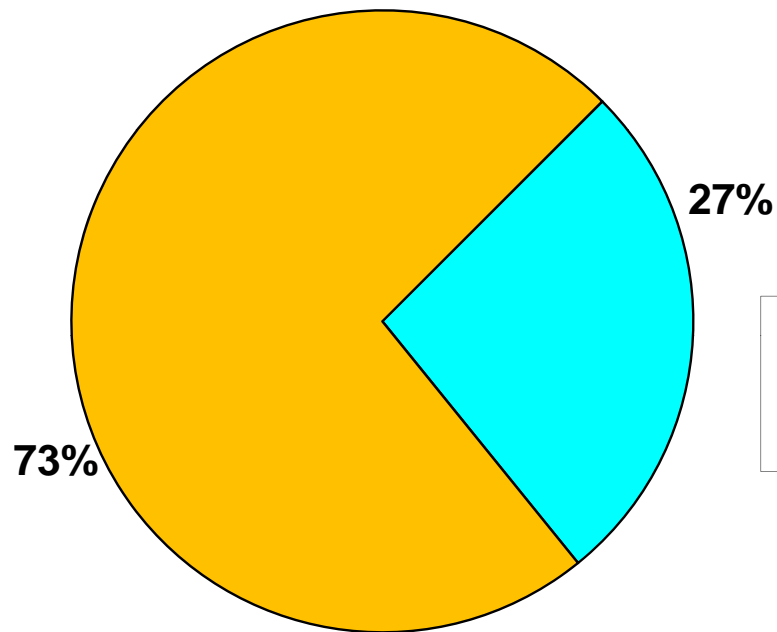
## AIDS N=38



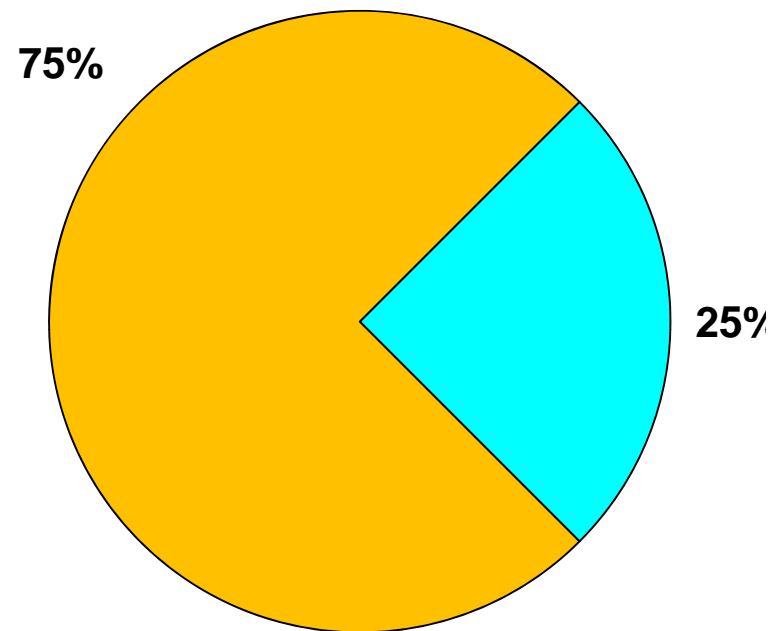
Note: NIRs redistributed. Among the male HIV infection and AIDS cases reported for 2014, male-to-male sexual contact (MSM) was the most common risk factor (78% and 74% respectively). The recent increase among MSM is indicated by the higher MSM among HIV infection cases compared to AIDS cases, as HIV infection cases tend to represent a more recent picture of the epidemic.

# Adult Female HIV Infection and AIDS Cases, by Mode of Exposure, Reported in 2014, Partnership 12

**HIV Infection**  
**N=30**



**AIDS**  
**N=20**



Note: NIRs redistributed. Among the female HIV infection and AIDS cases reported for 2014, heterosexual contact was the highest risk (73% and 75% respectively).



# Cases Living with HIV Disease

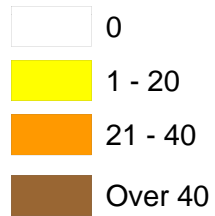
Unless otherwise noted, data in the following slides represent persons living with HIV/AIDS (PLWHAs), who were living in Florida (regardless where diagnosed) through the most recent calendar year. Living data are also referred to as prevalence cases or living with HIV disease.



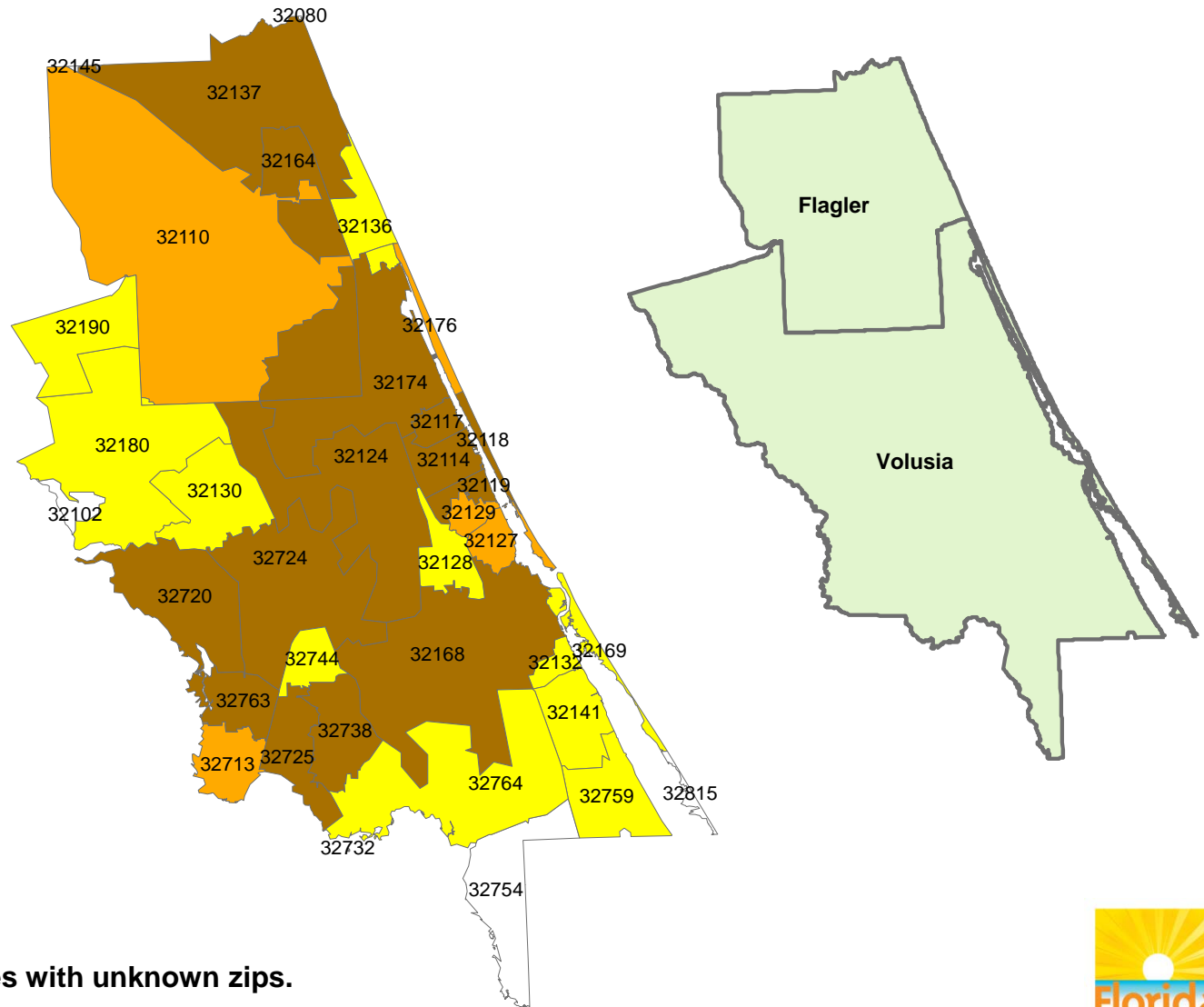


# Adults Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 12

## Total Adult Living HIV/AIDS Cases



**N=1,762**

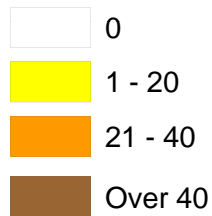


NIRs are not redistributed.  
Excludes DOC, homeless, and cases with unknown zips.  
Data as of 06/30/2015

