



HIV Infrastructure Study

Jacksonville, Florida

September 2015

<http://southernaidsstrategy.org>

Susan S. Reif – susan.reif@duke.edu

Kristen Sullivan – kristen.sullivan@duke.edu

Carolyn McAllaster – mcallaster@law.duke.edu

Miriam Berger – miriam.berger@duke.edu



With support from:



FORDFOUNDATION

EXECUTIVE SUMMARY

Background

Data from the CDC indicate that the Southern United States, particularly the US Deep South, has the highest HIV diagnosis rates and highest death rates among individuals diagnosed with HIV of any US region.¹ To determine best approaches for improving HIV-related outcomes in communities within the Deep South states, this study examines existing HIV-related prevention and care infrastructure and community characteristics of targeted state metropolitan statistical areas (MSAs) that are consistently among the 10 areas in the US with the highest HIV diagnosis rates. The study also examines HIV-related prevention and care infrastructure and community characteristics of MSAs with similar demographic characteristics to the high HIV impact MSAs but with less pronounced HIV/AIDS statistics. Jacksonville, Florida was selected as one of the MSAs of study due to its consistently high HIV and AIDS diagnosis rates.²

Methods

This case study examines the HIV prevention and care infrastructure in the Jacksonville MSA and explores the strengths and challenges related to addressing HIV within the area. Twelve structured, in-depth interviews with individuals working in the HIV prevention and care system were conducted, along with two focus groups with individuals living with HIV in the Jacksonville MSA. The interviews and focus groups explored participants' experiences and perspectives regarding HIV prevention and care, stigma, and other factors that may influence HIV epidemiology in the Jacksonville region. Qualitative data collection was completed in February 2015. Additionally, we identified and summarized existing data sources regarding HIV and STD epidemiology, other health status indicators, community health needs, and gaps in services in Jacksonville and the surrounding area.

Results

The Jacksonville MSA encompasses five Florida counties: Baker, Clay, Duval, Nassau and St. Johns. Surveillance data demonstrate high HIV and AIDS diagnosis rates in the area. The Jacksonville MSA is ranked 10th in the country for HIV diagnosis rates (33.5 per 100,000), with African Americans disproportionately affected. It is second among MSAs for HIV diagnosis rates of African American males (170.7 per 100,000), and sixth among MSAs for HIV diagnoses among African American females (72.2 per 100,000).³ Jacksonville also has high AIDS diagnosis rates and is ranked ninth among MSAs (16.9 per 100,000) for AIDS diagnosis rates.⁴

Study participants reported that HIV testing is readily available in Jacksonville. HIV medical care was also reported to be available, primarily through the three main clinics in the area: University of Florida Cares, AIDS Healthcare Foundation, and the Florida Department of Health in Duval County Comprehensive Care Center. There was a perception among several respondents that there is movement of doctors between clinics, resulting in care disruptions for some patients. Social services for people living with HIV/AIDS (PLWHA), including case management, mental health services, and housing were reported as not sufficiently available to meet the level of need in the MSA. Transportation was also noted as a significant barrier to care, due in part to the large geographic area encompassed by the city, and what some considered to be an insufficient bus system.

A high level of stigma towards PLWHA was identified as an important factor negatively affecting HIV prevention and care in the Jacksonville MSA, reportedly fueled in part by powerful conservative churches

in the area. Initiatives to engage the faith community in HIV prevention education are making progress but have not been universally embraced. The conservative tenor of the city is also credited for the lack of widespread comprehensive sex education in schools, a deficiency many respondents identified as a driver of the high rate of HIV infection in the area.

Strengths were also noted in the Jacksonville MSA HIV care and prevention infrastructure, including a high level of collaboration between some of the HIV providers in the Jacksonville area that has resulted in partnerships that maximize efficiency and impact. Innovative programs were lauded, including JASMYN, an organization providing much needed services and advocacy for the young LGBTQ population in the area, including a clinic imbedded in their youth center and wrap around linkage/case management services for HIV-positive youth. Additionally, recent efforts to utilize data systems to identify PLWHA who are out of care to inform outreach efforts were cited as improving HIV care utilization and outcomes.

Discussion

This assessment of the HIV prevention and treatment infrastructure of the Jacksonville MSA provides insight into the strengths and challenges of the system, and identifies factors that may be influencing the high HIV and AIDS diagnosis and prevalence rates, as well as high death rates for PLWHA. The collaborative relationships among HIV providers in the area should continue to be financially supported through joint funding opportunities. Additional resources and efforts are needed to improve HIV prevention efforts in the area, including universal access to comprehensive sex education for youth. Educational programs in schools, faith communities, and the larger community are necessary, and should be components of comprehensive stigma reduction efforts. Increased support for social services for PLWHA in the area is needed, specifically for case management, housing, mental health services, and transportation assistance. Enhancing these services will enable PLWHA to more consistently engage in the HIV medical care available, ultimately decreasing morbidity and mortality rates, improving quality of life, and reducing new infections in the Jacksonville MSA.

HIV INFRASTRUCTURE STUDY – JACKSONVILLE MSA

Background

Data from the Centers for Disease Control and Prevention (CDC) regarding new HIV diagnoses in 2011, summarized in a Southern HIV/AIDS Strategy Initiative (SASI) manuscript, indicated that the Southⁱ had the highest HIV diagnosis rate of any US region.¹ In 2011, nearly half (49%) of new HIV diagnoses reported (including any new HIV diagnoses regardless of stage of HIV disease) were located in the Southern US, while the South accounted for only 37% of the US population.^{1,5}

A subset of Southern states is particularly affected by HIV disease and shares characteristics such as overall poorer health, high poverty rates, an insufficient supply of medical care providers and a cultural climate that likely contributes to the spread of HIV.⁶⁻⁸ These states include Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and East Texas, henceforth referred to as the “targeted states.” HIV and other STDs disproportionately affect individuals within the targeted states and these states share similarities in HIV-related outcomes including the highest death rates among individuals diagnosed with HIV of any region in the US.^{9,10} In fact, 32% of new HIV diagnoses were in the targeted states in 2011 while this region accounted for only 22% of the US population.^{11,12} In addition, all 10 metropolitan areas with the highest AIDS diagnosis rates were located in the Southern region in 2011; nine of these areas were within the targeted states.¹²

To determine best approaches for improving HIV-related outcomes in communities within the targeted states, we examined existing HIV-related prevention and care infrastructure and community characteristics of targeted state metropolitan statistical areas (MSAs) that are consistently among the 10 areas with the highest HIV diagnosis rates. Due to high HIV diagnosis rates (10th among the MSAs) and high rates of persons living with HIV,⁴ Jacksonville Florida, was one of the MSAs selected for study and the results of this study of Jacksonville are described within.

Methods

To gain a more in-depth understanding of the HIV epidemic within the Southern MSAs, we conducted a community case study in Jacksonville, Florida using quantitative and qualitative data sources. This case study examined the infrastructure for HIV prevention and care in the Jacksonville MSA and the strengths and challenges of addressing the HIV epidemic within the area. The study included 12 structured interviews with personnel working within the HIV prevention and care system in the area, community leaders, and HIV advocates. In addition, two focus groups were conducted with HIV-positive individuals residing in Jacksonville to gather their experiences and perspectives regarding HIV prevention and care, stigma and factors that may impact HIV disease in their area. Data collection was completed in February 2015.

In addition to qualitative data collection, we identified and summarized existing data sources regarding HIV and STD epidemiology, other health status indicators, community health needs, and gaps in services in Jacksonville and the surrounding area. These data sources included community needs assessments, national surveillance reports, and state HIV epidemiologic reports.

ⁱ The United States Census Bureau defines the Southern Region as including Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Oklahoma, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

Findings

Metropolitan Area Description

The City of Jacksonville is located in the northeastern area of Florida with an estimated population of 842,583 in 2013.¹³ At over 841 square miles, Jacksonville is also the largest city by area in the continental US and is the 14th largest city in the country.¹⁴ Jacksonville is located in Duval County.¹³ The earliest use of the name “Jacksonville” was in an 1822 petition to the U.S. Secretary of State to create a port of entry in the area. Jacksonville was named for then General Andrew Jackson, the first military governor of Florida.¹⁴

The Office of Economic Development for the City of Jacksonville has identified seven sectors as key industries for the city including: advanced manufacturing; aviation and aerospace; finance and insurance; headquarters; information technologies; life sciences; and logistics and distribution. In 2012, the top regional companies headquartered in Jacksonville included Bank of America/Merrill Lynch (8,000 employees), Florida Blue-Blue Cross Blue Shield (6,500 employees), Citigroup (4,200 employees), JP Morgan Chase (4,200) and CSX (4,000 employees). Approximately 10% of the workforce in Jacksonville is employed within the financial or insurance sector, more than Orlando, Tampa and Miami. Jacksonville is also the site of a U.S. naval air station, the University of North Florida at Jacksonville, Florida State College at Jacksonville and the University of Florida Health Science Center –Jacksonville.^{15,16}

The Jacksonville, FL Metropolitan Statistical Area (Jacksonville MSA) covers five counties in the state: Baker, Clay, Duval, Nassau and St. Johns.¹⁷ The total estimated population of the Jacksonville MSA in 2013 was 1,394,624, ranking the area 40th in population size among the 381 total MSAs in the country.¹⁸ The total estimated population, population density and racial/ethnic breakdown for each of the five counties within the Jacksonville MSA are depicted in Table 1 below, from largest to smallest total estimated population size. The City of Jacksonville is located in Duval County, the most densely populated county in the MSA, with 885,855 estimated county residents in 2013.¹³ Duval is also the county with the highest proportion of black residents of all five Jacksonville MSA counties.

