DECEMBER 2020

ENDING THE HIV EPIDEMIC

MIAMI-DADE COUNTY

LOCAL HIV/AIDS JURISDICTIONAL PLAN

Florida HEALTH
Miami-Dade County

THE TIME IS NOW FOR MIAMI-DADE COUNTY

On September 21, 2020, the local planning body, known as the Miami-Dade HIV/AIDS Partnership, approved the Ending the HIV Epidemic (EHE) Plan for Miami-Dade County. The planning board oversees public programs for people with HIV and acts as an advisory committee to the Board of County Commissioners and Mayor of Miami-Dade County on HIV/AIDS-related issues. The new jurisdictional plan supports the national Ending the HIV Epidemic: A Plan for America initiative and its key strategies to reduce new HIV infections by 90% in the next ten years.

The creation of the plan provided an opportunity to expand and strengthen existing relationships and engage new voices in the local efforts. The feedback enabled a more robust plan that tackles the various social determinants of health that have fueled high HIV rates in our communities. The Joint EHE Committee's creation helped further develop the plan into twelve strategies and forty-seven activities detailing innovative efforts needed to move Miami-Dade County into a new era free of new HIV infections. As these efforts move forward, a collective impact approach will be vital to the plan's success and sustainability.

We thank the members of the Joint EHE Committee, Ryan White Part A, our partners, and the community for contributing to the creation of the plan that leaves no communities behind. The recommended strategies and activities will build upon the progress already made through state and local efforts. The time is now to end the HIV epidemic for Miami-Dade County.

Sincerely,

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INTRODUCTION

Miami-Dade County (MDC) faces one of the highest incidence rates of HIV in the United States. With more than 27,000 people living with HIV/AIDS in our county, HIV has a substantial impact on our communities. The Ending the HIV Epidemic (EHE) initiative, proposed by the U.S. Department of Health and Human Services, aims to address HIV on a national scale. The EHE initiative supports local efforts of communities impacted the hardest by HIV across the nation. The EHE initiative has identified Miami-Dade County as one of the geographical hotspots that will receive additional resources and technology for phase one. This initiative aims to reduce HIV transmission rates by 75% by 2025 and 90% by 2030.

Four pillars provide the backbone for the EHE initiative:

- Diagnose all people with HIV as early as possible.
- Treat people with HIV rapidly and effectively to reach sustained viral suppression.
- Prevent new HIV transmissions using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

The Florida Department of Health in Miami-Dade County (FDOH-MD), Health Council of South Florida (HCSF), Ryan White Part A, and other vital partners collaborated in the jurisdictional analysis and creation of the EHE plan for Miami-Dade county.

"TODAY WE HAVE THE RIGHT DATA, RIGHT TOOLS, AND RIGHT LEADERSHIP TO END THE HIV EPIDEMIC."—HHS SECRETARY ALEX M. AZAR II

WHERE WE'RE AT TODAY

Miami-Dade County's top priority populations for primary HIV prevention were identified based on the percentage of HIV cases diagnosed from 2017 to 2019. The data indicates that the top five priority populations are Hispanic/Latinx MSM (leading the chart with 49.5% of HIV cases diagnosed), followed by Black heterosexual (16.8%), Black MSM (11.7%), Hispanic/Latinx heterosexual (11.2%), and White MSM (7.4%). The percentage of cases in Miami-Dade County shows a significant difference compared to Florida, specifically for the Hispanic/Latinx MSM population (25.4%), which doubles the percentage of cases.

A recent jurisdictional analysis found that the top ten social determinants of health that the community felt impacted HIV prevention and care in Miami-Dade County were:

- Homelessness
- Mental health
- Substance use
- Immigration status
- Underinsured/uninsured
- Discrimination
- Transportation
- Underemployment/ unemployment
- Domestic violence/sexual assault
- Human trafficking
- Affordable housing
- Living wages
- Incarceration.

