ENDING THE HIV EPIDEMIC IN MIAMI-DADE COUNTY

Accelerating Local and State HIV Planning to End the Epidemic

Revised Version December 2020

Prepared by the Health Council of South Florida, in collaboration with the Florida Department of Health in Miami-Dade County

HCSF
Health Council of South Florida, Inc.

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MIAMI-DADE COUNTY

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Executive Summary

The Ending the HIV Epidemic (EHE) in Miami-Dade County project was developed in collaboration with the Florida Department of Health in Miami Dade County (FDOH-MD) and the Health Council of South Florida (HCSF), to provide the foundation for a plan to address Miami-Dade County's significantly high HIV transmission rates. This project is driven by the broader *Ending the HIV Epidemic: A Plan for America* initiative, based on four key pillars to fight HIV: **Diagnose**, **Treat**, **Prevent**, and **Respond**. This report outlines the activities completed in this project and provides analyses of data collected on the HIV prevention and care systems in Miami-Dade. The FDOH-MD and the HCSF rallied the community to obtain and gather feedback to aid in the development of this report. Public input sessions, in-depth interviews, reviews, needs assessments, survey results, and other methods informed the situational analysis presented throughout this report; strengths, weaknesses, opportunities, and threats (SWOTs) are also presented in various tables, albeit with many of the same factors overlapping.

The needs assessment findings and quantitative data analysis suggest that HIV significantly impacts the Miami-Dade community. There are substantially higher rates of HIV transmission in Miami-Dade compared to other metropolitan areas, and there are many health disparities that exist between at-risk groups. While men who have sex with men (MSM) continue to be the group at the highest risk for contracting HIV, Black and Latinx communities face additional risks and barriers to care. Findings from focus groups and interviews conducted show that there is a greater need for inclusivity and diversity in HIV efforts. A cluster analysis of Miami-Dade also found that there are specific issues faced by residents inclusive of people living with HIV/AIDS (PLWH) in the 13 areas that the county was divided by. There is a much larger proportion of heterosexual mode of transmission of HIV in Cluster 13 (Downtown and surrounding area) compared to Cluster 12 (Miami Beach), for example. Cluster 1 (Homestead) experiences unique barriers given its more rural location and lack of resources, even though there is a higher prevalence of HIV in this cluster compared to some other clusters.

The FDOH-MD EHE Survey and the EHE Provider Survey administered by HCSF were key tools used in engaging the community and gathering broader community input. The FDOH-MD EHE survey gathered 1,158 responses from community members and the provider survey had 37 HIV service providers give input on HIV care. Those surveyed with both tools come from a diverse background in all aspects: age, race, ethnicity, gender, among other demographic indicators. Results from the EHE survey show that participants highlighted homeless, mental health issues, and substance abuse as top issues which affect access to HIV services. Participants also highlighted the need for increased HIV testing and access to PrEP. Results from the EHE Provider Survey found that, while there are an array of services available to PLWH, many are underutilized or cannot be accessed easily due to existing barriers. Vision, nutrition, and mental health services are underutilized according to providers; barriers and challenges include long wait times, limited resources, stigma, and proper adherence. The issues raised in the FDOH-MD EHE Survey parallel those found in the EHE Provider Survey.

The main findings across all the project's components align generally with the four EHE pillars. There is a basic infrastructure in place within the HIV prevention and care systems of Miami-

Dade, with many strong points and key players. The FDOH-MD has cultivated key partners in their efforts and the rollout of their Test & Treat/Rapid Access model has been positive; other organizations have unique strategies and processes in place that also point to opportunity. There are weaknesses within these systems and factors that also concern participants, such as the lack of information on PrEP in the community and barriers to care for low-income and homeless PLWH. Findings suggest that there is an enormous amount of room for improvement in Miami-Dade, as participants shared multiple thoughts on opportunities and strategies to use for improving these HIV prevention and care systems. Technology, social media, and partnerships are all examples of factors that can help improve how information and services are delivered to Miami-Dade County residents. An additional opportunity lies in the finding that the organizations and key players are all present within Miami-Dade, the issue lies more with the fact that the systems themselves are fragmented. The main themes identified throughout the qualitative analyses, which parallel findings from the survey analyses and reviews, include but are not limited to: HIV testing, HIV education, social determinants of health, community engagement, linkages to care, medical providers, and prevention strategies.

From the findings of this report, key strategies and activities were developed in order to address the four EHE pillars and further engage the community on EHE efforts. Activities and strategies vary according to pillar. For example, strategies under Pillar Two (Treat) include capacity building for healthcare professionals, addressing the social needs of PLWH through social determinants of health, and destigmatizing HIV care by using media marketing strategies. Addressing Pillar Three (Prevent) will require the increased use of technology (such as telePrEP) and community engagement in order to familiarize the community with PrEP. Strategies and activities under different pillars can overlap and synergize in order to support overall EHE efforts in Miami-Dade County.

This EHE report provides a wealth of foundational information that, once implemented alongside other efforts, can have a tremendous and lasting impact on reducing transmission rates in Miami-Dade County. Activities aligned with the four pillars will ensure that we focus on our targets and stay on track to achieving our objective of getting to zero transmissions.

Introduction

Miami-Dade County (MDC) faces one of the highest incidence rates of HIV in the United States.[1] With more than 27,000 people living with HIV/AIDS (PLWH) in our County, the impact that HIV has in our community is substantial. 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. Miami-Dade County has been identified by EHE as one of the geographical hotspots during the 1st phase of the initiative. The goal of this initiative is to reduce HIV transmission rates 75% by 2025, and 90% by 2030.[2] 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 by 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), along with the Health Council of South Florida (HCSF), have partnered to complete a local EHE plan for the specific HIV needs of the Miami-Dade community. This report encompasses a comprehensive situational analysis of the HIV prevention and care systems in Miami-Dade, along with the activities completed that support this analysis. The activities completed as part of this EHE plan include the following:

- EHE Miami-Dade needs assessment
- Review of local needs assessments
- FDOH-MD EHE survey
- EHE provider survey
- FDOH-MD listening sessions
- Key informant interviews
- Key stakeholder interviews
- PLWH interviews
- Government representative interviews
- Town hall meetings
- Online community forums
- Best community engagement practices & innovative strategies

The following sections will elaborate on each activity completed and identify common themes that arise within discussions of our HIV prevention and care systems.

[1] https://www.cdc.gov/endhiv/priorities.html
[2] https://www.cdc.gov/endhiv/index.html

Methodology

Each separate activity completed as a part of this EHE plan had a unique methodology. Each one is described below in further detail along with the methods used to complete said activities:

EHE Miami-Dade needs assessment. As part of this EHE plan, HCSF conducted a needs assessment in order to identify health disparities affecting HIV prevention and care in Miami-Dade County. The EHE Miami-Dade needs assessment was conducted through a community cluster framework, such that the data analysis was guided by the 13 community clusters in Miami-Dade. These clusters are made up of zip codes linked according to their perceived community identity and geographic contiguity. However, at times these clusters also cross boundaries based upon socioeconomic status or population counts. There are 13 total clusters for sampling, 12 standard clusters and one oversampled cluster. The oversampled cluster consists of contiguous ZIP codes representing the most economically and socially deprived neighborhoods, many of which are disproportionately affected by HIV/AIDS.

For the first part of the EHE Miami-Dade needs assessment, HCSF analyzed surveillance data provided by the FDOH-MD. Data was analyzed and compiled at the state level, county level, and cluster level. This data includes incidence and prevalence statistics, as well as data on mode of transmission. General demographic data on Miami-Dade County from the US Census Bureau is also shown here. The second part of this needs assessment includes an analysis of the Statewide 2019 HIV Care Needs Survey, specifically of the data from Miami-Dade County.

Review of local needs assessments. HCSF and FDOH-MD identified two local needs assessments to review as part of this analysis. These two needs assessments include the 2019 Miami-Dade HIV/AIDS Partnership Needs Assessment and the 2017 Housing Gap Analysis from the City of Miami's Housing Opportunities for Persons with AIDS (HOPWA) program. HCSF reviewed the results from these needs assessments and included them as part of the broader situational analysis.

FDOH-MD EHE survey. This survey was designed and administered by the Florida Department of Health in Miami-Dade County. The survey was delivered to populations across Miami-Dade County in English, Spanish, and Creole; participants could complete it either online or on paper. The survey was live from October 22nd, 2019 to November 15th, 2019. HCSF reviewed and analyzed the collected data after the survey was closed.

EHE provider survey. HCSF developed and disseminated a survey to providers across Miami-Dade County who provide medical and/or support services to PLWH (Appendix F). Provider agencies were identified, and a cluster-level analysis was completed based on the geographical location of these agencies.

FDOH-MD listening sessions. FDOH-MD also conducted listening sessions with a variety of groups, including but not limited to: Transgender & gender non-conforming support groups, organizations that primarily serve Black & Latinx communities, and prevention committee members of the Miami-Dade HIV/AIDS Partnership. HCSF reviewed and analyzed the qualitative data from these listening sessions.

Key informant interviews. HCSF conducted nine key informant interviews with individuals involved in various field related to HIV prevention and care. Informants come from diverse organizations and are identified in this report anonymously as a representative of their respective fields. These individuals are senior-level professionals within their organizations. The nine categories encompassed here include: Ryan White Part A, Federally Qualified Health Centers (FQHCs), housing, syringe services programs (SSPs), private sector, homelessness, hospitals, mental health, and corrections. Six interviews were conducted in-person and three over the phone, and these interviews ranged from 45 minutes to one hour. The questions asked in these interviews involved HIV prevention and care, PrEP, and community engagement (Appendix A). NVivo 12 Plus was used to analyze and identify common themes throughout the set of interviews. Note that the gender-neutral "they" is used in place of "he/she" to further preserve the anonymity of the persons interviewed.

Key stakeholder interviews. HCSF completed six stakeholder interviews with individuals not represented on local HIV planning bodies (e.g. the Miami-Dade HIV/AIDS Partnership). Each stakeholder comes from a different background, providing a unique perspective on gaps in HIV prevention and care services. The six categories include: medical provider, social determinants, immigration, research, domestic violence, and support services. Interviews lasted between 45 minutes to an hour, and the interview tool can be found in Appendix G.

PLWH interviews. HCSF conducted three interviews with people living with HIV who are not primarily Ryan White recipients. Interviews conducted by phone lasted between 45 minutes to an hour. Due to confidentiality and feasibility issues, it was decided by FDOH-MD and HCSF that individual interviews would prove more successful for gathering input from this community. The interview tool for this group is attached in Appendix E.

Government representative interviews. HCSF completed five interviews with government representatives from the Miami-Dade area. Interviewees include a county commissioner, a city mayor, a US congressperson, and two non-elected government officials. Questions were tailored more towards policy and recommendations as they relate to the four EHE pillars. The corresponding interview tool is attached on Appendix H.

Town hall meetings. HCSF organized and led four town hall meetings on HIV/AIDS across Miami-Dade. Each town hall was in different geographic areas to capture different portions of the population. The Edison town hall was facilitated in Creole by a representative from FDOH-MD, and the South Dade town hall was facilitated in Spanish by HCSF. A "quasi" town hall event was also held at a World AIDS Day event at Betty T. Ferguson Recreational Complex. Each town hall lasted between one to two hours and were promoted through flyers individualized for each event (Appendix B). NVivo was used to analyze and identify common themes throughout the town halls, and basic demographic data of attendees was collected through sign-in sheets (Appendix C).

Online community forums. HCSF coordinated four online community forums with facilitators who are representatives of targeted communities (e.g. LGBTQ, Black, Latinx, and PLWH). These individuals are experts in the HIV field, many of whom sit on planning bodies and have a strong social media following. The facilitators led discussions on HIV/AIDS in an online setting. Facebook Live was used as the medium for each online forum, and Instagram Live was used simultaneously

for one of the activities. While a tool with questions was prepared as a guide (Appendix D), the session was driven mostly by the conversation between facilitators and the input provided by members in the online audience. Comments, number of views, and other data was captured through screen recordings of the live sessions. Each online forum lasted for about one hour. Due to technical errors, one of the recordings was deleted; as a result, this live session has limited data available for analysis. This same session was also conducted during a live radio session on Cadena Azul 1550 AM.

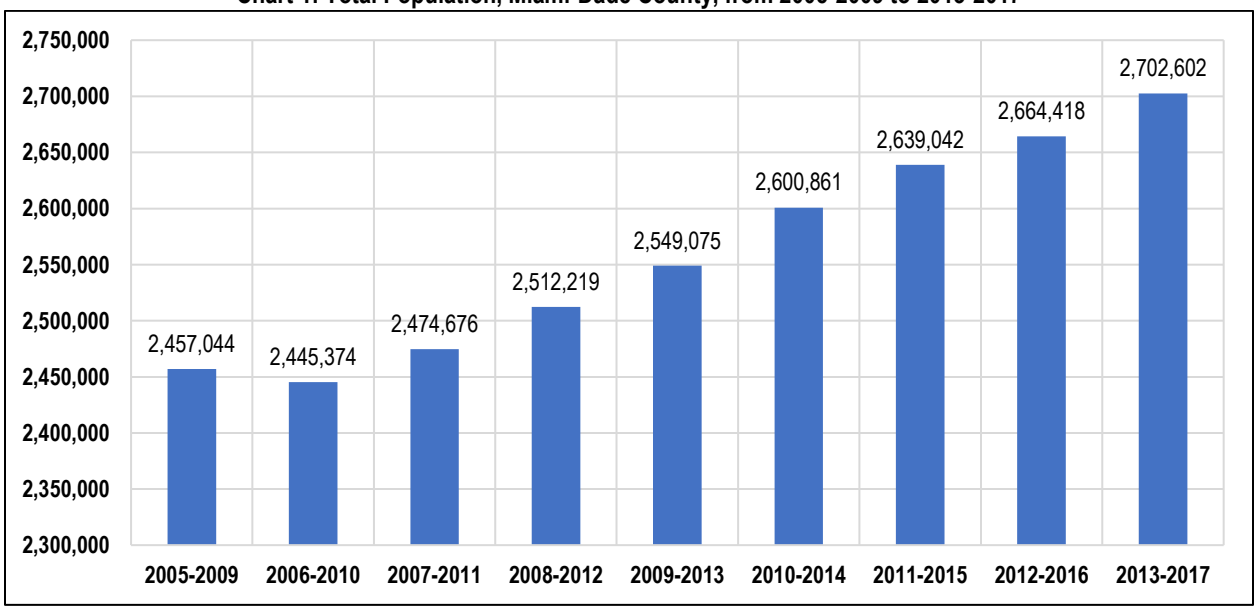
Best community engagement practices & innovative strategies. HCSF compiled a variety of best practices, tools, and innovative approaches from qualitative analyses as well as strategies from outside municipalities that have been effective in engaging their respective communities. These practices and strategies are tailored to the needs of the Miami-Dade community. Activities currently being done by FDOH-MD are also included in this section.

EHE Miami-Dade County Needs Assessment

Miami-Dade County Demographic Profile

Miami-Dade County, the 8th largest metropolitan area in the United States, has seen progressive growth over the last 9 years.[3] According to the U.S. Census, Miami-Dade County has grown 10.0% since the 2005-2009 rolling average, and projections only show that to continue (Chart 1).[4]

Chart 1: Total Population, Miami-Dade County, from 2005-2009 to 2013-2017

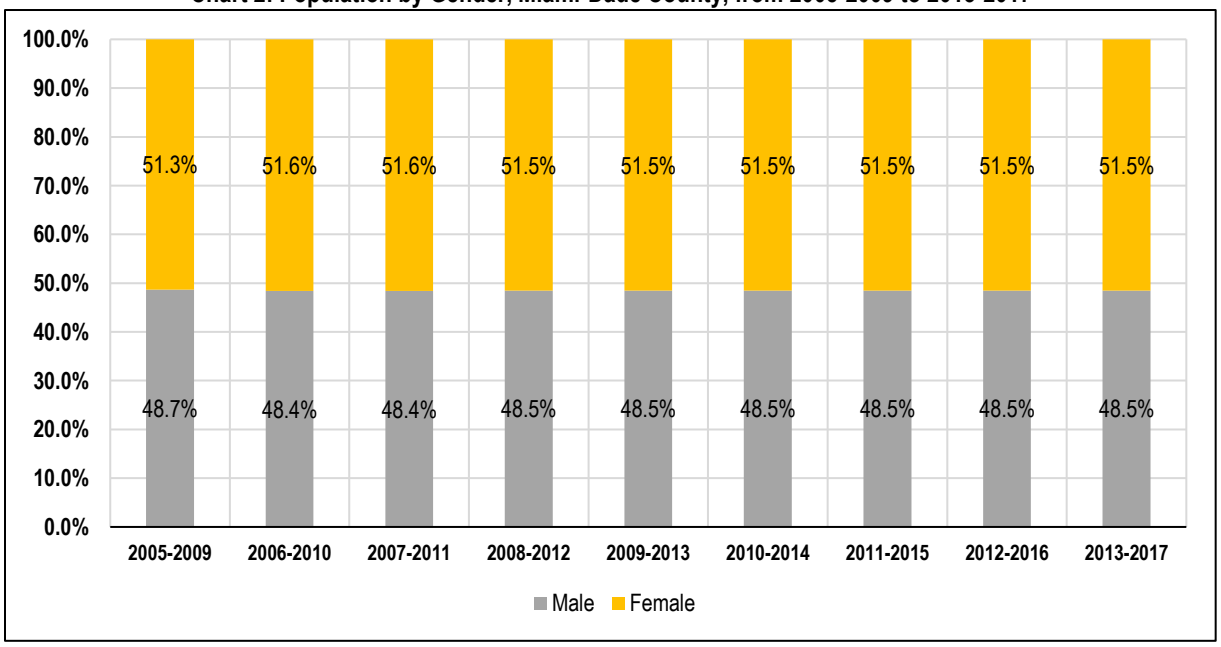


Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

While general population trends have shown consistent growth, the ratio of the population who are female compared to male has remained constant. In 2005-2009, 51.3% of the population considered themselves to be female compared to 48.7% who identified as male. In 2013-2017, the percentages were nearly identical with 51.5% of the population identifying as female and 48.5% identifying as male (Chart 2). Note that the ACS from the Census Bureau does not collect data that provides estimates for the transgender population.

[3] U.S. Census, American FactFinder, 2005-2009/2013-17 Population Statistics.
[4] Population Projections, Miami-Dade County Government. Found at: https://www.miamidade.gov/planning/library/presentations/2018-04-17-ueatf-presentation.pdf

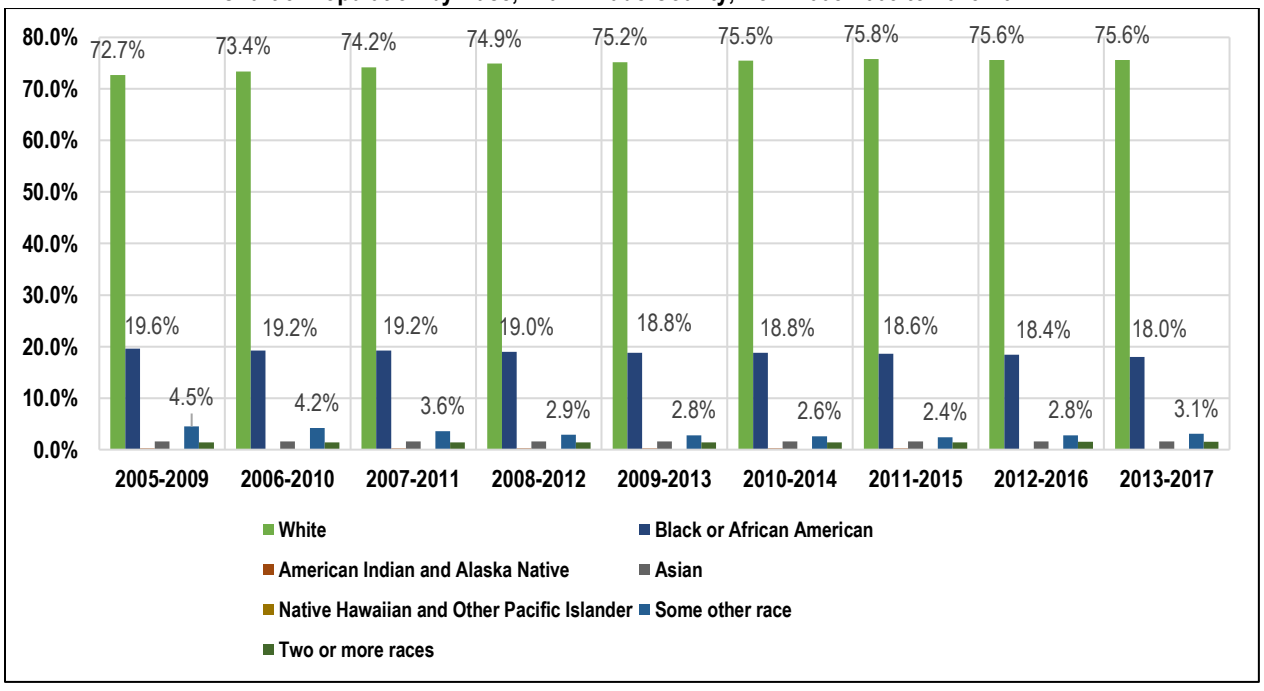
Chart 2: Population by Gender, Miami-Dade County, from 2005-2009 to 2013-2017



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

The population of Miami-Dade County has also seen slight changes in racial make-up. Over the past ten (10) years, the population who identify as White has slowly increased from 72.7% of the population to 75.6%, while the population who identify as Black has decreased from 19.6% to 18.0%. All other race designations remained relatively constant (Chart 3).