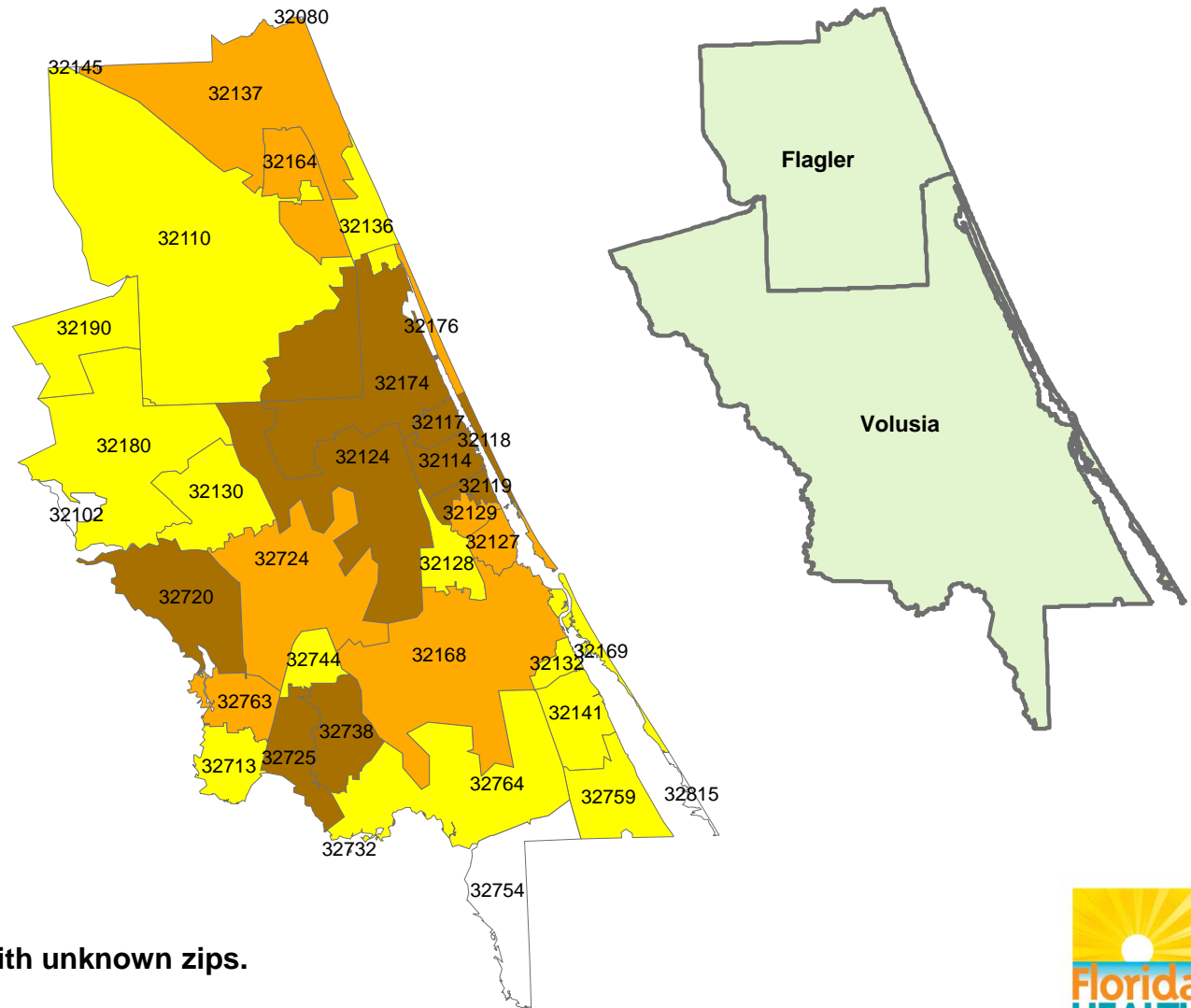


# Men who have Sex with Men (MSM)\* Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 12

## Presumed Living MSM HIV/AIDS Cases



**N=978**

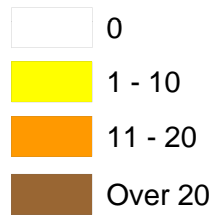


NIRs are not redistributed.  
Excludes DOC, homeless, and cases with unknown zips.  
\*Includes MSM/IDU cases.  
Data as of 06/30/2015

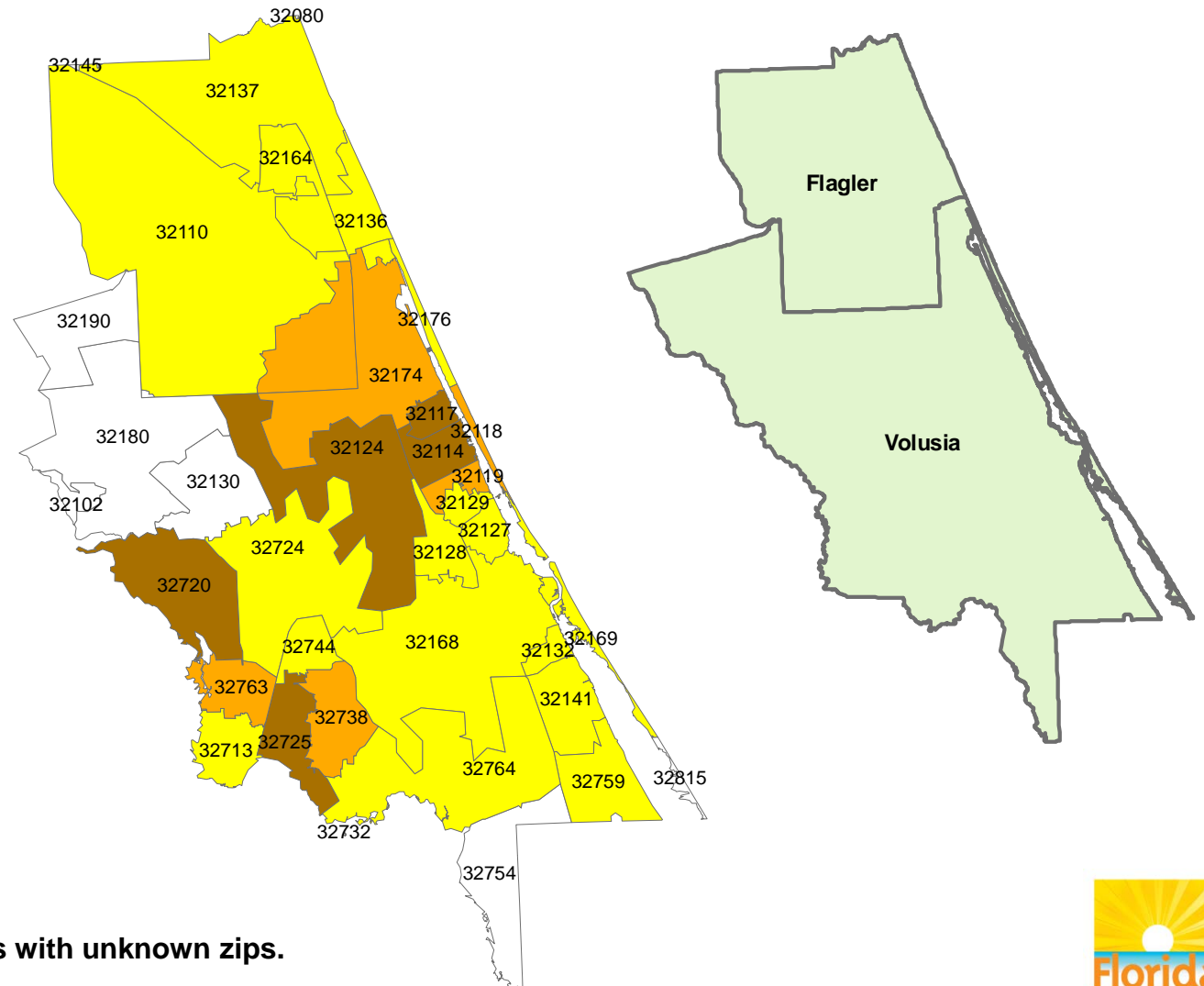


# Injection Drug Users (IDUs)\* Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 12

## Presumed Living IDU HIV/AIDS Cases



**N=352**

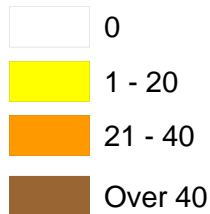


NIRs are not redistributed.  
Excludes DOC, homeless, and cases with unknown zips.  
\*Includes MSM/IDU cases.  
Data as of 06/30/2015