Table 1

POPULATION DEMOGRAPHICS AMONG THE JACKSONVILLE MSA COUNTIES¹³			
County	Total Estimated Population (2013)	Population Density – Persons per Square Mile (2010)	Racial/Ethnic Breakdown (2013)
Duval	885,855	1,113.9	White: 62.3% Black: 30.0% Latino: 8.3%
St. Johns	209,647	316.4	White: 89.7% Black: 5.7% Latino: 5.8%
Clay	196,399	315.8	White: 82.8% Black: 10.6% Latino: 8.7%

Table 1 (continued)

POPULATION DEMOGRAPHICS AMONG THE JACKSONVILLE MSA COUNTIES¹³			
County	Total Estimated Population (2013)	Population Density – Persons per Square Mile (2010)	Racial/Ethnic Breakdown (2013)
Nassau	75,710	113.0	White: 90.4% Black: 6.5% Latino: 3.8%
Baker	27,013	46.3	White: 84.0% Black: 13.4% Latino: 2.3%
Florida	19,552,860	350.6	White: 78.1% Black: 16.7% Latino: 23.6%

Within the City of Jacksonville, in 2010, 59.4% of residents were white, 30.7% were black, and 7.7% were Latino. The proportion of black residents was roughly the same in Jacksonville and Duval County.¹³

Socioeconomic Landscape

Florida

According to the US Census, in 2012, the percentage of people living in poverty in Florida was 17.8%, which was lower than the national average of 20.8%. However, when looking at the change in the poverty rate during the previous 12 months, in the years between 2000 and 2012, a statistically-significant increase of 4.3% was observed in Jacksonville, above the US average change during the same time period (3.7%).¹⁹ In addition, in 2013, the national children's poverty level (defined as the proportion of children under age 18 who live in families with incomes below the federal poverty level) in 2013 was 22%. In comparison, the children's poverty level in 2013 was 24% in Florida and 26% in the city of Jacksonville.²⁰

Jacksonville MSA

According to the US Bureau of Labor Statistics, employees in all sectors within the Jacksonville MSA earned a mean annual salary of \$42,380 and a median hourly wage of \$15.53 in May 2013, which was lower than the national median hourly wage of \$16.87.²¹ In addition, in 2013, the per capita personal income (PCPI) of the Jacksonville MSA ranked 108th in the country and was 96% of the national average.¹⁸ Within the City of Jacksonville, the median household income between 2009 and 2013 was \$47,557, slightly below Duval County's median household income (\$48,323) and slightly above Florida's median household income (\$46,956) during the same time period.¹³

Within the Jacksonville MSA, the differences among the income levels and poverty rates among the five individual counties reflect the socioeconomic disparities within the region (See Table 2 below). The overall poverty rate in the MSA counties from 2009 to 2013 ranged from a low of 9.6% to a high of 17.3% and the median household income ranged from \$48,323 to \$64,876. Duval County had the second highest overall poverty rate among the five MSA counties (16.9%).

Table 2

POVERTY AND INCOME DATA FROM JACKSONVILLE MSA COUNTIES¹³		
County	Poverty Rate-All Persons (2009-2013)	Median Household Income (2009-2013)
St. Johns	9.6%	\$64,876
Clay	9.8%	\$59,482
Nassau	12.6%	\$55,315
Duval	16.9%	\$48,323
Baker	17.3%	\$49,236
Florida	16.3%	\$46,956
US	15.4%	\$53,046

Note: Counties are listed from lowest to highest poverty rate.

Moreover, according to a report from the Brookings Institution, among the 100 largest U.S. metropolitan areas between 2005 and 2009, Jacksonville experienced a concentrated poverty rate increase of 3.3% from 2000. (Concentrated poverty rate is defined as neighborhoods with at least 40% of individuals living below the poverty line). In comparison, the overall concentrated poverty rate change among the 100 metropolitan areas during the same time period was 0.5%.²²

Within Duval County, between 2009 and 2013, 26.4% of county residents aged 25 and older possessed a Bachelor's degree or higher, which was identical to the state rate and slightly higher than the rate in the City of Jacksonville (25.5%). The proportion of residents aged 25 and older who possessed high school diplomas or higher between 2009 and 2013 was similar in Duval County and Jacksonville (87.9% and 87.5%, respectively), both of which were higher rates than in Florida overall (86.1%).¹³

Community Health and Health Outcomes

In 2011, several Jacksonville community partners, including local county health departments and hospital and healthcare facilities, aligned and formed the Jacksonville Metropolitan Community Benefit Partnership ("The Partnership") to conduct a community health needs assessment (CHNA). The CHNA focused on five counties in Northeast Florida, including four from the Jacksonville MSA (Clay, Duval, Nassau and northern St. Johns). In 2012, The Partnership conducted a community health survey, hosted focus groups and roundtable discussions and collected secondary health and quality of life data from a variety of sources. Within Duval County, the main health problems that were identified through the CHNA as critical health areas were: heart disease, stroke, diabetes, nutrition, infant mortality, mammograms, behavioral health, smoking cessation, access to food/physical activity and adult obesity. The report further concluded that access to healthcare was the most important issue in Northeast Florida; healthcare and community health should move from a system of caring for the sick to promoting wellness and preventing illness; and the Northeast Florida health community should support holistic approaches to improve individual health outcomes (e.g. physical, emotional, mind and spirit).²³

In 2010, the expected life expectancy at birth in Florida was 79.4 years, above the national average of 78.9 years.²⁴ In addition, Florida had a lower age-adjusted mortality rate (701.0 deaths per 100,000) than the national average (746.2 deaths per 100,000).²⁵ However, the combined age-adjusted mortality rate for all

five Jacksonville MSA counties in 2010 was 793.3 per 100,000 - higher than state and national averages. The top causes of death in 2012 among the five Jacksonville MSA counties were 1) cancer, 2) heart disease, 3) chronic lower respiratory disease, 4) unintentional injury and 5) cerebrovascular diseases.²⁶

Florida had the ninth highest adult diabetes rate in the US.²⁷ The overall diagnosed diabetes rate among adults in Duval County in 2010 was higher than the state average (11.4% in the county versus 10.4% in the state overall).²⁶ Teen pregnancy rates are also high in the region. In 2010, there were over 35,000 teen pregnancies in Florida, ranking the state's teen pregnancy rate at 32 out of the 50 states (with 1 being the lowest rate, and 50 being the highest rate); Florida's teen birth rate ranked the state 25 out of the 50 states.²⁸ Within the Jacksonville MSA, the three-year average (2010-2012) overall birth rate was higher in Duval County than in Florida overall, both among white and non-white mothers. In addition, the three-year average teen birth rate (births per 1,000 15 to 19 year-old girls) in Duval County (37.3) was higher than the state average (29.6), and the teen birth rate in Baker County (56.7) was almost double the state's overall rate.²⁹

In 2013, the infant mortality rate (defined as the number of deaths among infants less than one year of age per 1,000 live births) in Florida was 6.1. Three of the five Jacksonville MSA counties had infant mortality rates above the overall state rate, the highest of which was in Baker County (14.3), followed by Duval County (8.8), and St. Johns (7.0).³⁰ Although the three-year average (2010-2012) infant mortality rate among whites in Duval County was lower than in Florida overall during the same time period, the infant mortality rate among non-whites was higher in Duval County than in the state.²⁹

Sexually transmitted diseases (STDs) are also prevalent within Duval County, the Jacksonville MSA, and Florida. In 2013, the gonorrhea rate in Duval County was 289.7, the chlamydia rate was 802.2, and the primary and secondary syphilis rate was 5.4 - all per 100,000 population. These gonorrhea and chlamydia rates were higher in Duval County than in Florida overall; however, the rate in Duval County for primary and secondary syphilis was lower than Florida's overall rate the same year (9.4). In Duval County, the gonorrhea, syphilis and chlamydia rates have been dropping since 2008.³¹ Although the 2013 rates in Duval County for chlamydia and primary and secondary syphilis were lower than national averages, Duval County's gonorrhea rate was more than twice the national rate.³²

According to CDC STD surveillance data, within the Jacksonville MSA overall, the rates for chlamydia and gonorrhea were consistently higher in 2009 through 2013 than among the average rates in 50 selected US MSAs (based on largest population size) during the same time period. However, the syphilis rate in the Jacksonville MSA was lower in 2013 than the average rate among the 50 largest MSAs during the same year (13.7 in the Jacksonville MSA vs. 25.5 among the top 50 MSAs).³³

Health Care Access

According to the US Census, between 2009 and 2013, the City of Jacksonville, the Jacksonville MSA and state of Florida all experienced higher uninsured rates than national averages. (See Table 3 below). Florida's uninsured rates were higher than rates in the City of Jacksonville and the Jacksonville MSA.