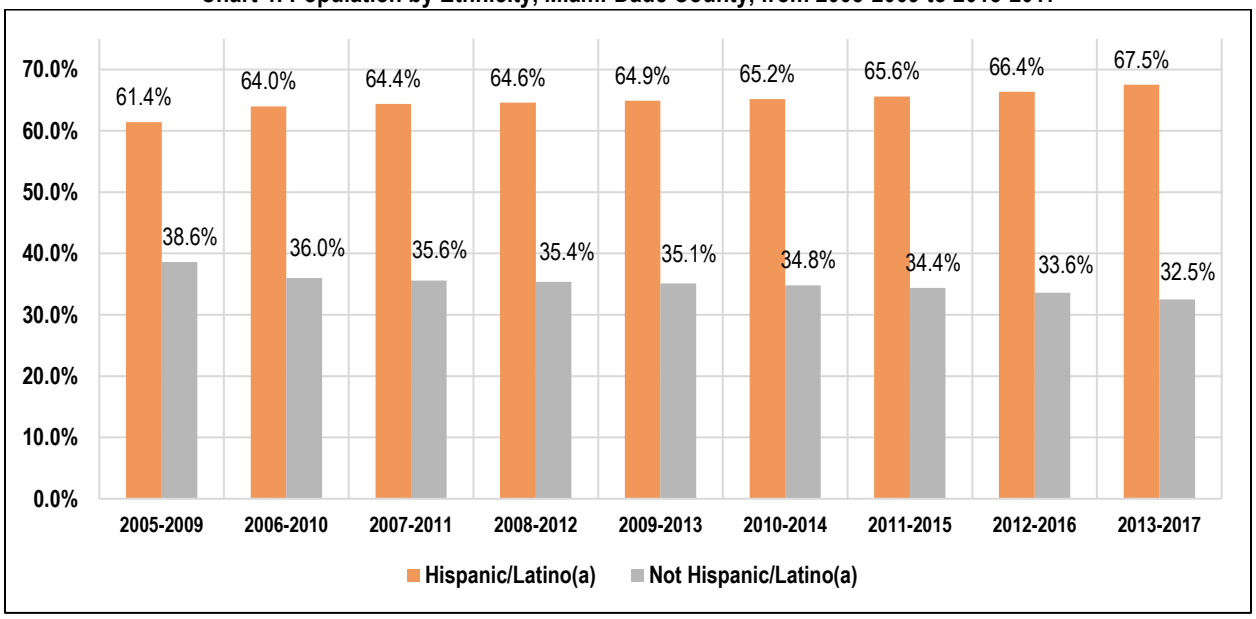
Chart 3: Population by Race, Miami-Dade County, from 2005-2009 to 2013-2017



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Miami-Dade County is also considered a "majority-minority" County, with a majority of the population belonging to a minority demographic. Since 2005-2009, the percentage of the population that considers themselves to be Hispanic has grown from 61.4% to 67.5% (Chart 4).

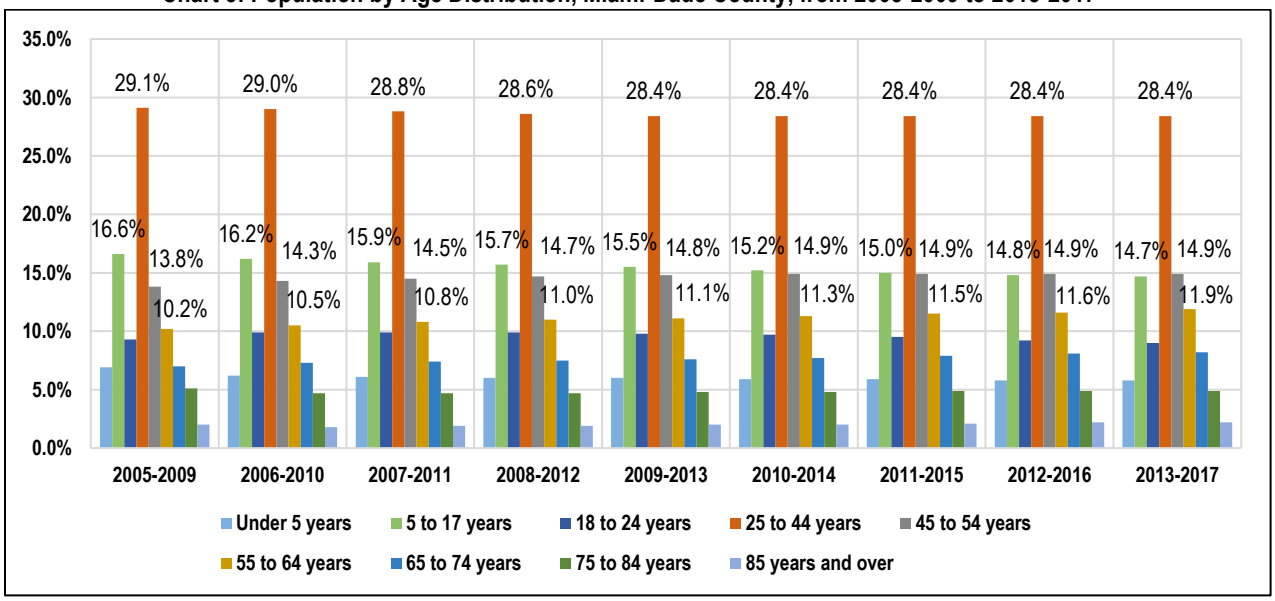
Chart 4: Population by Ethnicity, Miami-Dade County, from 2005-2009 to 2013-2017



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

The age distribution among Miami-Dade County residents has also seen subtle shifts since 2005-2009. The populations under 5 years and 5-17 years have slightly decreased (1.1% points and 1.9% points), while the populations 55-64 years and 65-74 years have grown from 10.2% to 11.9% and 7.0% to 8.2%, respectively. All other age groups remained consistent (Chart 5).

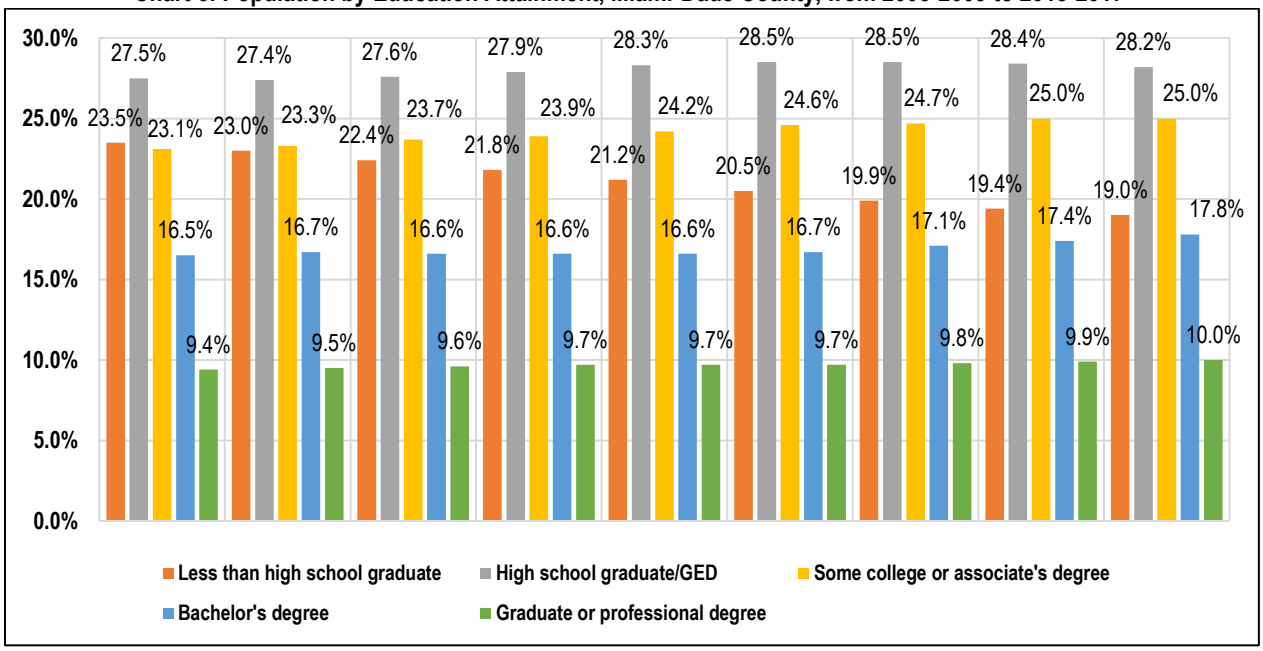
Chart 5: Population by Age Distribution, Miami-Dade County, from 2005-2009 to 2013-2017



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Furthermore, the educational attainment of Miami-Dade County residents has seen slight changes, as well. The number of residents that have earned less than a high school education has steadily declined, while those that have earned at least some college credit, an associate degree, or a bachelor's degree have consistently increased (Chart 6).

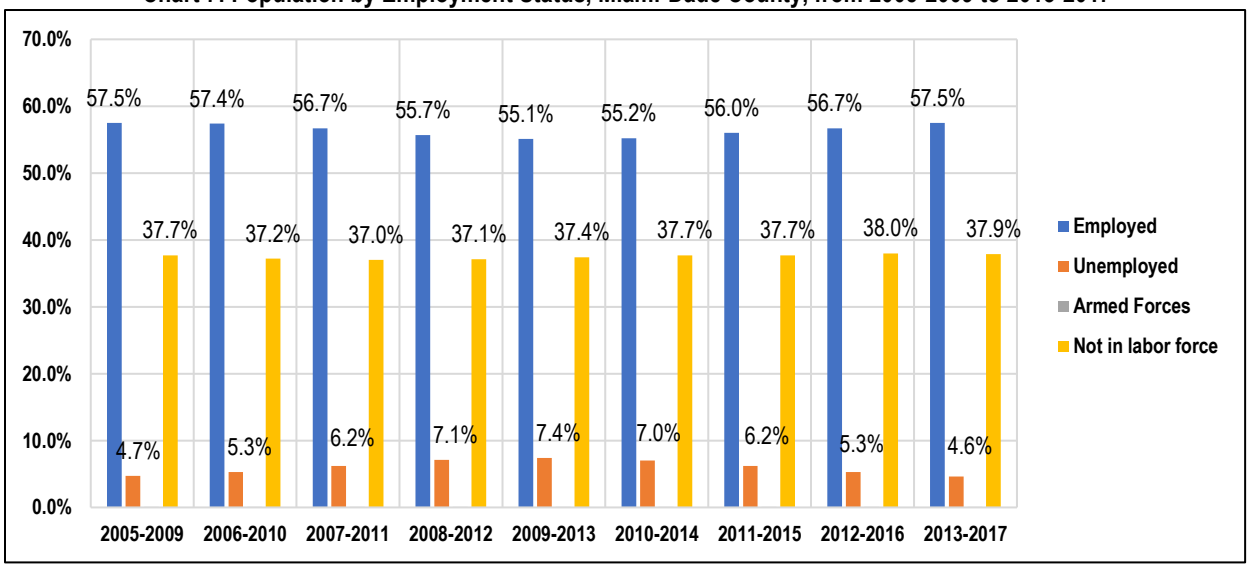
Chart 6: Population by Education Attainment, Miami-Dade County, from 2005-2009 to 2013-2017



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Following economic trends nationwide, the percentage of the population that is employed saw gradual decreases from 2005-2009 through 2009-2013 (57.5% to 55.1%), while the unemployed population saw increases over the same time span (4.7% to 7.4%). These trends reversed following 2009-2013 with steady increases in employment through 2013-2017 (57.5%) and decreases in unemployment (4.6%) (see Chart 7).

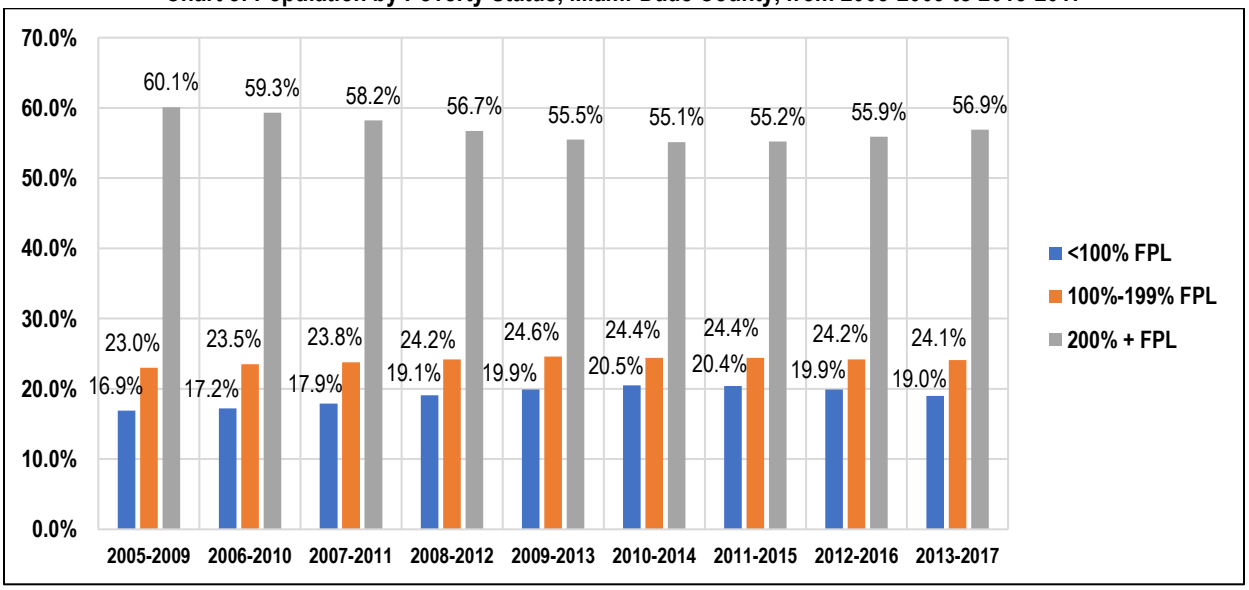
Chart 7: Population by Employment Status, Miami-Dade County, from 2005-2009 to 2013-2017



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

The proportion of residents in Miami-Dade County stratified by poverty status followed similar economic trends to employment data. From 2005-2009 to 2010-2014, the proportion of residents who were at 200% of the Federal Poverty Level (FPL) or above, declined from 60.1% to 55.1%, while the percentage of residents who were <100% FPL increased from 16.9% to 20.5%. These trends reversed following 2010-2014, with the percentage at 200% FPL or more increasing to 56.9% by 2013-2017 and the percentage at <100% FPL decreasing to 19.0% (Chart 8).

Chart 8: Population by Poverty Status, Miami-Dade County, from 2005-2009 to 2013-2017



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Miami-Dade County Demographic Profile by Cluster

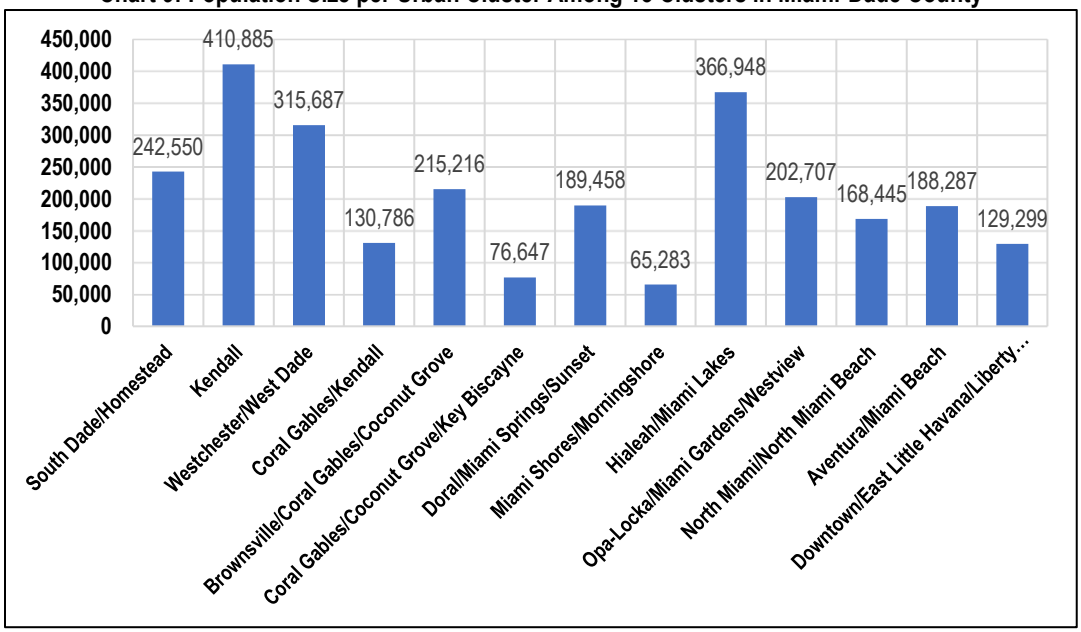
Miami-Dade County can be subdivided into 13 neighborhood clusters, which are represented by a specific set of zip codes that are linked by their apparent community distinctiveness and physical contiguity. Twelve of these clusters are classified as standard clusters while one of them (Downtown/East Little Havana/Liberty City/Little Haiti/Overtown) is classified as an oversampled cluster consisting of financially and socially depressed neighborhoods. The 13 Miami-Dade County neighborhood clusters are South Dade/Homestead, Kendall, Westchester/West Dade, Coral Gables/Kendall, Brownsville/Coral Gables/Coconut Grove, Coral Gables/Coconut Grove/Key Biscayne, Doral/Miami Springs/Sunset, Miami Shores/Morningside/, Hialeah/Miami Lakes, Opa-Locka/Miami Gardens/Westview, North Miami/North Miami Beach, Aventura/Miami Beach, and Downtown/East Little Havana/Liberty City/Little Haiti/Overtown. Table 1 indicates the zip codes that each of these neighborhood clusters comprise.

Table 1: Clusters by Name and Zip Code

Cluster	Name	ZIP Codes Included
Cluster 1	South Dade/Homestead	33030, 33031, 33032, 33033, 33034, 33035, 33039, 33170, 33189, 33190
Cluster 2	Kendall	33157, 33176, 33177, 33183, 33186, 33187, 33193, 33196
Cluster 3	Westchester/West Dade	33144, 33155, 33165, 33173, 33174, 33175, 33184, 33185, 33194
Cluster 4	Coral Gables/Kendall	33134, 33143, 33146, 33156, 33158
Cluster 5	Brownsville/Coral Gables/Coconut Grove	33125, 33130, 33135, 33142, 33145
Cluster 6	Coral Gables/Coconut Grove/Key Biscayne	33129, 33131, 33133, 33149
Cluster 7	Doral/Miami Springs/Sunset	33122, 33126, 33166, 33172, 33178, 33182
Cluster 8	Miami Shores/Morningside	33132, 33137, 33138
Cluster 9	Hialeah/Miami Lakes	33010, 33012, 33013, 33014, 33015, 33016, 33018
Cluster 10	Opa-Locka/Miami Gardens/Westview	33054, 33055, 33056, 33167, 33168, 33169
Cluster 11	North Miami/North Miami Beach	33161, 33162, 33179, 33181
Cluster 12	Aventura/Miami Beach	33139, 33140, 33141, 33154, 33160, 33180
Cluster 13	Downtown/East Little Havana/Liberty City/Little Haiti/Overtown	33127, 33128, 33136, 33147, 33150

Each of these clusters contains a specific population size, with clusters Kendall, Hialeah/Miami Lakes, and Westchester/West Dade containing more than 300,000 residents each, and with clusters Coral Gables/Coconut Grove/Key Biscayne and Miami Shores/Morningside containing less than 100,000 residents each, as indicated in Chart 9. Most clusters (eight of them) contain residents between 100,000 and 300,000 people each, South Dade/Homestead being the most populous among the latter (242,550) and Downtown/East Little Havana/Liberty City/Little Haiti/Overtown being the least populous (129,299).

Chart 9: Population Size per Urban Cluster Among 13 Clusters in Miami-Dade County

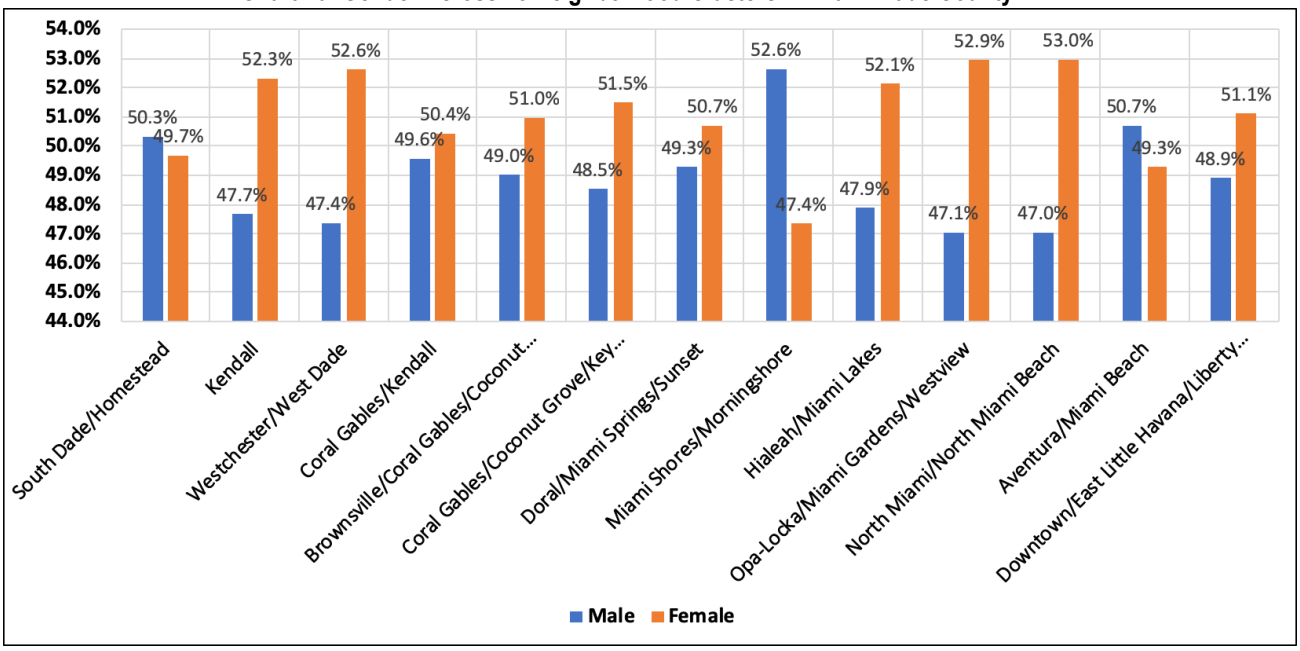


Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Gender

Overall, in Miami-Dade County there is a larger population of females than males. However, when Miami-Dade County is subdivided into its neighborhood clusters, three of these clusters reveal a greater percentage of males over females. These clusters are South Dade/Homestead, Miami Shores/Morningshore, and Aventura/Miami Beach, with the Miami Shores/Morningshore cluster showing the greatest difference between males and females (52.6% v. 47.4%, respectively) as indicated in Chart 10. In contrast, all remaining clusters have a larger population of females, with three of these clusters having the largest percentage difference between females and males, which include Westchester/West Dade, Opa-locka/Miami Gardens/Westview, and North Miami/North Miami Beach (difference of 5% to 6%).