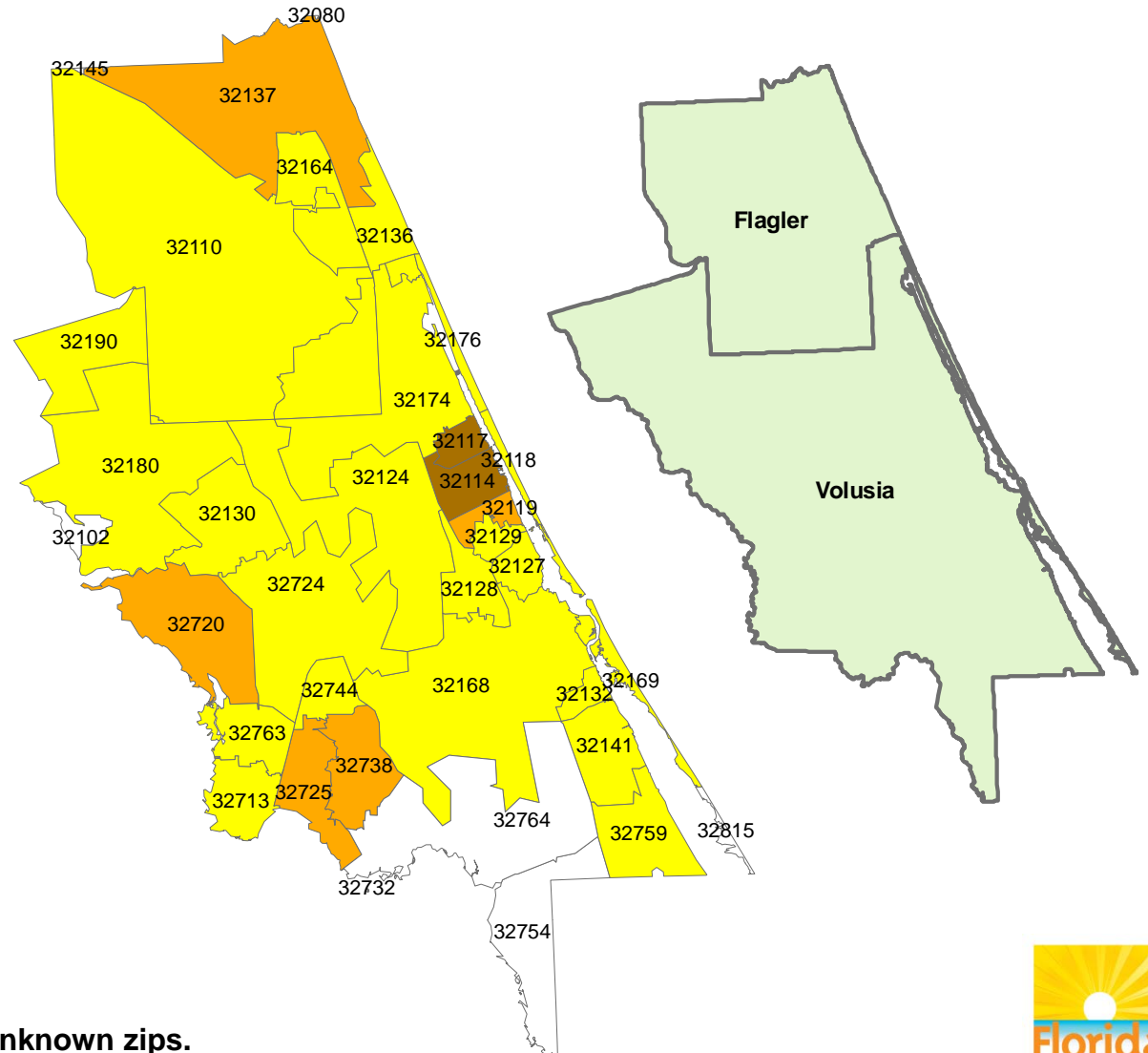


# Adult Heterosexuals Living with HIV Disease By Zip Code, Diagnosed through 2014, Partnership 12

## Presumed Living Heterosexual HIV/AIDS Cases



**N=494**



NIRs are not redistributed.  
Excludes DOC, homeless, and cases with unknown zips.  
Data as of 06/30/2015

