Tuesday, May 14, 2019
The meeting was called to order at 1:05 PM by Riley Johnson. Roll Call was conducted by Riley Johnson and quorum was established. Community members and guests introduced themselves.

Valerie Mincey, Area 2A Prevention Representative, thanked the entire group for their support following Hurricane Michael.

Due to the absence of the standing Patient Care Co-Chair, Article 4, Section 1 of the Patient Care and Prevention Planning Group Bylaws state that “In the event the Community Co-Chair cannot make a meeting, the seated members will select a sit in (alternate) for that meeting only.” The group selected Dan Wall, Area 11A Patient Care Representative to serve as pro-tem Patient Care Co-Chair for the Spring meeting.

Dan facilitated the meeting along with Jim Roth, Department of Health Co-Chair and Riley Johnson, Prevention Community Co-Chair.

Riley Johnson reviewed the content of the meeting packets.

The action items from the Fall 2018 Patient Care and Prevention Planning Group (PCPPG) Meeting were reviewed and discussed. As a point of clarification, the action registry only includes items that were discussed during the last face-to-face meeting. Any subsequent discussions that occurred during committee calls are not reflected in the registry. The HIV/AIDS Section is exploring methods to ensure that all actionable items are tracked and shared with the full-body membership.

There was a specific inquiry regarding the Germaine Solutions local area reports on Part B Lead Agencies and the method for distributing those reports. The HIV/AIDS Section indicated that the reports had been shared with the Part B Lead Agencies and those agencies were asked to share the report “as they deemed appropriate with their partners”. It was also stated that additional information was provided subsequent to the reports being distributed but since the reports were produced by an outside entity, the HIV/AIDS Section did not have the ability to update those reports. If local areas have questions or concerns regarding the reports, the HIV/AIDS Section agreed to provide clarification.

**HIV/AIDS Section Update**

**Laura Reeves, HIV/AIDS Section Administrator**

The HIV/AIDS Program Coordinators (HAPCs) present at the meeting were asked to stand to be acknowledged. Laura asked participants to work closely with the local area HAPC as collaboration would be essential moving forward in ending the epidemic in the state of Florida.

Laura reviewed the DOH Table of Organization with the group. She addressed the current vacancies, which included the State Surgeon General. Laura announced that Dr. Pat Ryder, Bureau Chief, Bureau of Communicable Diseases is scheduled to retire in September 2019.

Florida’s Plan to Eliminate HIV Transmission and Reduce HIV-Related Deaths (4-Key Component Plan) was discussed:

- Implement routine HIV and Sexually Transmitted Infections (STIs) screening in health care settings and priority testing in non-health care settings
- Provide rapid access to treatment and ensure retention in care (Test and Treat)
- Improve and promote access to antiretroviral pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP)
- Increase HIV awareness and community response through outreach, engagement, and messaging
The Ending the Epidemic Plan was presented.

The 90% reduction would be equivalent to approximately 3,000 new cases of HIV reported.

It was pointed out that Florida’s plan and activities closely align with the national plan. In addition to the four key components listed above, Florida is also using molecular surveillance to respond rapidly to detect and respond to growing HIV clusters.

The national strategy related to the HIV HealthForce is still vague.

The Ending the Epidemic is focused on 48 counties, Washington D.C, Sand Juan and 7 states with substantial HIV rural burden. Florida has 7 of those identified counties: Broward, Duval, Hillsborough, Miami-Dade, Orange, Pinellas, and West Palm.

In order for Florida to reduce their new infection rate by 90%, the number would need to fall below 500/year. Florida holds 12% of the national burden of HIV cases.

Next, Laura discussed some programmatic updates:


   Their report included recommendations at the federal level, state level, and Department of Health level.

   To address the recommendations for the Department of Health a call was held between several members of the community and the HIV/AIDS Section on March 3, 2019. Key discussion points included:
   - Data collection of transgender information
   - Ensure gender-affirming care in Ryan White provider sites
   - Include more hormone replacement therapies on the state AIDS Drug Assistance Formulary
   - Establish a statewide Transgender Workgroup

Laura discussed her vision of the Transgender Workgroup. Representation would be sought from each of the 15 local areas to further examine the recommendations outlined in the report.

Jen Laws to put together information for the Medication Access group related to hormone replacement therapies on the state AIDS Drug Assistance Program (ADAP) Formulary.

Dan Wall made a motion to have the HIV/AIDS Section form a Statewide Transgender Workgroup and Ken Bargar seconded the motion. Motion unanimously approved.

Discussion: The Statewide Transgender Workgroup will be administered directly by the HIV/AIDS Section. The workgroup will provide updates to the FCPN in the same manner as the Gay Men’s Workgroup and the Consumer Advisory Group.
Haitian Consultation was conducted by the HIV/AIDS Section with persons who are interested in improving access to care, prevention messaging, and how to work better with the Haitian population. A report from the consultation was prepared and included recommendations that have been incorporated into the agency strategic plan. These items deal specifically with the Haitian population.

*The HIV/AIDS Section to provide a copy of the Haitian Consultation Report to The AIDS Institute for distribution to the FCPN membership.*

Laura provided an update on the status of Florida Administrative Code 64-D. There is a current Florida statute that indicates that you cannot publish a proposed rule without a sitting State Surgeon General. Since there is not a current State Surgeon General, the proposed rule is on hold.

2019 Legislative Session updates were given on appropriations and the Infectious Disease Elimination Act.

First, the Infectious Diseases Elimination Act (IDEA) CS/CS/SB 366 was discussed. Effective July 1, 2019 county commissions can authorize sterile needle and syringe exchange programs. Exchanges must be one-to-one and programs must be funded through grants and private donations (no state, county, or local funds).

The Department of Health has the following responsibilities: counties must enter into a letter of agreement with DOH and consult with their CHD; programs must report annually to DOH by August 1; DOH must submit an aggregate report annually to the Governor, the Speaker of the House, and the President of the Senate by October 1.

Innovative methods of funding will be essential. As an example, Miami-Dade has funded the IDEA Exchange through fundraising and grants.

Senate Bill 2500 is the approved Appropriations Bill. Line 470 of the Bill is related to the HIV Program. There was level General Revenue funding of $29,528,611. A legislative budget request for additional spending authority was submitted and granted. The amount requested was:

<table>
<thead>
<tr>
<th>ADAP Emergency Relief Funding</th>
<th>$11,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOPWA</td>
<td></td>
</tr>
<tr>
<td>Proposed Recurring Authority Increase</td>
<td>$4,918,213</td>
</tr>
<tr>
<td>Non-Recurring Authority</td>
<td>$4,737,388</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Lauderdale, Jacksonville, Miami,</td>
<td></td>
</tr>
<tr>
<td>Orlando, Tampa, and West Palm Beach.</td>
<td></td>
</tr>
<tr>
<td>The department shall ensure funds are</td>
<td></td>
</tr>
<tr>
<td>used exclusively for temporary support</td>
<td></td>
</tr>
<tr>
<td>services that are not expected to last</td>
<td></td>
</tr>
<tr>
<td>a period of more than 12 continuous</td>
<td></td>
</tr>
<tr>
<td>months.</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$20,655,601</td>
</tr>
</tbody>
</table>

Patient Care Funding Update – Part B awards have been issued and Florida received a $1.9 million reduction in the ADAP line item.

Laura introduced the idea of tiering the ADAP Formulary in preparation for any needed reductions. A member suggested that the HIV/AIDS Section look at the Lead Agencies and local county health departments to address inefficiencies before looking at tiering the ADAP Formulary.

It was announced that the five-year cycle for Lead Agencies was concluding and that all contracts for funded Lead Agencies will expire at the end of the current contract year. The HIV/AIDS Section would be preparing a robust Request for Applications for Lead Agencies. *Prior to the Request for Applications for Lead Agencies being finalized, the HIV/AIDS Section agreed to hold conference calls with FCPN members to gather input and feedback.* The HIV/AIDS Section anticipates that these calls would commence very soon as the contracts for Lead Agencies must be executed by April 1, 2020.
Finally, proposed changes for 2020 legislative session were discussed. In particular, Section 381.0042, Florida Statutes, Patient Care for Persons with HIV Infection. The HIV/AIDS Section is currently considering any proposed statutory changes. Any proposed changes need to be submitted in July 2019. Changes were last made to this statute in 1997. The statute outlines the Patient Care Network for the state. The maps for the HIV Patient Care Networks (per Florida Administrative Code), Current HIV Patient Care Consortia Areas, and two alternatives for proposed Patient Care Areas were presented. Proposal 2 - Patient Care Area was divided to include a Part A, Part B, and HOPWA in each of the areas. The number of persons living with HIV in each of the areas was also taken into consideration. To view the maps, click here.

For the current RFA that is being developed for Lead Agencies, Laura asked the group to consider:
- the current Patient Care Consortia Areas and the two proposed Patient Care Areas
- clarifying terminology that is used (e.g. Consortia vs. Lead Agency)
- clarifying roles and responsibilities
- include some of the information in the Florida Statute

There was a request to have the Word version of Florida’s HIV System of Care Current Statute and Administrative Rule Language (Section 381.0042, Florida Statutes, Patient Care for Persons with HIV Infection) uploaded to the meeting webpage so that members could edit and submit suggested changes to the HIV/AIDS Section. The AIDS Institute to post the Word version of Florida’s HIV System of Care Current Statute and Administrative Rule Language (Section 381.0042, Florida Statutes, Patient Care for Persons with HIV Infection).

ADAP Program Feedback Session
Jimmy LLaque, Director, AIDS Drug Assistance Program
The session began with an update on the AIDS Drug Assistance Program (ADAP).