Chart 10: Gender Across 13 Neighborhood Clusters in Miami-Dade County

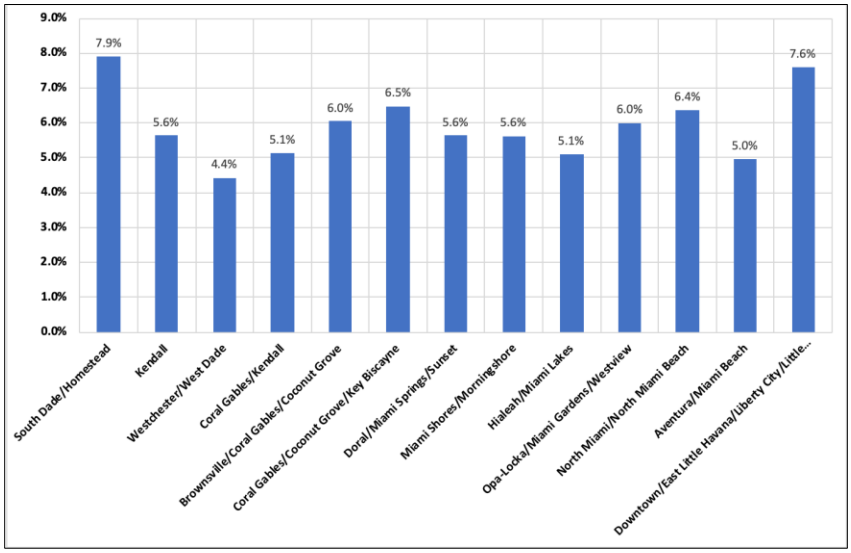


Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Age

In this report, age groups were assembled in five categories, including residents under 5 years, 5 to 19 years, 20 to 34 years, 35 to 64 years, and 65 years and older. Regarding children under 5 years, two Miami-Dade County neighborhood clusters, South Dade/Homestead and Downtown/East Little Havana/Liberty City/Little Haiti/Overtown, have the largest populations in this age group (7.9% and 7.6%, respectively), while Westchester/West Dade has the lowest representation of this age group (4.4%). All other neighborhood clusters range between 5.0% and 6.5% children under 5 years as indicated in Chart 11.

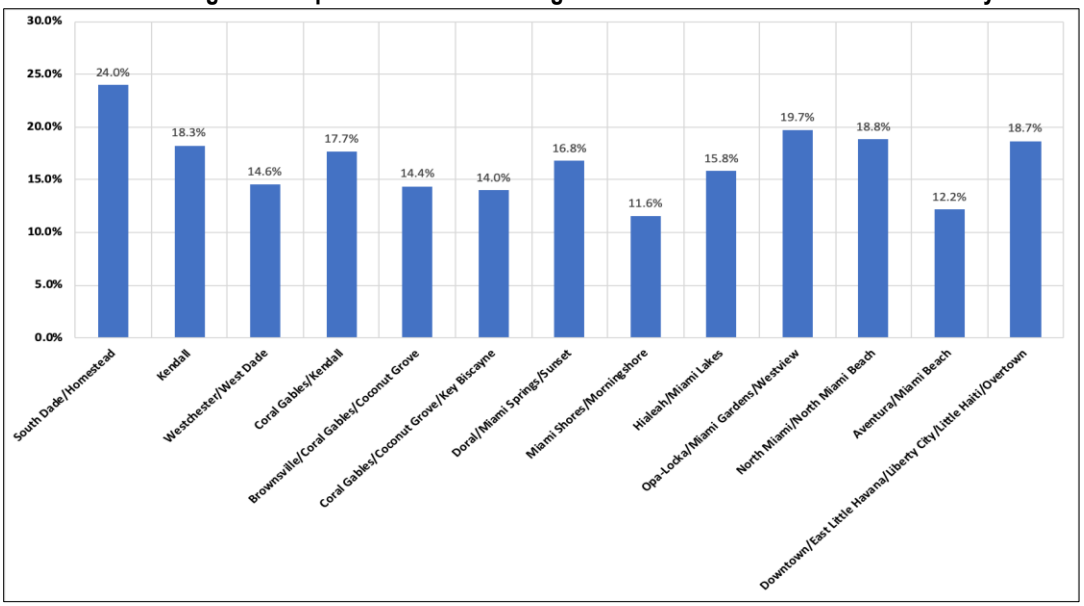
Chart 11: Under-5 Population Across 13 Neighborhood Clusters in Miami-Dade County



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Generally, juvenile residents 5 to 19 years were distributed dissimilarly across the 13 neighborhood clusters with South Dade/Homestead having the largest population in this age group (24.0%), and Miami Shores/Morningside and Aventura/Miami Beach having the lowest (11.6% and 12.2%, respectively). The remaining ten neighborhood clusters ranged from 19.7% (Opa-locka/Miami Gardens/Westview) to 14% residents of this age group (Coral Gables/Coconut Grove/Key Biscayne) as indicated in Chart 12.

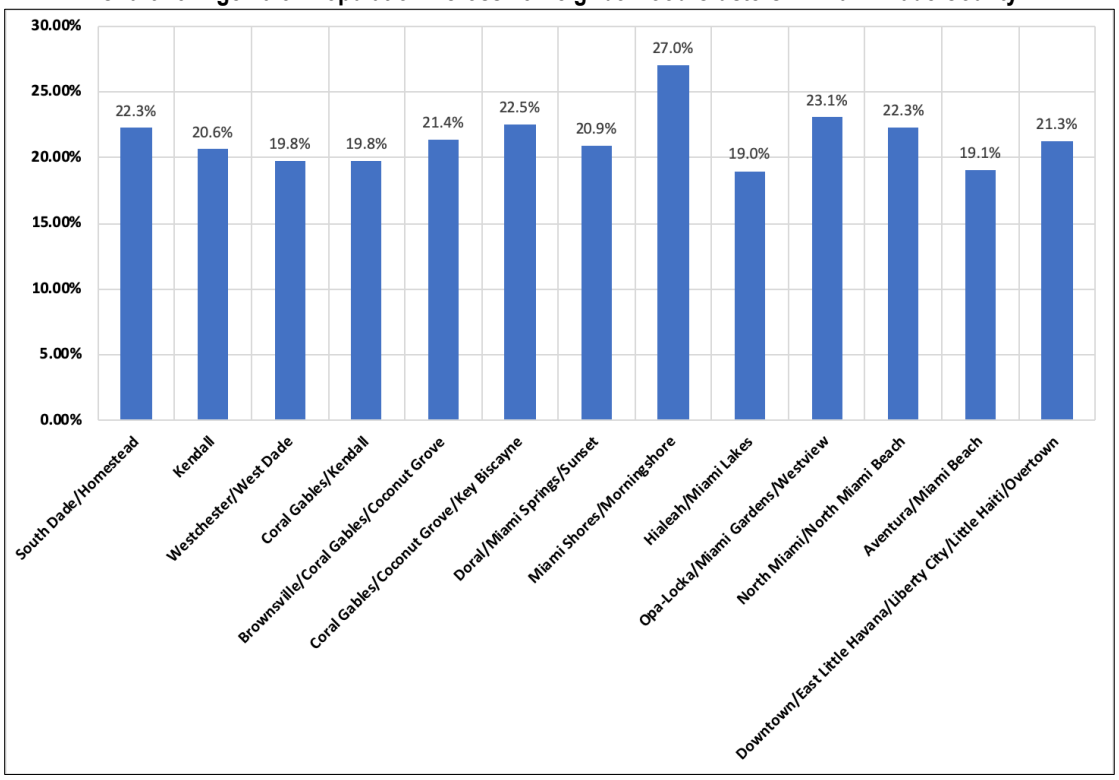
Chart 12: Age 5-19 Population Across 13 Neighborhood Clusters in Miami-Dade County



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Regarding the 20-34 age group, the population distribution across neighborhood clusters shows a more even distribution (less variation) except for Miami Shores/Morning Shore, which has a 27.0% resident representation for this age group. Apart from this exception, the percentage range among neighborhood clusters is of 4.1%, with Opa-locka/Miami Gardens/Westview having the largest representation (23.1%) and Hialeah/Miami Lakes having the lowest (19.0%) as shown in Chart 13.

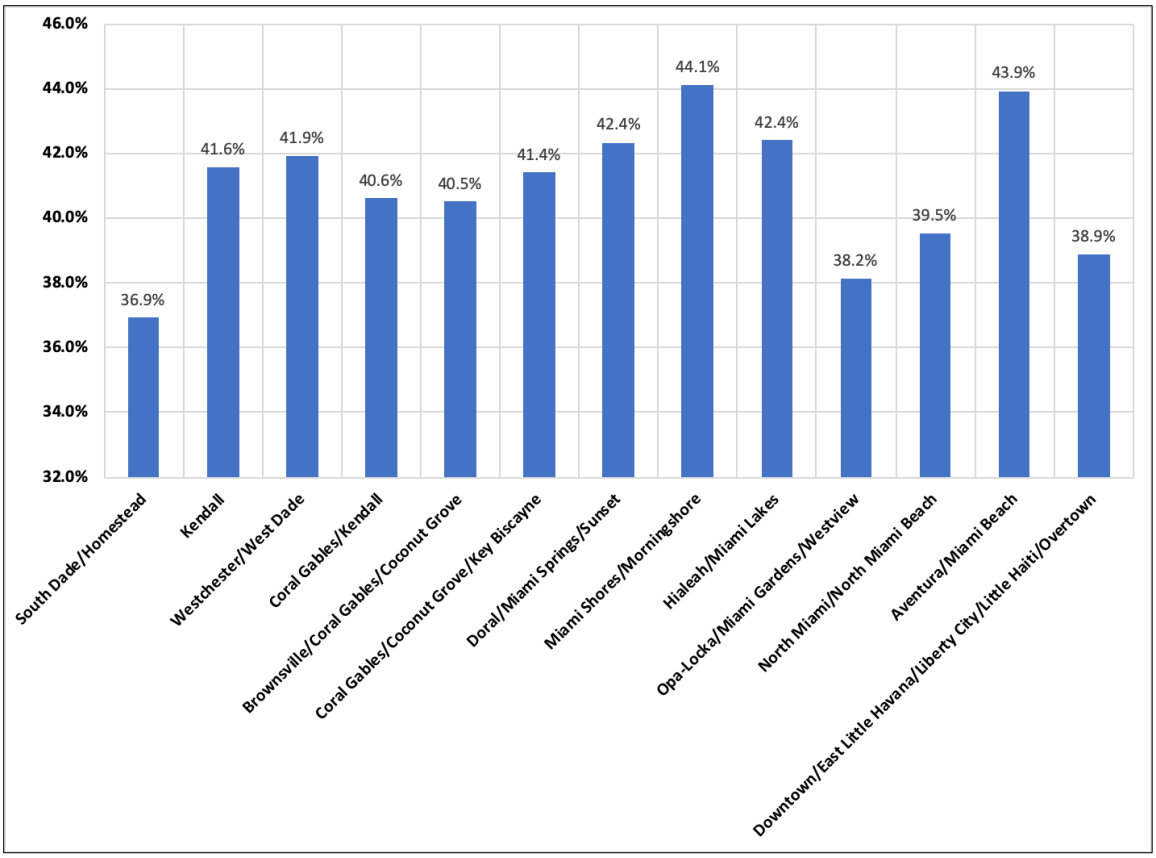
Chart 13: Age 20-34 Population Across 13 Neighborhood Clusters in Miami-Dade County



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

The 35-64 age group had a larger neighborhood cluster variation with a range of 7.2% residents between its largest and lowest clusters. The two most populous clusters for this age group are Miami Shores/Morningshore and Aventura/Miami Beach, while the least populous is South Dade/Homestead as indicated in Chart 14. Overall, this age group has a larger population than other age groups and is represented mainly by Xennials (born between 1975 and 1985), Generation X individuals (born between 1965 and 1979) and partly by Baby Boomers (born between 1946 and 1964).

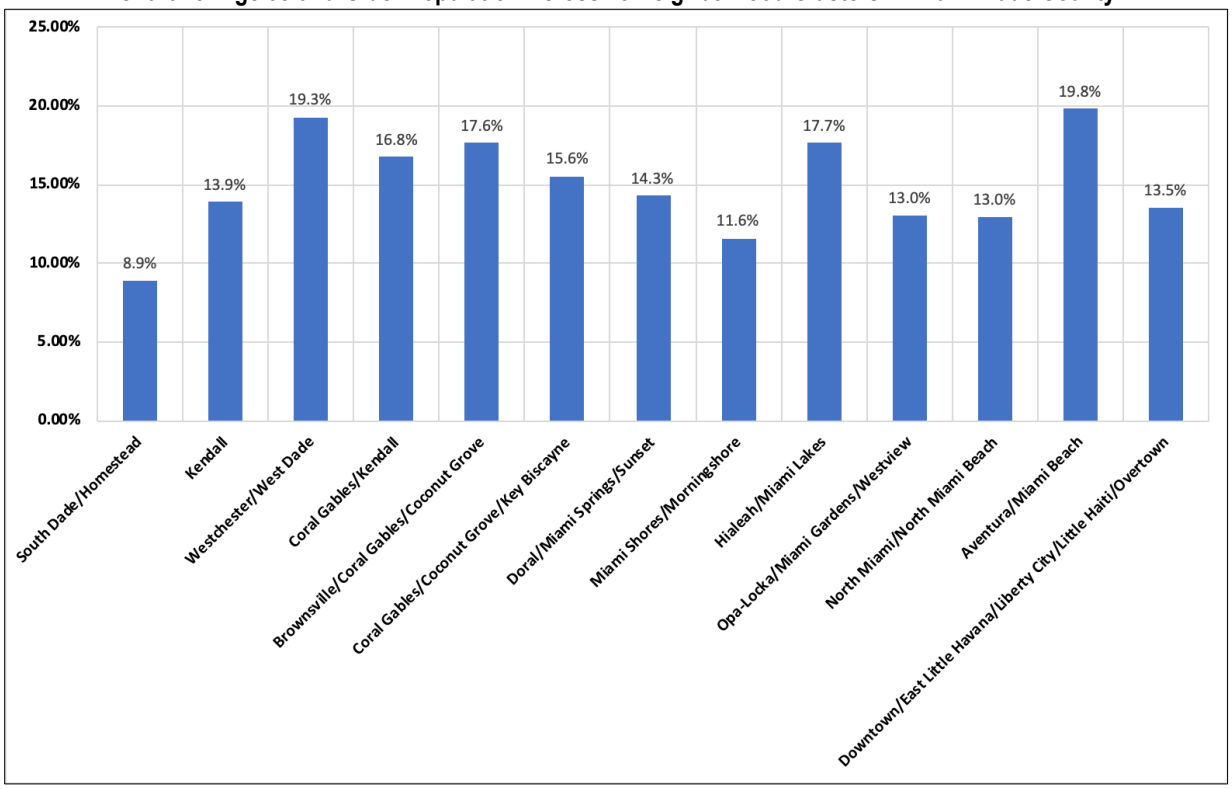
Chart 14: Age 35-64 Population Across 13 Neighborhood Clusters in Miami-Dade County



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Variation across neighborhood clusters for the 65-and-older age group has the largest variation of all age groups ranging from 19.8% for Aventura/Miami Beach to 8.9% for South Dade/Homestead, as indicated in Chart 15. This age group represents partly the Baby Boomer generation and older generations (e.g. Silent Generation, etc.). The low representation of residents of this age group in South Dade/Homestead (8.9%) contrasts with its larger representation on juvenile individuals 5-19 (24%) in this same cluster, while the large representation of residents in this age group for Aventura/Miami Beach (19.8%) contrasts with its lower representation on juvenile individuals 5-19 (12.2%), partially suggesting that there are more retirees in the Aventura/Miami Beach cluster and more youth in the South Dade/Homestead cluster, and vice versa.

Chart 15: Age 65-and-Older Population Across 13 Neighborhood Clusters in Miami-Dade County

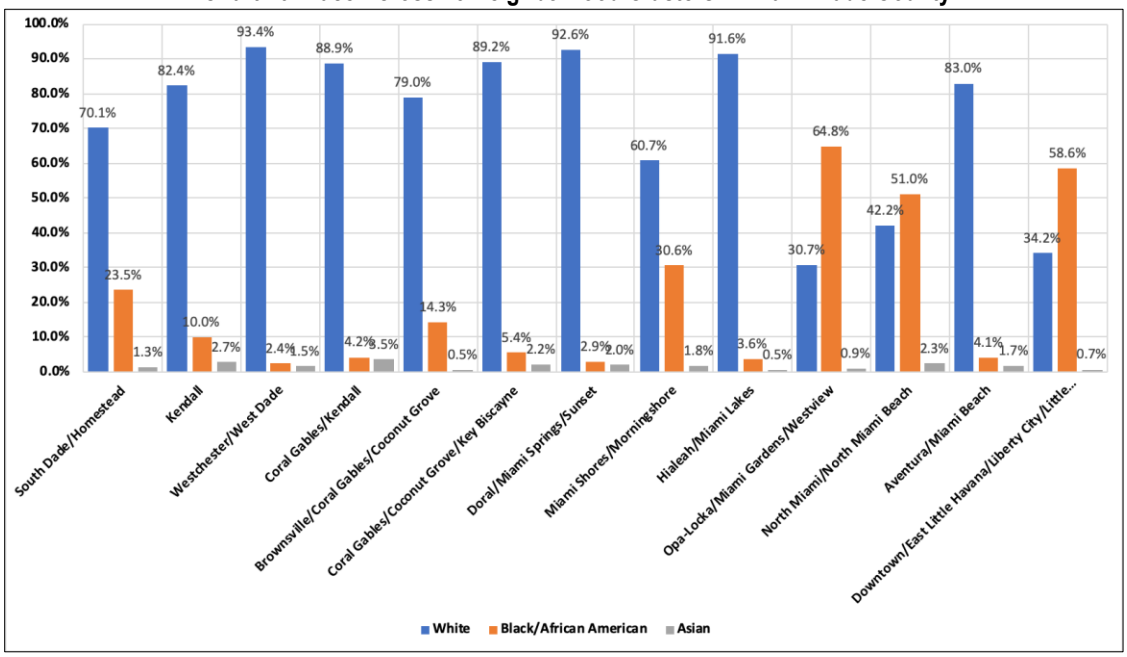


Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

Race/Ethnicity

In 10 of the 13 neighborhood clusters, residents who identify as White are significantly more populous than all other racial groups, with those residents identifying as Black/African Americans being the next most abundant racial group. Three neighborhood clusters, however, show the reverse trend with those residents identifying as Black/African American being the most common race group and those residents identifying as White being the second most abundant race group. These latter three neighborhood clusters include Opa-locka/Miami Gardens/Westview, North Miami/North Miami Beach, and Downtown/East Little Havana/Liberty City/Little Haiti/Overtown. Those residents identifying as Asians are the least populous in contrast to Whites and Black/African Americans in all neighborhood clusters, but they closely matched the population of Black/African Americans in clusters Westchester/West Dade, Coral Gables/Kendall, and Doral/Miami Springs/Sunset, as indicated in Chart 16.

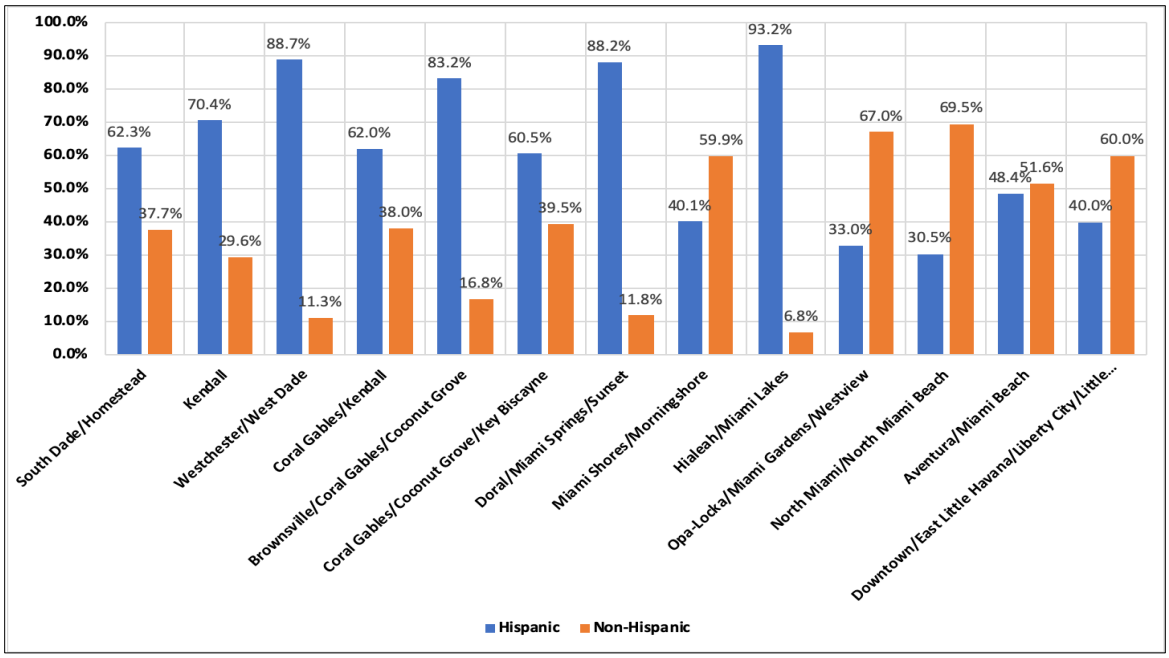
Chart 16: Race Across 13 Neighborhood Clusters in Miami-Dade County



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

More than half of all neighbor clusters (N=8) show a larger population of Hispanics in contrast to Non-Hispanics, and less than half of these (N=5) show the opposite. Pronounced population differences between Hispanic and Non-Hispanic residents where Hispanics are more numerous are found in Westchester/West Dade (77.4% difference), Doral/Miami Springs/Sunset (76.4% difference), and Hialeah/Miami Lakes (86.4% difference) as indicated in Chart 17. The greatest difference between Non-Hispanics and Hispanics where Non-Hispanics are more numerous is found in North Miami/North Miami Beach (39% difference).

Chart 17: Ethnicity Across 13 Neighborhood Clusters in Miami-Dade County



Source: US Census, American Community Survey, Five-Year Estimates, 2013-2017

SocioNeeds Index

The SocioNeeds Index, created by Conduent Healthy Communities, is a measure of socioeconomic need in the community at the zip code level which considers selected social and economic factors considered to be strong determinants of health outcomes. The index ranges between 0 (low need) to 100 (high need). It is important to note that geographic areas with the highest socioeconomic need are correlated with preventable hospitalizations and premature death.

Once the indices have been calculated for each zip code nationwide, they are further categorized or sorted into five ranks (1 representing low need, while 5 representing high need) to understand the relative level of need within a community. Map 1 illustrates the distribution of the SocioNeeds Index in Miami-Dade County according to rank and identified neighborhood clusters.