Table 3

Uninsured Rates Comparison of Jacksonville, Jacksonville MSA and Florida (5-year estimates, 2009-2013)³⁴				
Location	No health insurance, under 18 years old[^]	Employed, no health insurance*	Unemployed, no health insurance*	Not in labor force, no health insurance*
City of Jacksonville	9.6%	19.3%	50.1%	24.2%
Jacksonville MSA	8.9%	18.1%	49.3%	21.6%
Florida	12.3%	25.4%	56.5%	28.0%
U.S.	7.6%	17.5%	45.9%	21.8%

[^] Civilian noninstitutionalized population - under 18 years

* Civilian noninstitutionalized population - 18 to 64 years

Shortages of primary care physicians were a concern in several of the Jacksonville MSA counties, particularly in Duval County (See Table 4 below). According to the Health Resources and Services Administration (HRSA), two facilities in Duval County, including the Duval County health department and low-income population groups throughout Jacksonville, were designated as primary care health professional shortage areas (HPSA). A HPSA designation indicates that more than 3,500 people in a geographic area or more than 3,000 specific population groups (e.g. low-income populations) are served by one primary care physician.³⁵

According to HRSA's medically underserved area (MUA) designation, four out of the five Jacksonville MSA counties had service areas and/or Census Tracts that were deemed as MUA. (St. Johns did not have MUA designation; however, it contained a medical underserved population designation among low-income Western St. Johns residents). The MUA determination is calculated from four variables: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population aged 65 or over.³⁶

Table 4

Jacksonville MSA Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA)		
County	HPSA Designee³⁷	MUA Designee³⁸
Baker	3 facilities	Yes- county
Clay	1 service area; 1 low-income population group	Yes- service area
Duval	2 facilities, including Duval County Health Department; 6 population groups, including North, South, East and West Jacksonville	Yes- service area Also is Medically Underserved Population (MUP) designee: Low Income - North Jacksonville
Nassau	1 service area	Yes- county
St. Johns	1 low-income population group	No, but is Medically Underserved Population designee: Low Income - Western St. Johns

HIV/AIDS Landscape

Florida

At the end of 2012, an estimated 98,650 people were living with diagnosed HIV in Florida, translating to an HIV prevalence rate of 599.0 per 100,000 population, and ranking the state fourth in the country for highest HIV prevalence rate after Washington, DC, New York and Maryland, respectively.²

In 2012, there were 5,082 HIV new diagnoses in Florida, representing an HIV diagnosis rate of 30.8 per 100,000 population. The state was ranked fifth in the US for highest rate of HIV diagnosis.³² In 2013, among the new HIV diagnoses in the state, 77% were male; 43% were African American, 30% white, 26% Latino and 1% multi-race. In addition, there were 935 HIV-related deaths during the same year, representing an increase of 1.3% from 2012. HIV was the fifth leading cause of deaths among African Americans aged 25 to 44 in 2013; however, this was the first time that it was not the leading cause of death among African Americans since 1988.³⁹

HIV was the fifth leading cause of deaths among African Americans aged 25 to 44 in 2013.

In 2013, there were 3,282 AIDS cases diagnosed in Florida, representing an overall AIDS diagnosis rate of 17.1. Duval County ranked sixth in AIDS prevalence rates in the state.⁴⁰ There were over 129,000 cumulative AIDS cases in Florida through the end of 2013 of which 55% are known to be deceased.⁴¹

Jacksonville MSA

As of the end of 2011, an estimated total of 5,807 people were living with HIV within the Jacksonville MSA, representing an overall prevalence rate of 426.7 per 100,000 population. As a point of comparison, the overall HIV prevalence rate among US MSAs (containing greater than 500,000 residents) for the same time period was 354.8 per 100,000 population.⁴ (See Table 5 below for a summary of HIV prevalence among the individual Jacksonville MSA counties, sorted in descending order of HIV prevalence rate, by county).

In addition, in 2011, the Jacksonville MSA had an overall HIV diagnosis rate among adults and adolescents of 33.5 per 100,000 population, which ranked the MSA 10th in the country for HIV diagnoses. Moreover, among African American males, the top two MSAs in the US with the highest HIV diagnosis rates were in Florida; Miami was first - with an HIV diagnosis rate of 172.6 - followed by Jacksonville, with a rate of 170.7. Among females, the HIV diagnosis rate among black adolescent and adult women in the Jacksonville MSA was 72.2 per 100,000, representing an overall rank of sixth in diagnosis rates among women in the MSAs.³

The AIDS diagnosis rate in 2012 in the Jacksonville MSA was 16.9 per 100,000 population, ranking the MSA ninth in the country; this represents an AIDS diagnosis rate of 1.5 times the average rate in MSAs with greater than 500,000 residents (10.8 per 100,000 population). In addition, in 2010, the Jacksonville MSA was ranked 12th among the nation's MSAs for the highest death rate among males with HIV (20.4

The AIDS diagnosis rate in 2012 in the Jacksonville MSA was 16.9 per 100,000 population, ranking the MSA ninth in the country; this represents an AIDS diagnosis rate of 1.5 times the average rate in MSAs with greater than 500,000 residents (10.8 per 100,000 population).

per 100,000 population) and 8th for the death rates among females with HIV (9.5 per 100,000 population).³

Table 5

HIV Prevalence by Jacksonville MSA County (2012)³²		
County	HIV Prevalence Number	HIV Prevalence Rate, per 100,000 population
Duval	5,415	740.9
Baker	85	382.6
Clay	246	153.1
St. Johns	252	146.8
Nassau	88	138.6
Jacksonville MSA Total (end of 2011) ⁴	5,807	426.7
Florida ³²	98,650	599.0

As demonstrated in Table 5, among the Jacksonville MSA counties, Duval County had the highest HIV prevalence rate, which was also above Florida's overall HIV prevalence rate.²⁶

HIV Testing

In 2006, the CDC revised their HIV testing guidelines, recommending that healthcare professionals offer routine opt-out HIV testing to individuals between 13 and 64 years.⁴² In 2013, the Florida Behavioral Risk Factor Surveillance System, a county-level telephone survey conducted in partnership with the CDC, found that just over half of adults in Florida under the age of 65 had ever been tested for HIV. Within the Jacksonville MSA, the highest testing rates were in Clay County (55.8%) and the lowest testing rates were in Nassau County (43.7%). At 53.9%, Duval County's overall testing rates was slightly higher than the state average.²⁶

HIV/AIDS Funding Sources

During the 2013 fiscal year, Florida received over \$317.5 million in total HIV/AIDS federal grant funds from a variety of agencies, with the HRSA Ryan White Program comprising nearly three-quarters (72%) of the total federal funds provided.⁴³ In fiscal year 2014, Florida was awarded over \$75 million in Ryan White Part A funds and nearly \$143 million in Ryan White Part B funds to provide HIV/AIDS core medical and support services to indigent state residents.⁴⁴ During fiscal year 2012, there were 61 distinct providers in Florida receiving Ryan White funds. The Northeast Florida Pediatric AIDS Program in Jacksonville - in affiliation with University of Florida College of Medicine-Jacksonville and the University of Florida Center for HIV/AIDS Research, Education and Service - or UF CARES - received Ryan White Parts A, C, and D funding. Duval County Public Health Department received Ryan White Parts A, B, and C funding. In addition, UF CARES and River Region Human Service in Jacksonville received HRSA Ryan White Part D Special Projects of National Significance (SPNS) funds to provide a medical home for the HIV-positive homeless population.^{45,46} The distribution of Ryan White Part A funds in the Jacksonville MSA is determined by the Metropolitan Jacksonville Area HIV Health Services

Planning Council, within the guidelines of the Part A program. The Council currently has 26 members. Legislation dictates that 33% of the council membership be nonaligned PLWHAs (not working professionally in HIV services or a member of a board of a funded Ryan White agency).

Funding from Medicaid also covers medical care for HIV-positive individuals who are eligible. According to the Kaiser Family Foundation, to be eligible for Medicaid in Florida, as of April 2015, parents of dependent children (family of three) are covered if they subsist at 34% of the federal poverty level (FPL) or below, ranking the income restrictions as the eighth most stringent state in the country. Childless adults are also not covered under Florida's Medicaid program, unless they are determined to be disabled.⁴⁷ Moreover, Florida is currently not expanding Medicaid under the Affordable Care Act. According to analyses conducted by the Kaiser Family Foundation, it is anticipated that a total of 669,000 Florida residents will remain uninsured because they fall within the "coverage gap."⁴⁸

The average amount spent during fiscal year 2011 per Medicaid enrollee in Florida (including state and federal payment sources) was \$4,434, fourth in the country for least generous programs.⁴⁹ In addition, there is a limit of two primary care visits per month for non-pregnant adults and one specialty visit per month for chronic disease management. There is a limit on the types of prescription drugs covered under Florida's Medicaid program, particularly if they are not on the state's preferred drug list (PDL).⁵⁰ According to Florida's Medicaid Preferred Drug List, some HIV medications require clinical prior authorization in order to be dispensed.⁵¹ In addition, transportation to medical appointments under Medicaid is allowable for mandatory coverage populations and specific coverage populations with prior authorization; this service is limited to beneficiaries who cannot coordinate medically-necessary transportation through any other methods.⁵⁰

According to the Kaiser Family Foundation, in 2010, HIV testing under Florida Medicaid was provided solely to beneficiaries when determined to be medically necessary; this in contrast to the 34 states plus the District of Columbia that cover routine HIV testing for all Medicaid beneficiaries aged 15 to 65.⁵²

HIV Infrastructure

HIV Medical Services:

Interview participants described HIV medical care as provided primarily by three clinics in the Jacksonville area; the Florida Department of Health in Duval County (DOH-Duval), AIDS Healthcare Foundation (AHF) and the University of Florida (UF) Clinic. In addition, there are a few private providers that offer HIV medical care predominantly to individuals with private health insurance.