The social determinants are listed in order of priority and differed by the zip code cluster. Additional gaps specific to People with HIV (PWH) include underutilization or unavailability of vision care, nutrition, long wait times for services, limited resources, stigma, and proper adherence to medication. These social determinants of health exacerbate HIV health disparities. Therefore, understanding the multilevel and intersecting nature of these conditions were key to developing the local jurisdictional plan.

WHERE WE'RE **GOING**

To tackle the relevant county-level disparities, the Department of Health in Miami-Dade County will implement a collective impact approach by bringing together organizations from different sectors and aligning efforts to end the HIV epidemic. The Department of Health in Miami-Dade County will strengthen collaboration with non-traditional partners and invite new voices to the table. Critical Stakeholders include Black, Latinx, and LGBTQ+ leaders, faith-based organizations, local government representatives, and private agencies.

Additionally, fostering relationships with free clinics, federally qualified health centers, hospitals, and urgent care centers will expand the reach to communities who have yet to received HIV services. Targeted social media marketing strategies, education and funding opportunities to grassroots agencies will help reduce ethnic and racial health disparities and promote equity. The implementation of various activities denoted within the EHE plan aim to create a lasting impact on reducing transmission rates in Miami-Dade County.

COLLECTIVE **IMPACT APPROACH** TO EHE

September 2019 - September 2020
EHE Community Engagement Activities

More than 100 community engagement activities were conducted throughout the jurisdiction to strengthen existent and new relationships with diverse stakeholders

October 2019 - February 2020
Jurisdictional Analysis Report

Multiple town hall meetings, surveys, online efforts, needs assessments. interviews conducted by the Health Council of South Florida (HCSF),

February 2020 - September 2020
Community Meetings

FDOH provided updates on EHE, as well as opportunities for discussion and feedback on the plan and invited new groups to join in on EHE efforts.

February 2020
Community Survey

FDOH-MD released a survey on the EHE Draft Plan to gather additional feedback from the community.

June 2020
Creation of an EHE website

The HCSF created a website that will help track local EHE indicators..

March 2020 - September 2020
Joint EHE Committee Meetings

Multiple meetings led by the Strategic and Prevention committee in which community members were invited to be part of the review of the EHE plan.

September 2020
Jurisdictional Plan Approved

Concurrence reached on the EHE final plan by the Miami-Dade HIV/AIDS Partnership

JOINT EHE COMMITTEE

PREVENTION COMMITTEE & STRATEGIC PLANNING COMMITTEE

The Prevention Committee and the Strategic Planning Committee under the Miami-Dade HIV/AIDS Partnership joined in March 2020, to create the Joint Ending the HIV Epidemic (EHE) Committee. The Joint EHE Committee's purpose was to review further and analyze the EHE draft plan that resulted from the jurisdictional analysis conducted by the Health Council of South Florida. The review entailed discussing each strategy and activity under each of the four pillars in the plan (diagnose, treat, prevent, and respond). The committee and community members then provided further guidance on how to develop the plan further.

The final plan includes feedback from the EHE survey conducted in March 2020 (throughout Miami-Dade County), Federally Qualified Health Centers' (FQHCs) survey, key stakeholders, and multiple virtual EHE Joint meetings facilitated by the Behavioral Science Research team.

During the entire process, the plan was revised and tailored to the needs of the jurisdiction. The EHE final plan reached concurrence at the Partnership Committee meeting, in which it was voted and approved.

JURISDICTIONAL PLAN*

DECEMBER 2020

*PLEASE BE ADVISED THAT THIS IS A LIVING DOCUMENT AND MAY BE SUBJECT TO CHANGE AT ANY TIME.