Map 1: SocioNeeds Index, Miami-Dade County, 2019

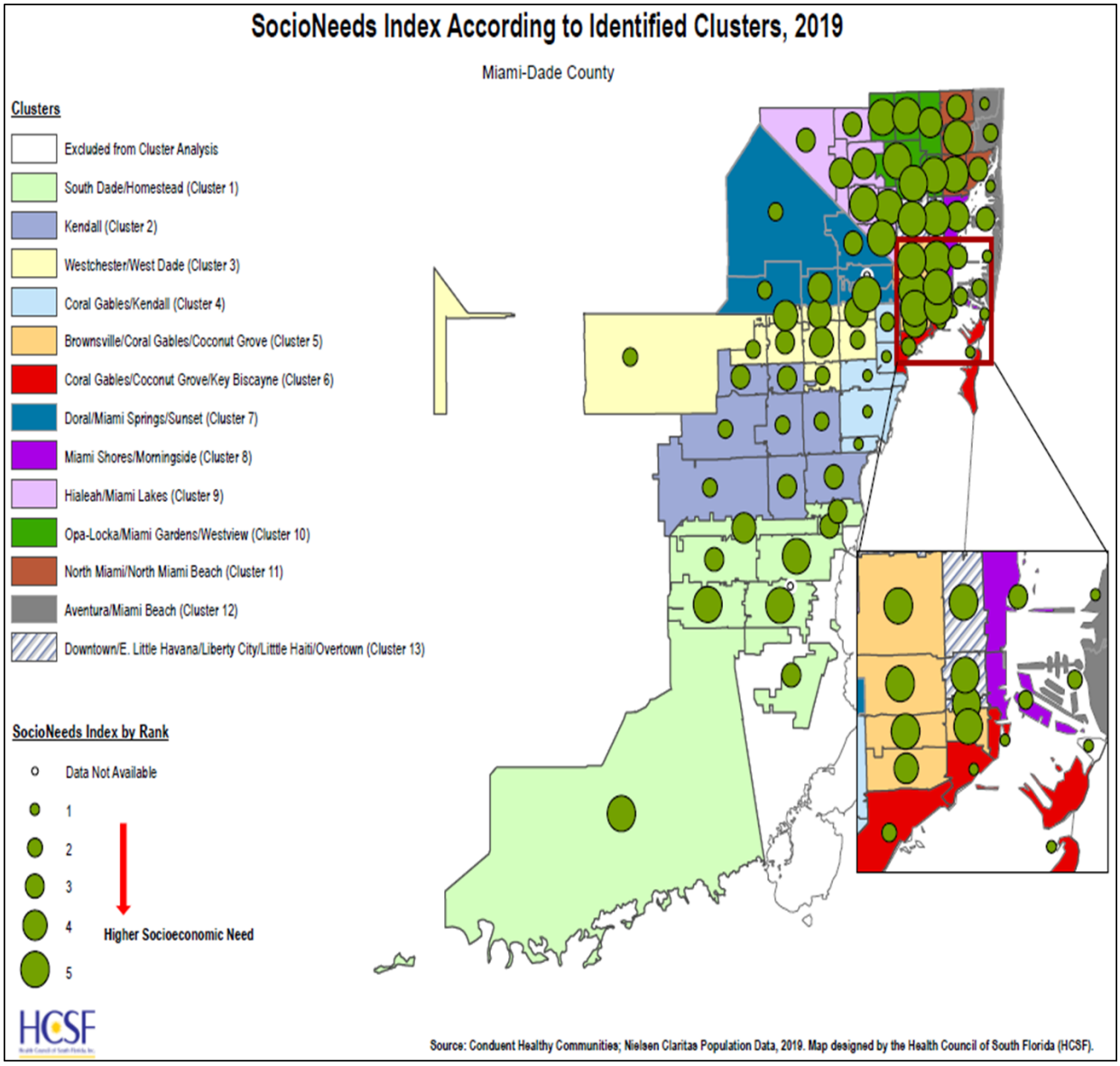


Table 2 depicts the top 10 zip codes in Miami-Dade County with the highest SocioNeeds Index according to rank. It is noteworthy that half of the top 10 zip codes derived from Downtown/E. Little Havana/Liberty City/Little Haiti/Overtown (Cluster 13) with indices that range between 97.5 and 98.9; all categorized as a rank of 5.

Table 2: Top 10 Zip Codes is Miami-Dade County with the Highest SocioNeeds Index, 2019

Geographic Areas	Neighborhood	Cluster	SocioNeeds Index	Rank
33142	Model City	5	99.1	5
33034	Florida City	1	99.0	5
33128	East Little Havana/Downtown	13	98.9	5
33030	Homestead	1	98.6	5
33127	Allapattah/Wynwood	13	98.1	5
33010	Hialeah	9	97.9	5
33136	Overtown	13	97.9	5
33150	El Portal	13	97.9	5
33135	West Little Havana	5	97.6	5
33147	Little Haiti	13	97.5	5

HIV/AIDS Epidemiological Profile

The data analyzed in this section is from the HIV/AIDS Epidemiological Profile, created by the Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section. HIV and AIDS are diagnosed in Florida based on the case definition from the CDC HIV Surveillance Report. An HIV diagnoses is defined as a diagnosis of HIV infection regardless of the stage of disease (stage 0, 1, 2, 3 [AIDS], or unknown) and refers to all persons with a diagnosis of HIV infection. An AIDS diagnoses refers specifically to persons with diagnosed HIV whose infection was classified as stage 3 (AIDS) during a given year (for diagnoses) or whose infection has ever been classified as stage 3 (AIDS) (for prevalence and deaths).[5] Florida Department of Corrections HIV incidence data is excluded from the dataset, while prevalence data from Department of Corrections is included.

HIV Diagnosed Infection

According to FDOH-MD, in 2018 there were 4.4 new HIV diagnosed cases per 10,000 Miami-Dade County residents compared to the statewide rate of 2.3 per 10,000 population (Please refer to Table 3). Table 1 also highlights the top five zip codes in Miami-Dade County with the highest rate of HIV new diagnosed cases (incidence), with Overtown (zip code 33136) exhibiting a rate of 35.2 per 10,000 which is eight times higher than the countywide rate and 15.3 times higher than the statewide rate.

[5] CDC HIV Surveillance Report, pg. 5
http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-us.pdf

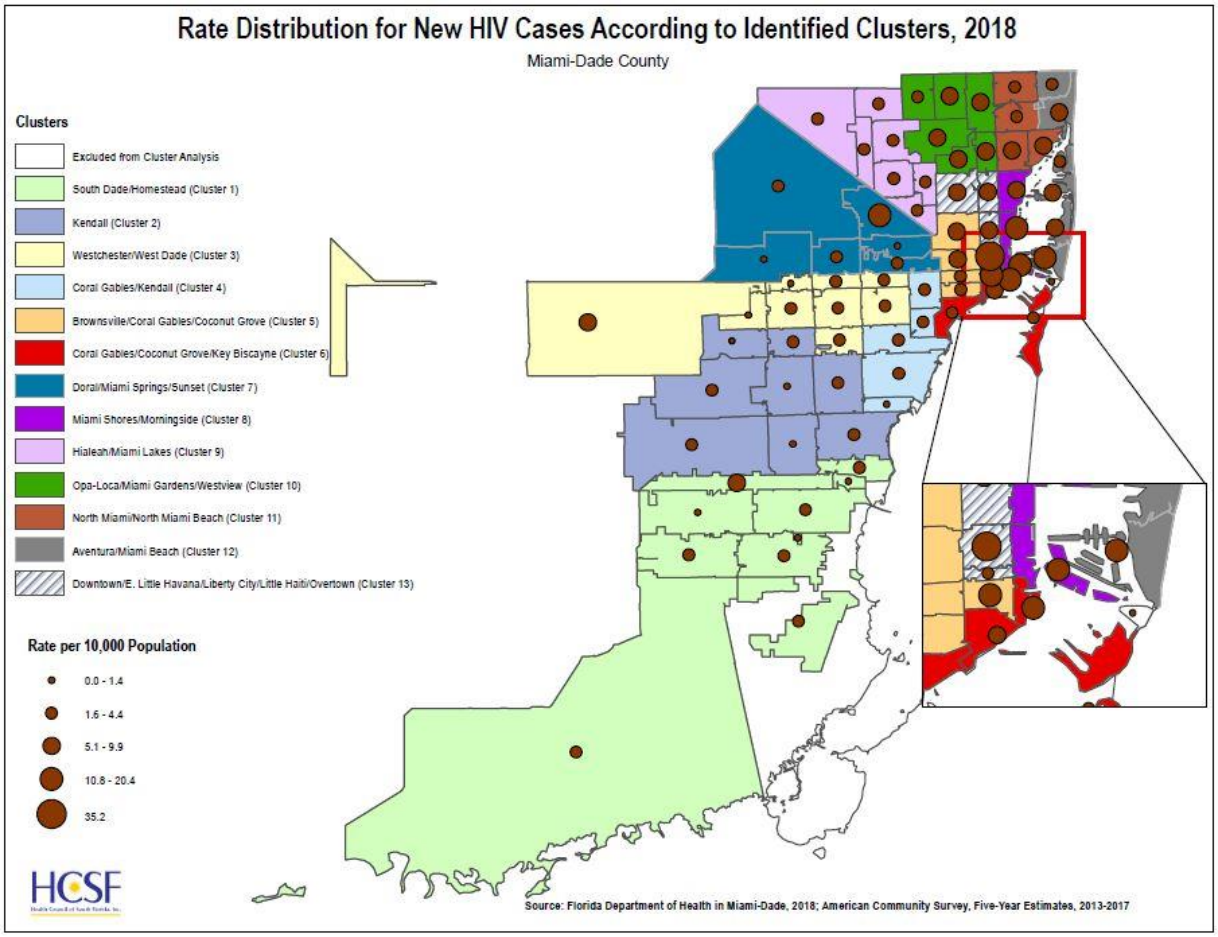
Table 3: HIV Cases, Rate Per 100,000 Population, Miami-Dade County, 2018

Top 5 Zip Codes	Neighborhood	Rate per 10,000
33136	Overtown	35.2
33139	Miami Beach - South	20.4
33132	Miami International/ Doral	15.2
33137	Little Haiti	13.7
33166	Miami Springs/Virginia Gardens	12.3
Miami-Dade County		4.4
Florida		2.3

Source: Florida Department of Health in Miami-Dade; Florida Department of Health (State), HIV/AIDS Section

Map 2 illustrates the rate distribution of newly diagnosed HIV cases in Miami-Dade County according to identified clusters, represented by the red circles. The five zip codes represented in Table 3 pertain to five different clusters which include: Downtown/East Little Havana/Liberty City/Little Haiti/Overtown (Cluster 13), Aventura/Miami Beach (Cluster 12), Miami Shores/Morningside (Cluster 8), Coral Gables/Coconut Grove/Key Biscayne (Cluster 6), and Brownsville/Coral Gables/Coconut Grove (Cluster 5).

Map 2: HIV Diagnosed Cases, Miami-Dade County, 2018



HIV Diagnoses by Demographics

This section analyzes the distribution of HIV diagnoses among various demographic categories at the state and county level for 2014-2018. HIV diagnoses by year of diagnosis represent persons whose HIV was diagnosed in that year, regardless of AIDS status at time of diagnosis.

Table 4 shows the number and percentage of HIV diagnoses stratified by race and ethnicity for Miami-Dade County from 2014 to 2018. In Miami-Dade County people identifying as Hispanic/Latinx accounted for the majority of HIV diagnoses each year from 2014-2018, followed by Black Non-Hispanics and White Non-Hispanics. People identifying as Asian, Multi-race, American Indian/Alaska Native, or Native Hawaiian/Pacific Islander (all Non-Hispanic) accounted for 0.5% or less of HIV diagnoses each year from 2014-2018. In 2018, 59.2% of HIV diagnoses were attributed to people identifying as Hispanic/Latinx, while Black Non-Hispanics accounted for 28.8% of HIV diagnoses and White Non-Hispanics accounted for 11.2%. Multi-race, Native Hawaiian/Pacific Islander, and Asian (all Non-Hispanic) accounted for 0.3%, 0.2%, and 0.2%, respectively in 2018 and the American Indian/Alaskan Native Non-Hispanic group accounted for 0%.

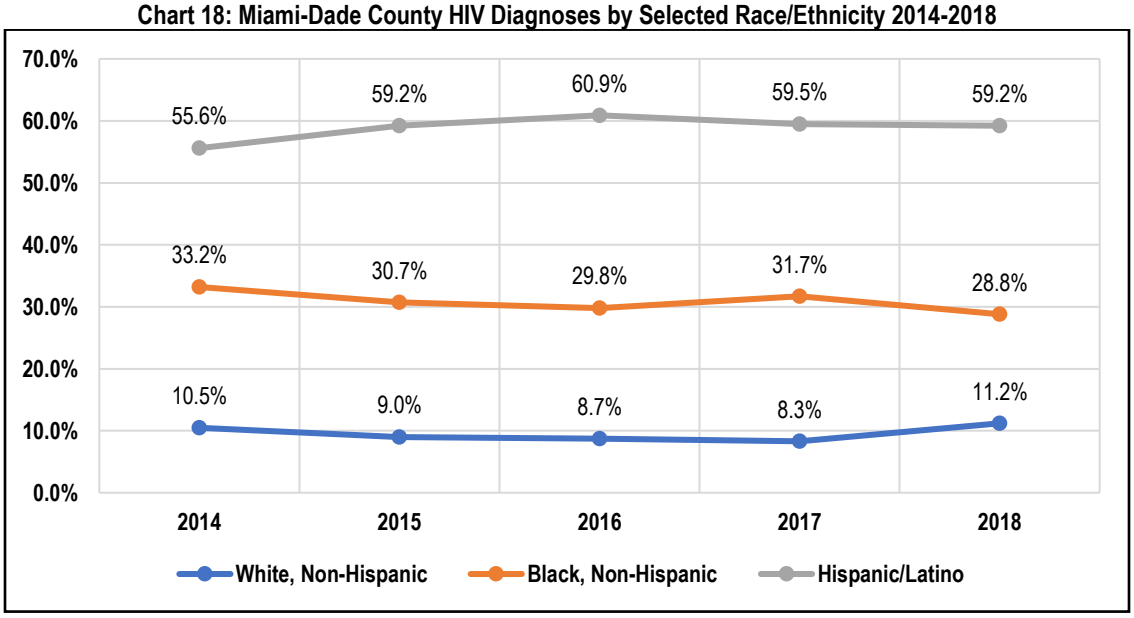
Table 4: Miami-Dade County HIV Diagnoses by Race/Ethnicity 2014-2018

	2014		2015		2016		2017		2018	
Race/Ethnicity	**N**	**% of Total**	**N**	**% of Total**	**N**	**% of Total**	**N**	**% of Total**	**N**	**% of Total**
Non-Hispanic/Latinx										
White	125	10.5%	120	9.0%	109	8.7%	97	8.3%	137	11.2%
Black	395	33.2%	409	30.7%	375	29.8%	369	31.7%	352	28.8%
Asian	3	0.3%	6	0.5%	6	0.5%	4	0.3%	3	0.2%
American Indian/Alaska Native	0	0.0%	2	0.2%	0	0.0%	2	0.2%	0	0.0%
Native Hawaiian/Pacific Islander	0	0.0%	2	0.2%	0	0.0%	0	0.0%	3	0.2%
Multi-race	5	0.4%	5	0.4%	3	0.2%	0	0.0%	4	0.3%
Hispanic/Latinx										
Hispanic/Latinx	661	55.6%	789	59.2%	767	60.9%	692	59.5%	725	59.2%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Chart 18 shows the percentage of HIV diagnoses among White Non-Hispanics, Black Non-Hispanics, and Hispanic/Latinxs in Miami-Dade County from 2014-2018. Over the course of four years, the Hispanic/Latinx group increased from 55.6% in 2014 to 59.2% in 2018. On the other hand, the percentage of HIV diagnoses attributed to Black Non-Hispanics decreased from 33.2% in 2014 to 28.8% in 2018. The percentage of HIV diagnoses attributed to White Non-Hispanics decreased from 10.5% in 2014 to 8.3% in 2017 and increased to 11.2% in 2018. People identifying as Asian, multi-race, American Indian/Alaska Native, or Native Hawaiian/Pacific Islander (all Non-Hispanic) are not shown, as each group accounted for less 0.5% or less of HIV diagnoses each year.

Chart 18: Miami-Dade County HIV Diagnoses by Selected Race/Ethnicity 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of HIV diagnoses by race and ethnicity at the state level differs from the distribution at the county level. For each year from 2014-2018, Black Non-Hispanics accounted for the highest percentage of HIV diagnoses in the state of Florida and Hispanic/Latinxs accounted for the second highest percentage, followed by White Non-Hispanics. Asian, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, and Multi-Race (all Non-Hispanic) each accounted for less than 1.3% of HIV diagnoses for 2014-2018. In 2018, Black Non-Hispanics accounted for 39.4% of HIV diagnoses, followed by Hispanic/Latinxs at 34.0%, White Non-Hispanics at 24.6%, Asian Non-Hispanics at 1.1%, and Multi-Race Non-Hispanics at 0.8%. American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) each accounted for 0.1% of HIV diagnoses at the state level in 2018 (Table 5).

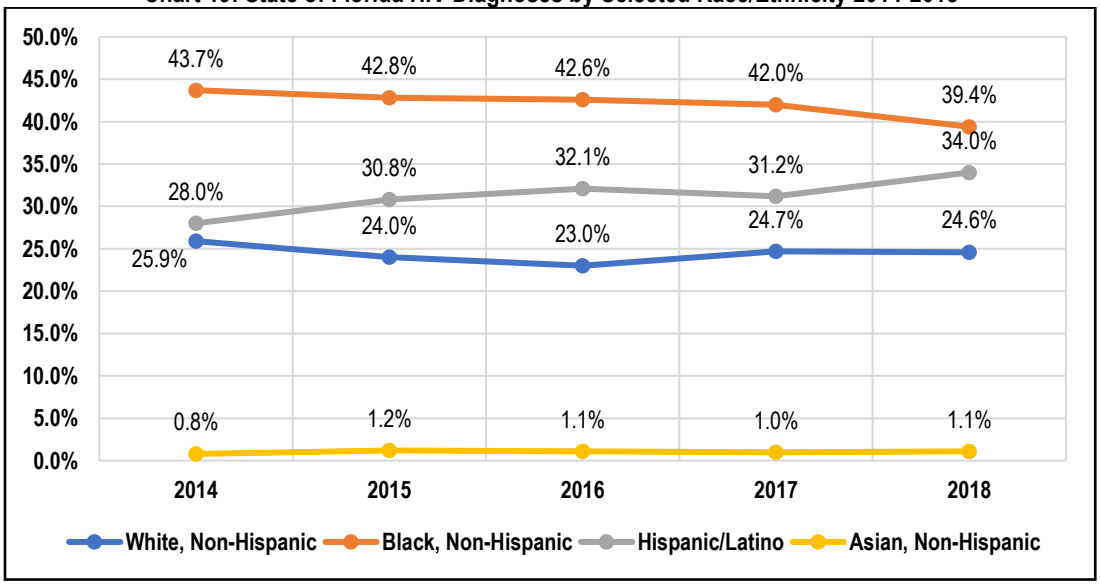
Table 5: State of Florida HIV Diagnoses by Race/Ethnicity 2014-2018

	2014		2015		2016		2017		2018	
Race/Ethnicity	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Hispanic/Latinx										
White	1,188	25.9%	1,125	24.0%	1,101	23.0%	1,177	24.7%	1,207	24.6%
Black	2,007	43.7%	2,001	42.8%	2,040	42.6%	2,004	42.0%	1,931	39.4%
Asian	38	0.8%	54	1.2%	54	1.1%	47	1.0%	55	1.1%
American Indian/Alaska Native	8	0.2%	4	0.1%	8	0.2%	9	0.2%	3	0.1%
Native Hawaiian/Pacific Islander	7	0.2%	7	0.1%	3	0.1%	5	0.1%	7	0.1%
Multi-race	54	1.2%	47	1.0%	45	0.9%	36	0.8%	37	0.8%
Hispanic/Latinx										
Hispanic/Latinx	1,286	28.0%	1,441	30.8%	1,538	32.1%	1,488	31.2%	1,666	34.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Following Chart 19, the percentage of HIV diagnoses at the state level attributed to Black Non-Hispanics decreased from 43.7% in 2014 to 39.4% in 2018. On the other hand, the percentage attributed to Hispanic/Latinxs increased from 28% in 2014 to 34% in 2018. The percentage of HIV diagnoses attributed to White Non-Hispanics remained relatively stable between 2014 and 2018, 25.9% to 24.6%, respectively. The percentage attributed to Asian Non-Hispanics also remained relatively stable between 2014 and 2018, 0.8% to 1.1%, respectively. The percentages of HIV diagnoses attributed to American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, and Multi-Race (all Non-Hispanic) are not shown in Chart 19 as they were each less than 1.3% each year.

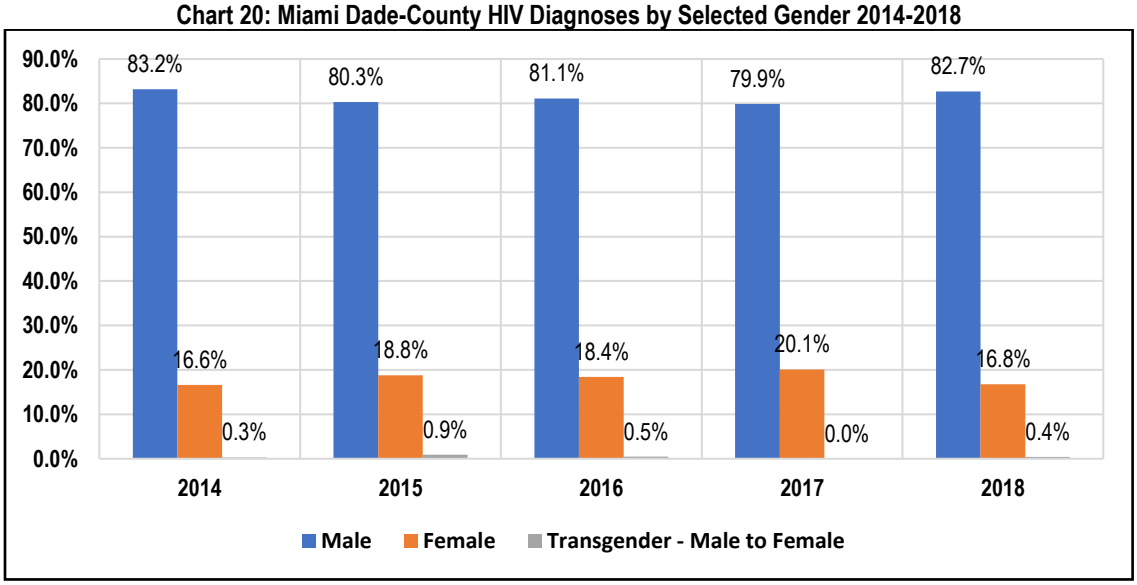
Chart 19: State of Florida HIV Diagnoses by Selected Race/Ethnicity 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Chart 20 shows the percentage of HIV diagnoses by selected gender in Miami-Dade County for 2014-2018. Males accounted for the largest percentage of HIV diagnoses each year, followed by females and transgender people (male to female). The transgender (female to male) category is not shown in Chart 20 as the percentage of HIV diagnoses was 0% each year from 2014-2017 and 0.1% in 2018. Over the course of 4 years the percentage of HIV diagnoses attributed to males remained relatively stable, decreasing from 83.2% in 2014 to 82.7% in 2018. The percentage attributed to females increased from 16.6% in 2014 to 20.1% in 2017 before decreasing to 16.8% in 2018. The percentage attributed to transgender people (male to female) remained below 1% each year from 2014-2018.