The DOH-Duval Comprehensive Care Center (CCC) provides medical care for approximately 1600 individuals living with HIV, making it the largest provider of HIV specialty medical care in Jacksonville, FL. Services offered at DOH-Duval CCC at Central Health Plaza include outpatient medical care, pharmacy, dermatology, laboratory, HIV testing/referral/linkage, case management, dental services, health education/risk reduction programs, mental health counseling, and medication adherence counseling. DOH-Duval CCC also provides HIV care one evening a week at two satellite clinics, one located in the Sulzbacher Center in Downtown Jacksonville, and the other at the Westconnett Family Health Center. Participants mentioned that individuals new to the clinic can usually make an appointment within a few weeks. However, waiting times once at the clinic were reported to be long at times. The DOH-Duval has a consumer advisory board that provides input to the clinic and assists in creating plans to address consumer complaints.

The AHF clinic provides HIV medical care and offers peer navigation and short-term mental health services. One participant said that young MSM and transgender clients often frequent this clinic, as they have experience and cultural sensitivity in working with these populations.

The UF Center for HIV/AIDS Research, Education and Service (UF CARES), also called the UF CARES Rainbow Center, initially focused on treating HIV-exposed and infected infants and children, then expanded to serve women living with HIV. The clinic began providing care to individuals living with HIV of all genders and ages approximately seven years ago. UF Cares receives Ryan White Part A, C, and D funds and provides primary, secondary and tertiary care for approximately 1200 individuals living with HIV and also provides pregnancy care for individuals who are HIV-positive. The clinic also offers HIV case management, mental health care, health education, nutritional assistance, and clinical research trials. One respondent discussed the clinic's strong record of success with perinatal prevention, noting that there is a high HIV exposure birth rate in the MSA, but the area has the lowest perinatal transmission rate in the state.

UF CARES also facilitates the PATH Home Project, which was funded through a HRSA Special Projects of National Significance (SPNS) grant and partners with River Region Health Services to provide HIV medical care to homeless individuals in the Jacksonville area. As part of the project, an ID care provider provides HIV medical care at a local homeless shelter and a peer navigator is available to assist individuals living with HIV to access services and receive HIV education.

Most individuals living with HIV in the areas of the Jacksonville MSA outside of Duval County were reported to travel into Jacksonville for HIV medical care. However, both the Clay County Health Department in Orange Park, FL, and the Baker County Health Department in MacClenny, FL, have ID clinics that provide HIV care for individuals residing in those areas. A few participants reported that some individuals living with HIV in Clay and Baker Counties prefer to travel to Jacksonville for their care, as they fear being identified as HIV-positive if they seek care in their community.

Transportation:

Transportation was described as a barrier to medical care for many individuals living with HIV. Jacksonville has a bus service, however concerns about this system were expressed. Participants reported that there are parts of the city where the buses are not available or come infrequently and also mentioned that there is a need for a bus transfer for most trips, which requires additional money. For individuals living outside of Jacksonville, transportation can be particularly difficult to obtain because no public transit systems exist and issues of stigma were reported to affect individuals' willingness to find rides to HIV care. Several ASOs, including Lutheran Social Services of Northeast FL, River Region Human Services, North Florida AIDS Network, Community Rehabilitation Center, and UF Cares have Ryan White funding to assist clients with transportation to medical and social services appointments. This assistance is primarily in the form of bus passes or gas cards, and in some instances cab rides. At times, HIV linkage coordinators transport clients to their first HIV care appointment. Participants reported that there is not enough Ryan White funding to cover the significant need for transportation assistance to medical care in the MSA. For individuals receiving Medicaid, some funds are available to assist with transportation to medical care. To access Medicaid transportation, individuals send their medical appointment information to Medicaid and the Medicaid program will provide bus passes for the appointment or a monthly bus pass if there are a high number of medical visits scheduled. Jacksonville

Participants reported that there is not enough Ryan White funding to cover the significant need for transportation assistance to medical care in the MSA.

Area Sexual Minority Youth Network (JASMYN),⁵³ a program for LGBTQ youth age 13-23, provides bus passes to the HIV positive youth they serve, and will also provide rides to HIV medical appointments if needed.

Linkage to Care /Reengagement in Care Programs:

Peer navigators are available at AHF and Lutheran Social Services to assist newly diagnosed individuals and individuals not engaged in medical care to connect with HIV medical services. River Region Human Services also provides linkage to care services through their HIV testing programs. This service includes accompanying newly diagnosed individuals to their medical appointments until they are comfortable with going alone or have someone else to accompany them. Additionally, JASMYN provides intensive linkage services to newly diagnosed LGBT youth and young adults, and is able to link most youth to HIV medical care within 30 days.

A recent initiative to reengage patients who were lost to HIV care was facilitated through the Jacksonville region Ryan White Part A Program. This initiative used the city's CAREWare system, which includes information on all individuals receiving Ryan White medical and supportive services, to identify individuals not receiving HIV medical care in the last 18 months. Ryan White Part A funds were used to employ peer navigators through local ASOs to contact these individuals and work with them to reduce barriers to entering and staying in HIV care. This work was done through phone and in-person outreach as needed. The Ryan White Part A program plans to retain two of the peer navigators to continue the linkage services on an ongoing basis and is also considering employing peer navigators to work with individuals living with HIV who miss mental health and dental visits.

Additionally, The FL Department of Health utilizes HIV surveillance data to run the CDC's Data to Care program,⁵⁴ which determines if newly-diagnosed individuals have evidence of a lab in the system, used as a proxy measure for being linked to care. If there is no evidence of a lab, a notification is sent to the county health department to investigate whether a lab has been missed. If it is determined no evidence of care exists, a referral is made to a linkage coordinator who works to link the client to care.

A weakness in utilizing CAREWare data to determine engagement in care in the Jacksonville MSA noted by participants is the existence of three distinct systems – 1) Part A “city CAREWare”, 2) DOH-Duval, which feeds into 3) the State of FL DOH system. Imports are made to try to keep the data integrated, but this process was described as a work in progress.

A participant described an in-progress evolution of utilizing data for HIV care outreach in the state, resulting from a CDC/HRSA Partnership in Care grant. A state level dashboard is being built that will integrate numerous data sources, including HIV care data, STD surveillance data, and electronic lab reports, with the goal of identifying newly diagnosed PLWHA who have not linked to care, those who have fallen out of care, and patients with persistently high viral loads. The system will be pilot tested, and then initially made accessible to county health departments.

Medical Care Availability and Barriers to Care:

Most participants reported that there is enough HIV medical care supply in the area though a shortage of doctors was mentioned by a few participants. Several respondents mentioned that providers move around to different practices so there is some lack of care continuity. One respondent described the situation as all of the doctors “playing musical chairs”. It was also noted that providers often do not have enough time to spend with their patients. Other HIV medical care concerns included lack of compassion by some providers and an increase in the cost sharing for patients who often have low incomes.

Interview participants named a number of additional barriers to medical care including lack of transportation, HIV-related stigma, including being afraid of being identified as HIV-positive if seen in an ID clinic, denial, and complicated insurance coverage that requires clients to go to different places for HIV care, labs etc. The Ryan White Part A program facilitated a survey of individuals who had dropped out of HIV care to identify reasons for not engaging in care. The most commonly cited barriers to care were substance use, mental health issues, and reporting that they did not like the way they were treated by their HIV care provider.

Focus group participants living with HIV were also asked about availability of HIV care and barriers to HIV care. One participant said that care is accessible if people are savvy enough to find it and want to go. Barriers to care engagement and retention cited by focus group participants included low literacy, persistent stigma and racism, feelings of shame, and health plans and health services that are difficult to navigate. A lack of adequate availability of critical services for individuals living with HIV was also cited as an important barrier. This lack of adequate levels of service availability was said to include mental health and substance abuse treatment, HIV case management and transportation. One participant said that bus tickets used to be more readily available but now policies on getting tickets are more restrictive. Lack of consistent agency collaboration among HIV care providers was also included as a barrier to improving care coordination for clients.

Barriers to care engagement and retention cited by focus group participants included low literacy, persistent stigma and racism, feelings of shame, and health plans and health services that are difficult to navigate.

Social Services:

Case management and support groups:

HIV case management is primarily provided by Northeast Florida AIDS Network (NFAN), UF CARES, Lutheran Social Services of Northeast FL, AIDS Healthcare Foundation-Riverside Clinic, Northwest Behavioral Health Services, and Community Rehabilitation Center. NFAN has the largest case management program with 10 HIV case managers. These case managers have caseloads of approximately 75 clients each. HIV case managers from NFAN will travel to see clients in other counties in the Jacksonville MSA. NFAN also has a food pantry for anyone who is HIV-positive. Case management services are funded through Ryan White and Medicaid. Interview participants reported that reimbursements are relatively low for case management from both Medicaid and Ryan White and have declined over time creating a situation where organizations have had to limit their HIV case management services. The local Ryan White Part A program is reported to be working to realign funding to improve this situation. Focus group participants reported that HIV case management services were available in the community and differed in opinions regarding the quality of the case management services. Most participants agreed that funding cuts and high caseloads were a concern. Some focus group participants believed that many of the case managers have become burned out due to the stressful funding environment. In the outlying counties of the MSA, HIV case management services are covered through Ryan White Part B funds and located in county health departments.

JASMYN offers case management, food, support groups and social activities for their clients. Their case management focuses on addressing housing issues and other social services and educational needs.

JASMYN serves 400-500 youth, approximately 40 of these individuals are HIV-positive. For their HIV-positive youth, the case management services also focus on linking and retaining clients in medical care. This activity is often particularly challenging for the youth who are underage due to issues of parental consent and insurance coverage; JASMYN has been very involved in advocacy work in the community and relationship building with providers to ensure that the rights of HIV-positive youth to access care without parental consent are respected.