PILLAR ONE: DIAGNOSE

ROUTINIZED OPT-OUT TESTING

a) Identify the barriers for routinized opt-out testing in specific health systems and design ways to reduce the systemic cost of testing.
   i. Support legislation that addresses barriers identified for opt-out testing.

b) Educate medical providers, Federally Qualified Health Centers (FQHCs), emergency rooms (ERs), and other clinical organizations throughout the county (i.e. not just those funded by Florida Department of Health (FDOH) and/or the Ryan White HIV/AIDS Program (RWP)) on the importance of cost-efficient HIV testing and the benefits that come with opt-out testing.
   i. Utilize academic detailing to educate providers on routine testing inclusive of Hepatitis C virus (HCV) and sexually transmitted infections (STIs).
   ii. Partner with Dade County Medical Association and other professional groups to educate and promote HIV testing in the health care settings.
   iii. Highlight changes in HIV Florida law as it applies to healthcare settings.

c) Recruit hospitals/urgent care centers to routinize HIV testing in the ER.
   i. Facilitate meetings between hospitals/urgent cares and community partners for partnership development.
   ii. Promote public/private partnerships to support testing and linkage in the ER.

d) Expand routinized testing for HCV and STIs together with HIV.
   i. Provide capacity building and technical assistance to providers.
   ii. Identify funding opportunities to support STI testing.

COMMUNITY ENGAGEMENT

a) Use social marketing strategies to encourage people to get tested and into care with a focus on populations most at risk for HIV.
   i. Build a media campaign that highlights the importance of knowing your status while addressing stigma.
   ii. Include community leaders, community members and social media influencers from diverse backgrounds in messages to promote diversity and inclusion.
      i. Disseminate messages through partnerships/collaboration with community partners, faith-based organizations, community mobilization groups, grassroots agencies, substance abuse and mental health agencies, domestic violence shelters, jails, etc.
   iii. Increase efforts on social media, while maintaining a consistent presence in other venues (i.e. billboards, TV/radio, etc.) and incorporate innovative strategies such as geofencing.

PILLAR ONE: DIAGNOSE

b) Promote the use of home testing kits (HIV) as an alternative option specially for hard to reach populations including youth, transgender persons, sex workers, and men who have sex with men (MSM).
   i. Use social media platforms as potential ways of connecting individuals with an HIV counselor.
   ii. Collaborate with community partners to expand access points and mail-order options, inclusive of dental providers.

c) Partner with Miami-Dade County Public Schools to increase access to HIV/STI testing and education among youth.
   i. Educate Parent Teacher Association (PTA) and members of the school board on the scope of the HIV epidemic among youth in Miami-Dade, inclusive of charter schools.
   ii. Active participation in the School Health Advisory Committee (SHAC).

d) Increase the number of HIV/STIs testing sites in the community.
   i. Partner with faith-based organizations, domestic violence/human trafficking agencies and other non-traditional partners to offer HIV/STI testing outside traditional settings.
      i. Provide capacity building and technical assistance on an ongoing basis.
      ii. Identify funding to support additional HIV/STI testing sites.

e) Increase the number of mobile units offering HIV/STI testing in the community.
   i. Avoid related stigma, by ensuring activities and include other services needed in the community (i.e. mental health counseling).

f) Increase capacity building and education among HIV counselors and/or case managers.
   i. Update HIV counselor training to include information on social determinants of health (i.e. human trafficking, trauma-informed care, domestic violence, mental health, stigma, and LGBTQ cultural competency, etc.).
   ii. Support the development of ongoing HIV learning for case managers, providers, peers, and outreach workers (retention in care).

g) Determine the needs of Disease Intervention Specialist (DIS) workforce.
   i. Build capacity, workforce, and tailor activities to align with Ending the HIV Epidemic (EHE) efforts.

PILLAR TWO: TREAT

CAPACITY AND ACCESS TO LOCAL TEST AND TREAT/RAPID ACCESS (TTRA)

a) Review current TTRA partners and identify strategies to engage potential and non-traditional partners.
   i. Focus explicitly on vulnerable populations with limited access to testing and treatment (i.e. Black and Latinx communities).

b) Promote and educate private sectors including insurance companies, hospitals, and health care providers on the benefits of TTRA.

c) Work with hospitals and healthcare organizations that routinely screen for HIV/HCV to ensure a streamlined path to TTRA for patients in ER settings.
   i. Foster collaboration between ER settings, healthcare organizations, and TTRA providers in the community.

d) Maintain a comprehensive database of resources or information for TTRA partners to facilitate linking clients to appropriate care programs and services based on income and eligibility for insurance and other benefits programs.

e) Expand the use of technology to agencies and clients to reduce barriers to care for eligible patients.
   i. Evaluate barriers for implementation and expansion of TTRA through qualitative methods (i.e. surveys, focus groups, etc.).