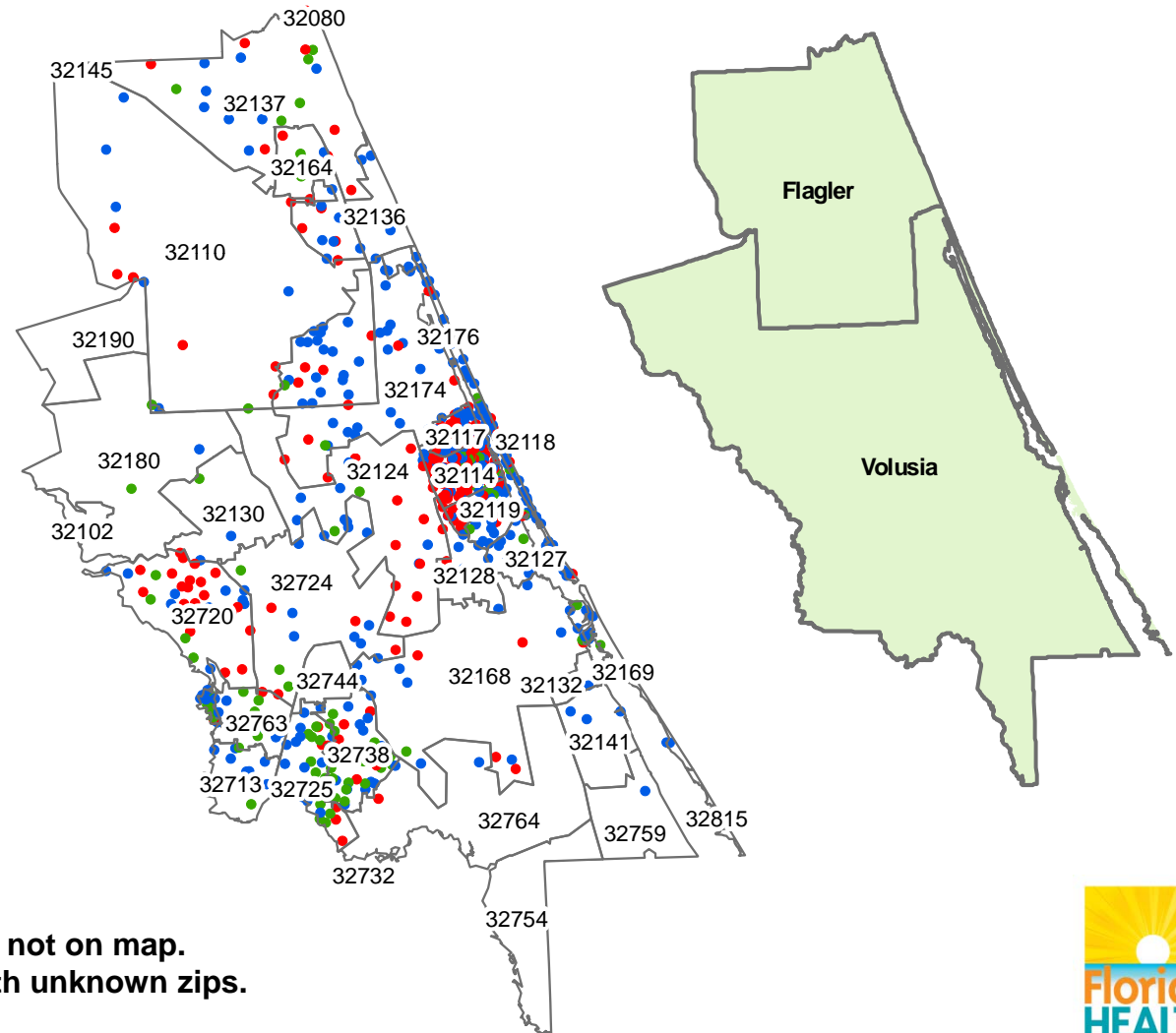


# Adults Living with HIV Disease By Zip Code and Race/Ethnicity, Diagnosed through 2014, Partnership 12

1 Dot = 3 cases  
Dots are randomly  
placed within zip codes.

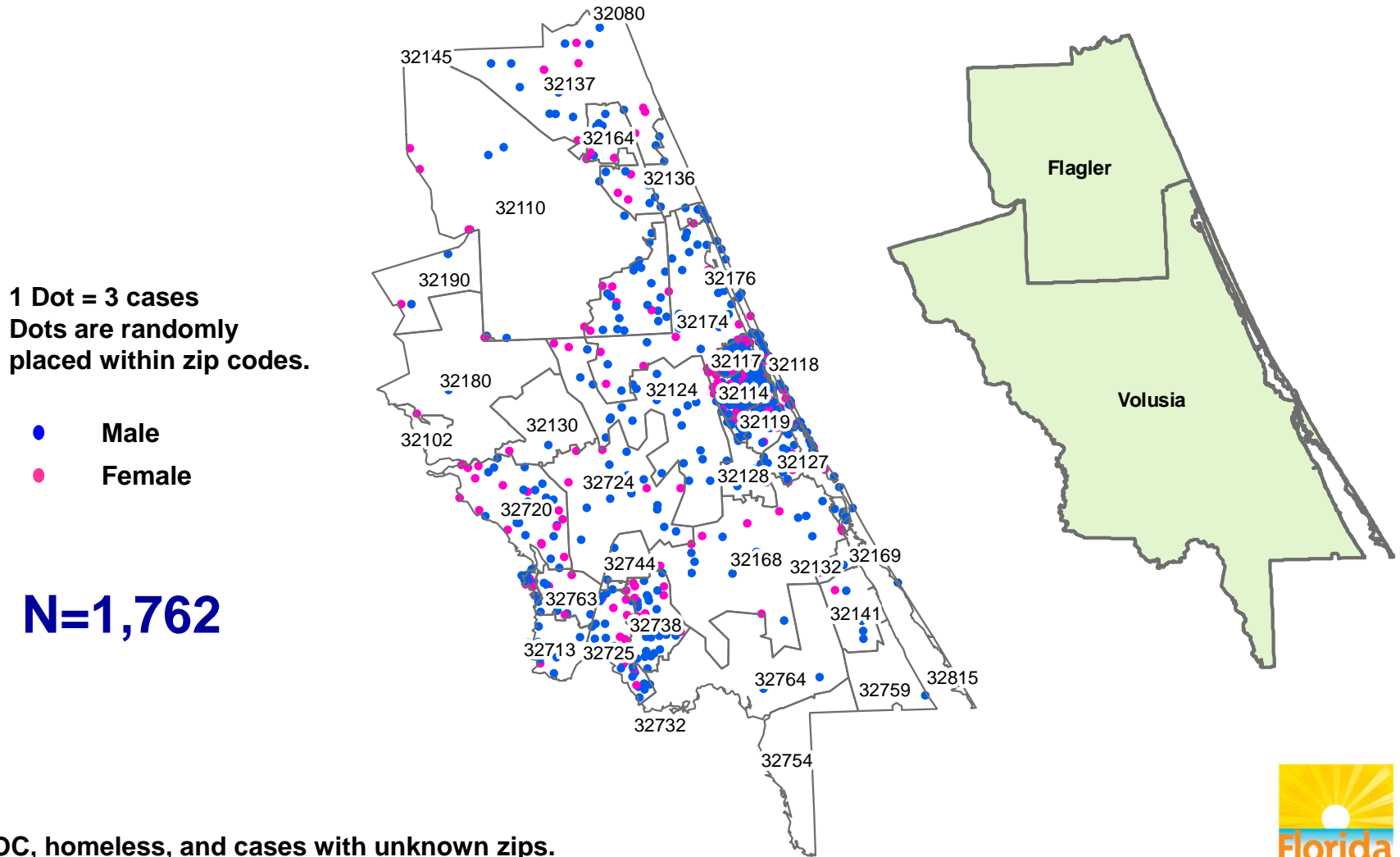
- Hispanic
- Black, not-Hispanic
- White, not-Hispanic

**N=1,713**



Total includes all races, some which are not on map.  
Excludes DOC, homeless, and cases with unknown zips.  
Data as of 06/30/2015