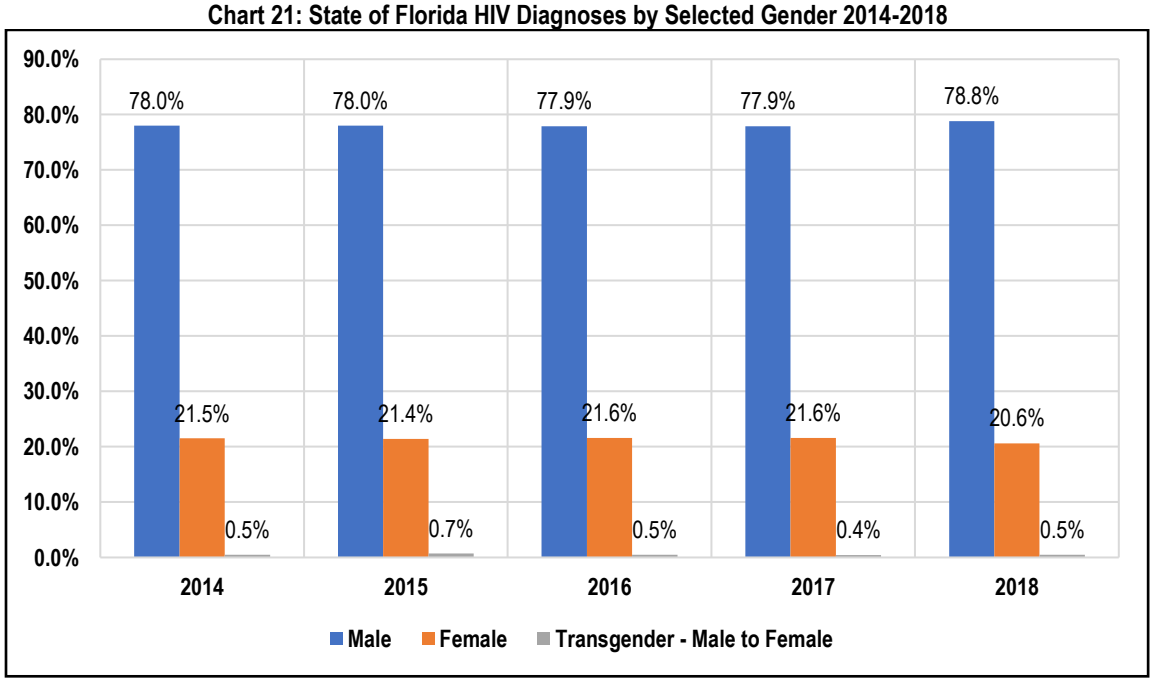
Chart 20: Miami Dade-County HIV Diagnoses by Selected Gender 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Chart 21 illustrates the percentage of HIV diagnoses by selected gender at the state level for 2014-2018. Like Miami-Dade County, at the state level males accounted for the largest percentage of HIV diagnoses each year. The percentage of HIV diagnoses attributed to males remained relatively stable from 78.0% in 2014 to 78.8% in 2018. The next highest percentage of HIV diagnoses was attributed to females, which slightly decreased from 21.5% in 2014 to 20.6% in 2018. The percentage attributed to transgender people (male to female) also remained relatively stable over the four-year time period, only ranging from 0.4% to 0.7%. The transgender (female to male) category is not shown in Chart 21 as the percentage of HIV diagnoses was 0% each year, apart from 2017 when 0.1% was observed.

Chart 21: State of Florida HIV Diagnoses by Selected Gender 2014-2018

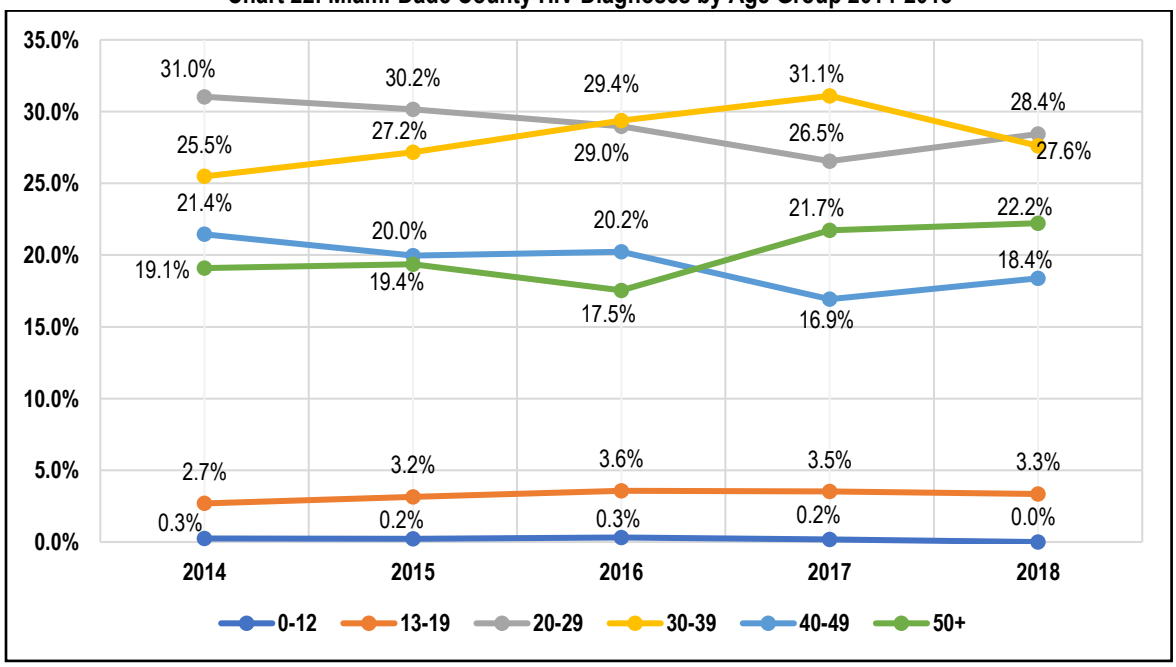


Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

For HIV diagnoses data, the age at diagnoses is used when analyzing the age group distribution among HIV diagnoses. Chart 22 shows the percentage of HIV diagnoses by age group from 2014 to 2018 in Miami-Dade County. The highest percentages of HIV diagnoses have been attributed to both the 20-29 age group and the 30-39 age group during the four-year time span. The percentage of HIV diagnoses attributed to the 20-29 age group started off as the highest percentage in 2014 at 31.0%, but then decreased to 29.0% in 2016, falling below the percentage attributed to the 30-39 age group (29.4%). The 30-39 age group accounted for the highest percentage again in 2017 (31.1%), but then decreased to 27.6% in 2018, falling below the percentage attributed to the 20-29 age group. The percentages of HIV diagnoses attributed to the 40-49 age group and the 50+ age group presented a similar pattern. The 40-49 age group accounted for 21.4% of the HIV diagnoses in 2014 (a higher percentage than the 50+ age group), but decreased to 16.9% in 2017, falling below the 50+ age group (21.7%). The 50+ age group continued to account for a higher percentage of HIV diagnoses (22.2%) than the 40-49 age group (18.4%) in 2018. The 13-19 age group remained relatively stable, increasing slightly from 2.7% in 2014 to 3.3% in 2018. The 0-12 age group accounted for the smallest percentage of HIV diagnoses and decreased from 0.3% in 2014 to 0.0% in 2018.

In 2018 the 20-29 age group accounted for the highest percentage of HIV diagnoses in Miami-Dade County at 28.4%. The 20-39 age group accounted for the second highest percentage of HIV diagnoses and was only 0.8% lower than the 20-29 age group at 27.6%. The 50+ age group and the 40-49 age-group followed with 22.2% and 18.4% of HIV diagnoses, respectively. The 13-19 age group only accounted for 3.3% of HIV diagnoses, and the 0-12 age group accounted for 0% (Chart 22).

Chart 22: Miami-Dade County HIV Diagnoses by Age Group 2014-2018



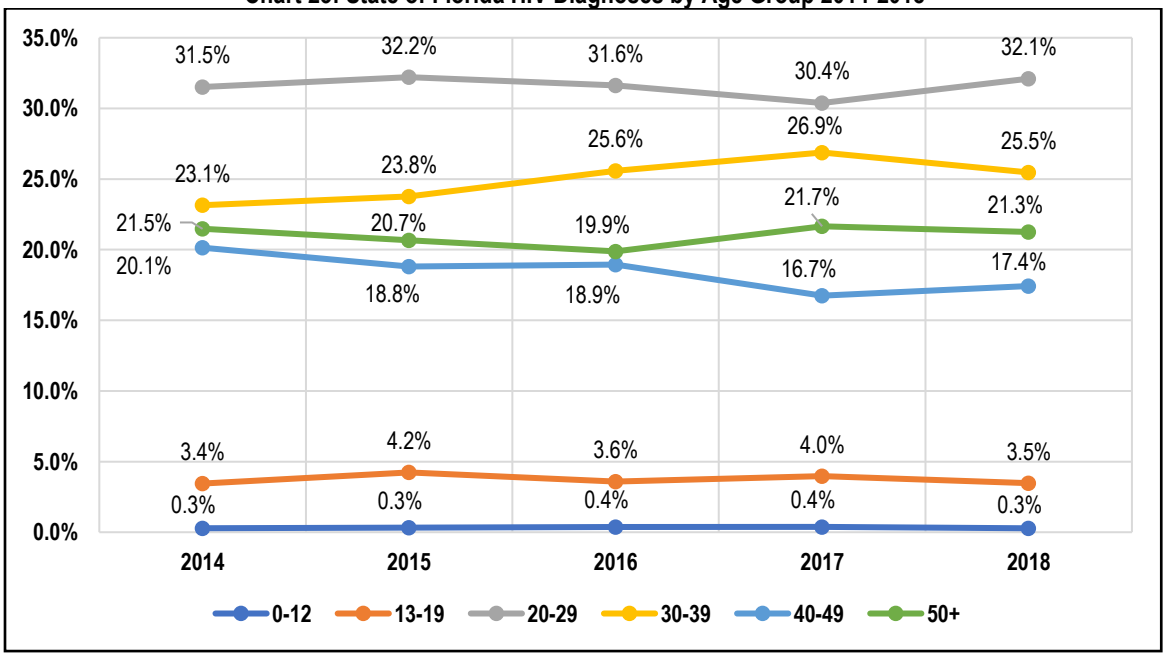
Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The age group distribution among HIV diagnoses in the state of Florida during 2018 was similar to the distribution in Miami-Dade County during 2018. In 2018 the 20-29 age group accounted for the highest percentage of HIV diagnoses at 32.1% in the state of Florida, followed by the 30-39

age group at 25.5%. The 50+ age group accounted for the third highest percentage of HIV diagnoses at 21.3%, followed by the 40-49 age group at 17.4%. The 13-19 age group only accounted for 3.5% of HIV diagnoses and the 0-12 age group accounted for the smallest percentage at 0.3% (Chart 23).

Compared to Miami-Dade County, the percentages of HIV diagnoses attributed to each age group were more stable over the four-year time period at the state level (Chart 23). The 20-29 age group accounted for the highest percentage of HIV diagnoses for each year from 2014-2018 and increased from 31.5% in 2014 to 32.1% in 2018. The 30-39 age group accounted for the second highest percentage of HIV diagnoses each year, starting at 23.1% in 2014 and increasing to 26.9% in 2017, before decreasing slightly to 25.5% in 2018. The percentages of HIV diagnoses attributed to the 50+ and 40-49 age groups differed only slightly from 2014 (21.5% and 20.1% respectively) to 2016 (19.9% and 18.9% respectively). In 2017 the gap between the two age groups increased as the percentage of HIV diagnoses attributed to the 50+ age group increased to 21.7% and the percentage attributed to the 40-49 age group decreased to 16.7%. The percentage of HIV diagnoses attributed to the13-19 age group remained relatively stable and the 0-12 age group accounted for the lowest percentage of HIV diagnoses each year.

Chart 23: State of Florida HIV Diagnoses by Age Group 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

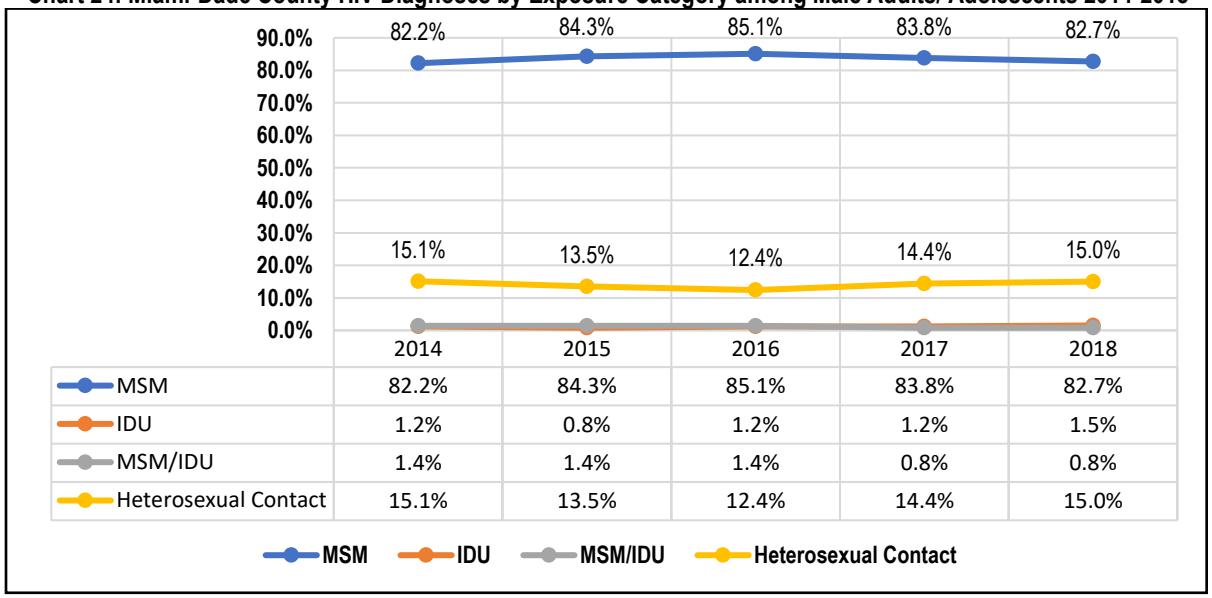
HIV Diagnoses by Mode of Transmission

This section analyzes the distribution of HIV diagnoses among various exposure categories at the state and county level for 2014-2018. As previously noted, HIV diagnoses by year of diagnosis represent persons whose HIV was diagnosed in that year, regardless of AIDS status at time of diagnosis. The exposure categories used to describe the mode of transmission of HIV by the Florida Department of Health include; men who have sex with men (MSM), injection drug use (IDU), MSM/IDU, heterosexual contact, sexual contact, other risk. MSM refers to men wo have

sex with men or male-to-male sexual contact. The MSM/IDU category includes men who have sex with men or men who use injection drugs. Heterosexual contact refers to heterosexual contact with a person living with HIV or a person of known HIV risk. Transgender persons with sexual contact as a mode of exposure are not included in the heterosexual contact category. The sexual contact category refers to transgender people who had sexual contact with a person living with HIV or a person of known HIV risk. The 'other risk' category includes hemophilia, transfusion, perinatal, other pediatric risks, and other confirmed risks.

Chart 24 shows the percentage of HIV diagnoses by exposure category among male adults and adolescents in Miami-Dade County from 2014-2018. The adult and adolescent group is defined as persons 13 years of age and older. MSM accounted for the highest percentage of HIV diagnoses each year and remained relatively stable from 82.2% in 2014 to 82.7% in 2018. The second highest percentage of HIV diagnoses was attributed to heterosexual contact each year, ranging from 12.4% in 2016 to 15.1% in 2014 and reached 15% in 2018. The percentage of HIV diagnoses attributed to IDU remained relatively stable from 1.2% in 2014 to 1.5% in 2018. MSM/IDU accounted for 0.8% of the HIV diagnoses in 2018, having only decreased slightly from 1.4% in 2014. The "other risk" exposure category is not included in Chart 51, as the percentage was only 0.1% in 2014 and 0.0% each year after.

Chart 24: Miami-Dade County HIV Diagnoses by Exposure Category among Male Adults/ Adolescents 2014-2018

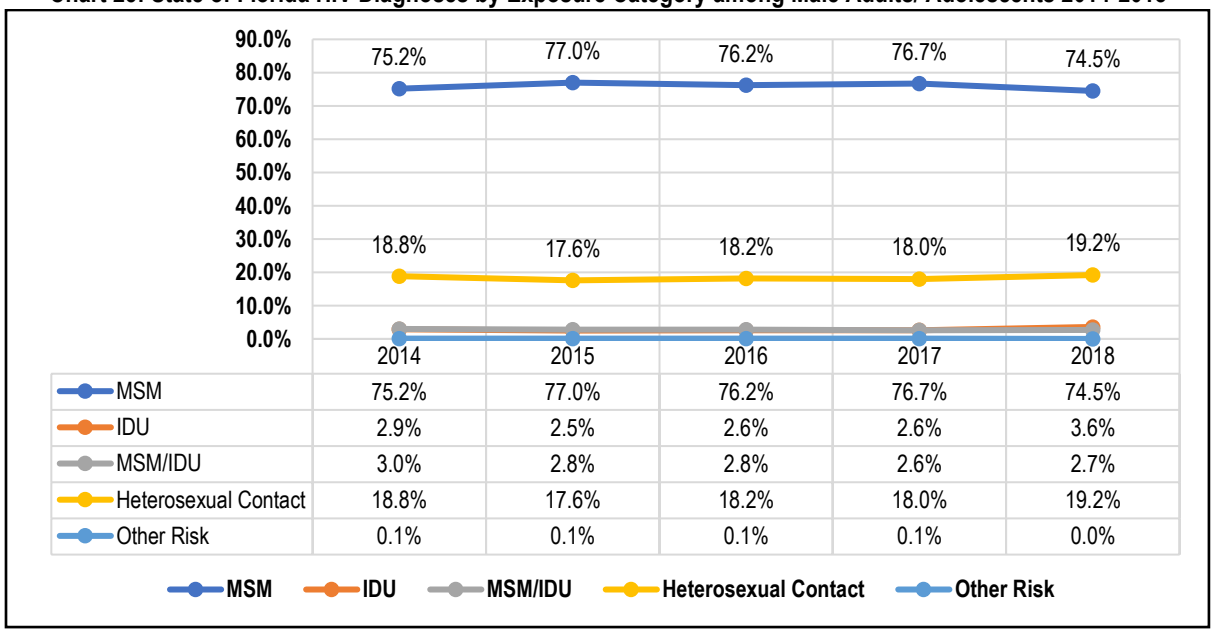


	2014	2015	2016	2017	2018
MSM	82.2%	84.3%	85.1%	83.8%	82.7%
IDU	1.2%	0.8%	1.2%	1.2%	1.5%
MSM/IDU	1.4%	1.4%	1.4%	0.8%	0.8%
Heterosexual Contact	15.1%	13.5%	12.4%	14.4%	15.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The percentage of HIV diagnoses by exposure category among male adults and adolescents presents a similar pattern at the state level. MSM accounted for the highest percentage each year from 75.2% in 2014 to 74.5% in 2018. The second highest percentage of HIV diagnoses is attributed to heterosexual contact, which remained relatively stable from 18.8% in 2014 to 19.2% in 2018. The IDU and MSM/IDU exposure categories each accounted for approximately 3% of HIV diagnoses each year. The percentage attributed to "other risk" remained constant at 0.1% for 2014 to 2017 before falling to 0% in 2018 (Chart 25).

Chart 25: State of Florida HIV Diagnoses by Exposure Category among Male Adults/ Adolescents 2014-2018

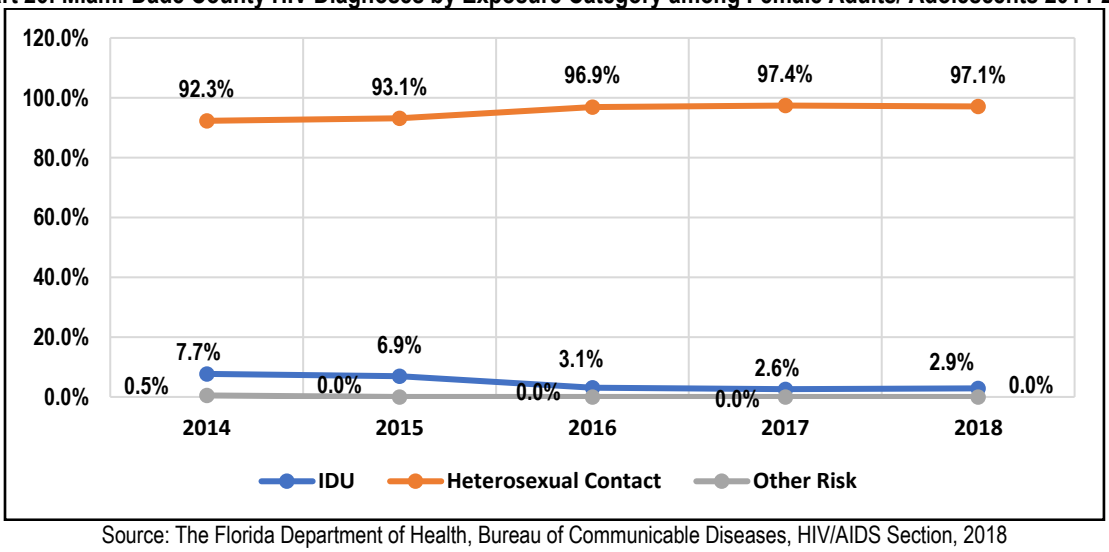


	2014	2015	2016	2017	2018
MSM	75.2%	77.0%	76.2%	76.7%	74.5%
IDU	2.9%	2.5%	2.6%	2.6%	3.6%
MSM/IDU	3.0%	2.8%	2.8%	2.6%	2.7%
Heterosexual Contact	18.8%	17.6%	18.2%	18.0%	19.2%
Other Risk	0.1%	0.1%	0.1%	0.1%	0.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Compared to males, females living with HIV are divided into less exposure categories; heterosexual contact, IDU and other risk. In Miami-Dade County, most female adults and adolescents contracted HIV through heterosexual contact each year from 2014 to 2018.The percentage of HIV diagnoses attributed to heterosexual contact increased from 92.3% in 2014 to 97.1% in 2018. The IDU exposure category accounted for 7.7% of HIV diagnoses in 2014 and decreased to 2.9% in 2018. The other risk category accounted for only 0.5% of HIV diagnoses in 2014 and decreased to 0.0% each year after (Chart 26).