CAPACITY BUILDING FOR HEALTHCARE PROFESSIONALS

a) Encourage primary care providers and clinical staff to seek HIV certification.
   i. Special focus on South Dade/Homestead, Hialeah, and other places where HIV specialists are scarce.
   ii. Support policies that require HIV education as part of standard curriculum and required continuing education credits.

b) Promote events and trainings where health care providers and clinical staff can learn about cultural sensitivity and competency as it relates to providing care for people with HIV.
   i. Collaborate with RWP Part A to encourage providers to complete AIDS Education and Training Center (AETC) cultural diversity training.

c) Educate physicians and nurse practitioners on RWP services.
   i. Engage health care community through medical associations and provider grand rounds.

d) Expand service-hour availability for oral health care providers under RWP Part A.
   i. Identify and share dental care resources to individuals not eligible for RWP.

PILLAR TWO: TREAT

SOCIAL NEEDS OF PEOPLE WITH HIV AND SOCIAL DETERMINANTS OF HEALTH

a) Housing resources and access.
   i. Increase collaboration and coordination with Housing Opportunities for Persons with AIDS (HOPWA) to further develop housing support programs.
      i. Determine feasibility and potential of having public-private partnerships to secure subsidized and affordable housing for people with HIV.
      ii. Include partnerships with the County and the City as well as the private sector, and support programs that promote economic stability for people with HIV.

b) Improving transportation access.
   i. Provide transportation for people with HIV to services including case management, AIDS Drug Assistance Program (ADAP), etc.
   ii. Determine feasibility with private transportation systems such as Uber Health and Lyft to increase access to services, as well as expand Special Transportation Services (STS) options.

c) Improve access to and retention in care.
   i. Support changes in ADAP policy to allow for more than one ADAP pharmacy, extended hours, or for medications to be made accessible at other pharmacies.
   ii. Increase the number of HIV service providers that offer extended hours for case management and clinical services.
      i. After-hours during the week and/or weekends.
   iii. Increase the number of agencies that offer telehealth services for medical care, medical case management, and mental health services.
      i. Video Direct Observation Therapy (VDOT) protocol to assist clients who struggle with treatment adherence issues.
      ii. Enhanced peer educator services.
   iv. Support cost-sharing mechanisms that can help reduce the cost burden on people with HIV who are insured or underinsured.
   v. Utilize findings from the needs-assessment (conducted by the county and the state) to address barriers to retention in care by collaborating with AIDS organizations, community-based organizations (CBOs), FQHCs, RWP, etc.

d) Support marginalized communities.
   i. Partner with agencies that serve individuals who have recently arrived at the jurisdiction, immigrants, uninsured, and underinsured populations and provide information on available resources (i.e. faith-based organizations/legal aid organizations, etc.).
   ii. Improve linkage-to-care systems for those who have been recently released from jails.

PILLAR TWO: TREAT

MARKETING STRATEGIES THAT DESTIGMATIZE HIV CARE AND ENCOURAGE PEOPLE WITH HIV TO STAY IN CARE

a) Promote messages on various social media platforms and increase messaging in high prevalence areas.
   i. Develop and support culturally tailored prevention messages to destigmatize HIV (i.e. Undetectable=Untransmittable (U=U)).
   ii. Deliver messages to people with HIV through peer educators and representatives of the HIV-affected community.
   iii. Have peer educators highlight personal success and struggles by empowering people with HIV to thrive despite their status.