ADAP Client Enrollment

<table>
<thead>
<tr>
<th>Month</th>
<th>Direct-Dispense</th>
<th>Insurance</th>
<th>Combined</th>
<th>Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>April, 2017</td>
<td>13,415 (70%)</td>
<td>5,634 (30%)</td>
<td>19,049 (100%)</td>
<td></td>
</tr>
<tr>
<td>April, 2018</td>
<td>14,060 (68%)</td>
<td>6,704 (32%)</td>
<td>20,765 (100%)</td>
<td>9.0%</td>
</tr>
<tr>
<td>April, 2019</td>
<td>14,213 (62%)</td>
<td>8,609 (38%)</td>
<td>22,823 (100%)</td>
<td>9.9%</td>
</tr>
</tbody>
</table>

Each client in the Direct-Dispense program costs ADAP between $8-10,000/year. When they move into Medicare the annual cost drops to about $4,800/year. For 2019, there are 1,514 are Medicare clients.

ADAP Viral Load Suppression

<table>
<thead>
<tr>
<th>Month</th>
<th>Direct-Dispense</th>
<th>Insurance</th>
<th>Combined</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>April, 2017</td>
<td>84.08%</td>
<td>95.29%</td>
<td>87.49%</td>
<td></td>
</tr>
<tr>
<td>April, 2018</td>
<td>84.16%</td>
<td>96.05%</td>
<td>88.03%</td>
<td>0.6%</td>
</tr>
<tr>
<td>April, 2019</td>
<td>86.33%</td>
<td>96.16%</td>
<td>90.13%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Prescription Pickup for ADAP Direct-Dispense Clients

<table>
<thead>
<tr>
<th>Month</th>
<th>Direct-Dispense</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>April, 2017</td>
<td>85.11%</td>
<td></td>
</tr>
<tr>
<td>April, 2018</td>
<td>86.51%</td>
<td>1.4%</td>
</tr>
<tr>
<td>April, 2019</td>
<td>88.96%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>
2019-20 ADAP Expenditures vs. Funding

<table>
<thead>
<tr>
<th>Category</th>
<th>Projected Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct/Indirect</td>
<td>$9.9 mil</td>
</tr>
<tr>
<td>Medications</td>
<td>$117.7 mil</td>
</tr>
<tr>
<td>Contracts</td>
<td>$76.1 mil</td>
</tr>
<tr>
<td>Total</td>
<td>$203.8 mil</td>
</tr>
</tbody>
</table>

Direct/Indirect is comprised of personnel, fringe benefits, travel, miscellaneous direct costs (infrastructure), indirect costs for State of Florida employees statewide. Contracts consist of CVS, Broward Regional (premiums), costs of maintaining Provide Enterprise, and scanning project. The current contract with CVS is for approximately $20.5 million. The contract pays for co-pay deductibles for all clients and most recently, the emergency refill program. It was emphasized that administrative costs for contracts were minimal.

Members expressed concern about cuts in ADAP. Instead, it was suggested that the HIV/AIDS Section look at expenditures across the board to look for other cost saving measures before making any changes to ADAP funding. It was also suggested that the methodology for cost projections be examined.

Rebate Return on Investment Ratio

<table>
<thead>
<tr>
<th>Month</th>
<th>Premiums</th>
<th>Co-Pays/Deductibles</th>
<th>Combined</th>
<th>Rebates Received</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>$9.2 mil</td>
<td>$10.2 mil</td>
<td>$19.4 mil</td>
<td>$41.7 mil</td>
<td>2.14</td>
</tr>
<tr>
<td>2017</td>
<td>$20.4 mil</td>
<td>$10.6 mil</td>
<td>$31 mil</td>
<td>$52.5 mil</td>
<td>1.69</td>
</tr>
<tr>
<td>2018</td>
<td>$35.8 mil</td>
<td>$11.7 mil</td>
<td>$47.5 mil</td>
<td>$57.7 mil</td>
<td>1.21</td>
</tr>
</tbody>
</table>

In 2017, the eligibility criteria were expanded to include 100-400% of the federal poverty level. In addition, the number of plans increased from 11 to 27. Some of the plans were not as cost-effective but did increase access to clients, especially those in rural areas. As a result of these two factors, the return on investment ratio decreased from 2.14 to 1.69. In 2018, the number of plans increased to 33 plans and ratio was further reduced to 1.21.

Specialty Pharmacy Model

The Specialty Pharmacy Project is a 2-year project with CVS Health Specialty Pharmacy aimed at improving client access to ADAP drugs. It is anticipated that clients served in this project will recognize additional benefits and services. Clients will have greater access points, see shorter turn-around times for their prescriptions, and will receive medication adherence services, which includes advice on limiting and managing side effects, dosage and administration checks, changes to a client’s treatment plan, safety tips and preparing for an emergency, etc. The term of the project is 24 months, from 4/1/2019 – 3/31/2021.

Approximately 5,500 current uninsured ADAP clients will be transitioned into the project. The clients are currently served by Central Pharmacy or the Florida Department of Health in Orange County.

All current prescriptions will be transferred to the Specialty Pharmacy in Monroeville, PA. New prescriptions issued by Providers in counties typically served by Central Pharmacy or in Orange County will be able to be electronically submit directly to the CVS Specialty Pharmacy in Monroeville, PA to be filled.

Laura Reeves clarified that there are currently two CVS contracts. The first contract was competitively procured to serve as the State of Florida Pharmacy Benefits Manager. The second CVS agreement is the Specialty Pharmacy Model.
Timeline for Implementation
April 1, 2019 – Begin Specialty Pharmacy Project
June 30, 2019 – Complete transfer of clients' active prescriptions
July-September 2019 – Client’s select delivery location
October 2019-January 2020 (Anticipated) – Evaluate Specialty Project and obtain client feedback
February-October 2020 (Anticipated) – Start competitive procurement proves for revised Specialty Pharmacy Model
January 2021 (Anticipated) – Begin long-term contract for revised Specialty Pharmacy Model

A question was asked regarding the cost savings recognized from moving prescriptions from the Central Pharmacy to the Specialty Pharmacy Model. The HIV/AIDS Section is uncertain of the cost savings at this point. The impetus for moving to the model was to reduce wait times for prescription fills for clients and increase access. Concerns were raised that there was not a cost analysis conducted prior to moving to the Specialty Pharmacy Model.

The project will work under a replenishment model, where the drugs are still purchased at 340B or sub-340B prices by Central Pharmacy. However, the drugs will not be shipped to Central Pharmacy. Rather, they will be shipped from the wholesaler to the CVS Specialty Pharmacy in Monroeville, Pennsylvania. Dispensing fees for CVS will costs approximately $4.9 million over the two-year period. In contrast, the Emergency Fill Program cost the program $14 million. These costs were largely due to delays in clients receiving medications from the Central Pharmacy. It is anticipated that the move to the Specialty Pharmacy Model will eliminate these delays.

This program will not replace other hurricane contingency plans for medication pick-up. It was suggested that this information be communicated to clients. The HIV/AIDS Section to work on messaging to ADAP clients regarding hurricane contingency plans.

Providers will be able to e-prescribe to CVS once the program has been implemented. The HIV/AIDS Section is working to establish messaging to providers and clients to ensure that the right pharmacy is selected.

For an complete overview of the Specialty Pharmacy Project Overview, please click here.

Finally, Jimmy asked that PCPPG members review the tiering of the ADAP Formulary and provide comments to the Medication Access Committee.

Public Comments
Q: Did Legislative Budget Request include the proposed reorganization of Patient Care Networks and how will those proposed changes affect the distribution of monies to the local areas?
A: The Legislative Budget Request was done at the agency level. Decisions are made by the HIV/AIDS Section on how those funds are distributed. The Mercer Report is a separate issue and deals with the methodology to provide funding to local areas.
Q: What is the method of evaluation to assess the effectiveness of these programs that are implemented?

It was asked that clarification be provided by the PCPPG Co-Chairs as to how the group will make decisions (consensus vs. voting).

One member expressed concerns over any potential cuts to the ADAP Program. They strongly encouraged the HIV/AIDS Section to review the entire system to look for inefficiencies and hold ADAP harmless. The member explained that if there were any cuts made to ADAP that there would be protests from advocacy groups.

The PCPPG Executive Committee agreed to meet after the face-to-face committee meetings.
Face-to-Face Committee Meetings
The Co-Chairs of each of the standing committees provided a brief introduction of their committee purpose and current projects. The Patient Care and Prevention Planning Group committees then met face-to-face to discuss key committee issues and confirm standing committee call dates/times.

Day One of the meeting was adjourned at 5:30pm.
Wednesday, May 15, 2019
The meeting was called to order at 8:35 a.m. by Riley Johnson, Prevention Community Co-Chair. Roll Call was conducted by Riley Johnson and quorum was established.

The moment of silence was dedicated to Shelley Taylor-Donahue, Mark Curtis-Jones, and all those who have been affected by HIV/AIDS. Laura Reeves announced that the updated Case Management Guidelines will be dedicated in memory of Shelley Taylor-Donahue.

**Committee Report Out**
**Statewide Quality Management Committee** (Robert Bobo)
The committee voted to move from under the umbrella of the Florida Comprehensive Planning Network (FCPN) to become statewide workgroup reporting directly to the HIV/AIDS Section. The new structure will include a DOH nurse and Community Co-Chair.

**Coordination of Efforts** (Timothy Dean and Joey Wynn)
The committee discussed the format of the concurrence session. They are also working with the HIV/AIDS Section to update HIV Continuum Dashboard. The VMSG (Vision, Mission, Services, and Goals) Dashboard Public Health Performance Management System was reviewed. The tool will be used to track progress towards the goals and objectives outlined in the State of Florida’s Integrated HIV Prevention and Care Plan (2018-2021). The committee will work on strategies for ending the epidemic in preparation for a presentation at the Fall 2019 FCPN meeting.

**Medication Access Committee** (Dan Wall and Sharon Murphy)
Notion of the tiering of medications was discussed. Based on the discussion that took place, Dan Wall made a motion that HIV/AIDS Section work with the FCPN to explore all other cost cutting measures and efficiencies beginning with administration and overhead costs, then looking at all other services provided by the Section, before exploring the cost cutting-measures for primary medical care and prescription drugs, including the establishment of tiers on the ADAP Formulary. The HIV/AIDS Section to provide recommendations within 120 days and Ken Bargar seconded the motion. The motion was unanimously accepted.