# Adults Living with HIV Disease By Zip Code and Sex, Diagnosed through 2014, Partnership 12

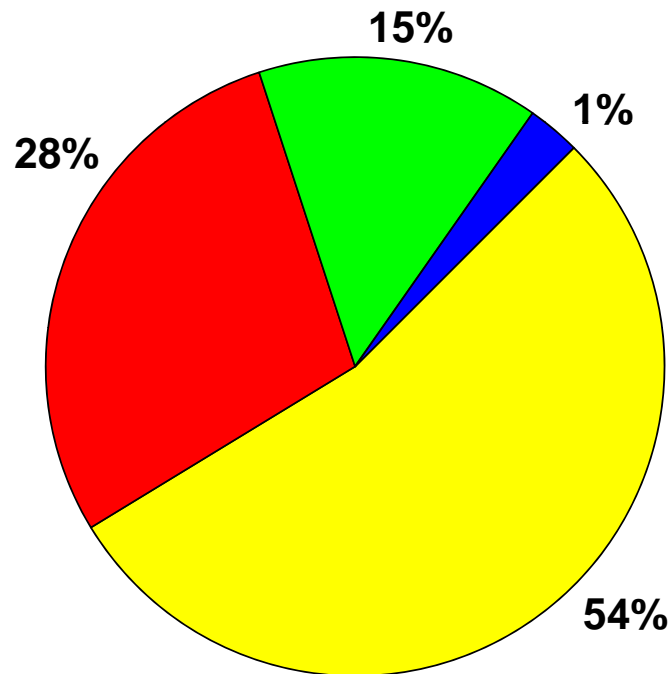


Excludes DOC, homeless, and cases with unknown zips.  
Data as of 06/30/2015

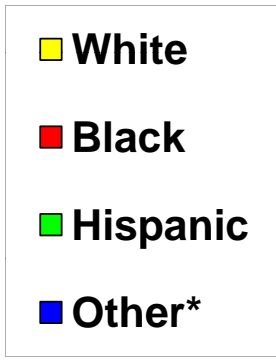
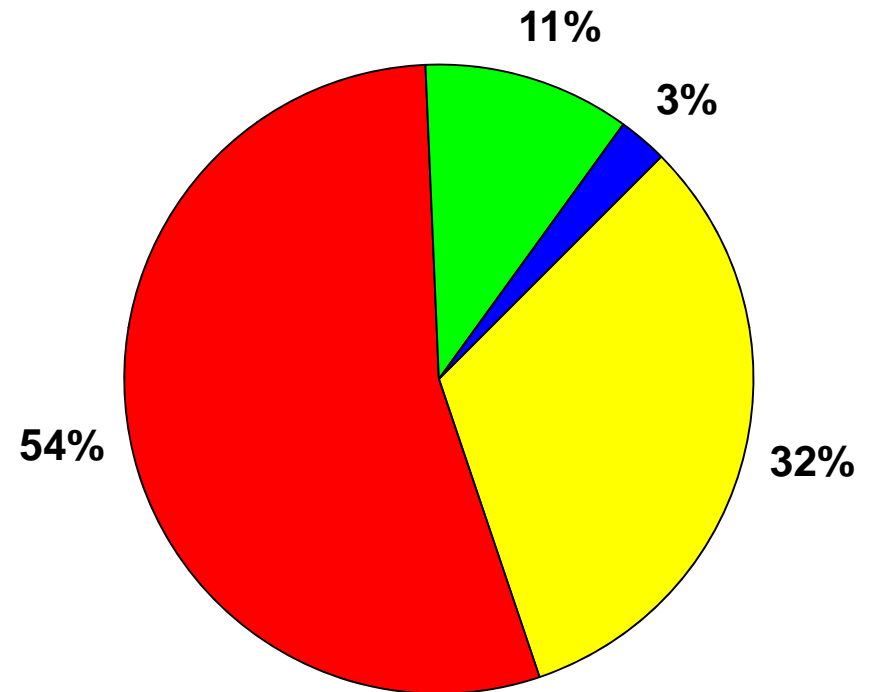


# Adults Living with HIV Disease, by Sex and Race/Ethnicity Diagnosed through 2014, Partnership 12

**Males**  
N=1,227



**Females**  
N=554

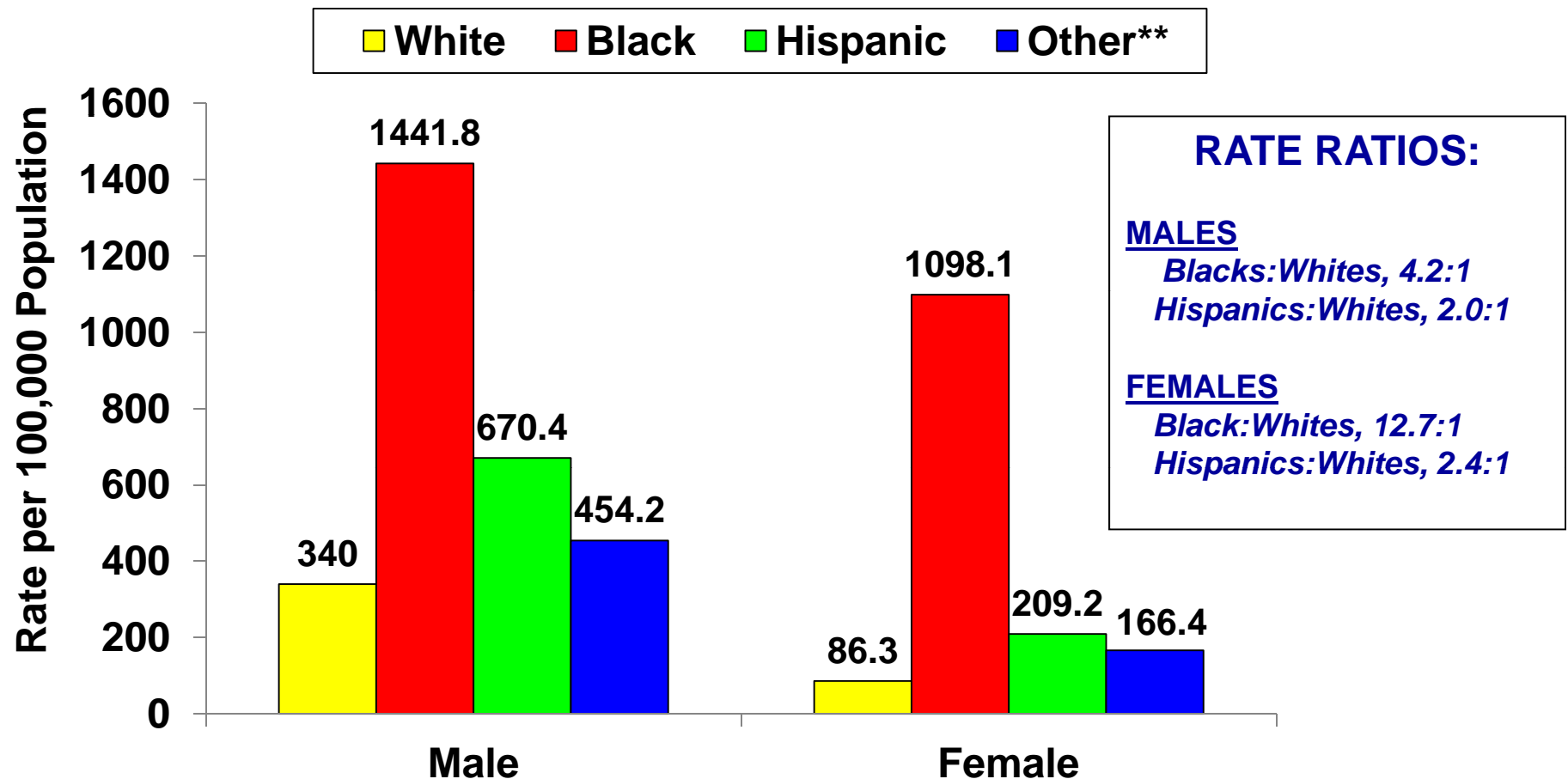


**Note:** Among adult males living with HIV disease, whites represent the race most affected (54%). Among adult females living with HIV disease, blacks represent the race most affected (54%).

\*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.



# Case Rates\* of Adults Living with HIV Disease, by Sex and Race/Ethnicity, Diagnosed through 2014, Partnership 12



Note: Among black males living with HIV disease Diagnosed through 2014, the case rate is 5 times higher than the rate among white males. Among black females living with HIV disease, the case rate is nearly 13 times higher than the rate among white females. The case rate among Hispanic males and females is higher than the rate among their white counterparts. Data excludes Department of Corrections cases.

\*Source: Population estimates are provided by Florida CHARTS as of 7/9/2015.

\*\*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.

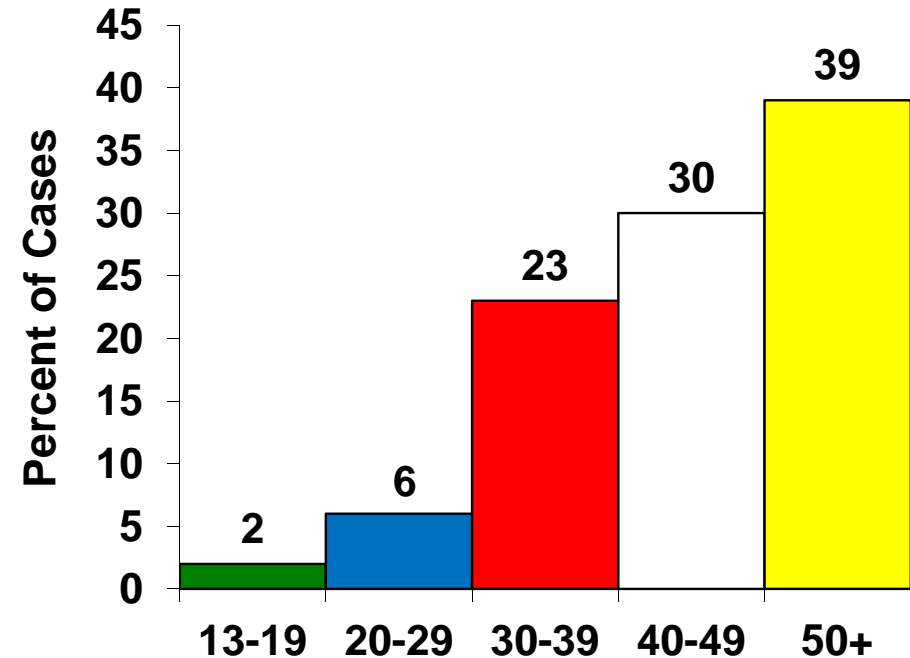
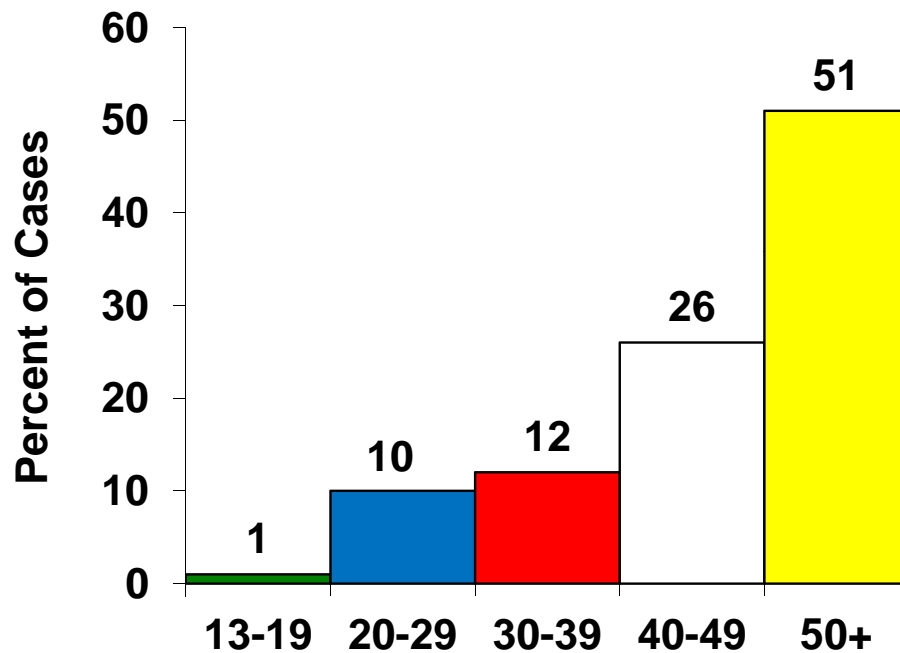