Chart 26: Miami-Dade County HIV Diagnoses by Exposure Category among Female Adults/ Adolescents 2014-2018

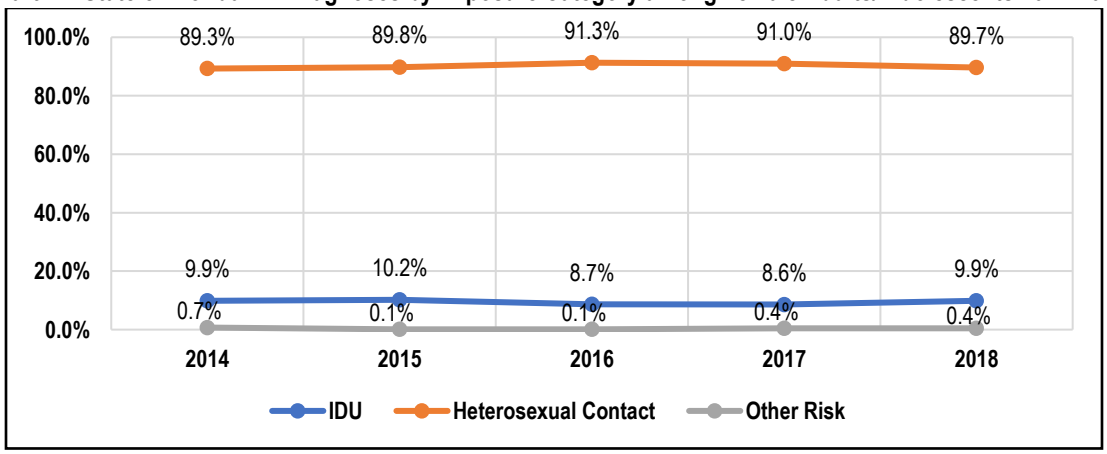


Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of HIV diagnoses by exposure category among females at the state level is similar to the distribution observed in Miami-Dade County. At the state level, heterosexual contact also accounted for the majority of HIV diagnoses among female adults and adolescents each year,

increasing from 89.3% in 2014 to 89.7% in 2018. The percentage of HIV diagnoses attributed to the IDU exposure category remained relatively stable over the four-year time period, ranging from 8.6% to 10.2%, and reached 9.9% in 2018. The "other risk" exposure category only accounted for 0.7% of HIV diagnose in 2014 and decreased to 0.4% in 2018 (Chart 27).

Chart 27: State of Florida HIV Diagnoses by Exposure Category among Female Adults/ Adolescents 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Following Table 6, 27 HIV diagnoses among transgender adults and adolescents between 2014 and 2018 were observed in Miami-Dade County. The number of HIV diagnoses among transgender adults and adolescents increased from 3 in 2014 to 12 in 2015 before decreasing to 6 in 2016 and 2018. There were 0 cases reported in 2017. The sexual contact exposure category accounted for 100% of HIV diagnoses among transgender adults and adolescents each year in Miami-Dade County.

Table 6: Miami-Dade County HIV Diagnoses by Exposure Category among Transgender Adults/ Adolescents 2014-2018

Transgender Adult/Adolescent Exposure Categories	2014		2015		2016		2017	2018	
	N	% of Total	N	% of Total	N	% of Total	N	N	% of Total
IDU	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%
Sexual Contact	3	100.0%	12	100.0%	6	100.0%	0	6	100.0%
Other Risk	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%
Total	**3**	**100.0%**	**12**	**100.0%**	**6**	**100.0%**	**0**	**6**	**100.0%**

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

At the state level, 126 HIV diagnoses were observed among transgender adults and adolescents between 2014 and 2018. The sexual contact exposure category accounted 100% of HIV diagnoses among transgender adults and adolescents from 2015-2017. In 2014 the IDU exposure category accounted for 8.3% (2 cases) of HIV diagnoses and 3.8% (1 case) in 2018 (Table 7).

Table 7: State of Florida HIV Diagnoses by Exposure Category among Transgender Adults/ Adolescents 2014-2018

Transgender Adult/Adolescent Exposure Categories	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
IDU	2	8.3%	0	0.0%	0	0.0%	0	0.0%	1	3.8%
Sexual Contact	22	91.7%	32	100.0%	23	100.0%	21	100.0%	25	96.2%
Other Risk	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**24**	**100.0%**	**32**	**100.0%**	**23**	**100.0%**	**21**	**100.0%**	**26**	**100.0%**

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Pediatric diagnoses refer to persons under the age of 13. In Miami-Dade County 12 pediatric HIV diagnoses were observed between 2014 and 2017 and 0 pediatric HIV diagnoses were in 2018. Perinatal exposure accounted for 100% of pediatric HIV diagnoses between 2014 and 2017 (Table 8).

Table 8: Miami-Dade County HIV Diagnoses by Exposure Category among Children 2014-2018

Pediatric Exposure Categories	2014		2015		2016		2017		2018
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N
Perinatal Exposure	3	100%	3	100.0%	4	100.0%	2	100.0%	0
Non-perinatal Exposure	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0
Total	**3**	**100.0%**	**3**	**100.0%**	**4**	**100.0%**	**2**	**100.0%**	**0**

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

At the state level, 78 pediatric HIV diagnoses were observed between 2014 and 2018. Perinatal exposure accounted for 100% of pediatric HIV diagnoses in 2014 and 2016. Non-perinatal exposure accounted for 20.0% (3 cases) of pediatric HIV diagnoses in 2015, 5.6% (1 case) in 2017 and 21.4% (3 cases) in 2018 (Table 9).

Table 9: State of Florida HIV Diagnoses by Exposure Category among Children 2014-2018

Pediatric Exposure Categories	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Perinatal Exposure	13	100%	12	80.0%	18	100.0%	17	94.4%	11	78.6%
Non-perinatal Exposure	0	0.0%	3	20.0%	0	0.0%	1	5.6%	3	21.4%
Total	**13**	**100.0%**	**15**	**100.0%**	**18**	**100.0%**	**18**	**100.0%**	**14**	**100.0%**

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

AIDS Diagnoses by Demographics

Table 10 shows the distribution of AIDS diagnoses by race and ethnicity in Miami-Dade County for 2014 to 2018. Black Non-Hispanics and Hispanic/Latinxs account for the highest percentages each year, followed by White Non-Hispanics, Multi-race Non-Hispanics, and Asian Non-Hispanics, respectively. American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) each accounted for 0% of AIDS diagnoses from 2014-2018.

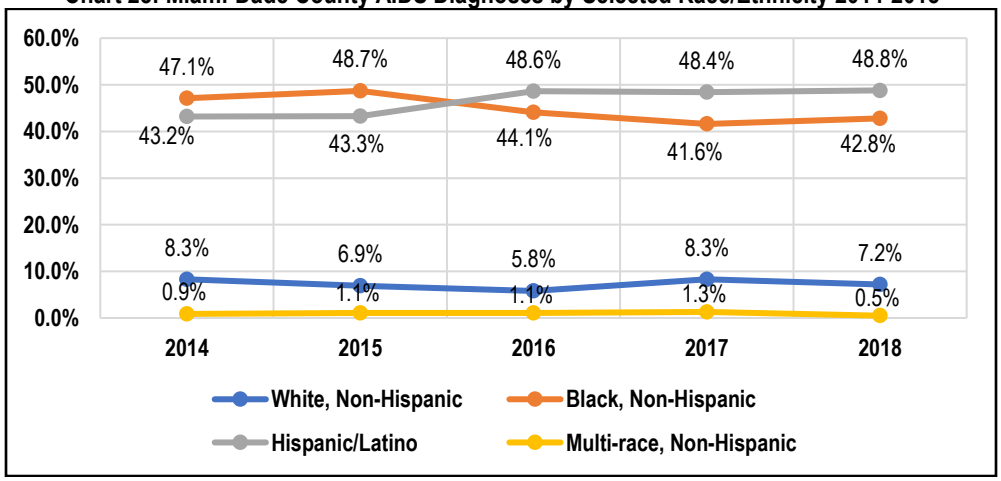
Table 10: Miami-Dade County AIDS Diagnoses by Race/Ethnicity 2014-2018

Race/Ethnicity	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Non-Hispanic/Latinx										
White	36	8.3%	32	6.9%	27	5.8%	33	8.3%	29	7.2%
Black	205	47.1%	227	48.7%	205	44.1%	166	41.6%	172	42.8%
Asian	2	0.5%	0	0.0%	2	0.4%	2	0.5%	3	0.7%
American Indian/Alaska Native	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Native Hawaiian/Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Multi-race	4	0.9%	5	1.1%	5	1.1%	5	1.3%	2	0.5%
Hispanic/Latinx										
Hispanic/Latinx	188	43.2%	202	43.3%	226	48.6%	193	48.4%	196	48.8%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Following Chart 28, Black Non-Hispanics accounted for the highest percentage of AIDS diagnoses in Miami-Dade County in 2014 and 2015 at 47.1% and 48.7%, respectively. In 2016 the percentage of AIDS diagnoses attributed to Black Non-Hispanics decreased to 44.1%, falling below the percentage attributed to Hispanic/Latinxs, which had increased from 43.3% in 2015 to 48.6% in 2016. The percentage attributed to Hispanic/Latinxs remained relatively stable at 48.4% in 2017 and 48.8% in 2018. The percentage attributed to Black Non-Hispanics remained relatively stable and below the percentages attributed to Hispanic/Latinxs in 2017 and 2018, at 41.6% and 42.8%, respectively. The percentage of AIDS diagnoses contributed to White Non-Hispanics decreased from 8.3% in 2014 to 7.2% in 2018 and reached its lowest point of the four-year period in 2016 at 5.8%. The percentage of AIDS diagnoses attributed to Multi-race Non-Hispanics remained relatively stable from 0.9% in 2014 to 0.5% in 2018, reaching its highest point over the four-year period in 2017 at 1.3%. American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) are not included in Chart 28 as each accounted for 0% of AIDS diagnoses from 2014-2018.

Chart 28: Miami-Dade County AIDS Diagnoses by Selected Race/Ethnicity 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of AIDS diagnoses among race and ethnicity at the state level differs from the county level. At the state level, Black Non-Hispanics accounted for the highest percentage of AIDS diagnoses each year from 2014 to 2018. The percentages of AIDS diagnoses attributed to White Non-Hispanics and Hispanic/Latinxs were observed in the 20%-25% range over the four-year period. Multi-race Non-Hispanics and Asian Non-Hispanics each accounted for less than 2.2% of AIDS diagnoses over the four-year period. American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) accounted for the lowest percentages of AIDS diagnoses, ranging from 0.0%-0.3% over the four-year period (Table 11).

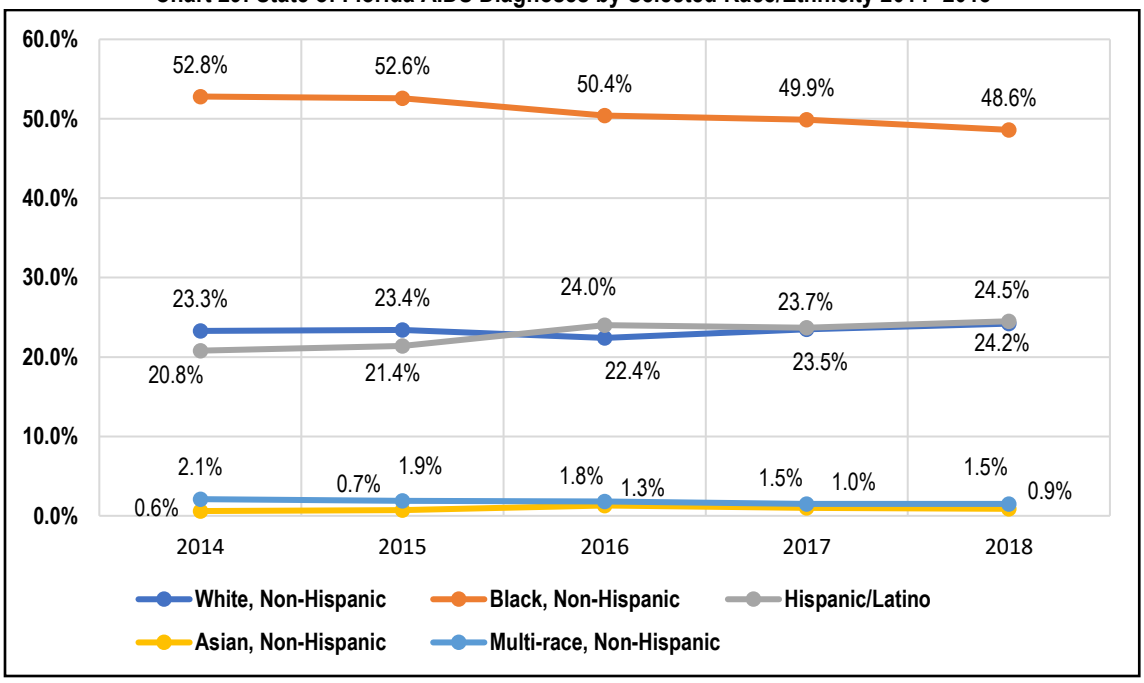
Table 11: State of Florida AIDS Diagnoses by Race/Ethnicity 2014- 2018

Race/Ethnicity	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Non-Hispanic/Latinx										
White	507	23.3%	499	23.4%	473	22.4%	479	23.5%	464	24.2%
Black	1,147	52.8%	1,123	52.6%	1,065	50.4%	1,017	49.9%	932	48.6%
Asian	14	0.6%	15	0.7%	27	1.3%	20	1.0%	18	0.9%
American Indian/Alaska Native	4	0.2%	2	0.1%	3	0.1%	6	0.3%	2	0.1%
Native Hawaiian/Pacific Islander	2	0.1%	1	0.0%	1	0.0%	4	0.2%	4	0.2%
Multi-race	46	2.1%	40	1.9%	38	1.8%	31	1.5%	29	1.5%
Hispanic/Latinx										
Hispanic/Latinx	452	20.8%	457	21.4%	507	24.0%	483	23.7%	469	24.5%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Chart 29 illustrates the trend over time for AIDS diagnoses by selected race and ethnicity in the state of Florida for 2014-2018. The percentage of AIDS diagnoses attributed to Black Non-Hispanics decreased slightly from 52.8% in 2014 to 48.6% in 2018. The percentage of AIDS diagnoses attributed to White Non-Hispanics was the second highest percentage at 23.3% in 2014 and decreased to 22.4% in 2016, falling below the percentage attributed to Hispanic/Latinxs, which had increased from 21.4% in 2015 to 24.0% in 2016. In 2017 the percentages attributed to White Non-Hispanics and Hispanic/Latinxs were almost equal, 23.5% and 23.7%, respectively. Similarly, in 2018 the percentages attributed to White Non-Hispanics and Hispanic/Latinxs were almost equal, 24.2% and 24.5%, respectively. The percentages of AIDS diagnoses attributed to Multi-Race Non-Hispanics and Asian Non-Hispanics remained relatively stable over the four-year period. American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) are not included in Chart 29, as their percentages were less than 0.4% each year.

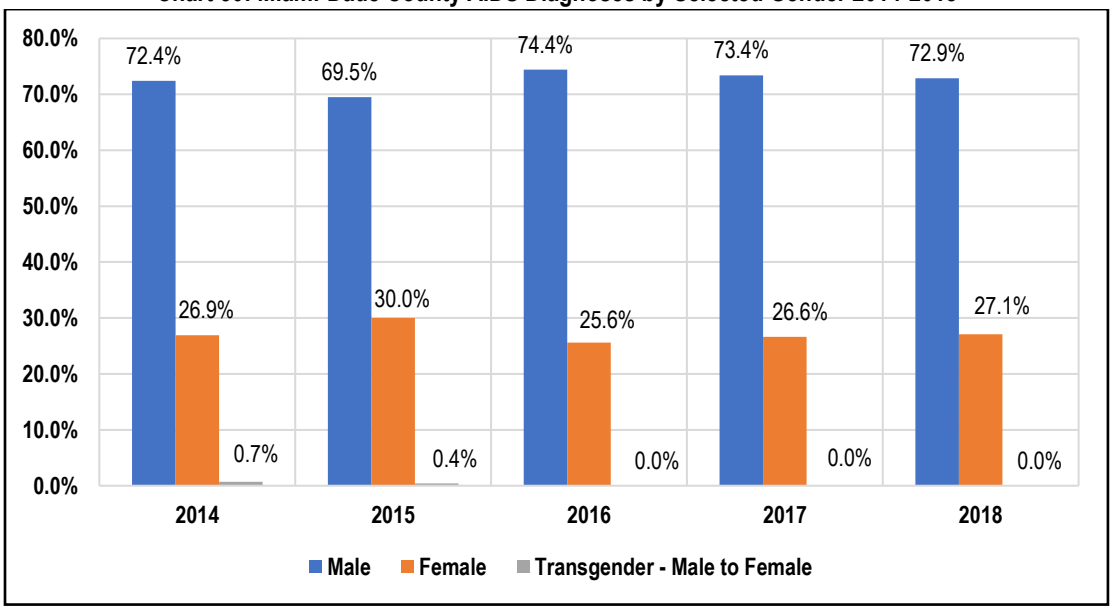
Chart 29: State of Florida AIDS Diagnoses by Selected Race/Ethnicity 2014- 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Chart 30 depicts the distribution of AIDS diagnoses by gender in Miami-Dade County for 2014-2018. Males accounted for the highest percentage of AIDS diagnoses each year, which remained relatively stable from 72.4% in 2014 to 72.9% in 2018. Females accounted for the second highest percentage of AIDS diagnoses each year, which remained relatively stable from 26.9% in 2014 to 27.1% in 2018. Transgender people (male to female) only accounted for 0.7% of AIDS diagnoses in 2014, which decreased to 0.0% in 2018. The transgender (female to male) category is not included in Chart 30 as this category accounted for 0.0% of AIDS diagnoses each year.

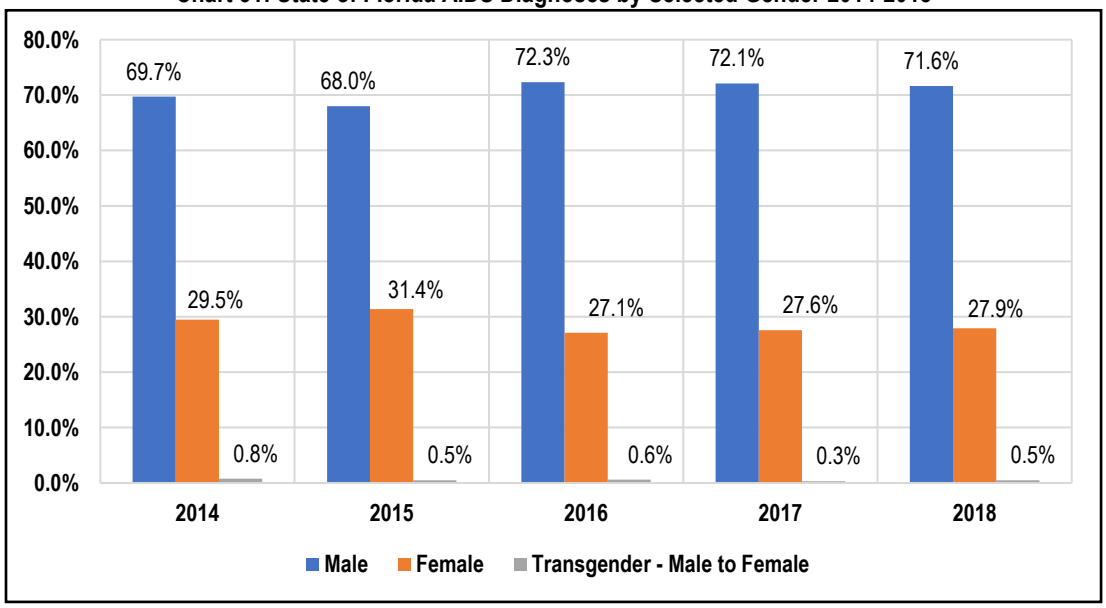
Chart 30: Miami-Dade County AIDS Diagnoses by Selected Gender 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of AIDS diagnoses by gender observed at the state level is similar to the distribution observed at the county level. At the state level, males also accounted for the highest percentage of AIDS diagnoses and the percentage remained relatively stable from 69.7% in 2014 to 71.6% in 2018. Females accounted for the second highest percentage of AIDS diagnoses each year, which remained relatively stable from 29.5% in 2014 to 27.9% in 2018. Transgender people (male to female) only accounted for 0.8% of AIDS diagnoses in 2014 and decreased to 0.5% in 2018. The transgender (female to male) category is not included in Chart 31 as this category accounted for 0.0% of AIDS diagnoses each year.