The group agreed to a deadline of October 1, 2019 for the HIV/AIDS Section to provide recommendations and present at Fall 2019 meeting. The HIV/AIDS Section to provide a more detailed timeline. The discussion will happen over email and webinars before the next FCPN meeting.

The committee will begin the review the tiers in concert with the additional meetings with the HIV/AIDS Section. Dr. Beal to provide the Medication Access Committee with additional information regarding the rationale used to tier the medications.

The HIV/AIDS Section is working to respond to a request to address the issue of providing drug samples to county health departments.

The committee agreed that the ADAP Formulary Review Subcommittee will be moved to report directly to the section. The Medication Access Committee will still be connected to the ADAP Formulary Workgroup through the Medical Director of the HIV/AIDS Section.

**Membership, Nominations, and Bylaws** (David Brakebill and Ken Bargar)
The committee discussed the issue of community members who serve as committee chairs. Per the current contract with The AIDS Institute community members are not supported to attend face-to-face meetings. The M, N, and B committee would like input from the full-body membership on whether community members and FCPN alternates should be allowed to serve as the chair of a standing committee. Members are asked to provide comments to Brandi Knight at brandi.knight@flhealth.gov.

The M, N, & B Committee decided that in lieu of a FCPN brochure, the committee would develop a FCPN Frequently Asked Questions (FAQ) sheet.
The M, N, & B Committee proposed a face-to-face orientation for newly seated members beginning Fall 2019. The proposed orientation would take place the morning before day one of the FCPN meeting and new members would be paired with a mentor for the meeting.

As previously discussed, Statewide Quality Management Advisory Committee to move out from under the FCPN and become a workgroup reporting directly to the HIV/AIDS Section. The change is requested due to the requirement that Clinical Quality Management include participation by clinicians. Currently, FCPN membership alone does not contain the required clinical expertise to serve on the workgroup. FCPN members are still welcomed to become a part of the Statewide Quality Management Workgroup. The Bylaws will be reviewed and updated to reflect that participation on an FCPN standing committee or HIV/AIDS Section workgroup is required. The Chair(s) of the HIV/AIDS Section workgroups will provide updates to the full-body membership of the FCPN at each face-to-face meeting.

Clarification was provided on whether the group was operating under consensus or by voting. All motions require a vote. Otherwise the group will operate under consensus. A question was raised about what happens in the event that the group does not reach consensus. Does the HIV/AIDS Section get to decide?

The M, N, and B Committee will review and make suggestion on proposed changes to Article 3—Members, Section 7—Duties and Responsibilities and Article 5—Meetings, Section 3—Conduct of Meetings based on the previously mentioned discussion.

The group voted by consensus to accept the current proposed changes to the Bylaws. **The AIDS Institute to update the proposed PCPPG Bylaws to reflect the changes approved during the meeting and distribute to FCPN members**

**Needs Assessment Committee (Joe Parramore for Earl Hunt and Alelia Munroe)**
The statewide 2019 HIV Care Needs Assessment will be opened electronically by Friday, May 17, 2019. The survey will close on July 22, 2019*. Paper copies will be distributed to the Lead Agencies, HAPCs, and Part A recipients with postage paid return envelopes. The goal statewide is to gather approximately 2,900 completed surveys.

*post meeting, the end date for the survey was extended to July 26, 2019.

**HIV Prevention Update**

**Mara Michniewicz, M.P.H., Prevention Program Manager**

There was a brief discussion of the Ending the Epidemic.

Mara provided information on 2018 HIV testing highlights, 2018 PrEP highlights, and High-Impact Prevention (RFA 18-001)

**2018 HIV Testing Highlights**

- Total of 341,563 PS18-1802 supported HIV tests conducted
  - 2,969 persons diagnosed with HIV (0.9% positivity)
  - 1,874 new HIV diagnoses (0.6% positivity)
- Added 50 registered HIV testing sites
- Central Office conducted 68 rapid HIV testing trainings and certified 751 HIV testing counselors
- Approximately 86 HIV 500/501 trainings and 122 HIV 501 Update trainings conducted by field staff
- Progress related to electronic ordering and resulting of HIV tests/results from community-based providers
  - Over 40 high-volume testing sites successfully retrieved test results securely with no paper mail
  - All CHDs currently have electronic lab ordering (ELO) and electronic lab resulting (ELR) capabilities
  - ELO/ELR through the HIV testing application (CTLS2) expected to go live Summer 2019

Mara highlighted the public/private testing partnerships which include:
Gilead FOCUS Project

- In 2018:
  - Over 102,300 HIV tests (1.6% positivity, 84% linked to care)
  - Over 83,690 hepatitis C (HCV) tests (4.3% positivity, 70% linked to care)
  - 13 partners with 26 locations
- In 2019, 16 partners with 30 locations

DOH does not receive Gilead funds but supports the project with in-kind contributions (e.g. funding for linkage specialists).

2018 PrEP Highlights

- As of December 31, 2018, 67 of 67 (100%) CHDs have provided PrEP services to clients
- Total of 38 community-based high-impact prevention (HIP) providers funded
  - As of December 31, 2018, 21 of the 38 (55%) providers reported 3,185 PrEP referrals and 756 clients receiving PrEP
  - During this same period, 10 of the 38 (26%) providers reported 132 nPEP referrals and 108 clients receiving nPEP
- Launched new Health Management System (HMS) PrEP reports and trainings for CHDs (December 2018)
  - PrEP Template
  - Clinical Decision Alert for PrEP

There has been a steady uptake of individuals receiving PrEP throughout Florida. Not everyone who received an initial PrEP prescription came back for refills. There are multiple explanations for why this could occur. The important thing to reinforce with clients is that they should be taking their PrEP medication regularly.

On May 9, 2019, Health and Human Services Secretary Alex Azar announced that the Trump Administration had reached an agreement with Gilead Sciences to donate up to 200,000 uninsured individuals PrEP medication annually through 2030. Gilead would begin by donating Truvada® until Descovy® is approved by the Food and Drug Administration (FDA) for PrEP use. From that point forward, Gilead would continue to donate Descovy® until the eleven-year time frame expired or until a generic form of Descovy® becomes available.

The HIV/AIDS Section is seeking funding for PrEP navigators. Also, to increase access, five providers are currently offering telehealth for PrEP.

High-Impact Prevention (HIP) RFA 18-001

- Awarded 44 applicants (out of 64 responsive applications) a total of approximately $10 million.
  - 5/44 Category 1: Community Outreach, Engagement, and Education
  - 6/44 Category 2: HIV Testing and Linkage
  - 33/44 Category 3: Comprehensive Prevention Services
- HIV testing: 40 out of 44 providers
  - 32/44 Prioritized Testing
  - 8/44 Routine and Prioritized Testing
  - 15/44 Integrated STI Screening
- PrEP/nPEP
  - 40/44 Screening and Referrals
  - 15/44 Provision
- Social Media, Marketing:
  - 37/44 conducting social media posts, digital ads and/or out-of-home advertising
- Condom Distribution (44/44 providers)
- Prevention with Positives:
  - Anti-Retroviral Treatment and Access to Services (ARTAS), the behavioral intervention Choosing Life: Empowerment, Action, Results! (CLEAR), peer/patient navigation services, Partnership for Health, medication adherence counseling, Healthy Relationships
- Prevention for High-Risk Negatives:
Mpowerment (young gay and bisexual men), Community PROMISE, risk reduction counseling, Cognitive Behavioral Therapy, Personalized Cognitive Counseling, Brief Group Counseling

- Hispanic: 30/44
  - Hispanic MSM and Transgender: 24/44
- Black/African-American: 41/44
  - Black/African-American MSM and Transgender: 34/44
- White: 25/44
  - White MSM and Transgender: 25/44
- Youth Programs: 4/44
- Minority Organizations: 17/44

A map was presented to illustrate HIV diagnoses by county, registered testing sites, and funded HIP providers. As a point of clarification, the number of testing sites includes county health departments and may include multiple testing sites of any given CHD because of unique testing site numbers. It was suggested that the map be revised for external stakeholders to reflect actual locations (i.e. count each CHD once).

To view the entire presentation and for specific demographic information related to HIV testing and PrEP, please click here.

Update from 2019 National HIV Prevention Conference
Mara Michniewicz, M.P.H., Prevention Program Manager
David Brakebill, Area 11B Patient Care Representative
Joey Wynn, Area 10 Patient Care Alternate

CDC’s National HIV Prevention Conference was held March 18-21, 2019 in Atlanta, GA. The conference gathered more than 3,000 HIV stakeholders to share and discuss refining, improving, and strengthening the nation’s response to HIV.

DOH Central Office staff and CBO from Florida, along with representatives from Texas, New York, Puerto Rico, and Houston were invited to participate in a pre-conference meeting on Sunday, March 17, 2019 to discuss prevention efforts among Hispanic/Latino men who have sex with men (MSM) and trans-Latinas. The group was charged with providing recommendations for ending the epidemic in their respective state/jurisdictions based on the pillars outlined in the Ending the Epidemic (ETE) Plan. The following were the recommendations provided:

Diagnose
- Request that CDC revised PS 18-1802 Prevention funding guidelines to increase the amount of funds that are allowed to be spent on STD screening. Currently only allowed to spend 5% of funds for STD screening
- Developing a heat map showing the locations of registered HIV test sites in the top seven most affected counties as identified in the ETE Plan
- Measuring the uptake of HIV testing among Latinx populations, specifically Hispanic MSM and trans-Latinx

Protect
- Developing a Hispanic led and tailored awareness/education campaign specifically for Hispanic MSM and trans-Latinas.

Treat
- Exploring the use of culturally competent linkage staff in CBOs
- Increasing information on transgender services on the state’s AIDS hotline (1-800-FLA-AIDS).