# Adults Living with HIV Disease, by Sex and Current Age Group, Diagnosed through 2014, Partnership 12

**Males**  
N=1,227

**Females**  
N=554



Note: Males living with HIV disease have a higher proportion of cases who are currently 40 years of age or older (77%), compared with females living with HIV disease (69%).

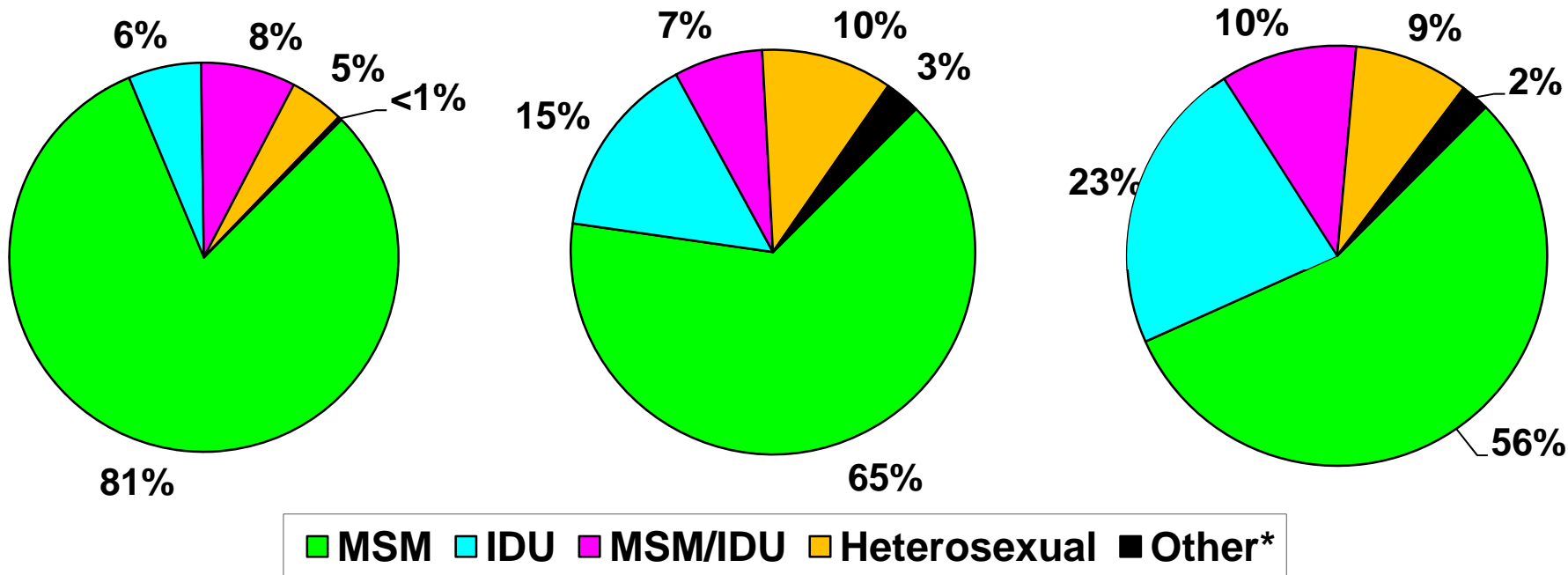


# Adult Males Living with HIV Disease by Race/Ethnicity and Mode of Exposure Diagnosed through 2014, Partnership 12

White Non-Hispanic,  
N=660

Black Non-Hispanic,  
N=352

Hispanic  
N=181

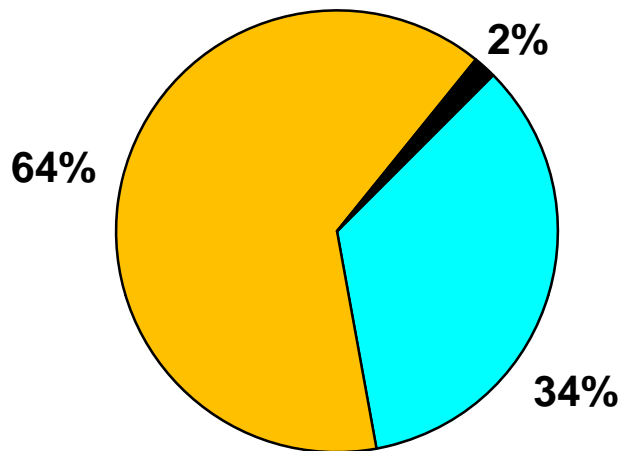


Note: NIRs redistributed. Male-to-male sexual contact (MSM) represents the highest risk for all races. White males have the smallest proportion of heterosexual contact risk.

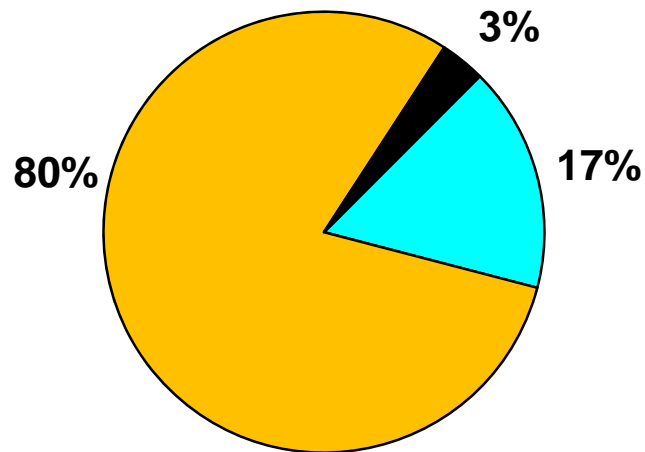
\* Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.