PILLAR THREE: PREVENT

SOCIAL MARKETING & MEDIA

a) Customize messaging on pre-exposure prophylaxis (PrEP)/ nonoccupational post-exposure prophylaxis (nPEP) to at risk populations, with an inclusive message that promotes diversity (inclusive of multi-lingual messages).
   i. Identify strategies to track and evaluate the effectiveness of marketing campaigns (i.e. surveys, focus groups).

b) Increase social media efforts to engage and connect the population on PrEP/nPEP and educate the online community about the benefits and accessibility of PrEP/nPEP.
   i. Use social media influencers to disseminate messages.
   ii. Develop campaigns to engage health care professionals within the health care settings and identify PrEP ambassadors.

c) Collaborate with CBOs and engage non-traditional partners to support HIV prevention messages to further destigmatize HIV.

COMMUNITY ENGAGEMENT

a) Utilize mobile units to increase PrEP/nPEP uptake.
   i. Include a referral system for continued PrEP services.
   ii. Support coordination of efforts among providers to avoid duplication of services.
   iii. Utilize surveillance data to identify high risk communities.

b) Outreach and education:
   i. Utilize peer educators/community health workers to better reach communities where they are and provide education on PrEP/nPEP and HIV prevention.
      i. Promote Ready, Set, PrEP initiative.
   ii. Host interactive community events with diverse partners on PrEP/nPEP and resources on sexual health.
   iii. Continue distribution of free condoms at outreach events and non-traditional settings.
   iv. Utilize academic detailing to educate health care providers on PrEP/nPEP, to increase accessibility.

c) Inform the community about post-exposure prophylaxis (PEP) and where to obtain it.
   i. Increase access points and extend afterhours and weekend hours.
   ii. Create a comprehensive list of PrEP/nPEP providers.
   iii. Assess the feasibility of a PEP referral system.

d) Support local Syringe Service Programs (SSPs) and partner in EHE efforts when possible.

PILLAR THREE: PREVENT

ACCESS TO PREP

a) Pharmacy access:
   i. Support pharmacy-driven PrEP protocols.
   ii. Identify best practices in other jurisdictions and develop a local protocol in collaboration with pharmacies and partners.
   iii. Evaluate potential barriers to initiating PrEP in a pharmacy setting compared to a medical provider.

b) Educate community members and providers on the Ready, Set, PrEP initiative.

c) Identify and address barriers that providers may have on prescribing same-day PrEP.

d) Identify and share best practices by agencies that have utilized TelePrEP to expand providers' capacity of offering TelePrEP services.

e) Support the utilization and accessibility of TelePrEP services for underserved and at-risk communities, through education.

f) Use academic detailing to engage and educate medical providers to further increase potential access points for PrEP.
   i. Review PrEP provider database to target areas in need.

g) Support state policy change to allow 13-17-year-olds to access PrEP without parental consent.

PILLAR FOUR: RESPOND

MOBILE RESPONSE TEAM

a) Improve linkage to care in response to HIV clusters, including mobile response unit or team to engage clients and link them to appropriate resources (medical home, HIV medical care, and antiretroviral therapy (ART)) in the community.

b) Identify HIV/STI testing partners/agencies to support the mobile response team.
   i. Include RWP partners in the mobile response team efforts to facilitate immediate linkage to care.

c) Incorporate information on resources for delivery to at-risk communities.
   i. Have PEP and PrEP available in mobile units.

COMMUNITY ENGAGEMENT

a) Identify key community partners that can educate the community and assist in disseminating information on cluster-related activities.
   i. Collaborate with community mobilization groups to support the delivery of messaging.
   ii. Provide additional resources to support CBOs' ability to provide HIV prevention and care services.

b) Encourage medical providers to participate more heavily in outbreak situations.

STRATEGY AND PLANNING

a) Develop a communication plan to be shared with partners.

b) Develop a protocol for cluster investigations.

c) Increase HIV genotyping testing to better determine clusters or "pockets" of HIV cases.