David Brakebill noted that there was a presence of care providers at the conference. This differed from prior years. David highlighted a study that took place at the University of Washington Emergency Room. The basis of the study was if a person presented in the ER and was identified as a person living with HIV, an alert was initiated to ensure that the person was in care. If the person was identified as not being in care, they were linked to care through the ER.
The HIV Care Continuum for individuals who received Ryan White services was presented and indicated that 90% of persons are virally suppressed.

Joey Wynn noted that top leadership from HRSA, SAMSHA, NIH, and the CDC were in attendance for the entire meeting. Joey emphasized that the Ending the Epidemic Plan was one component of the National HIV/AIDS Strategy (NHAS) and that the national strategy will continue to be updated.

It was also announced that Carl Schmid, The AIDS Institute and Rafeale Narvaez, Latinos Salud have been appointed to the Presidential Advisory Council on HIV/AIDS (PACHA). Carl Schmid serves as Co-Chair of PACHA.

For additional information about the conference, please [click here](#).

**National Strategy/Plan to End the HIV Epidemic by 2030**

*Laura Reeves, Administrator, HIV/AIDS Section*

*Michael Ruppal, Executive Director, The AIDS Institute*

The interactive session discussion of the National Strategy in relation to the current Integrated HIV Prevention and Care Plan, identification of key activities that need to remain and be the focus for the next two years.

Laura reviewed the 2017 HIV Care Continuum for Florida

![HIV Care Continuum Chart](image)

- 88% of the 4,949 persons who received an HIV diagnosis in 2017 had documented HIV-related care within 3 months of diagnosis.
- 75% of the 4,949 persons who received an HIV diagnosis in 2017 had documented HIV-related care within 30 days of diagnosis.
- 83% of PLWH in care had a suppressed viral load in 2017.
- 86% of PLWH retained in care had a suppressed viral load in 2017.
- 25% of PLWH were not in care in 2017.

Michael Ruppal stated that although the Ending the Epidemic Plan was just announced during the State of the Union address, work has been happening behind the scenes for over a year. The CDC will be issuing two funding opportunities related to Ending the Epidemic. The first funding opportunity will be 2019 using existing dollars to get the Plan started and will be sent directly to the targeted jurisdictions. The second is a five-year cooperative agreement notice of funding opportunity which will be larger sum of money ($291 million) for 2020 budget that would begin October 1, 2020 (Year 1). Monies are to be used to engage in activities that are effective and each state will have their own set of responsibilities. Year 1 is dedicated to ramp-up, planning, innovation, and starting programs that are replicable around the country. It is anticipated that over $500 million will be allocated in Year 2. Funds are contingent on how effective Year 1 activities are.
The FCPN membership was asked to provide new and innovative ideas to spend additional funds that will be targeted at the seven counties in Florida (Broward, Duval, Hillsborough, Miami-Dade, Orange, Pinellas, and West Palm).

Michael Ruppal requested questions from the membership. The following questions were asked:

Q: How do dollars flow, do you know specifics?
A: HRSA plans to use the Part A recipients to get monies to the targeted jurisdictions. Based on recent information, CDC is joining HRSA to get those dollars to the same planning bodies. Some of those entities have not dealt with prevention in the past.

Q: Has there been any dialogue with the Part A to date?
A: Many of the Part As have not received any information yet. Dr. Laura Cheever, HRSA, is aware of this and are working to get information to the jurisdictions as fast as HRSA is getting it. There have been hold ups in operationalizing the Plan. During a recently held HRSA webinar on the ETE Plan, it was announced that HRSA would be visiting each of the jurisdictions in the summer 2019. Laura reported that she was aware of a CDC visit to Miami in late July 2019.

Two Florida projects have been identified as national best-practices by the CDC. The first is the FOCUS Initiative, which began in Homestead, and the other is Florida Partnerships for Care (P4C) which was a collaboration between HRSA and the CDC. HRSA funded the community health centers and Department of Health funded the prevention portion. It is believed that the CDC site-visit is targeted at those programs and not what the jurisdiction is doing.

During the HRSA listening session, it was announced that Federally Qualified Health Centers (FQHCs), as well as Community Health Center look-alikes, in the areas they had designated and prioritize the ones that already receive Ryan White funding since those funding mechanisms were already in place.

Q: Will there be mechanism get support for sustained viral load suppression (e.g. support for housing)?
A: The current focus is on medical support and on the medicalization of PrEP. Housing was an outlier in their planning process. Housing is important, as well as the other social determinants of health. They are working to build in flexibility since the monies will not have the same constraints as Ryan White dollars. Hoping that when money hits, that it can be used to support sustaining viral load suppression. The same holds true for mental health services. It has also been requested that there be increased flexibility for 340b dollars.

Q: In the current budget proposal, there was a $170 million cut proposed to Housing for Persons Living with AIDS (HOPWA) dollars. This plan will requires more staffing. How will the staffing issue be addressed?
A: We’re reading it as there’s more workforce to do this. At the federal level, they will have more positions to place in the targeted jurisdictions to help support implementation of the EHE Plan. There is also the issue of losing medical providers. There are plans work with medical schools to recruit more infectious disease specialists but how the workforce development will happen is still being worked out. New benchmarks to show that money is being used properly and are effective.

Q: Keeping existing infrastructure in mind, could this be an opportunity to build on best-practices already in place? Should we be looking at cost-effectiveness across the board? For example, what does it cost to do case management in Orlando vs. Tampa?
A: The HIV/AIDS Bureau (HAB) has assembled consulting team on data management. They realize that local jurisdictions need data that is timely and manageable but we need your input on what information you will want to receive.

Q: Where is the opportunity for private partnerships? What can we start leveraging?
A: We need those partnerships to engage in the new and innovative projects that are expected. For example, Gilead is willing to provide advertisements that can be customized to an organization.

Q: Are you involving the groups that are highest impact with highest rates of cases?
A: This is why replicable programs are essential. There needs to be a mechanism to disseminate the information. We need to think about how the personalities of the individual jurisdictions and targeted populations differ.

Q: With innovation in mind, how are the Centers for AIDS Research (CFARs) being incorporated into the Plan?
A: An important part of the Plan are the monies that will go to the National Institute of Health (NIH) for increased research. CFARs are an important component over next 10 years. There are talks about using a different model for the CFARs.

Q: How to track who’s going on and off PrEP?
A: Zero Pinellas project asked for that to be added to their data collection process. This information will be used in their prevention program summary

Q: How do PrEP injections and other generic options affect the new conversation?
A: The Florida Insurance Commissioner announced that all HIV drugs approved except for new injectable which in not yet approved. More conversations need to take place because this has a huge financial impact. Another issue that will have a huge financial impact is with increased testing and identification of more cases, more people will require assistance. The Ryan White system cannot absorb all of costs.

Q: Why are Florida’s new diagnoses twice the rates of California and significantly higher than New York? Would that help us figure out money and what we’re doing wrong or not quite doing right?
A: We just started doing PrEP this year and recently started Test and Treat. California and New York have been doing those activities for a while. So, part of the issue is that Florida is behind in implementing activities and have not yet reached a point were noticeable improvements can be seen. It is not the only reason but it certainly should be part of the discussion. We must also realize that we are in the deep south and that stigma plays a huge role. Also, we only talk about four key components but really there are five, if you include molecular surveillance to identify clusters of new HIV cases. It should be noted that Florida is ahead of other states in this regard.

Q: How is administration rationalizing giving money to this Plan but also cutting things like Medicare, Medicaid, and Affordable Care Act and other things that run contrary to the Plan?
A: There is no direct rationalization. Some items are politically motivated and others are staff trying to do the right thing. We’re trying to reconcile this. It’s complicated right now.

Q: What’s the plan, we have all this money in these 7 counties in Florida? What about the other counties? What is the plan to get information on what works to other counties?
A: The first year the focus is on these counties, but as money increase each year, the plan is to spread outside those counties and make it nationwide. Laura emphasized that the FCPN forum should be utilized to share information on what is happening in the seven targeted counties and best-practices. There should also be coordinated effort in the seven counties to share information among themselves.

The following comments and recommendations were made by meeting participants:

- The Miami-Dade Part A requested a meeting with HRSA and all the impacted Florida jurisdictions. HRSA’s response was that they did not have the time to engage in a meeting at this time. It was asked that the HIV/AIDS Section reach out to HRSA and request the same meeting.

  The HIV/AIDS Section to coordinate a meeting with all Part A recipients and invite federal representatives to attend. HIV/AIDS Section to also schedule regular conference calls with the Part A recipients to share information freely.

- It was suggested that targets be established for each jurisdiction. For example, Orange county needs to increase PrEP uptake by 300 people annually.

- We need more hand-holding for people not receiving care. Hospitals and ER need more education because they’re not interested in routine HIV testing. Need more involvement of
medical community and that has to come from the top down. The AIDS Education and Training Centers (AETCs) will play an integral part in the Plan.

- Miami’s Getting to Zero Project is a resource that can be utilized to determine what’s going well and where the challenges are. Also, utilizing the fast-track cities around the country that have recognized successes as a resource.

- We need to do more research on why individuals do something other than what we had hoped. Why do people drop out of care? Need to address the systemic barriers such as long wait-times as it’s a dehumanizing experience. Resources are being utilized to bring individuals back into care but the system is not working for them so they fall out of care again.

- Why do people decline PrEP? In some instances it is because you are asking them to engage in a healthcare system that is time-consuming and dehumanizing. We also need a better grasp on why people are stopping their use of PrEP. It’s not always a negative. For some it is because they are no longer in a situation where PrEP is needed. That should not be viewed as a failure but rather as a person understanding what their risk factors are.

- Treatment as prevention is just as important as PrEP in preventing new HIV infections. Directly observed therapy was suggested as an option.

- Criminalization of HIV is a barrier to people getting tested. Need to do more work with getting the laws in Florida changed.