Several agencies have support groups for individuals living with HIV including NFAN, which has a support group for women. The UF CARES Clinic has support groups for adults and adolescents, including an HIV/AIDS Christian Women's Coalition Support Group, and a Men's and Women's Spiritual Support Group. Community Rehabilitation Center has support groups for individuals affected by HIV to provide support and educational services.

Duval Comprehensive Care Center facilitates a Peer Educational Group Support (PEGs) for newly diagnosed individuals that, in addition to meeting as a group, also pairs newly diagnosed individuals with someone who is farther along in HIV treatment. Respondents discussed PEGS' role in providing emotional support as well as improving their knowledge of resources and how to navigate the care system. A participant described her experience with the group:

(T)hey [DOH-Duval CCC employees] took it upon themselves to persuade me to come into the group; it took me a year and a half. Go into the room, find someone like yourself, get to know people around you, and that's how I branched out and found out how to go -- they told me to go to the therapist, I went to the therapist...So that's how I worked my way through the system.

Legal Assistance:

Legal assistance is available for individuals living with HIV in the Jacksonville MSA through Jacksonville Area Legal Aid (JALA), funded through Ryan White. Appointments are available in the JALA offices in Duval, Clay, and Saint Johns counties, as well as at satellite locations in DOH-Duval CCC, UF CARES, and the Nassau County Health Department.

Substance Abuse and Mental Health Treatment:

Several clinics and organizations that treat individuals living with HIV have Ryan White funding to provide mental health care including UF CARES, Lutheran Social Services, River Region Human Services, and the Community Rehabilitation Center.⁵⁵ At UF CARES, individuals receiving HIV medical care are screened for mental health concerns and the clinic has a psychiatrist and two psychologists who provide services in the clinic. The clinic can bill Medicaid or insurance for these services if patients have this coverage. Several participants reported that these HIV-specific services are not being utilized by individuals covered by Ryan White as much as they would have expected. One potential explanation offered for this lower utilization was high levels of stigma regarding mental illness. One focus group participant reported believing that there were not enough referrals being made to Ryan White providers and that if there were more referrals, the providers would be overwhelmed and inundated. Mental health services were also said to be available through the public mental health system.

There were differences in opinions among study participants regarding whether there was an adequate supply of mental health care to meet the needs of individuals with HIV. Some study participants believed that there would be sufficient mental health services to meet all of the needs of individuals living with HIV if they would utilize the services. In contrast, others believed that there was a shortage of available services to meet the mental health needs of individuals living with HIV, particularly in the public mental

health system. One participant cited research that identified Jacksonville as having the lowest public mental health spending in the state. This participant also emphasized the critical need for mental health services due to the high levels of trauma and depression among the HIV positive individuals with whom they work in the region. Another participant said that the poor reimbursement for mental health care through Medicaid results in a lack of mental health care availability, as many providers are reluctant to accept these reimbursement levels. A focus group participant mentioned that finding a psychiatrist in a timely fashion can be difficult, whereas finding a therapist is an easier process. One respondent living with HIV discussed her difficulty getting an appointment with a psychiatrist upon moving to the area,

... I could see a therapist here but I couldn't see a psychiatrist ... So I went without medicine for like four months.

Study participants identified crack as the primary drug that they see among HIV-positive individuals with substance abuse concerns. Injection drug use was reported to be much less of a concern in the community. Several Ryan White-funded substance abuse providers were listed by participants including the Gateway Community Services program and River Region Human Services. In addition, the counselors at UF CARES and Lutheran Social Services provide substance abuse counseling as well as mental health counseling for individuals living with HIV. Finally, River Region Human Services has a housing program for individuals in recovery. Federal Housing Opportunities for Persons with AIDS (HOPWA) funds are used to pay for people living with HIV to reside in this housing program. Some interview and focus group participants reported that the substance abuse services, particularly residential services, can be difficult to access for individuals living with HIV in the community.

Housing:

Interview and focus group participants reported that adequate housing is difficult to find in the area for individuals with lower incomes regardless of HIV status. There is a long waiting list for Section 8 housing and a lack of affordable housing in the region. Individuals living with HIV often face other barriers that limit their housing eligibility including substance abuse, mental health issues, and criminal records. The homeless shelter system was reported to be difficult to access at times because of eligibility restrictions and restrictions on duration of stay. There is a city rescue mission that will assist individuals who are homeless but participants noted that this program has restrictions regarding religious beliefs.

Interview and focus group participants reported that adequate housing is difficult to find in the area for individuals with lower incomes regardless of HIV status.

The federal Housing Opportunities for Persons with AIDS (HOPWA) program provides funding for housing for individuals living with HIV in the Jacksonville MSA. The funding is awarded to the city of Jacksonville to be dispersed to local agencies, including Catholic Charities, Northeast Florida AIDS Network, River Region Human Services and, Lutheran Social Services, that work with individuals living with HIV. For individuals that meet HOPWA eligibility criteria, the program can provide short-term mortgage assistance, short-term housing facilities payment, short-term utilities payment, rent and utilities deposits, and housing case management services. River Region Human Services has a long-term housing HOPWA program, Andy's Place, for individuals who have been homeless.⁵⁶ Participants reported that the HOPWA programs often run out of money before the fiscal year ends. Another participant discussed the significant need for more housing options for LGBT youth. This participant believed that additional housing options would help youth break the cycle of "sex to sleep," an exchange of sexual acts for lodging, which increases risk for acquiring HIV.

The Sulzbacher Center was also mentioned by several interview participants as a resource for HIV-positive individuals who are homeless.⁵⁷ In addition to providing HIV medical services for homeless individuals, the center offers shelter services including a residential center and case management.

HIV Prevention:

Participants described several sources that provide HIV testing including the Health Departments in each county, AHF, River Region Human Services, and Planned Parenthood. AHF and River Region Human Services have testing vans that are used to provide rapid HIV tests. River Region also offers testing on a daily basis at one of their locations and provides immediate linkage to medical care for individuals testing positive through their testing van or at their testing site. The UF Emergency Department will recommend HIV testing for individuals with another STI or other medical indicator/risk but does not have a standard protocol in place for HIV screening and testing. In addition, JASMYN, an organization working with LGBT youth offers HIV/STI testing as part of their STD testing and treatment clinic which is held two afternoons per month. Their HIV positivity rate among young black MSM is 10% and their positivity rate for other STIs is approximately 30%. JASMYN also has CDC funding for evidence-based HIV prevention interventions. Study participants generally believed that there was enough HIV testing availability in the area.

Most study participants reported frustration at the lack of prevention and education efforts directed to the general population such as billboards and other media campaigns. They believed that these broader efforts were needed in addition to prevention interventions directed at the highest risk populations in order to address a lack of education about HIV in the community and to combat HIV-related stigma. Participants did describe some efforts to provide HIV education in substance abuse treatment facilities and local churches. For example, the Duval County Health Department has an HIV education and testing initiative in black churches. One participant described improvement in how some of the churches respond to HIV; however, this individual felt that most still had a “love the sinner, hate the sin” mentality. This individual also described how many African American youth, particularly MSM, are detached from their churches for this reason. Another participant reported that smaller churches have been more likely to be supportive of HIV prevention efforts whereas the larger or “mega” churches have been slower to consider collaborating in prevention efforts. NFAN also provides HIV education in local churches. In addition, there is a peer-led organization, Women on a Mission, that provides education to churches in the area about HIV/AIDS. Colleges in the area were reported to be open to and supportive of HIV education and testing on their campuses. Condoms were reported to be widely available through the Duval Health Department and other prevention organizations.

Most study participants reported frustration at the lack of prevention and education efforts directed to the general population such as billboards and other media campaigns. They believed that these broader efforts were needed in addition to prevention interventions directed at the highest risk populations in order to address a lack of education about HIV in the community and to combat HIV-related stigma.

Participants did describe some efforts to provide HIV education in substance abuse treatment facilities and local churches. For example, the Duval County Health Department has an HIV education and testing initiative in black churches. One participant described improvement in how some of the churches respond to HIV; however, this individual felt that most still had a “love the sinner, hate the sin” mentality. This individual also described how many African American youth, particularly MSM, are detached from their churches for this reason. Another participant reported that smaller churches have been more likely to be supportive of HIV prevention efforts whereas the larger or “mega” churches have been slower to consider collaborating in prevention efforts. NFAN also provides HIV education in local churches. In addition, there is a peer-led organization, Women on a Mission, that provides education to churches in the area about HIV/AIDS. Colleges in the area were reported to be open to and supportive of HIV education and testing on their campuses. Condoms were reported to be widely available through the Duval Health Department and other prevention organizations.

In addition to providing HIV case management, the AIDS Service Organization, NFAN, runs a group for girls ages 5 to 15, called the Princess Club. Participants are mentored by members of the Healing Women support group, and learn the importance of self-respect and self-esteem and are encouraged to take control of their lives and decisions. They also learn how to stay HIV negative and be healthy.

Several participants lamented the absence of options to provide PrEP in the MSA. They said that very few of the medical providers have been willing to provide this service and reported some confusion in the community about how the costs associated with PrEP would be covered.

Study participants described a public school system that has been primarily abstinence focused in their approach to educating youth regarding sexuality/sexually transmitted diseases. However, the Duval County School Board is now implementing an abstinence-plus curriculum in health education classes that includes information on contraception and condoms within the context of strong abstinence messages. Additionally, the school system has a CDC Division of Adolescent School Health (DASH) grant that supports more comprehensive sex education in some schools.⁵⁸ The DASH grant, which is administered by Duval County Public Schools and began in 2011, provided five years of funding for the Duval County Health Department, working in partnership with JASMYN, to administer HIV and STI testing, STI treatment, linkage to HIV care, and comprehensive sex education to students at three family resource centers in Jacksonville. JASMYN assists in facilitating intake and connecting youth to educational and support resources. The family resource centers were developed through United Way's Full Service School program, to bring access for students and families to a range of therapeutic, health and social services on school campuses. The Health Department plans to bring the program to six of the Full Service School sites over the course of the five-year grant period.