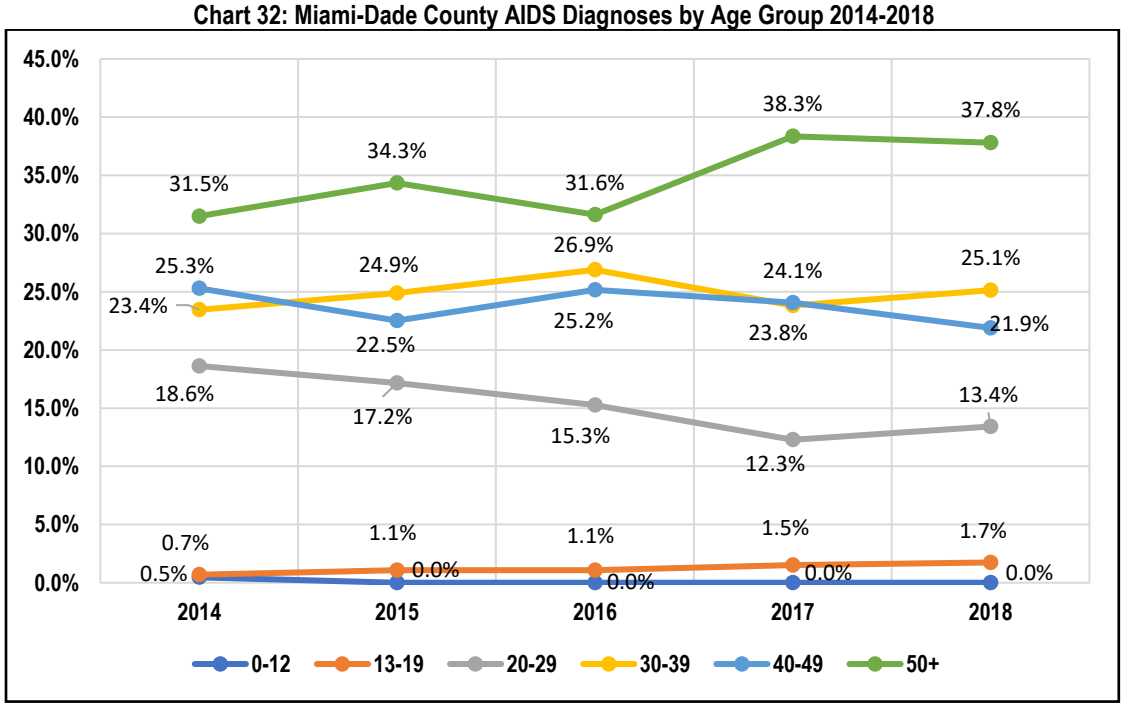
Chart 31: State of Florida AIDS Diagnoses by Selected Gender 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

In 2018 the 50+ age group accounted for the highest percentage of AIDS diagnoses in Miami-Dade County at 37.8%, followed by the 30-39 age group at 25.1%, the 40-49 age group at 21.9%, the 20-29 at 13.4% and the 13-19 age group at 1.7%. The 0-12 age group accounted for 0.0% of AIDS diagnoses in 2018. When observing trends over time, the percentage of AIDS diagnoses attributed to the 50+ age group increased from 31.5% of AIDS diagnoses in 2014 to 37.8% in 2018. The percentage attributed to the 40-49 age group decreased from 25.3% in 2014 to 21.9% in 2018 and the percentage attributed to the 30-39 age group remained relatively stable from 23.4% in 2014 to 25.1% in 2018. The percentage attributed to the 20-29 age group decreased from 18.6% in 2014 to 12.3% in 2017 and then increased slightly to 13.4% in 2018. The 0-12 age group accounted for only 0.5% of AIDS diagnoses in 2014 and 0.0% each year following 2014 (Chart 32).

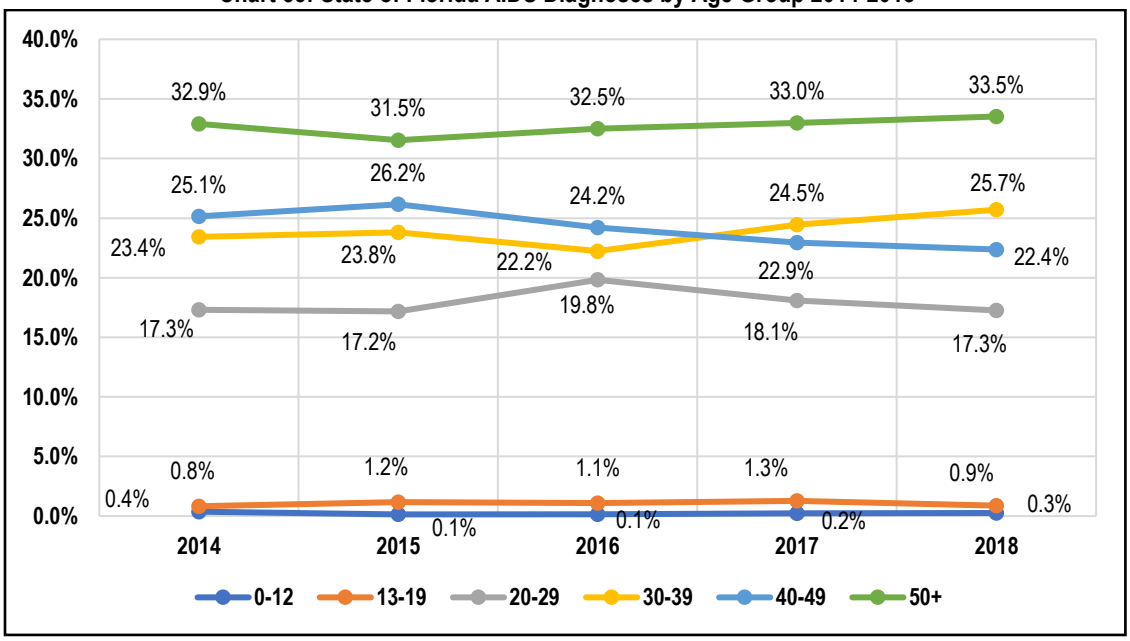
Chart 32: Miami-Dade County AIDS Diagnoses by Age Group 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of AIDS diagnoses by age group presented a similar pattern at the state level in 2018. The 50+ age group accounted for the highest percentage of AIDS diagnoses at 33.5%, followed by the 30-39 age group at 25.7%, the 40-49 age-group at 22.4%, the 20-29 age group at 17.3%, the 13-19 age group at 0.9%, and the 0-12 age group at 0.3%. The percentage of AIDS diagnoses attributed to the 50+ age group remained relatively stable from 32.9% in 2014 to 33.5% in 2018. The 40-49 age group displayed a slight decrease over time, from 25.1% in 2014 to 22.4% in 2018, while the 30-39 age group displayed a slight increase from 23.4% in 2014 to 25.7% in 2018. The percentage of AIDS diagnoses attributed to the 20-29 age group was 17.3% in 2014, as well as in 2018, and was at its highest point over the four-year period at 19.8% in 2016. The percentages of AIDS diagnoses attributed to the 0-12 and 13-19 age groups remained relatively stable over time (Chart 33).

Chart 33: State of Florida AIDS Diagnoses by Age Group 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

People Living with HIV/AIDS (PLWH)

The Florida Department of Health, HIV/AIDS Section, defines People Living with HIV as people living with a known diagnosis of HIV (PLWH) in the State of Florida through the end of the previous year, regardless where residents were diagnosed and whether they have since their diagnosis been also diagnosed with AIDS.

In 2018, there were 28,345 PLWH in Miami-Dade County. This statistic represents a rate of 101.2 PLWH per 10,000 population which is twice as high as the statewide rate of 57.1 per 10,000 population (please refer to Table 12). Overtown (zip code 33136) exhibited a significantly high rate compared to other geographical areas with 575.0 per 10,000 population, followed by residents of Miami Beach (zip code 33139) with 514.2 per 10,000.

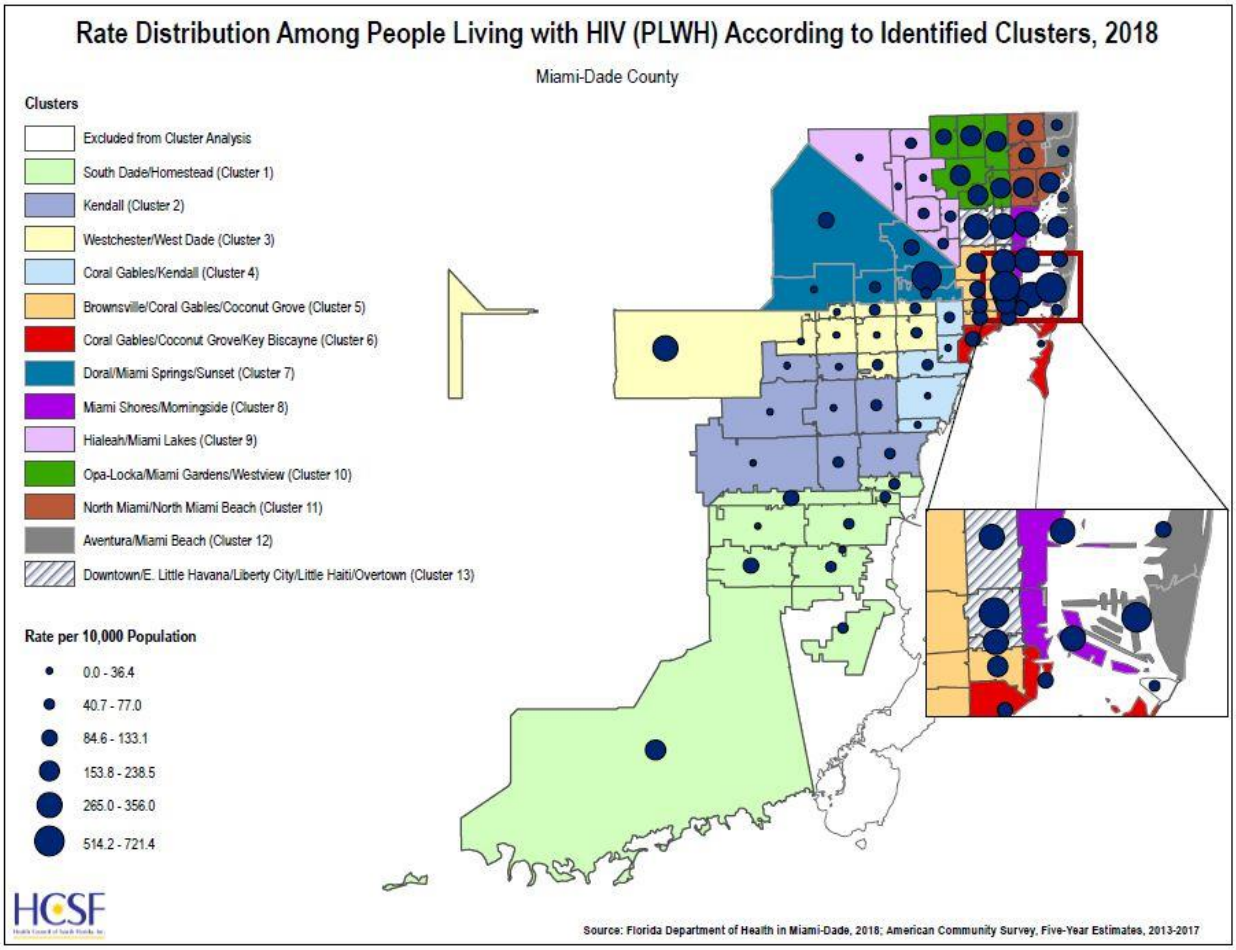
Table 12: Persons Living with HIV (PLWH), Rate per 10,000, Miami-Dade County, 2018

Top 5 Zip Codes	Neighborhood	Rate per 10,000
33136	Overtown	575.0
33139	Miami Beach - South	514.2
33137	Little Haiti	356.0
33194	West Kendall	352.1
33138	Miami Shores/El Portal	348.6
Miami-Dade County		101.2
Florida		57.1

Source: Florida Department of Health in Miami-Dade; Florida Department of Health (State), HIV/AIDS Section

Map 3 illustrates the rate distribution of PLWH in Miami-Dade County represented by the purple circles. It is important to note that two out of the three zip codes that comprise Miami Shores/Morningside (Cluster 8) exhibited the highest rate of PLWH as also represented in Table 12.

Map 3 – People Living with HIV, Miami-Dade County, 2018



People Living with HIV/AIDS by Demographics

Table 13 shows the number and percentage of people living with HIV/AIDS (PLWH) by race and ethnicity in Miami-Dade County from 2014-2018. In 2018 46% of PLWH identified as Hispanic/Latinx, followed by 42% who identified as Black Non-Hispanic. White Non-Hispanics accounted for 10.7% of PLWH in 2018, followed by Multi-race Non-Hispanics (1.0%) and Asian Non-Hispanics (0.3%). American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) each accounted for 0.0% of PLWH in 2018.

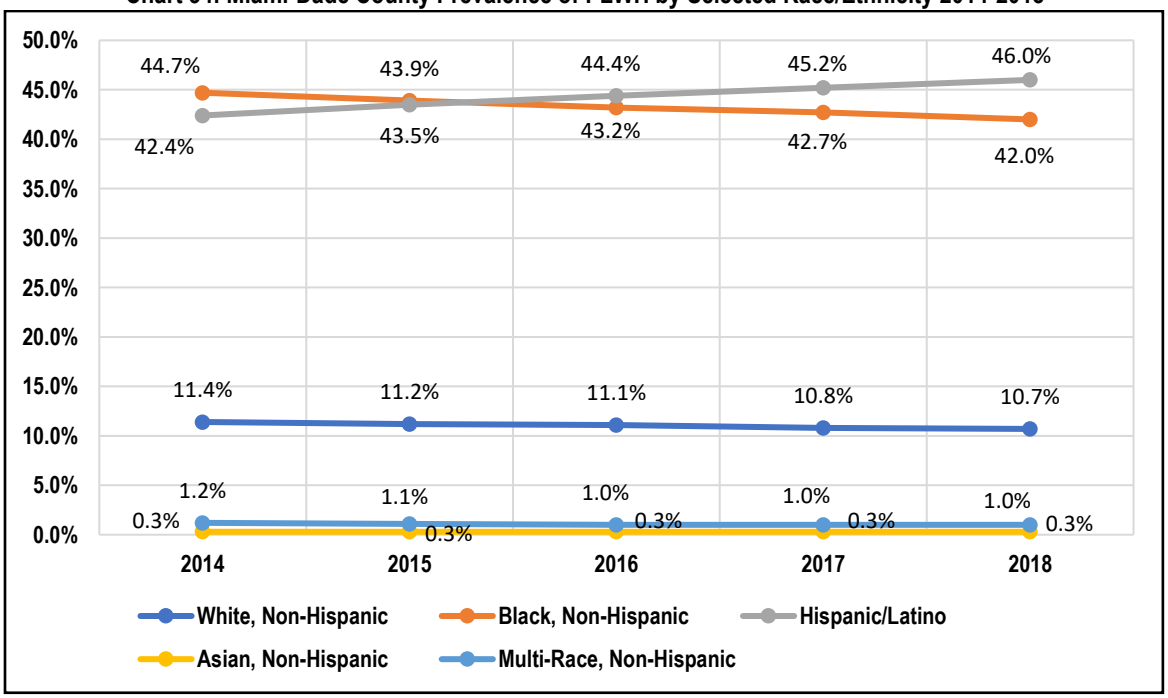
Table 13: Miami-Dade County Prevalence of PLWH by Race/Ethnicity 2014-2018

Race/Ethnicity	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Non-Hispanic/Latinx										
White	3,066	11.4%	3,040	11.2%	3,069	11.1%	3,035	10.8%	3,047	10.7%
Black	11,969	44.7%	11,925	43.9%	11,982	43.2%	11,983	42.7%	11,894	42.0%
Asian	68	0.3%	78	0.3%	78	0.3%	80	0.3%	86	0.3%
American Indian/Alaska Native	4	0.0%	5	0.0%	5	0.0%	7	0.0%	7	0.0%
Native Hawaiian/Pacific Islander	4	0.0%	6	0.0%	6	0.0%	8	0.0%	9	0.0%
Multi-race	316	1.2%	300	1.1%	291	1.0%	274	1.0%	272	1.0%
Hispanic/Latinx										
Hispanic/Latinx	11,371	42.4%	11,804	43.5%	12,308	44.4%	12,668	45.2%	13,030	46.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Chart 34 illustrates the percentage of PLWH by race and ethnicity over time, from 2014 to 2018. The percentage of PLWH identifying as Hispanic/Latinxs has increased from 42.4% in 2014 to 46.0% in 2018 and surpassed the percentage identifying as Black Non-Hispanics in 2016. The Percentage of PLWH identifying as Black Non-Hispanics decreased from 44.1% in 2014 to 42.0% in 2018. The percentage of PLWH attributed to White Non-Hispanics, Multi-race Non-Hispanics and Asian Non-Hispanics each remained relatively stable over the four-year period. American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) are not included in Chart 34 as both groups accounted for 0.0% of PLWH each year.

Chart 34: Miami-Dade County Prevalence of PLWH by Selected Race/Ethnicity 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of PLWH by race and ethnicity differs at the state level from the county level. For the state of Florida in 2018 45.2% of PLWH identified as Black Non-Hispanics, followed by White Non-Hispanics (28.8%), Hispanic/Latinxs (23.9%), Multi-race Non- Hispanics (1.4%), and Asian Non-Hispanics (0.6%). American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) each accounted for 0.1% of PLWH in 2018 (Table 14).

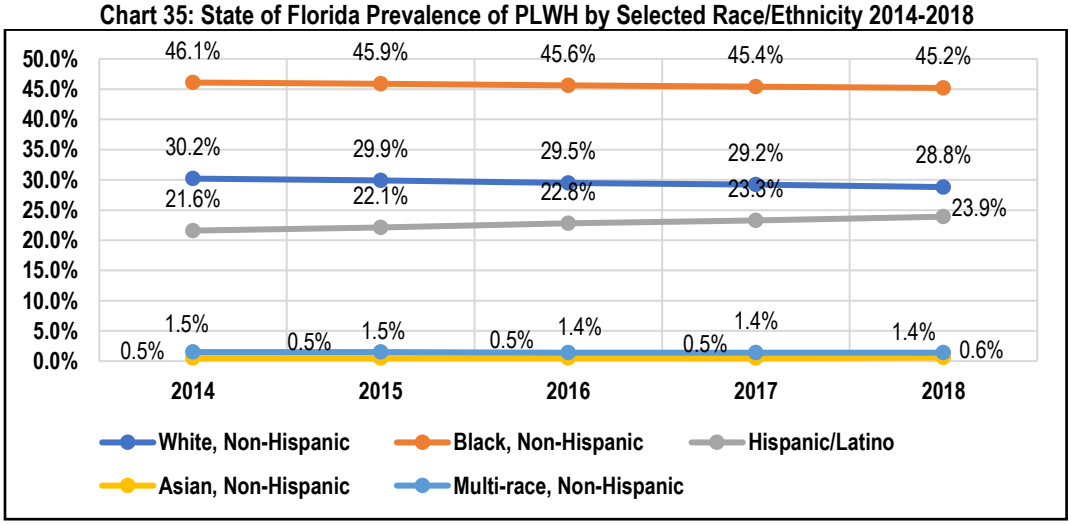
Table 14: State of Florida Prevalence of PLWH by Race/Ethnicity 2014-2018

	2014		2015		2016		2017		2018	
Race/Ethnicity	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Non-Hispanic/Latinx										
White	34,096	30.2%	34,262	29.9%	34,427	29.5%	34,548	29.2%	34,475	28.8%
Black	52,014	46.1%	52,644	45.9%	53,197	45.6%	53,640	45.4%	54,117	45.2%
Asian	519	0.5%	560	0.5%	597	0.5%	630	0.5%	678	0.6%
American Indian/Alaska Native	87	0.1%	90	0.1%	93	0.1%	104	0.1%	105	0.1%
Native Hawaiian/Pacific Islander	50	0.0%	55	0.0%	57	0.0%	62	0.1%	66	0.1%
Multi-race	1,681	1.5%	1,667	1.5%	1,657	1.4%	1,640	1.4%	1,634	1.4%
Hispanic/Latinx										
Hispanic/Latinx	24,436	21.6%	25,390	22.1%	26,523	22.8%	27,553	23.3%	28,586	23.9%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Chart 35 shows the trends over time for PLWH by race and ethnicity at the state level. The percentage of PLWH identifying as Black Non-Hispanic has remained relatively stable from 26.1% in 2014 to 45.2% in 2018. The percentage of PLWH identifying as White Non-Hispanic has also remained relatively stable from 2014 (30.2%) to 2018 (28.8%), while the percentage of PLWH identifying as Hispanic/Latinx has increased from 21.6% in 2014 to 23.9% in 2018. American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic) are not included in Chart 35 as each accounted for 0.1% or less of PLWH each year.

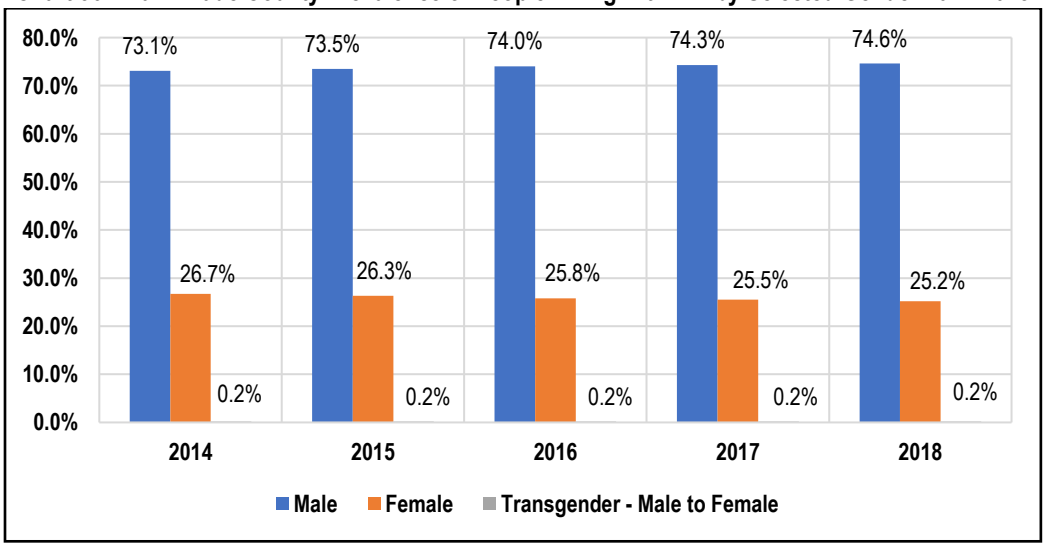
Chart 35: State of Florida Prevalence of PLWH by Selected Race/Ethnicity 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Following Chart 36, among PLWH in Miami-Dade County, males accounted for the highest percentage each year, which has increased from 73.1% in 2014 to 74.6% in 2018. The percentage of PLWH identifying as female has decreased from 26.7% in 2014 to 25.3% in 2018. Each year, only 0.2% of PLWH identified as transgender (male to female). The transgender (female to male) category is not shown in Chart 36, as the percentage was 0.0% each year.