- Suggest that we work more to make sure Medicaid providers are included in the discussion because they are a significant player in the eliminating HIV. The U.S. Preventive Services Task Force (USPSTF) recommendation for PrEP is forthcoming. If it is an “A” recommendation, perhaps we could get more private medical providers involved. Also, if there was a Healthcare Effectiveness Data and Information Set (HEDIS) measure implemented around HIV testing and PrEP, that might encourage participation by private medical providers.

- The focus has been on building the Infectious Diseases workforce. It was pointed out that HIV is a Family Practice, Internal Medicine, and Primary Care illness now. In the seven targeted counties, we need to involve our University partners to help them understand the responsibility of routine HIV testing and HIV testing in pregnant women. Until we do so, we are not going to get a handle on ending the epidemic. Continuing Education is also critical.

- Housing and substance abuse are key issues that need to be addressed. For many people HIV is not their first concern.

**Patient Care Discussion**

Clayton Weiss, M.P.H., Patient Care Program Manager

Clayton Weiss facilitated a discussion on program updates, issues and concerns related to Housing Opportunities for Persons Living with AIDS (HOPWA), Patient Care Networks, and Ryan White Allocation Methodology

**HOPWA**

It was reported that there has been a slight decrease in overall HOPWA utilization between 2015-2017. In 2015 we served 1,457 households, 1,407 households in 2016, and 1,402 households in 2017. There have been decreases in some services where utilization has increased. For example, short-term housing program and tenant-based rental assistance (TBRA). There have been decreases in short-term rental and mortgage assistance.

HOPWA services are set up for large metropolitan areas that are lined up with Part A service areas. These programs are not funded by state HOPWA Program but receive their HOPWA funds directly from Housing and Urban Development (HUD). There are six areas that are considered growing counties by HUD: Deltona (all of Volusia and Flagler County), Palm Bay (all of Brevard County), Port St. Lucie (all of...
St. Lucie and Martin County), Cape Coral (all of Lee County), North Port (all of Manatee and Sarasota County), and Lakeland (all of Polk County). Funding for these areas are re-designated to the state. In addition, there are smaller less populated areas that receive state HOPWA dollars.

Florida receives roughly $4 million a year for the HOPWA program for the smaller less populated areas and an additional $3.7 million for the re-designated areas.

In addition to housing, there are a number of supportive services funded by HOPWA. Adult-day care and personal assistance, alcohol and drug abuse services, child-care, and educational services, employment assistance and training, life-skills management, mental health services, and transportation.

The upcoming HOPWA procurement will integrate these services and allow for more collaboration with entities that receive Ryan White funding. There is also an opportunity to include project-based rental assistance which is tied to a specific project or facility.

Clayton solicited feedback from the group on their level of involvement with HOPWA programs and opportunities for better collaboration between the Ryan White Program and HOPWA.

The following comments were made:

- Area 3-13 reported that a HOPWA representative is present at every consortia meeting and that the two groups work very well together.
- Area 11B suggested that the HIV/AIDS Section have a conversation with Scott Pridgen, AIDS Help in Key West and the National AIDS Housing Coalition. Key West has done a great job with project-based building projects.
- Area 2A reported that it was easy to maximize the resources of both programs. They have a working relationship with the Public Housing Authority. More opportunities to get stable housing for people. One of the challenges faced is that a lot of organizations don’t want checks, they want a credit card. Agencies have the capability of doing that if it’s permitted by their contract manager, HAPC, and the State.
- Area 2B is running it out of housing funds. There will be whole month for which they will not be able to provide services. Affordable housing is limited in the area because it is situated in the university community. There is currently a waitlist for TBRA.
- Area 11A suggested asking the six cities for copies of their contracts to demonstrate how their contracts are developed with local providers.
- Q: Is Ensure considered a drug or nutritional service?
  A: Nutritional services include food banks, nutritional supplements, and counseling on proper nutrition by a certified nutritionist.
- Q: Years ago, there was a program where the state would purchase Ensure and drop-ship it to agencies where it could be distributed directly to clients. Could that be considered again?
  The HIV/AIDS Section to research the previous TB model for providing nutritional supplements and consider replicating.
- Area 12 did reach out to Monroe county and are developing better relationships to expand services. The email sent last week about diminishing lifelong ban on sex offenders was great news and will help clients find housing.
- Q: What educational services are allowed?
  A: Education services that are allowed include: GED classes, job training/coaching to include resident development, English as a second language classes, literacy, any under health education classes, education services including instruction and training in consumer education.
- Q: In the email that was distributed it stated that TBRA funds could be used to service people who have no income. It was also stated earlier that HOPWA money had to be spent in one year. Are the two related and will we have money to sustain these individuals after 1 year?
  A: The non-reoccurring funding authority is for the big cities and has to be used within 12 months. There was additional $4.9 million in recurring authority to enable the program to spend the full $7.4 million.

Patient Care Networks
Clayton reviewed the Patient Care Network maps. First, the maps outlining the HIV Patient Care Networks (per Florida Administrative Code) and current HIV Patient Care Consortia were discussed. Next feedback was solicited from members on two new proposed Patient Care Area maps.

Proposal 1 aligns with Part A and B service areas and HOPWA re-designated areas.

**Area 1**, Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, Jefferson, Madison, Taylor (18 counties; 5,703 total PLWH)

**Area 2**, Hamilton, Suwannee, Lafayette, Dixie, Gilchrist, Columbia, Alachua, Union, Bradford, Levy, Citrus, Sumter, Marion, Putnam (14 counties; 4,223 total PLWH)

**Area 3**, Clay, St. Johns, Duval, Nassau, Flagler, Volusia, and Baker (7 counties; 9,505 total PLWH)

**Area 4**, Hernando, Pasco, Pinellas, Hillsborough, Manatee, Sarasota, Polk, Hardee, Highlands (9 counties; 18,612 total PLWH)

**Area 5**, DeSoto, Charlotte, Lee, Collier, Hendry, Glades (6 counties; 4,016 total PLWH)

**Area 6**, Lake, Seminole, Orange, Osceola, Brevard (5 counties; 14,491 total PLWH)

**Area 7**, Indian River, Okeechobee, St. Lucie, Martin, Palm Beach (5 counties; 11,116 total PLWH)

**Area 10**, Broward (20,661 total PLWH)

**Area 11A**, Miami-Dade (27,969 total PLWH)

**Area 11B**, Monroe (648 total PLWH)

Proposal 2 allows for more effective management and oversight of the Ryan White system of care at the state-level. This option also allows for the lowest level of variance of PLWH in any given area.


**Region 2**, Hillsborough/Pinellas Network: Levy, Marion, Citrus, Sumter, Hernando, Pasco, Pinellas, Hillsborough, Manatee, and Sarasota (10 counties; 17,512 total PLWH)

**Region 3**, Miami-Dade Network: Miami-Dade and Monroe (2 counties; 28,617 total PLWH)

**Region 4**, Broward Network: Broward and Collier, (2 counties; 21,656 total PLWH)

**Region 5**, Palm Beach Network: Palm Beach, Lee, Hendry, Glades, Charlotte, Highlands, DeSoto, Hardee, Martin, St. Lucie, Okeechobee, and Indian River (12 counties; 14,464 total PLWH)

**Region 6**, Orange Network: Polk, Osceola, Brevard, Lake, Orange, Seminole, Volusia, Flagler, and Putnam (9 counties; 19,298 total PLWH)

Q: What's driving the change? Why are we even talking about this, why are we contemplating this?

A: There are a couple reasons. First, there is an opportunity to better collaborate. Ryan White dollars and housing dollars as they are currently managed by two separate processes and organizations. Some are working well together. Better opportunity to provide housing and providing care in all aspects. Making sure PLWH have access to care across the board. Intent is to better collaborate and plan around those resources and not have so many distinct planning efforts that don’t really connect with one another.

It was emphasized that there was a need to ensure monitoring is in place to do this well so we can be accountable for those dollars. Each entity that receives funding has a separate contract and someone has to manage those contracts. It is 2019, our patient care areas have shifted and these artificial lines give us an opportunity to update our networks to be reflective of the current HIV incidence in our state.

Additional feedback included:

- Condensing areas means condensing the associated consortia. Since money isn’t going to be allocated in the same manner, the increased collaboration is not clear. If there is one lead agency in each of these areas there will be travel barriers.
- Huge leap of faith to think that redrawing the lines will accomplish increased collaboration. At a time where we should be coming together to end the epidemic, we are instead proposing to break relationships and ties that we are already established.
- Dan Wall made suggested to change the Patient Care Networks to align with the current HIV Patient Care Consortia Areas.
- The map affects the upcoming RFA for Lead Agencies.
- Have we looked at STD services on this map?
• Will these changes better serve the Bureau or the clients better?  
• Monroe County was the center of the HIV epidemic in Florida in the beginning. The Patient Care Networks were created at the time. Miami is a blackhole. Monroe would be lost if they were to be combined with them. It would make more sense to align Monroe with the west coast.  
• In the current Consortia structure we already have people feeling disenfranchised. The increased travel time will make it even more difficult to bring people to the table. A change would affect the Consortia’s ability to be effective.  
• The Patient Care Networks are defined in statute and based on AIDS cases. Their requirement is that each area plan and coordinate care. The Consortia are the 14 areas and are the mechanism for planning for Patient Care dollars at the local level. For each area there is Lead Agency who receives the funding for the area. They are required to do an annual budget that should be based on needs assessment.  
• Q: Since the money isn’t being allocated through the networks anymore, why don’t we throw the law away? If we go with Proposal 2, would we have only 12 people around this table? We would lose a lot of diversity.  
• A: The people in this room can decide that. Representation in this room doesn’t have to follow those maps.  
• Area 11B needs its own money. Easy to use electronic platforms for meetings to increase participation across the state.  
• Consolidating could leave more money for patient care. This new approach could have some flexibility and have a positive impact on the system.

An ad-hoc committee was formed to work on the Patient Care Network map. Members interested in serving on the ad-hoc committee were asked to sign up with the FCPN Co-Chairs.