A participant described how community participation in the Youth Risk Behavior Survey (YRBS), which highlighted the significant problem of youth sexual risk behaviors, was beneficial in demonstrating the need for more comprehensive sex education and support services in Jacksonville schools. In recent years, the YRBS included a section on LGBT, which has shown a very high prevalence of violence/threats in this population in Jacksonville schools. Surveys conducted among Jacksonville residents regarding sex education in schools found that a majority of those surveyed supported comprehensive sexual education, highlighting a disconnect between current policies and public opinion.

When asked about the high rates of HIV among women in the Jacksonville MSA in comparison to other MSAs, several participants attributed the higher rates to factors such as high unemployment and lower levels of education among minority women that place them at higher risk for participating in survival sex. It was also mentioned that married women and older women often believe they are safe from HIV so are not adequately practicing safe sex practices. One participant reported that primary care practitioners generally do not think it is important to educate or test married women so miss the opportunity to provide HIV prevention education in this population. A concern was also raised that primary care physicians do not address HIV and HIV risk among older women and men as these individuals are often not perceived as at risk and often do not perceive themselves at risk. Community Rehabilitation Center has a SAMHSA grant to address this issue. This grant provides funding for an evidenced-based HIV and substance abuse prevention program, called Ready to Respond, among older minority individuals in the Jacksonville community.

Stigma

Interview and focus group participants were unanimous in reporting that HIV-related stigma is still very high in the Jacksonville MSA. Most reported that stigma has changed little over time. Stigma was said to even be found in some of the health and social services organizations in the community. HIV-related stigma was reported to

Interview and focus group participants were unanimous in reporting that HIV-related stigma is still very high in the Jacksonville MSA.

permeate all facets of HIV care and prevention including willingness to participate in HIV testing, HIV treatment, and HIV advocacy. A participant described how individuals living with HIV are often afraid to attend the Ryan White planning council meetings lest they be seen and identified as HIV-positive. One participant stated that “*the stigma in this city is thick.*”

HIV-related stigma was reported to permeate all facets of HIV care and prevention including willingness to participate in HIV testing, HIV treatment, and HIV advocacy.

Stigma was reported to be particularly salient in the African American community and related to issues of gender identity and sexual orientation. A participant stated that stigma is particularly high for MSM:

Especially in the church. People will not disclose. They will not come out as HIV positive. They will not come out about being MSM.

Another participant stated that the

Health department has a whole initiative to work in the African-American faith community around HIV and so there are churches that do testing and that really there are a few pastors who are really welcoming, but they still love the sinner, hate the sin kind of thing and so it doesn't feel as welcoming to a lot of sexual minority folks or the LGBT folks. They go, they are in churches, we are in churches everywhere, but not necessarily feel like fully accepted and so that hiding, that experience of hiding oneself, that breeds problems.

The relationship of age and stigma was discussed by most participants. Some participants described the bravado they see among many youth, as they espouse the view that they can just “take a pill” if they contract HIV. However, one participant talked about how once the youth become positive and experience side effects and/or health issues they become very concerned about their health. Another participant reported that even the younger individuals they see still experience stigma, particularly internalized stigma. This individual reported not seeing as much complacency among young MSM, as she/he finds that many of the young men are terrified of the diagnosis and ashamed if they “slip-up” and have unprotected sex. The stigma was reported to be lower for these young men in the community of younger MSM than it is outside of this community.

The LGBT youth organization, JASMYN, started a youth panel, which includes local LGBT youth who provide education to community organizations on their experiences and offer recommendations about how to interact with LGBT youth. This program is described as addressing community stigma by providing education to dispel myths and prejudices in the community, as well as reducing feelings of stigma for youth involved in the program.

Participants described the MSA as very conservative and generally lacking in support from leaders for addressing HIV issues, which they believe contributes to the high community stigma. The mayor reportedly has never said the word HIV and has never agreed to participate in World AIDS Day activities. Several participants mentioned that there is a large Baptist Church in the area that is not supportive regarding HIV-related issues and wields considerable power in the community. One respondent noted that the “*city is owned by*” this

Participants described the MSA as very conservative and generally lacking in support from leaders for addressing HIV issues, which they believe contributes to the high community stigma.

church, and that, “*They have a huge stranglehold on this city and a lot of times it’s felt, perceived that what the Baptist church says goes for this whole city.*”

Political Climate and Advocacy

The Jacksonville MSA has both a Ryan White Part A planning group and an HIV prevention planning group that examine community needs and plans to address these needs through use of current funding or advocacy for additional funding. In addition, local organizations are reported to determine barriers in their HIV caseload and advocate with Ryan White or policymakers around specific issues that are identified.

There is a state-wide HIV/AIDS advocacy organization, Florida Advocacy Network, that some of the Jacksonville MSA organizations work with to advocate with state and local lawmakers. Very few consistent or structured advocacy efforts involving individuals living with HIV were identified in the Jacksonville MSA.

One respondent noted prior involvement in political advocacy efforts by local ASOs, but said that this involvement has diminished in recent years,

Years ago when I first started here ... we would send busloads of people up to Washington, DC when they do the march on Washington at that time. They were a few Rally in Tally and some people but that hasn’t happened in a very long time. One, none of us have the money. As far as I know, none of us have lobbyists on our staff so there’s really not any of that going on.

Community Strengths

Interview participants outlined a number of community strengths with respect to HIV care and prevention services. A majority of providers discussed collaboration between community providers as a significant strength. The collaboration between providers has been furthered in some instances because of funding requirements for collaboration. Participants had the following to say about collaboration:

A majority of providers discussed collaboration between community providers as a significant strength.

As a team, we all work well together.

It is small enough that providers really know each other and it is southern enough that people kind of get along...here, we may disagree, but we are still going to be civil, friendly, and I think part of being in the Bible belt is that there is a real earnestness, people really genuinely care and there is a lot of people who really want to make it better. They are like, do the right thing, make it right, there is that element.

A respondent discussed the intensive work that the Part A administrator, Dee Kelley, has done to facilitate communication and collaboration among stakeholders, as well as funding incentives to collaborate,

I mean I will tell you what really helps make it happen is funding. So, when the federal government says, collaborate ... you get points if you address this population and the only way to address is to work with those people. Then we are all at the table together, we are all trying to drop money down, everybody has got a stake in it, it funds staff to work together. That really has

been incredible and we have been the beneficiary of that four or five of those kinds of collaborations to build the programs.

However, there were a few participants that expressed reservations about community collaborations, believing that more work needed to be done to better collaborate and coordinate services.

Another strength mentioned by participants was that many HIV care and prevention leaders have substantial experience in providing HIV services in the Jacksonville community. In addition, several participants listed the Ryan White director as a strong advocate, leader and asset in the community. The presence of innovative programs, such as the prevention and care programs for LGBT youth at JASMYN and the linkage coordinator program utilizing peer navigators, was listed as a community strength.

Contributing Factors and Recommendations

When asked specifically about the factors contributing to the high HIV and AIDS diagnosis rates in the community, focus group and interview participants provided insight into causality including stigma-related concerns such as family rejection, fear of disclosure and hostility toward people living with HIV. Other factors included misinformation about HIV particularly in the African American community, lack of access to medical care because of barriers to care including transportation, issues of racial and socioeconomic segregation, and an adult gay population that is often disempowered. A respondent noted:

Here in Jacksonville, you don't want to be black. You don't want to be poor. You don't want to be uneducated. You don't want to have HIV and you don't want to be gay. Don't have any of those and when you start putting two or three of them together, you've got huge problems in this city... We're not just against people with HIV here. Like I said, those are five things you don't want that you have to box.

"Here in Jacksonville, you don't want to be black. You don't want to be poor. You don't want to be uneducated. You don't want to have HIV and you don't want to be gay. Don't have any of those and when you start putting two or three of them together, you've got huge problems in this city... We're not just against people with HIV here. Like I said, those are five things you don't want that you have to box."

When asked for ideas about addressing HIV in the Jacksonville area, respondents had the following suggestions including an increase in routine testing, initiation of syringe exchange, greater availability of PrEP, and having more centralized services, as several participants believed that services are often fragmented requiring travel between multiple types of services. A number of the recommendations centered around enhancing HIV education. More programs for teens/young adults were said to be needed, particularly that focus on comprehensive sex education rather than abstinence centered education.

An increase in general HIV education was recommended such as having information about HIV and other STDs on billboards, buses, and on the radio. One participant explained this by saying

I believe if we opened up about it more, talked about it more... put it on billboards. And all STDs, not just HIV. And not just emails; a lot of the target population we're talking about don't read

emails. I think it needs to be FB, Instagram, everything the younger people use.... I believe HIV has been forgotten... we are pushing that to the corner. And now we're talking about getting to zero as if this is ending, and it's not.

CONCLUSIONS

Collaboration between HIV providers in the Jacksonville area was one of the primary strengths cited by respondents who work in the HIV prevention and care system. Partnerships and collaborations between organizations were seen to enhance their efficiency, capacity, and to attenuate, when possible, the negative impact of limited resources to address HIV in the region. These collaborations benefit the organizations involved, and most importantly, the clients being served. As partnerships are often centered around funding streams, opportunities and structures for sustained collaboration were desired.