# Adult Females Living with HIV Disease by Race/Ethnicity and Mode of Exposure Diagnosed through 2014, Partnership 12

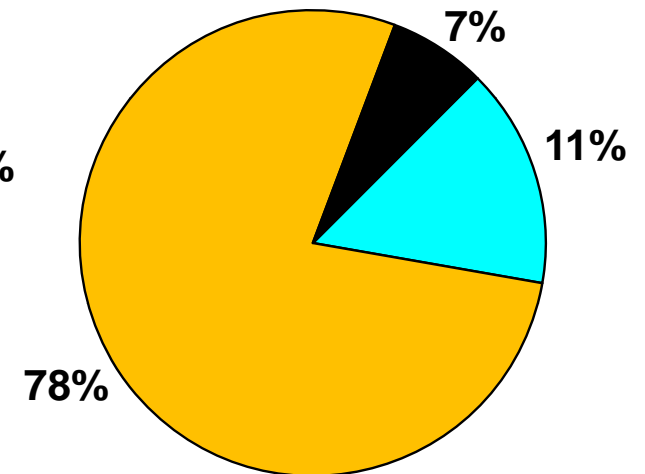
White Non-Hispanic,  
N=179



Black Non-Hispanic,  
N=302



Hispanic,  
N=59

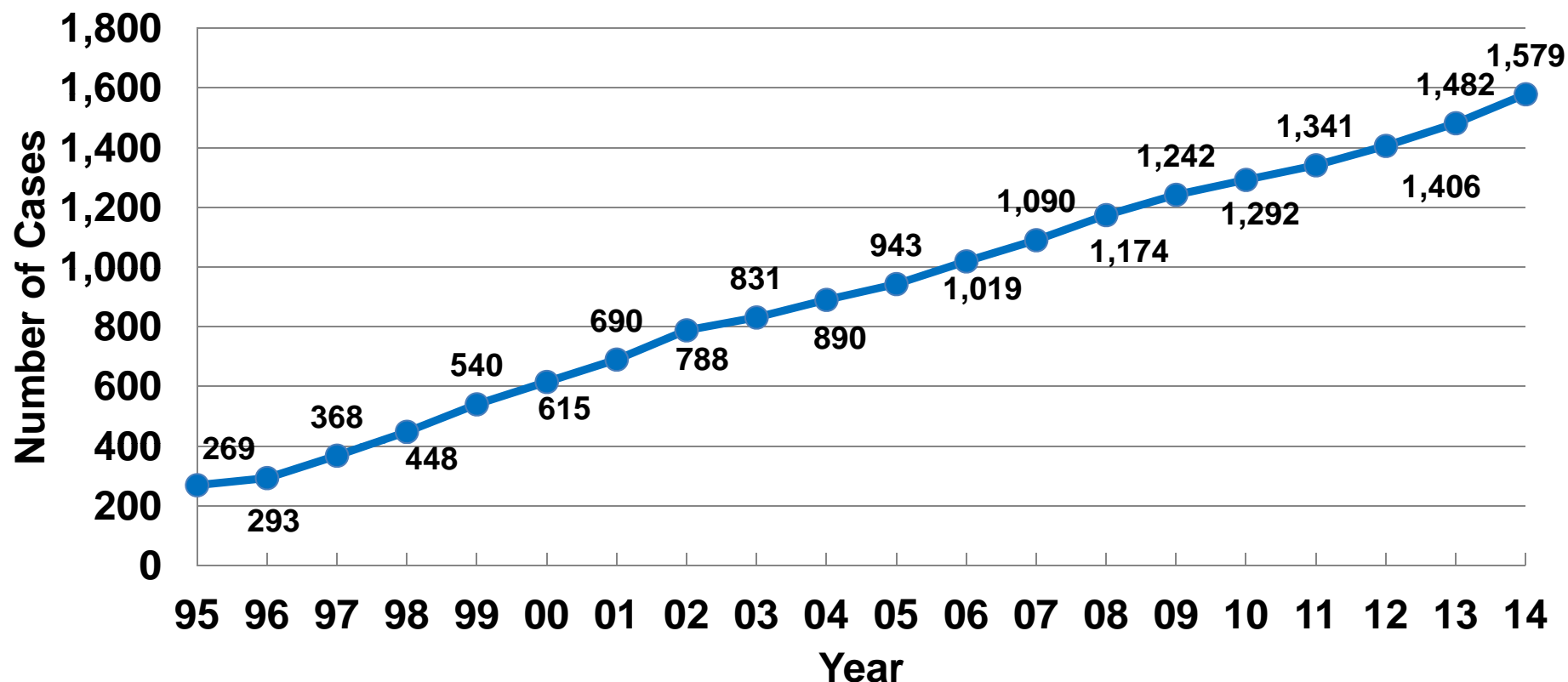


■ IDU ■ Heterosexual ■ Other\*

Note: NIRs redistributed. Heterosexual contact is the majority risk for all races. However, whites have the largest proportion of IDU risk.

\* Other includes hemophilia, transfusion, perinatal, other pediatric risks and other confirmed risks.

# Annual Prevalence of Adults Living with HIV Disease, 1995-2014, Partnership 12



As a result of declining deaths, annual HIV/AIDS diagnoses have exceeded deaths since 1995, and the number of persons reported with HIV/AIDS who are presumed to be alive have been increasing. Since 1995, the number of persons reported living with HIV/AIDS have increased over 460%. In 2014, the prevalence increased by 6.5% since the previous year.

Note: These data represent adults living with HIV disease diagnosed in Florida regardless of their current residence.



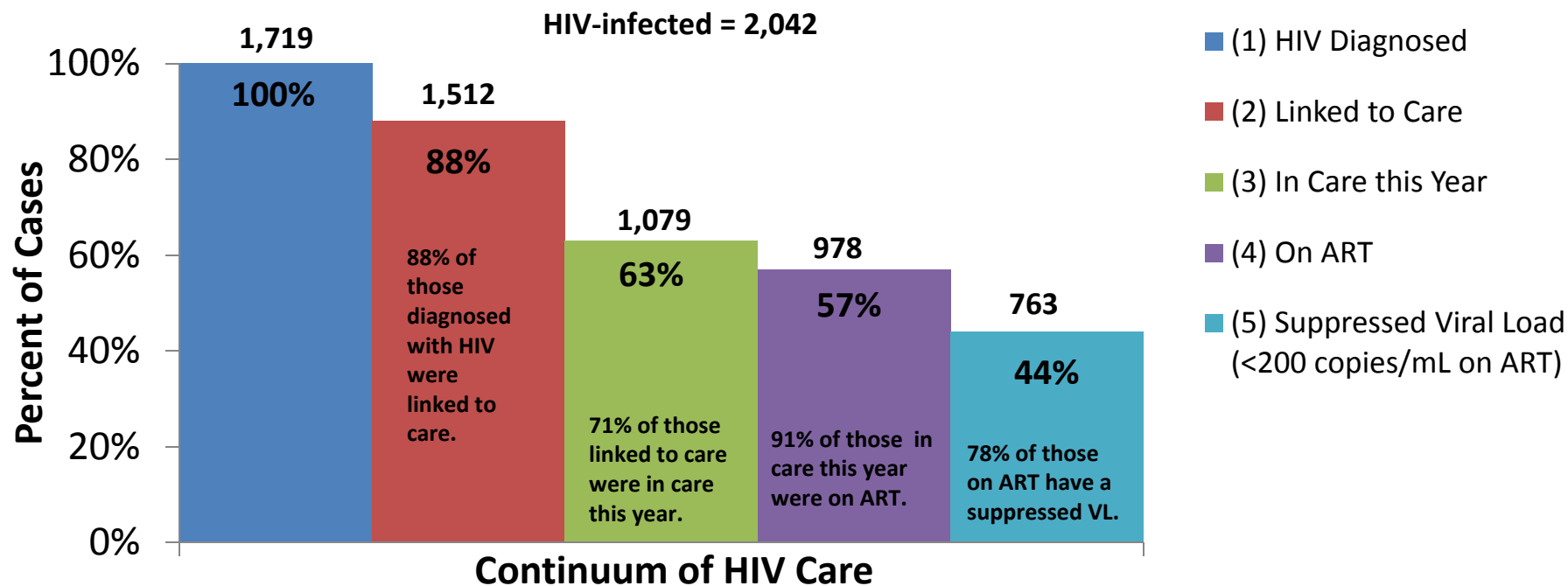
# **Partnership 12's Top-9 Priority Populations in 2013 for Primary and Secondary HIV Prevention Based on Persons Living with HIV Disease**

- 1. White Men who have sex with Men**
- 2. Black Men who have sex with Men**
- 3. Black Heterosexual men and women**
- 4. White Injection Drug User**
- 5. Hispanic Men who have sex with Men**
- 6. White Heterosexual men and women**
- 7. Black Men who have sex with Men**
- 8. Black Heterosexual men and women**
- 9. Hispanic Heterosexual men and women**

This final ranking is a result of ranking 9 race/risk groups among those newly reported in eHARS with HIV disease in Partnership 12 from the 3 most recent years, plus ranking these same 9 race/risk groups from all persons who were reported and living with HIV disease in eHARS in Partnership 1 through the most recent calendar year. The two ranks were then weighted and combined resulting in the final rank.