Ryan White Part B Funding Methodology – Mercer Report

The Mercer Report proposed methods for allocating Ryan White Part B funds. With the old methodology $45,000 was distributed to each area and then there was parity distribution. Any remaining funds went to Area 7 on a recurring basis.

The Mercer Report indicated that there were six guiding principles to developing an allocation methodology:

1) Fairness – equitable access to services around the state  
2) Transparency – clearly communicated and well understood by stakeholders  
3) Efficiency – funds should be used in a manner that maximize the quantity and quality of services provided to clients  
4) Flexibility – being able to accommodate changes over time  
5) Effectiveness – align programs and statewide goals  
6) Budget neutrality – distribute funds in a cost-neutral manner.

The Mercer Report provided three options for allocating funds.

1) Allocate Funds Based on Number of PLWH in Each Area. This option is straightforward and consistent with how HRSA allocates funds to states. The challenge is that this method would result in significant differences between current and future funding levels. It does not consider other funding that an area might receive (e.g. Part A funds) therefore, the money would be concentrated in large metropolitan areas. Also, there is no mechanism to account for the areas that are not spending their full allocation.

2) Allocate Funds Based on Historical Expenditures and Parity. The challenges are that this option lacks accountability and does not tie allocations to points.

3) Allocate Funds Based on Historical Expenditures, Parity and Performance. This option looks all sources of funding in an area and considers areas who are not spending their full allocation (3-year trend). And finally, this method includes incentives for performance. Challenges are that DOH must have clear and careful communication regarding the methodology to stakeholders. This methodology is not the same approach used in 2002 and performance has never been linked to funding in the past.
With time running short on the session, the group agreed to extend the discussion for 15 additional minutes.

Additional comments and feedback:
- A clarification was provided that additional funding considered would be Ryan White Parts A-D, MAI, Emerging Communities, and General Revenue only.
- It was requested that the HIV/AIDS Section provide back-up for the data provided in the Mercer Report.
- There is no discussion of the needs of the community in any of the listed options.
- There were no face-to-face meetings with stakeholder to get a better understanding of the issues of individual communities prior to dissemination of the report.
- Laura Reeves provided clarification that the topic was discussed at prior FCPN meetings and a stakeholder group of FCPN and community members were involved initially. The HIV/AIDS Section erred and did not share the final report with the FCPN prior to the meeting, however, a copy of the report will be furnished to The AIDS Institute for distribution to the membership. The AIDS Institute to distribute Mercer Report to FCPN membership.
- Funding based on performance of a Lead Agency will affect patients who have nothing to do with the performance measures.

An ad-hoc committee was formed to work with the HIV/AIDS Section to discuss the issues related to the Mercer Report. The committee will prepare a report that will be distributed prior to the next face-to-face meeting where a presentation and further discussion will take place.

Follow-up on Stigma in HIV Discussion
Christa Cook, PhD, MSN, RN & Robert L. Cook, MD, MPH

Dr. Christa Cook provided an overview of the Stigma Working Group, early analyses from the Medical Monitoring Project (MMP) data from 2015-2016, and year one final recommendations to the HIV/AIDS Section.

The mission of the Stigma Working Group is to engage community members, researchers, and Department of Health representatives to identify sources of HIV related stigma and create strategies to decrease stigma in Florida.

The Stigma Reduction Framework was presented:
- Assessment (2018)
  - Stigma Taskforce
  - Survey
  - MMP Analysis
- Prioritization (2019)
  - Populations
  - Level of intervention (Individual, Community, Policy)
  - Types of Stigma
- Specific Intervention to Reduce Stigma in Florida (Future)

Analyses of MMP Data (2015)
There were 10 questions related to stigma and participants were asked about their experiences of discrimination. Of those surveyed, 24% reported negative self-image, 49% experienced personalized stigma, 69% experienced stigma related to public attitudes, 87% reported disclosure concerns. Overall stigma was recognized by 94% of those who completed the survey.

The final recommendations to the HIV/AIDS Section were created by incorporated ideas and suggestions from:
- Stigma Task Force (phone discussions)
- Meetings with DOH team
- MMP data analyses
- Expert consultation (individuals and other states)
The following recommendations were made:

1. Expand target audiences and potential reach of DOH messaging to address HIV-related stigma and misconceptions about HIV.
   a. Ensure that social media is extended to general population as well as high-risk groups
   b. Use PLWH within messaging to present a positive image and success stories
   c. Ensure people-first language in all communications

2. Expand HIV-related stigma surveillance to under-represented populations.
   a. Identify optimal “measures” of stigma to monitor changes over time
   b. Conduct supplemental data collection among priority populations who are under-represented by the MMP survey

3. Create a publicly-available repository of existing information from DOH and local agencies related to stigma
   a. Create a website that includes DOH information related to stigma, as well as other documents from local communities or agencies (e.g. Ryan White needs assessments, community assessments or focus groups).

4. Implement structural changes to reduce the risk or perceived risk of accidental disclosure in settings providing HIV-related healthcare or services.
   a. Ensure availability of more discrete locations for receiving HIV services (e.g. not an obvious “HIV clinic”)
   b. Continue to expand access to HIV care and prevention services that are more anonymous, e.g. telemedicine, mail-order pharmacy, home HIV testing

5. Develop new trainings related to HIV-related stigma (including stigma related to PrEP and HIV testing) for all healthcare workers and staff who encounter PLWH.
   a. Training could address stigmatizing language and examples of stigmatizing behavior
   b. Training could be incorporated into other required HIV training for healthcare providers

6. Continue to explore the role of religion and religious organizations in contributing to HIV-related stigma, and also that help to reduce HIV-related stigma.
   a. Develop messages appropriate to be distributed in church settings and provide examples of positive messages provided by churches and religious organizations as examples.
   b. Consider how to address religious leaders more broadly, especially those who serve higher-risk populations, and identify religious leaders willing to help work towards HIV stigma reduction in Florida.

Next Steps 2019-2020

- Collect new data
  - Stigma examples survey (ongoing)
  - Ryan White Needs Assessment – question added
- Prioritization of populations and interventions
  - Stigma task force calls
  - Continued input from community stakeholders
- Complete several new analyses and manuscripts
  - Stigma and HIV viral suppression
  - Stigma and disability
  - Improving measurement
  - PrEP-related stigma

To view the entire presentation, please click here.
• Statewide Mobilization and MSM Coordinator, Brandon Moton has resigned. That position will be posted in the near future.
• Claudia Sanchez will serve as the Latinx Coordinator
• The Educational Review Panel has moved to the Communications and Health Equity Unit.
• National HIV Testing Day on June 27th. Considering a week-long event. (promote PrEP and the importance of viral suppression). The HIV/AIDS Section will develop promotional items for the week to drop ship to agencies.

Discussion of communication process started last fall and the flowchart below was created.

Feedback indicated a need for a more detailed plan. The purpose of the communications plan is to detail how the HIV/AIDS Section will share information with community partners, stakeholders, clients, advocates, and field-based Department staff.

A member pointed out that communication is a two-way flow of information. It was suggested that the plan and diagram be updated to reflect a two-way flow of information.

**Communications and Health Equity Unit to update to Communications Plan and Flow Chart to include how information from external stakeholders is handled.**

**Key Concepts and Principles**
- Transparency
- Community Engagement and Dialogue
- Timeliness
- Inclusivity
- Transparency

**Information Flow**
- Policy/Procedure Development
  - Program creates draft
  - Draft is shared for feedback
  - Feedback is incorporated
  - Document is routed for approval
  - Approved document is shared
- Information Dissemination
  - Internal
    - Program unit emails information within two business days
      - HIV/AIDS Program Coordinators
      - Minority AIDS Coordinators
      - Early Intervention Consultants
Prevention Training Coordinator
   - Recipient shares information within two business days
     - External Track
       - FCPN facilitator shares with listserv within two days
       - Listserv recipients share as appropriate

It was suggested that additional detail be provided on this process. The HIV/AIDS Section to add appendices to the communications plan to show how specific items are routed (e.g. policy and procedures, administrative rules, educational materials, and general information). Members also asked for definitions – various audiences, communication modes and channels, outline the internal and external process, feedback mechanism, and timelines.

Constant Contact was offered as a suggested platform for the HIV/AIDS Section to maintain a listserv for communications.

A member requested that communications to the Part A recipients come directly from the HIV/AIDS Section and not through a third-party. It was noted that Part A was missing from the list of individuals that the program unit distributes information to.

Communications plan to be updated to add Part A recipients to the list of “internal track” members.

HAPCs were asked to provide feedback on communications and the following suggestions were made:
   - Messaging in plain language
   - Utilize press release templates
   - The AIDS Institute has been efficient in disseminating information.

Laura Reeves asked that members forward local communications plans to the HIV/AIDS Section as examples. Laura also clarified that due to the Sunshine Law, The HIV/AIDS Section cannot communicate directly with an advisory body. All communications must be handled through a third-party.

It was requested that a regular calendar of events be shared by the HIV/AIDS Section. The HIV/AIDS Section will research the ability to share their calendar of activities on the HIV/AIDS Section website.

Q: What is the HIV/AIDS Section’s process for translating materials and double-checking to ensure that there are no errors?
A: The HIV/AIDS Section contracts an agency for all translation activities. The HIV/AIDS Section does utilize its own staff to review. Members were asked to report back to the HIV/AIDS Section if materials distributed contained errors.

Q: What was done with the information and feedback on the PrEP campaign?
A: Feedback was summarized by the HIV/AIDS Section and provided to Evoke.

It was strongly encouraged that the Sunshine Law be reviewed by the HIV/AIDS Section. A member noted that the Sunshine Law does allow for one-way communication.

Public Comments
   - Ken Bargar announced an upcoming Florida HIV/AIDS Advocacy Network (FHAAN) scheduled for Monday, May 20, 2019. Ken invited anyone who was interested in joining the group to please contact The AIDS Institute to be added to the FHAAN distribution list.
   - The voice of the HIV community is missing from the decision-making process.