Respondents agreed that HIV testing is sufficient and available in the area, and most believed that medical care is available in the Jacksonville MSA to those who seek it and have transportation. The three main clinics, UF Cares, AHF, and DOH-Duval CCC, provide the majority of the HIV care in the area, without significant wait times for appointments. Concern regarding the movement of some of the HIV care physicians between clinics was discussed, and may negatively affect patients' retention in care due to the disruption of the provider-patient relationship and challenges navigating the system to follow their provider.

Social support services in Jacksonville were largely identified as in need of additional funding to meet the existing needs. HIV case management providers have faced funding cuts and are carrying high caseloads, potentially compromising the level of supportive services they can provide. Additionally, the availability of mental health services may be insufficient, and the stigma associated with mental illness inhibits access by many in need. Housing for those with low incomes was also seen as significantly lacking.

The expansive land area of the city itself and the larger MSA create significant transportation challenges for individuals without ready access to reliable transportation and for those living in more rural areas. The public bus system in the city was seen to be a financially prohibitive for those living in poverty.

Stigma is a significant barrier for prevention and engagement in HIV in Jacksonville. HIV stigma was described as deep and multi-faceted, synergistically enhanced by sexual orientation-related stigma. Respondents believed these stigmas were largely rooted in and sustained by the powerful, socially conservative Christian church presence in the area, found in both predominantly white and predominantly black churches. Programs that engage the churches in HIV education, testing and anti-stigma initiatives are present, but as of yet, limited in their dissemination and acceptance.

Respondents lamented the lack of comprehensive sexual education in schools and identified this deficiency as a driver of the high rate of HIV infection in the area. However, the innovative partnership between DOH-Duval and JASMYN to bring HIV and STI testing and comprehensive sexual education to the Full Service Schools in the area was lauded as a much needed step in the right direction. JASMYN was also highly praised as an effective and innovative program, providing much needed services and advocacy for the young LGBT population in the area, including a clinic imbedded

Recent efforts to utilize surveillance and care data to inform outreach to re-engage PLWHA who are lost-to-care was also regarded as an initiative likely to improve care engagement and secondary prevention.

in the youth center and high quality, wrap around linkage/case management services for HIV-positive youth. Recent efforts to utilize surveillance and care data to inform outreach to re-engage PLWHA who are lost-to-care was also regarded as an initiative likely to improve care engagement and secondary prevention.

The organizations providing HIV prevention and care are generally operating at maximum capacity, and lack resources to engage in sustained political advocacy at the local, state, and national levels. Advocacy opportunities for individuals living with HIV were also found to be lacking in the MSA.

This assessment of the HIV prevention and treatment infrastructure of the Jacksonville MSA provides insight into the strengths and challenges of the system, and identifies factors that may be influencing the high HIV and AIDS diagnosis and prevalence rates, as well as high death rates for PLWHA. The collaborative relationships among HIV care and prevention providers in the area should continue to be financially supported through joint funding opportunities. Additional resources and efforts are needed to improve HIV prevention efforts in the area, including universal access to comprehensive sexual education for youth. Educational programs in schools, faith communities, and the larger community are a necessity, and may have the added benefit of reducing stigma as well as decreasing HIV transmission. Increased

Barriers:

- ▶ *Lack of adequate transportation services*
- ▶ *Need for additional funding for case management*
- ▶ *Lack of affordable and adequate housing options*
- ▶ *High level of HIV-related stigma and stigma related to LGBT*
- ▶ *Lack of comprehensive sex education*
- ▶ *Little opportunity for advocacy for PLWHA*

Recommendations:

- ▶ *Increased resources for social services including transportation and case management*
- ▶ *Increase in housing options*
- ▶ *Community prevention and education efforts, particularly media focused*
- ▶ *Enhancing partnerships for education in faith communities*
- ▶ *Increasing PrEP availability*
- ▶ *Creation of advocacy opportunities for PLWHA*

support for social services for PLWHA in the area is needed, specifically for case management, housing, mental health services, and transportation assistance. The services will enable PLWHA to more consistently engage in the HIV medical care available, ultimately decreasing morbidity and mortality rates, improving their quality of life, and reducing new infections.

Figure 1. Jacksonville MSA Services and Service Gaps for each Step of the HIV Care Continuum

Prevent New Infections	Identify Those Infected	Link to Care	Retain in Care	Treat/Suppress Viral Load
SERVICE STRENGTHS				
HIV PREVENTION	HIV TESTING	LINKAGE TO HIV CARE	RETENTION IN HIV CARE	VIRAL SUPPRESSION
<ul style="list-style-type: none"> ▶ Evidence-based prevention programs (JASMYN); ▶ Duval Health Department (HD) some prevention in schools (DASH) ▶ HIV prevention/ education in churches (Duval HD, NFAN, Women on a Mission) ▶ Community Rehabilitation Center provides HIV prevention among older minority individuals 	<ul style="list-style-type: none"> ▶ HIV/STD testing at all Health Departments in MSA ▶ STD clinic at JASMYN provides STD/HIV testing ▶ River Region Human Services provides on-site testing ▶ Testing services in the community through River Region, AHF, JASMYN) ▶ Mobile outreach testing van through River Region and AHF 	<ul style="list-style-type: none"> ▶ Linkage services provided through River Region and JASMYN testing programs and linkage services provided by Duval HD and Lutheran Social Services ▶ Recent effort funded through Ryan White to hire peers to assist individuals not in medical care to return to care if willing. Program may continue on a smaller scale 	<ul style="list-style-type: none"> ▶ Bus passes/gas stipends to reach medical care through local ASOs ▶ Case management services through ASOs ▶ HOPWA (housing) services provided by Catholic Charities, Lutheran Social Services, River Region ▶ Legal services through Jackson Area Legal Aid ▶ Support groups available through ASOs and medical care 	<ul style="list-style-type: none"> ▶ UF Cares ID Clinic ▶ AIDS Healthcare Foundation ▶ Duval HD ID clinic (CCC) ▶ HIV primary care clinics in Clay and Baker Counties
SERVICE GAPS				
<ul style="list-style-type: none"> ▶ Lack of funding for HIV/STD education and health promotion programs in the community ▶ Challenges reaching youth with effective prevention programs (lack of comprehensive sex education in most schools) ▶ Lack of PrEP availability 	<ul style="list-style-type: none"> ▶ Stigma concerns delay testing ▶ Lack of standard HIV screening and testing protocols in ERs ▶ Lack of education and testing by primary care providers 	<ul style="list-style-type: none"> ▶ Lack of consistently available transportation resources ▶ Stigma concerns limit effectiveness of linkage efforts 	<ul style="list-style-type: none"> ▶ Stigma/disclosure concerns affect client engagement ▶ Lack of stable housing and not enough transportation funding ▶ Limited mental health/substance abuse care ▶ Reductions in funding for case management 	<ul style="list-style-type: none"> ▶ Significant travel to care is necessary for many individuals in outlying areas of the MSA ▶ Stigma concerns ▶ Clinic level barriers including movement of care providers and some of perception of lack of welcoming clinic environment

REFERENCES

1. Reif SS, Whetten K, Wilson ER, et al. HIV/AIDS in the Southern USA: A disproportionate epidemic. *AIDS care*. 2014;26(3):351-359.
2. Centers for Disease Control and Prevention. HIV Surveillance Report 2013, vol 25; published February 2015. http://www.cdc.gov/hiv/pdf/g-l/hiv_surveillance_report_vol_25.pdf.
3. Centers for Disease Control and Prevention. Diagnosed HIV infection among adults and adolescents in metropolitan statistical areas—United States and Puerto Rico, 2011. HIV Surveillance Supplemental Report 2013;18(No. 8). Revised edition. 2014; http://www.cdc.gov/hiv/pdf/HSSR_MSA_2013_REVISED-PDF04.pdf. Accessed February 10, 2015.
4. Centers for Disease Control and Prevention. Diagnoses of HIV infection in the United States and dependent areas. 2012; http://www.cdc.gov/hiv/pdf/statistics_2012_HIV_Surveillance_Report_vol_24.pdf. Accessed June 16, 2015.
5. United States Census Bureau. Selected data from the 2010 Census. http://www.census.gov/geo/reference/guidestloc/select_data.htmlfiles/155/select_data.html. Accessed June 27, 2014.
6. Kaiser Family Foundation. State Health Facts, 2011. <http://kff.org/statedata/files/157/statedata.html>. Accessed October 1, 2011.
7. Reif S, Geonnotti KL, Whetten K. HIV infection and AIDS in the Deep South. *American Journal of Public Health*. 2006;96(6):970-973.
8. Reif S, Whetten K, Lowe K. HIV/AIDS epidemic in the South reaches crisis proportions in the last decade. 2011; <http://chpir.org/wp-content/uploads/2012/11/HIVAIDS-Epidemic-in-the-South-Reaches-Crisis-Proportions-in-Last-Decade.pdf>. Accessed June 27, 2014.
9. Hanna DB, Selik RM, Tang T, Gange SJ. Disparities among US states in HIV-related mortality in persons with HIV infection, 2001-2007. *AIDS (London, England)*. Jan 2 2012;26(1):95-103.
10. Reif S, Pence BW, Hall I, Hu X, Whetten K, Wilson E. HIV diagnoses, prevalence and cutcomes in nine southern states. *J Community Health*. Dec 19 2014.
11. United States Census Bureau. Annual estimates of the resident population for the United States, regions, states, and Puerto Rico: April 1, 2010 to July 1, 2011. <http://www.census.gov/popest/data/state/totals/2011/files/162/2011.html>.
12. Centers for Disease Control and Prevention. Diagnoses of HIV infection in the United States and dependent areas. 2011; http://www.cdc.gov/hiv/library/reports/surveillance/2011/surveillance_Report_vol_23.html. Accessed June 27, 2011.
13. United States Census Bureau. State and county quickfacts: Florida. 2013; <http://quickfacts.census.gov/qfd/states/12000.html>. Accessed January 5, 2015.
14. City of Jacksonville. A rich and vibrant history. <http://www.coj.net/about-jacksonville/history.aspx>. Accessed January 5, 2015.
15. City of Jacksonville. Targeted industries. <http://www.coj.net/departments/office-of-economic-development/business-development/jacksonville-business-overview/targeted-industries.aspx>. Accessed January 6, 2015.