# Number and Percentage of HIV-Infected Persons Engaged in Selected Stages of The Continuum of HIV Care — Partnership 12, 2013



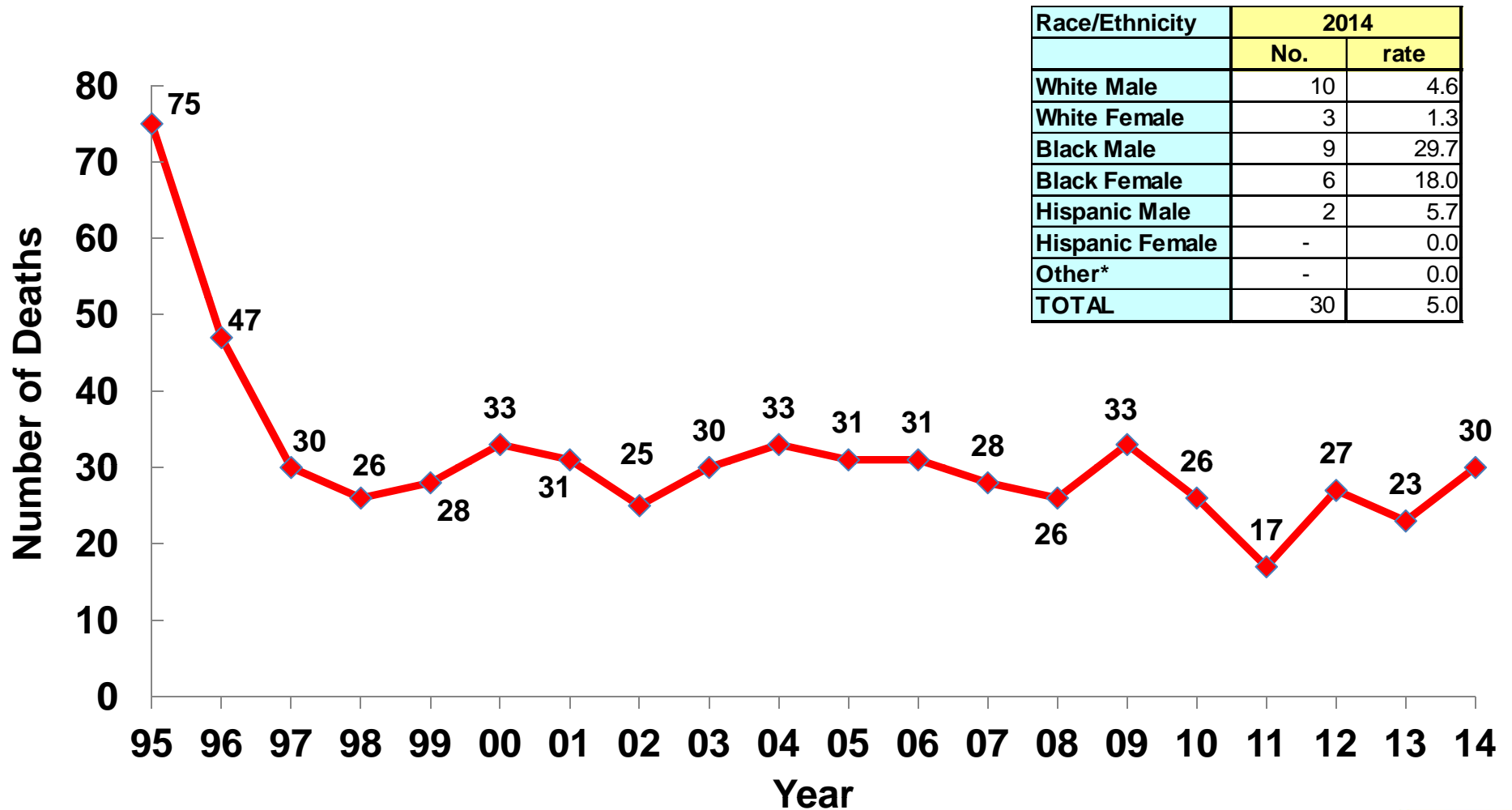
- (1) Number of cases known to be alive and living in Florida through 2013, regardless where diagnosed, as of 06/30/2014 (used for unmet need calculations).
- (2) Ever in Care = 86% of those cases were linked to care, based on persons living with HIV disease in Florida (regardless of where diagnosed) who ever had a CD4 or Viral load (VL) test in the electronic HIV/AIDS Reporting System (eHARS). (2010 National estimates are 79%\*).
- (3) 55% of cases were in care this year, based on HRSA unmet need definition, for persons living with HIV in Florida (regardless of where diagnosed) and having at least 1 HIV-related care service involving either a VL or CD4 test or a refill of HIV-related RX. (2010 National estimates for in care are 56%\*).
- (4) Estimated 90.6% of In care and on ART this year in Florida per 2011 MMP data (2010 National estimates are 80%\*).
- (5) Estimated 78.0% on ART & the viral load is <200 this year in Florida per 2011 MMP data (2010 National estimates are 70%\*).

\*Continuum of HIV care among Ryan White HIV/AIDS Program clients, U.S., 2010 (<http://hab.hrsa.gov/data/reports/continuumofcare/index.html>)

For additional information please refer to the Florida Continuum of Care slide set accessible at <http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html>



# Resident Deaths due to HIV Disease by Year of Death, 1995-2014, Partnershi p 12



| Race/Ethnicity  | 2014      |            |
|-----------------|-----------|------------|
|                 | No.       | rate       |
| White Male      | 10        | 4.6        |
| White Female    | 3         | 1.3        |
| Black Male      | 9         | 29.7       |
| Black Female    | 6         | 18.0       |
| Hispanic Male   | 2         | 5.7        |
| Hispanic Female | -         | 0.0        |
| Other*          | -         | 0.0        |
| <b>TOTAL</b>    | <b>30</b> | <b>5.0</b> |

Source: Florida Department of Health, Bureau of Vital Statistics, Death Certificates (as of 05/31/2015). Population data are provided by Florida CHARTS as of 7/9/2015.

\*Other includes Asian/Pacific Islanders, Native Alaskans/American Indians and Multi-racial individuals.



## Some Useful Links

- ⓧ CDC HIV/AIDS Surveillance Reports  
(State and Metro Data):  
<http://www.cdc.gov/hiv/stats/hasrlink.htm>
  
- ⓧ MMWR (Special Articles on Diseases, Including HIV/AIDS):  
<http://www.cdc.gov/mmwr/>
  
- ⓧ U.S. Census Data (Available by State, County):  
<http://www.census.gov>
  
- ⓧ Partnership 12 Dept. of Health, HIV/AIDS Section  
Website (Slide sets, Facts Sheets, Monthly Surveillance  
Report, Counseling & Testing Data, etc. ):  
<http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html>





- **“The reason for collecting, analyzing and disseminating information on a disease is to control that disease. Collection and analysis should not be allowed to consume resources if action does not follow.”**

--Foege WH et al. Int. J of Epidemiology 1976; 5:29-37



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**Ext. 2612**

**Madgene Moise, MPH**

**Ext. 2373**

**Visit Florida's internet site for:**  
**Monthly Surveillance Reports**  
**Slide Sets and Fact Sheets**  
**Annual Reports and Epi Profiles**

**<http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/index.html>**

**Visit CDC's HIV/AIDS internet site for:**  
**Surveillance Reports, fact sheets and slide sets**

**<http://www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm>**