Day two of the meeting was adjourned at 5:15pm.
Thursday, May 16, 2019
The meeting was called to order at 8:33 a.m. by Riley Johnson, Prevention Community Co-Chair. Roll Call was conducted by Riley Johnson and quorum was established.

Jim Roth, DOH Co-Chair, thanked the NAMES Project for providing the quilt displays at the meeting. The quilts were supported by Clear Health Alliance.

Riley Johnson requested a moment of silence for those who have and passed from and those affected by HIV.

Concurrence on Integrated Plan Changes
Brandi Knight, M.P.H., Performance and Quality Manager & Kassandra McGlonn, M.S., Integrated Planning Coordinator/ Clinical Quality Management Liaison
The packet has the final version but the one on the screen isn’t the final one. There was some confusion because the pages don’t line up.

The HIV/AIDS Section announced that they have completed the review and editing of the State of Florida’s Integrated HIV Prevention and Care Plan’s Activity Table. The following is a breakdown of the edits made:

- NHAS Goal 1: Reducing New HIV Infections – 23 activities were removed and 17 activities modified. No strategies were affected.
- NHAS Goal 2: Increasing access to care and improving health outcomes for persons living with HIV (PLWH) – 22 activities were removed and 19 activities modified. One strategy was modified.
- NHAS Goal 3: Reducing HIV related disparities and health inequities – 11 activities were removed and 5 activities modified. No strategies were affected.

Activities that were removed were either redundant or a part of normal operations. The activities modified were adjusted to ensure that the activity was quantifiable and clearly indicated the person(s) responsible.

The plan was based on 2014 baseline changes.

There were concerns that certain items were eliminated entirely. It was suggested that the HIV/AIDS Section prepare a one-page summary of where items were moved or noting that the item was eliminated.

The HIV/AIDS Section to work with The AIDS Institute to distribute a one-page Executive Summary outlining all edits proposed to the Integrated Plan’s Activity Table. This information will be distributed to the full FCPN membership Concurrence Process.

There was a concern raised that there were no activities related to the transgender population. It was explained that things have changed since the Integrated Plan was first submitted and the group needed to discuss the next steps in incorporating those changes. The HIV/AIDS Section proposed using a portion of the Fall 2019 FCPN meeting to discuss the items that need to be added to the Integrated Plan moving forward.

The following feedback was offered:

- A feedback mechanism from the local areas on their local level progress towards goals and objectives needs to be established.
- Local areas are supposed to fund activities. The HIV Care Continuum Dashboard is one mechanism to see where gaps at the local level may exist.
- The Local Highlights Template should be updated to include information on specific items that the HIV/AIDS Section would like to gather local level information from.
- Do not include actual names in the Activity Table.
- Should the plan include Ending the Epidemic plan? For example, currently there are specific items in the Activity Table targeted at Miami and Broward. Should those items be expanded to include the seven targeted jurisdictions in Florida?
Use of the VMSG (Vision, Mission, Services, and Goals) Dashboard Public Health Performance Management System will help track progress on the Plan at both the state and local level.

A member suggested that an appendix be added to the Integrated Plan that includes a process map for planning for each of the 15 local areas.

The HIV/AIDS Section gathered information from the membership on how local planning done.

Area 11A – There is a Strategic Planning Committee that reviews the Plan on a monthly basis and updates the Plan accordingly. Dan Wall invited the HIV/AIDS Section to participate in those meetings.

Area 5/6/14 – Planning and Evaluation Committee meets every month and review of the Integrated Plan is a standing agenda item. Every six months gather data on the performance metrics.

Areas that do not have a Part A recipient use the State’s Plan for planning purposes per contractual agreement.

If gaps exist in the Plan, FCPN members should discuss how to fill those gaps.

The HIV/AIDS Section requested that a large portion of the Fall 2019 be utilized to engage in additional planning in order to update the Integrated Plan Activity Table. Local areas are requested to review the Activity Table and indicate which activities are being conducted at the local level prior to the Fall meeting.

The HIV/AIDS Section is responsible for updating the entire Integrated Plan. While outlining the process the reporting on Part A Plans needs to be clarified.

It was suggested that an annual Executive Summary be prepared that identifies gaps and concerns for the overall State Plan. Part As would also submit an annual Executive Summary detailing overlap, gaps, and concerns. This would allow for a quick review of progress and barriers.

Concurrence on the changes to the Integrated Plan will be postponed until the group receives an Executive Summary outlining the proposed updates to the activity table.

Local Area Highlights
Representatives from Areas 2A, 2B, 4, 5/6/14, 8, 10, and 12 provided updates on key local innovations and challenges as they relate to the goals and objectives outlined in the State of Florida Integrated HIV Prevention and Care Plan (2017-2021). Click here for additional details on local area activities.

Paula Burns, Area 12 DOH Representative and Samantha Kwiatkowski. Area 12 Prevention Representative presented on best practices with working with local universities (Daytona State College, Bethune-Cookman University, Embry Riddle Aeronautical University, and Stetson University) and community partners (CAN Community Health, Outreach Community Care, Florida Department of Health, and Joel Lawrence Foundation Hispanic Health Initiatives, Inc.) in their local area.

The successes have resulted in an increase in:

- Relationships
  - New and Renewed
  - Strengthened
  - Community

- Coordination
  - Meetings
  - Notifications of Availability

- Planning
  - Focus on HIP-PLOT
  - Calendar
  - EIC/PTC/HAPC

- Communication
  - Presentations
The link to the request for proposal for the Insurance Benefits Manager was shared with the group. For more information, please visit: http://www.myflorida.com/apps/vbs/vbs_www.ad_r2.view_ad?advertisement_key_num=146367

State and Federal Update

**Michael Ruppal, Executive Director, The AIDS Institute**

Michael Ruppal provided an overview of federal and state policy updates.

Federal Appropriations
- Senate appropriations mark-up will occur during the first or second week in June
- Congress to complete the budget process by September 30, 2019
  - Federal 2020 fiscal year begins 10/1/19

**Administration’s Ending the HIV Epidemic Plan**
- The Initiative will target new resources to the 48 highest burden counties, Washington, D.C., San Juan, Puerto Rico, and 7 states with a substantial rural HIV burden.
- Will focus on innovations for expanded treatment, prevention, surveillance and workforce.
- The HHS Office of the Assistant Secretary for Health is coordinating this cross-agency Plan.
  - Centers for Disease Control and Prevention (CDC)
  - Health Resources and Services Administration (HRSA)
  - Indian Health Service (IHS)
  - National Institutes of Health (NIH)
  - Office of the Health and Human Services (HHS) Assistant Secretary for Health
  - Substance Abuse and Mental Health Services Administration (SAMHSA)

Preparing Phase 1 Jurisdictions for Initiative
- Local Community EtHE Plans
  - CDC is preparing a notice of funding opportunity (NOFO) to provide resources that will support the drafting of local community EtHE plans by Phase 1 jurisdictions
  - Funded with FY19 Minority AIDS Initiative Funds
  - NOFO will be managed by CDC on behalf of HRSA and CDC
  - Build on existing HIV planning activities and EtHE plans
  - Focus on community engagement in planning and execution of plans
  - Anticipated NOFO publication in Summer 2019
  - Anticipated award date is late September 2019

- Main EtHE NOFO
  - Award contingent on Congressional FY20 appropriation
  - CDC is drafting a 5-year EtHE NOFO
  - Anticipated NOFO publication in summer/fall 2019 (timing with HRSA NOFO)
  - Proposed award date is January 2020 (subject to the availability of funding)
  - Announcement of this NOFO will occur before award for Local Community EtHE Plans NOFO to inform content of those plans
  - CDC hosted three 2-hour calls with stakeholders for input regarding this NOFO (e.g., HIV community, public health, clinical care)

- Every state in the South is either a state targeted in this plan or has high burden counties.
- The plan has proposed $291 m in the first year, with much more to be proposed in the years following.
• $6 min the first year will go to NIH’s Centers for AIDS Research to do implementation science and guide best practices for the 6 of the 19 CFARs are located at universities in the South.
• $140 m will go to the CDC to do prevention and surveillance efforts in the areas targeted in the Plan. This funding could go to colleges and universities that engage in prevention activities and have received CDC funding in the past.

Cost of Healthcare
• Congress and the Administration want to change the way that the federal government pays for prescription drugs through the programs it oversees, such as: Medicare, Medicaid, and Affordable Care Act
• Opportunities for researchers and providers to study the impact of these changes on access and outcomes for patients.

State of Florida Policy Highlights
Infectious Disease Elimination Act (HB 171/SB 366)
• Authorizes certain eligible entities to establish sterile needle and syringe exchange programs.
• Expands disease-preventing program from Miami-Dade to all of Florida.
• Needles will be distributed as medically necessary.
• Communities can opt-in by county.
• County and local funds can be used to operate these exchanges.
• No longer a pilot program.

Florida 2019 Legislative Session
• Florida Legislature concluded business Saturday, May 4th
• Over 1,800 bills were submitted I 195 were passed
• Passed a $91.1 billion budget
• Education I $783 million increase in K-12 education funding
• Water Quality and protection I $682.6 million
• Hurricane Michael Recovery I $1.85 billion
• Total Reserves I $3.4 billion
• Tax relief package I $90 million I includes sales taxes "holiday" periods on back-to-school items and for hurricane season supplies. A reduction in the sales tax on commercial leases from the current rate of 5.7% down to a rate of 5.5% was also part of the tax package.
• HB 21 I Removing the "certificate of need" system for hospitals, nursing homes and hospices.
• $500,000 I SB 2500 I memorial for victims of the Pulse nightclub shooting
• HB 19 /HB7073 creates a Canadian Prescription Drug Importation Program for Florida within the Agency for Health Care Administration (AHCA). The legislation provides eligibility criteria for prescription drugs, for Canadian suppliers, and for importers under the program and requires the AHCA to request federal approval of the program. Further, the bill requires the Department of Business and Professional Regulation to establish the International Prescription Drug Importation Program.
• HB 366 Infectious Disease Elimination Programs
  o Three years after lawmakers approved a pilot needle-exchange program for Miami-Dade County through the University of Miami, legislation is being considered to expand the program.
  o Infectious Disease Elimination Act (IDEA) allows counties to establish sterile needle and syringe exchange programs through the adoption of a county ordinance and satisfaction of the specified program requirements:
    o one-to-one needle exchange ratio
    o prohibition on the use of state, county, or municipal funds
must be funded through grants and donations from private sources.