16. UF Health Science Center - Jacksonville. About us. <http://www.hscj.ufl.edu/about.aspx>. Accessed February 11, 2015.
17. Executive Office of the President, Office of Management and Budget. OMB Bulletin No. 13-01: Revised delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineations of these areas. February 28, 2013. <http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b13-01.pdf>. Accessed November 12, 2014.
18. United States Department of Commerce, Bureau of Economic Analysis. Bear facts: Jacksonville. <http://www.bea.gov/regional/bearfacts/action.cfm>. Accessed January 5, 2015.
19. United States Census Bureau. Poverty in the U.S. 2000-2012; September 2013. <http://www.census.gov/prod/2013pubs/acsbr12-01.pdf>. Accessed January 5, 2015.
20. Kids Count. Children in poverty, 2013. <http://datacenter.kidscount.org/data/Tables/43-children-in-poverty>. Accessed January 6, 2015.
21. United States Bureau of Labor Statistics. Occupational employment statistics, May 2013. <http://www.bls.gov/oes/tables.htm>. Accessed January 6, 2015.
22. Kneebone E, Nadeau C, Berube A. The re-emergence of concentrated poverty: Metropolitan trends in the 2000s. 2011; <http://www.brookings.edu/research/papers/2011/11/03-poverty-kneebone-nadeau-berube>. Accessed January 28, 2015.
23. Jacksonville Metropolitan Community Partnership. Community Health Needs Assessment. 2012; http://shands.thehcn.net/content/sites/hpcnef/2012_CHNA_REPORT_FINAL.pdf/. Accessed January 15, 2015.
24. Kaiser Family Foundation. State health facts: Life expectancy at birth (in years). <http://kff.org/other/state-indicator/life-expectancy/>. Accessed January 15, 2015.
25. Miniño AM, Murphy SL. Death in the united states, 2010. *NCHS Data Brief*. 2012 2012;99(10):1-8.
26. Florida Department of Health, Division of Public Health Statistics and Performance Management. Florida CHARTS (Community Health Assessment Resource Tool Set). http://www.floridacharts.com/charts/mapp_report.aspx. Accessed January 15, 2015.
27. Trust for America, Robert Wood Johnson Foundation. The state of obesity. <http://www.fasinfat.org/states>. Accessed January 15, 2015.
28. The National Campaign to Prevent Teen and Unplanned Pregnancy. Fact sheet: Key information about Florida. <http://thenationalcampaign.org/sites/default/files/resource-primary-download/Florida.pdf>. Accessed January 30, 2015.
29. Florida Department of Health, Division of Public Health Statistics and Performance Management. Florida CHARTS (Community Health Assessment Resource Tool Set): County birth data comparison. http://www.floridacharts.com/charts/mapp_report.aspx. Accessed January 28, 2015.
30. Florida Department of Health, Division of Public Health Statistics and Performance Management. Florida CHARTS (Community Health Assessment Resource Tool Set): Infant deaths. <http://www.floridacharts.com/charts/DataViewer/InfantDeathViewer/InfantDeathViewer.aspx>. Accessed January 28, 2015.

31. Florida Department of Health, HIV/AIDS Section. County or state comparison: Disease rates 1990-2012. <http://www.floridahealth.gov/diseases-and-conditions/sexually-transmitted-diseases/std-statistics/index.html>. Accessed January 28, 2015.
32. Centers for Disease Control and Prevention. NCHHSTP Atlas 2012; <http://gis.cdc.gov/GRASP/NCHHSTPAtlas/main.html>. Accessed October 5, 2015.
33. Centers for Disease Control and Prevention. 2013 sexually transmitted diseases surveillance. Tables. 2014; <http://www.cdc.gov/std/stats13/tables.htm>. Accessed October 5, 2015.
34. United States Census Bureau. Selected economic characteristics. 2009-2013 American Community Survey 5-Year estimates. <http://factfinder2.census.gov>. Accessed February 4, 2015.
35. Health Resources and Services Administration. Designating places & populations as medically underserved: A proposal for a new approach. <http://bhpr.hrsa.gov/shortage/proposedrule/designatingplaces.html>. Accessed September 22, 2015.
36. Health Resources Services Administration. Medically underserved areas/populations: Guidelines for MUA and MUP designation. <http://hrsa.gov/shortage/mua/index.html>. Accessed February 4, 2015.
37. Health Resources Services Administration. HPSA designations, 2014. http://datawarehouse.hrsa.gov/DataDownload/FRN/D_BCD_HPSA_H1_FederalRegister.pdf. Accessed February 4, 2015.
38. Health Resources Services Administration. Find shortage areas: MUA/P by state and county. <http://muafind.hrsa.gov/index.aspx>. Accessed December 4, 2014.
39. Florida Department of Health, Bureau of Communicable Disease,, HIV/AIDS Section. 2013 United States vs. Florida factsheet. http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/fact-sheet/2013-us-vs-fl.pdf. Accessed February 5, 2015.
40. Florida Department of Health, Division of Public Health Statistics and Performance Management. Florida CHARTS (Community Health Assessment Resource Tool Set): AIDS cases, 2013. <http://www.floridacharts.com/charts/CommunicableDiseases/>. Accessed February 5, 2015.
41. Florida Department of Health, HIV/AIDS Section,,Division of Disease Control and Health Promotion. Epidemiology of HIV infection trends in Florida reported through 2013. http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/hiv-aids-slide-sets/state-trends-20131.pdf. Accessed February 5, 2015.
42. Branson BM, Handsfield HH, Lampe MA, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR. Recommendations and reports : Morbidity and mortality weekly report*. Recommendations and reports / Centers for Disease Control. Sep 22 2006;55(Rr-14):1-17; quiz CE11-14.
43. Kaiser Family Foundation. Total federal HIV/AIDS grant funding, 2013. <http://kff.org/hivaids/state-indicator/total-federal-grant-funding/>. Accessed February 10, 2015.
44. Kaiser Family Foundation. Ryan White Program funding by part, FY 2014. <http://kff.org/hivaids/state-indicator/funding-by-part/>. Accessed September 22, 2015.

45. Health Resources Services Administration. Data Warehouse: HIV/AIDS, Ryan White HIV/AIDS Program annual data report providers by state report. <http://datawarehouse.hrsa.gov/Topics/Hab.aspx>. Accessed February 10, 2015.
46. UF Center for HIV/AIDS Research, Education and Service. About the center. <http://www.hscj.ufl.edu/pediatrics/ufcares/about.aspx>. Accessed February 10, 2015.
47. Kaiser Family Foundation. Medicaid income eligibility limits for adults at application, as of April 2015. <http://kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/>. Accessed August 24, 2015.
48. Kaiser Family Foundation. The coverage gap: Uninsured poor adults in states that do not expand Medicaid - an update. 2014; <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>. Accessed August 24, 2015.
49. Kaiser Family Foundation. Medicaid payments per enrollee, FY2011. <http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/>. Accessed February 10, 2015.
50. Kaiser Family Foundation. Medicaid benefits: Online database. 2012. <http://medicaidbenefits.kff.org/>. Accessed February 11, 2015.
51. Florida Agency For Health Care Administration. Florida Medicaid Preferred Drug List (08-24-2015). http://www.fdhc.state.fl.us/medicaid/Prescribed_Drug/pharm_thera/pdf/PDL_08-24-2015.pdf. Accessed September 22, 2015.
52. Kaiser Family Foundation. State Medicaid coverage of routine HIV screening. <http://kff.org/hivaids/fact-sheet/state-medicaid-coverage-of-routine-hiv-screening>. Accessed February 11, 2015.
53. Jacksonville Area Sexual Minority Youth Network, JASMYN. Homepage. <http://jasmyn.org/>. Accessed August 25, 2015.
54. Centers for Disease Control and Prevention. Effective interventions. High impact prevention: Data to care. <https://effectiveinterventions.cdc.gov/en/highimpactprevention/publichealthstrategies/DataToCare.aspx>. Accessed August 25, 2015.
55. City of Jacksonville. Metropolitan Jacksonville area HIV health services. <http://www.coj.net/departments/special-services/behavioral-and-human-services/ryan-white-c-a-r-e-act,-part-a/ryan-white-services-and-providers.aspx>. Accessed August 25, 2015.
56. River Region Human Services Inc. Supportive housing in Northeast Florida. <http://www.rrhs.org/housing-3/>. Accessed August 25, 2015.
57. Sulzbacher Center. Homepage. <http://www.sulzbachercenter.org/>. Accessed August 25, 2015.
58. United Way of Northeast Florida. Onsite clinics help fight HIV and STI epidemic among youth. <http://www.unitedwaynefl.org/blog/hiv-std-full-service-schools-health-clinics/>. Accessed August 25, 2015.