- Senate Health Policy Committee Health Care Package HB 843 is a comprehensive health care bill that:
  - Creates the dental student loan repayment program.
  - Creates the Donated Dental Services Program.
  - Requires hospital notification to patients of the rate of hospital required infections, rating of the Hospital Consumer Assessment of Healthcare Providers and System survey and the 15-day readmission rate.
  - Requires hospital notification to the patient’s primary provider of admission or discharge from a hospital.
  - Allows an ambulatory surgical center to keep patients for 24 hours and allows the Agency to adopt rules that establish minimum standards for pediatric patients.
  - Makes changes to the pediatric cardiac technical advisory panel.
  - Requires notification to the patient of observation status rather than inpatient status at a hospital.
  - Provides that CLIA certified providers are not clinics for purposes of Chapter 400, F.S.
  - Contains language dealing with restrictive covenants for physicians.
  - Modifies the direct primary care agreements to be direct health care agreements.
  - Requires notification to the patient of observation status rather than inpatient status at a hospital.
  - Provides that CLIA certified providers are not clinics for purposes of Chapter 400, F.S.
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  - Requires notification to the patient of observation status rather than inpatient status at a hospital.
- Closing the Gap Grant Program
  - HB 1045 Adds a priority focus area eligible for funding under the Closing the Gap (CTG) grant program to include Alzheimer’s disease and dementia.
  - The bill removes the requirement that up to 20 percent of any grants awarded under the program be set-aside for projects related to Front Porch Florida Communities.
  - The bill also prohibits the Department of Health (DOH) from establishing a minimum or maximum award amount, requires the DOH to determine grant award amounts based on the merit of the application, and requires the DOH to award grants in various regions of the state.
  - The bill requires DOH to promote synergistic initiatives between the Closing the Gap grant program and the HIV/AIDS program to leverage the expertise of the CTG program.

- SB 642 HIV Prevention Justice Act - Failed to pass

2020 Legislative Session
- Interim Committee weeks begin in September

Updates and Discussion of Activities from Statewide Advisory Groups
Gay Men’s Workgroup (Ken Bargar, Co-Chair)
- The group increased its membership to include more MSM of color and Latinos representing priority populations.
- A new Co-Chair has been elected, Michael Greene from EmpowerU, Miami.
• The workgroup has provided input to address the state’s increase in hepatitis infection and creative concepts for the PrEP Initiative. The workgroup also continues to work with the HIV/AIDS Section on the Integrated Plan and prioritization of strategis.

**Consumer Advisory Group (David Brakebill, Chair)**

David announced that the CAG Meeting would take place immediately following the FCPN Meeting. The agenda for the meeting includes:

- Changing the name of the group
- Workgroup formed to review the Case Management Guidelines
- Updates to the group’s brochure and materials related to onboarding of new members
- Medical Monitoring Project (MMP) review and update

**Public Comment**

- The upcoming 2019 FCPN Member Recruitment was discussed. The AIDS Institute will work with the Membership, Nominations, and Bylaws Committee to distribute information on the upcoming recruitment in mid-June for odd-numbered areas, At-Large Behavioral Science, At-Large Transgender, At-Large Youth, and Part A. It was noted that the FCPN membership should be reflective of the epidemic in the state. Local consortia are asked to take the areas 2017 epidemiological profile in consideration when nominating members.
- Marketplace and those who lose employment
- Other workgroups, native American, Asian
- Hearing in the House oversite committee on the pricing of Truvada.
- The importance of mentoring of new members was emphasized. New members often feel lost.
  - Make it easier for lay persons to be involved by clearly outlining the expectations of members.
  - Face-to-face orientation prior to Fall 2019 meeting for new members.
  - Limit the use of acronyms or provide members with a “cheat sheet” to use during meetings.

Joey Wynn motioned that the HIV/AIDS Section create a resource inventory of local planning body orientation tools and to collect HRSA technical assistance resources and tools. The task of creating an orientation package to the Membership, Nominations, and Bylaws and Bobby Davis seconded the motion. Motion was unanimously approved.

- A question was asked about whether or not there was a delay in transitioning ADAP to the CVS Specialty Pharmacy model. The HIV/AIDS Section stated that they could not currently comment on the issue.
- HealthHIV is currently looking to pilot a planning body assessment tool in 3-5 jurisdictions. The pilot is to evaluate the effectiveness in the structure, membership, community engagement, and how well state planning bodies are evaluating the Integrated Plan. The assessment would be online and anonymous followed by a formal interview with a consumer, the Department of Health, and a diverse group of key members. Once the assessment is complete, an assessment summary and key findings would be presented. Following the issuance of the summary, HealthHIV would come onsite to discuss with the planning body the summary, recommendations, and strategies. A final report would be issued. The pilot would occur over the summer.

The group agreed by consensus to participate in the assessment. **The HIV/AIDS Section will notify HealthHIV that the FCPN is interested in participating.**

**Next Steps, Future Meeting Topics and Proposed Dates**

The following items were suggested as topics for the Fall meeting:

- Recommendations on cost-savings measures
- Patient Care Network maps
- Funding Allocation methodology
- Significant discussion about the Integrated Plan updates
- Standing ADAP Update

Members were asked to include additional detailed agenda items for the Fall meeting through the online evaluation.
The HIV/AIDS Section to conduct webinar for FCPN membership to present 2018 HIV Data as soon as it becomes available and prior to the Fall meeting.

The group narrowed the list of available dates for the Fall meeting to the following:
October 28-30, 2019
November 4-8, 2019
November 18-22, 2019

The HIV/AIDS Section to work with The AIDS Institute to secure dates and location for Fall FCPN Meeting.

Day three of the meeting adjourned at 12:30pm.
### Action Registry from Spring 2019 FCPN Meeting

<table>
<thead>
<tr>
<th>Summary of Discussion</th>
<th>Action Items</th>
<th>Person(s) Responsible</th>
<th>Time Period</th>
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<tbody>
<tr>
<td>Transgender Workgroup</td>
<td>Establish a Statewide Transgender Workgroup</td>
<td>HIV/AIDS Section/Community Members</td>
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<td>Haitian Consultation</td>
<td>Distribute copies of the Haitian Consultation Report to FCPN members.</td>
<td>HIV/AIDS Section/The AIDS Institute</td>
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<tr>
<td>Request for Applications (RFA) for Lead Agencies</td>
<td>HIV/AIDS Section to gather input from FCPN membership via conference prior to finalizing the RFA.</td>
<td>HIV/AIDS Section/The AIDS Institute/FCPN Members</td>
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<tr>
<td>Florida’s HIV System of Care Current Statute and Administrative Rule Language (Section 381.0042, Florida Statutes, Patient Care for Persons with HIV Infection)</td>
<td>Upload Word version of document to the meeting website.</td>
<td>The AIDS Institute</td>
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<tr>
<td>Messaging to clients enrolled in the Specialty Pharmacy Program regarding contingency plans in the event of a hurricane</td>
<td>HIV/AIDS Section to develop messaging for clients.</td>
<td>HIV/AIDS Section/Medication Access Committee</td>
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<td>Analysis of proposed cost cutting measures and efficiencies</td>
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<tr>
<td>HIV/AIDS Section to work with the FCPN to explore all other cost cutting measures and efficiencies beginning with administration and overhead costs, then looking at all other services provided by the Section, before exploring the cost cutting-measures for primary medical care and prescription drugs, including the establishment of tiers on the ADAP Formulary. The HIV/AIDS Section to provide recommendations within 120 days.</td>
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<td>HIV/AIDS Section/FCPN Members</td>
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<tr>
<th>FCPN Brochure/Frequently Asked Questions (FAQ) sheet</th>
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<tr>
<td>Develop an FCPN FAQ sheet.</td>
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<td>HIV/AIDS Section/The AIDS Institute/Membership, Nominations, and Bylaws Committee</td>
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<th>FCPN Bylaws</th>
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<tr>
<td>Update the proposed PCPPG Bylaws to reflect the changes approved during the Spring 2019 meeting and distribute to FCPN members</td>
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<td>The AIDS Institute/Membership, Nominations and Bylaws Co-Chairs</td>
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<tr>
<td>Review and make suggestion on proposed changes to Article 3 – Members, Section 7 –</td>
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<tr>
<td>The AIDS Institute/Membership, Nominations and Bylaws Co-Chairs</td>
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<tr>
<td>Duties and Responsibilities and Article 5 – Meetings, Section 3 – Conduct of Meetings based on the discussion at the Spring 2019 meeting.</td>
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<td>Statewide Ending the Epidemic Meeting.</td>
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<td>Nutritional Supplements</td>
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<td>Patient Care Network Maps</td>
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<td>HIV/AIDS Section Communications Plan</td>
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<td>Calendar of Events</td>
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<td>Agenda Items</td>
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<td>Concurrency on the Integrated Plan Changes</td>
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<td>New Member Orientation</td>
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<td>HealthHIV Planning Body Assessment Tool</td>
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<td>2018 HIV Epidemiological Data</td>
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<td>Standing Committee calls</td>
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<tr>
<td>Agenda Items for Future Meetings</td>
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</tbody>
</table>
| Dates for Fall 2019 FCPN Meeting | Secure dates and location for the Fall FCPN Meeting. Preferred dates are:  
- October 28-30  
- November 4-8  
- November 18-22 | The AIDS Institute/HIV/AIDS Section | Post Meeting |
| Presentation follow-up/Red Ribbon Report | Distribute approved PowerPoint presentations and handouts from the meeting to the members. | The AIDS Institute/HIV/AIDS Section | Post Meeting |