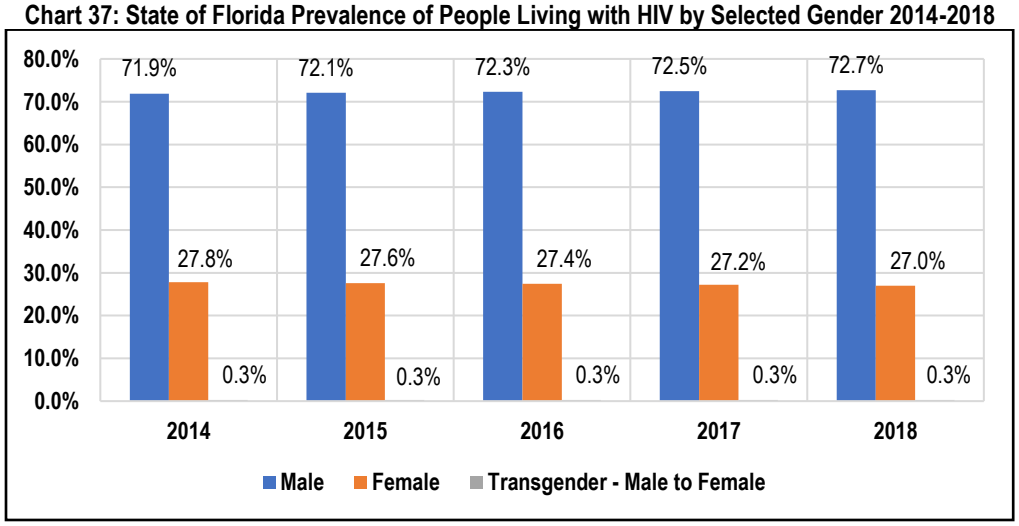
Chart 36: Miami-Dade County Prevalence of People Living with HIV by Selected Gender 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of PLWH by gender for the state of Florida is almost identical to the distribution for Miami-Dade County. Following Chart 37, among PLWH in Florida, males accounted for the highest percentage each year, which has increased from 71.9% in 2014 to 72.7% in 2018. The percentage of PLWH identifying as female has decreased from 27.8% in 2014 to 27.0% in 2018. Each year, only 0.3% of PLWH identified as transgender (male to female). The transgender (female to male) category is not shown in Chart 37, as the percentage was 0.0% each year.

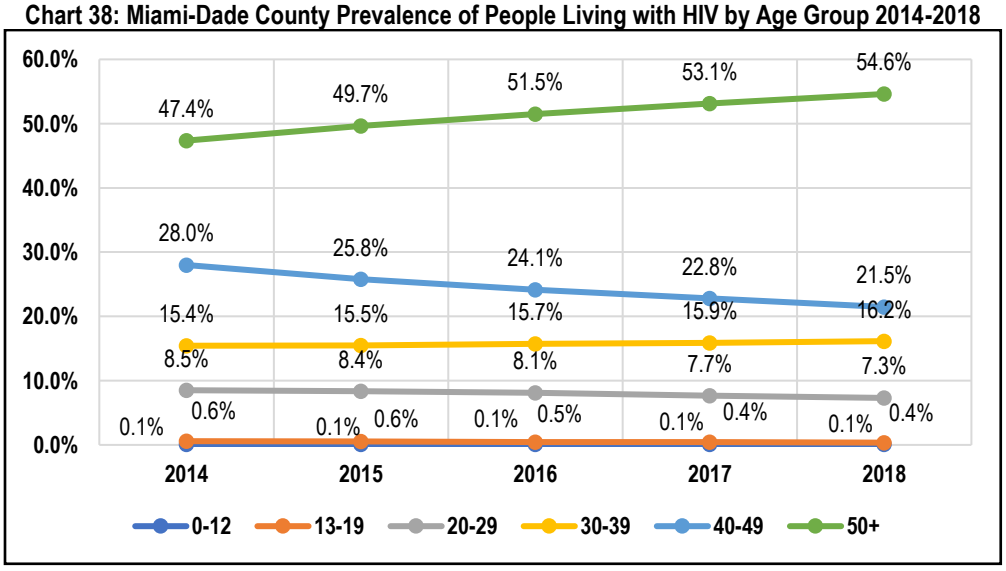
Chart 37: State of Florida Prevalence of People Living with HIV by Selected Gender 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

For Miami-Dade County in 2018, the majority of PLWH belonged to the 50+ age group (54.6%), followed by the 40-49 age group (21.5%), the 30-39 age group (16.2%), the 20-29 age group (7.3%), the 13-19 age group (0.4%), and the 0-12 age group (0.1%). The percentage of PLWH attributed to the 50+ age group has increased from 47.4% in 2014 to 54.6% in 2018, while the percentage attributed to the 40-49 age group has decreased from 28.0% in 2014 to 21.5% in 2018. All other age groups have remained relatively stable (Chart 38).

Chart 38: Miami-Dade County Prevalence of People Living with HIV by Age Group 2014-2018

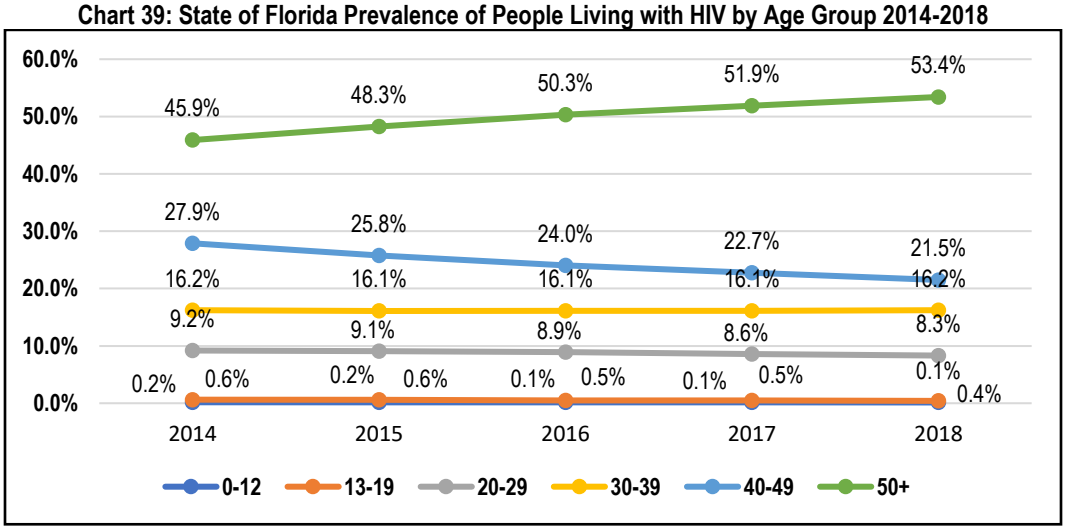


Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of PLWH by age group in the state of Florida is similar to the distribution in Miami-Dade County. For the state of Florida in 2018, the majority of PLWH belonged to the 50+ age group (53.4%), followed by the 40-49 age group (21.5%), the 30-39 age group (16.2%), the 20-29 age group (8.3%), the 13-19 age group (0.4%), and the 0-12 age group (0.1%). The percentage

of PLWH attributed to the 50+ age group has increased from 45.9% in 2014 to 53.4% in 2018, while the percentage attributed to the 40-49 age group has decreased from 27.9% in 2014 to 21.5% in 2018. All other age groups have remained relatively stable (Chart 39).

Chart 39: State of Florida Prevalence of People Living with HIV by Age Group 2014-2018

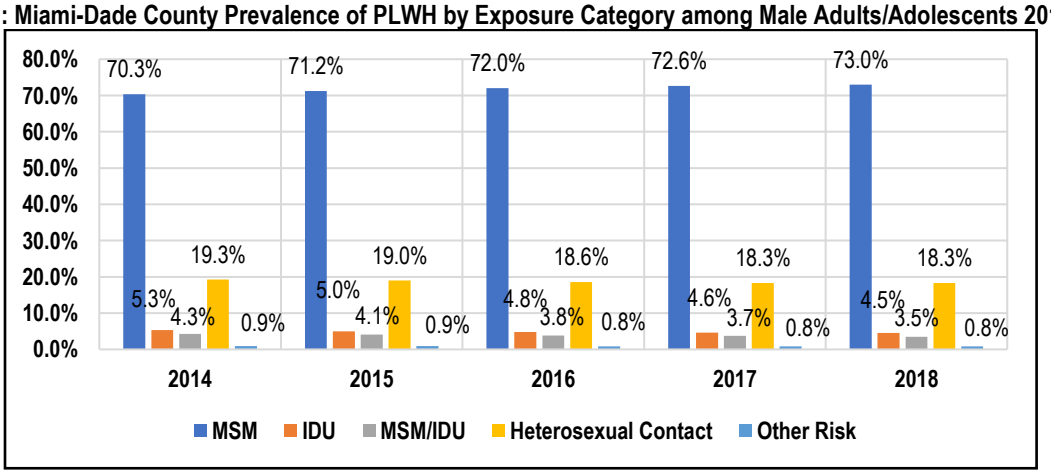


Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

People Living with HIV/AIDS by Mode of Transmission

For Miami-Dade County in 2018, the highest percentage of Male adults and adolescents living with HIV was attributed to the MSM exposure category at 73.0%. The heterosexual contact exposure category accounted for 18.3% of male adults and adolescents living with HIV in 2018, followed by the IDU (4.5%), the MSM/IDU (3.5%), and the Other Risk (0.8%) exposure categories. The distribution of exposure category among male adults and adolescents living with HIV has remained relatively stable for each exposure category from 2014 to 2018 (Chart 40).

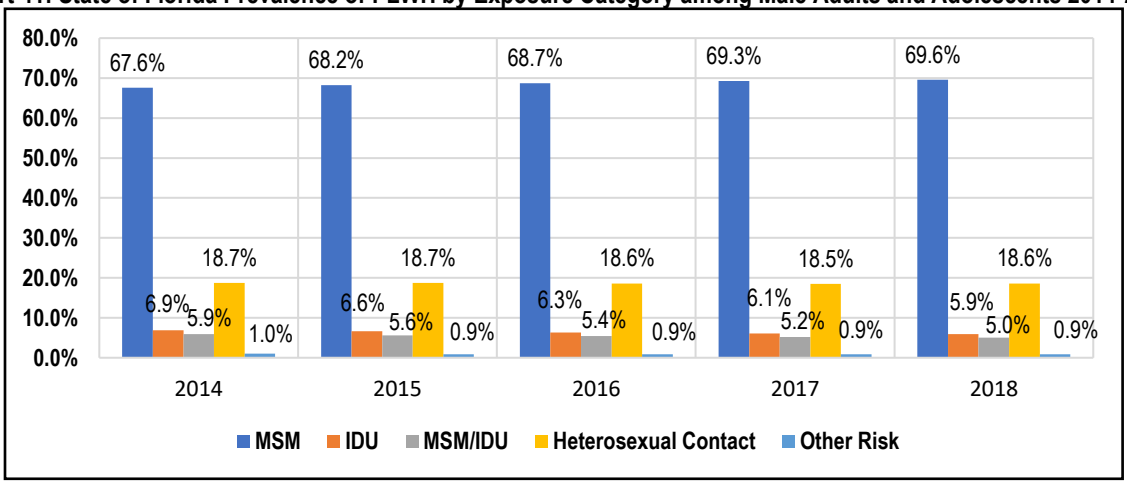
Chart 40: Miami-Dade County Prevalence of PLWH by Exposure Category among Male Adults/Adolescents 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of exposure categories among male adults and adolescents living with HIV in the state of Florida is similar to the distribution in Miami-Dade County. For the State of Florida in 2018, the highest percentage of Male adults and adolescents living with HIV was attributed to the MSM exposure category at 69.6%. The heterosexual contact exposure category accounted for 18.6% of male adults and adolescents living with HIV in 2018, followed by the IDU (5.9%), the MSM/IDU (5.0%), and the Other Risk (0.9%) exposure categories. The distribution of exposure category among male adults and adolescents living with HIV has remained relatively stable for each exposure category from 2014 to 2018 (Chart 41).

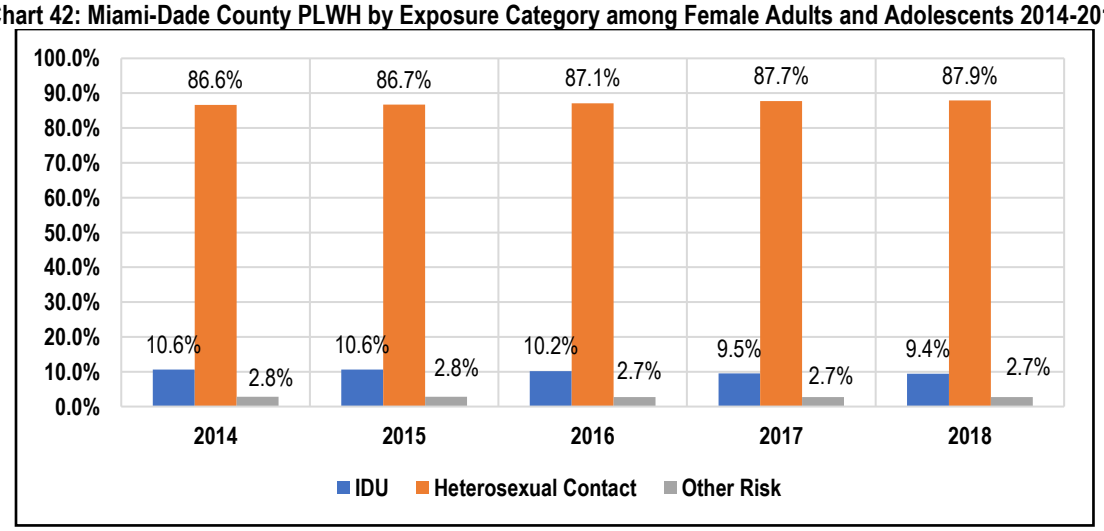
Chart 41: State of Florida Prevalence of PLWH by Exposure Category among Male Adults and Adolescents 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

In 2018, 87.9% of female adults and adolescents living with HIV in Miami-Dade County contracted HIV through heterosexual contact, while 9.4% contracted the virus through injection drug use and 2.7% contracted HIV through other methods. The distribution of exposure categories among female adults and adolescents living with HIV has remained relatively stable for each exposure category from 2014 to 2018 (Chart 42).

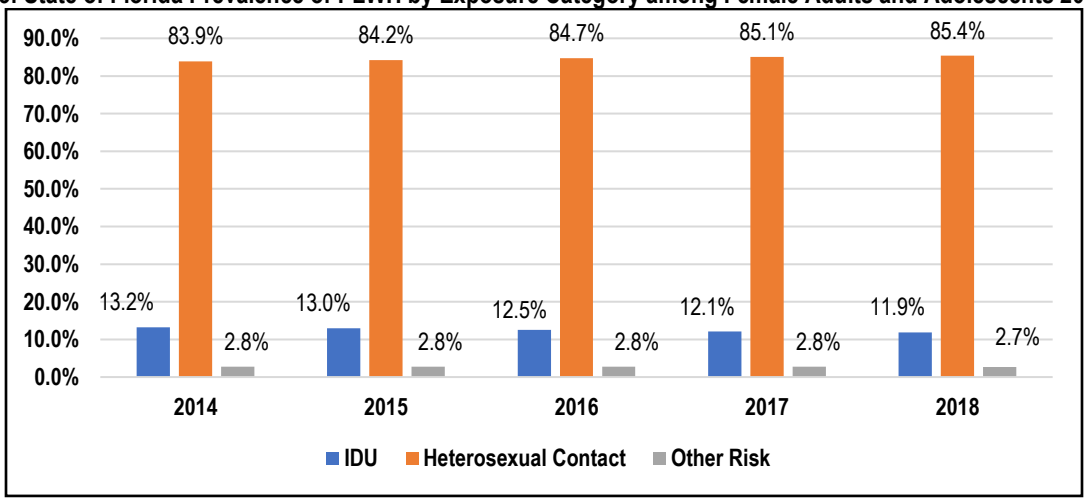
Chart 42: Miami-Dade County PLWH by Exposure Category among Female Adults and Adolescents 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The state level distribution of exposure categories among female adults and adolescents living with HIV is similar to the distribution in Miami-Dade County. In 2018, 85.4% of female adults and adolescents living with HIV in the state of Florida contracted HIV through heterosexual contact, while 11.9% contracted the virus through injection drug use and 2.7% contracted HIV through other methods. The distribution of exposure categories among female adults and adolescents living with HIV in Florida has remained relatively stable for each exposure category from 2014 to 2018 (Chart 43).

Chart 43: State of Florida Prevalence of PLWH by Exposure Category among Female Adults and Adolescents 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

In Miami-Dade County, most transgender adults and adolescents living with HIV contracted the virus through sexual contact. Each year from 2014-2018, over 92% of transgender adults and adolescents living with HIV contracted the virus through sexual contact, while less than 7.3% contracted the virus through injection drug use (Table 15).

Table 15: Miami-Dade County PLWH by Exposure Category among Transgender Adults and Adolescents 2014-2018

Transgender Adults/Adolescents Exposure Categories	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
IDU	3	5.6%	3	4.6%	4	5.8%	5	7.2%	3	4.5%
Sexual Contact	51	94.4%	62	95.4%	65	94.2%	64	92.8%	63	95.5%
Other Risk	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**54**	**100.0%**	**65**	**100.0%**	**69**	**100.0%**	**69**	**100.0%**	**66**	**100.0%**

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of exposure categories among transgender adults and adolescents for 2014-2018 is similar at the state level. Each year from 2014-2018, over 85.9% of transgender adults and adolescents living with HIV contracted the virus through sexual contact, while less than 13.5% contracted the virus through injection drug use. The percentage attributed to sexual contact has increased slightly each year from 85.9% in 2014 to 89.4% in 2018, while the percentage attributed to IDU has decreased each year from 13.4% in 2014 to 9.7% in 2018 (Table 16).

Table 16: State of Florida PLWH by Exposure Category among Transgender Adults and Adolescents 2014-2018

Transgender Adults/Adolescents Exposure Categories	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
IDU	41	13.4%	38	11.3%	38	11.0%	37	10.7%	34	9.7%
Sexual Contact	262	85.9%	294	87.8%	304	88.1%	306	88.4%	312	89.4%
Other Risk	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**305**	**100.0%**	**335**	**100.0%**	**345**	**100.0%**	**346**	**100.0%**	**349**	**100.0%**

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

In Miami-Dade County in 2014, 96.8% of children (less than 13 years old) living with HIV contracted the virus through perinatal exposure, while 3.2% (1 case) contracted the virus through non-perinatal exposure. For years 2015-2018, 100% of children living with HIV contracted the virus through perinatal exposure (Table 17).

Table 17: Miami-Dade County Prevalence of PLWH by Exposure Category among Children 2014-2018

Pediatric Exposure Categories	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Perinatal Exposure	30	96.8%	29	100.0%	30	100.0%	31	100.0%	27	100.0%
Non-perinatal Exposure	1	3.2%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Total	**31**	**100.0%**	**29**	**100.0%**	**30**	**100.0%**	**31**	**100.0%**	**27**	**100.0%**

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

At the state level, the percentage of children living with HIV that contracted the virus through perinatal exposure decreased slightly from 98.4% in 2014 to 97.5% in 2018, while the percentage of children living with HIV that contracted the virus through non-perinatal exposure increased slightly from 1.6% in 2014 to 2.5% in 2018 (Table 18).

Table 18: State of Florida Prevalence of PLWH by Exposure Category among Children 2014-2018

Pediatric Exposure Categories	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Perinatal Exposure	186	98.4%	175	98.3%	168	98.2%	164	98.2%	155	97.5%
Non-perinatal Exposure	3	1.6%	3	1.7%	3	1.8%	3	1.8%	4	2.5%
Total	**189**	**100.0%**	**178**	**100.0%**	**171**	**100.0%**	**167**	**100.0%**	**159**	**100.0%**

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Co-Occurring Conditions among People Living with HIV/AIDS

Tables 19 and 20 show the rates of various co-occurring conditions among PLWH in Miami-Dade County and Florida, respectively, in 2018, including; hepatitis B, hepatitis C, tuberculosis (TB), early syphilis, gonorrhea, chlamydia, history of substance use, history of mental illness,

homelessness, and release from prison. Hepatitis B, Hepatitis C[6], and TB[7] are reported in Florida based on the case definitions from the Florida Department of Health. Syphilis (at its various stages)[8], gonorrhea[9], and chlamydia[10] are diagnosed in Florida based on the case definitions provided by the CDC.

Hepatitis B and C cases are defined as the number of acute and chronic cases reported with an event date in the period specified. Hepatitis B and C comorbidity data includes acute diagnoses in the period specified, with an HIV diagnosis date before or within 6 months of the acute event date. They also include chronic diagnoses in the period specified with an HIV diagnosis date at any time before or after the chronic event date. TB comorbidity data includes TB diagnoses occurring in the period specified with an HIV diagnosis date before or coinciding with TB diagnosis.

Early syphilis is used to describe syphilis that has been acquired in the previous 12 months and includes three stages of syphilis: primary, secondary, and early non-primary non-secondary. Early syphilis comorbidity data includes early syphilis diagnoses in the period specified with an HIV diagnosis date before or within 30 days of an early syphilis initial lab specimen collection date. Gonorrhea and chlamydia comorbidity data includes diagnoses in the period specified with an HIV diagnosis date before or within 30 days of an initial lab specimen collection date.

Early syphilis, gonorrhea, and chlamydia data were provided by the Sexually Transmitted Disease Section's STARS database as of June 29, 2019. TB data was provided by the TB Section of the Florida Department of Health as of May 24, 2019 and hepatitis B and C data were provided by the Hepatitis Surveillance Program as of August 13, 2019. TB, hepatitis, early syphilis, chlamydia, and gonorrhea data presented in this report may not match data presented in Florida Health Charts or other publications due to differences in reporting timeframes and how the data was pulled.

The top three co-occurring conditions with the highest rates in Miami-Dade County among PLWH are history of substance abuse, history of mental illness, and early syphilis. In 2018 the rate of history of substance use reached 158.9 per 1,000 PLWH, while a rate of 42.3 per 1,000 PLWH was observed for history of mental illness. Early syphilis presented the third highest rate of 32.4 per 1,000 PLWH in Miami-Dade County (Table 19).

[6]Florida Department of Health Disease Reporting and Surveillance, available from: http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/surveillance-and investigationguidance/index.html

[7] Florida Department of Health Disease Reporting and Surveillance, available from: http://www.floridahealth.gov/diseases-and-conditions/tuberculosis/tb-professionals/tb-report- require .html

[8] CDC National Notifiable Diseases Surveillance System, available from: https://wwwn.cdc.gov/nndss/conditions/syphilis/case-definition/2019/

[9] CDC National Notifiable Diseases Surveillance System, available from: https://wwwn.cdc.gov/nndss/conditions/gonorrhea/case-definition/2014/

[10]CDC National Notifiable Diseases Surveillance System, available from: https://wwwn.cdc.gov/nndss/conditions/chlamydia-trachomatis-infection/case-definition/2010/

Table 19: Conditions Co-occurring with HIV/AIDS among PLWH in Miami-Dade County 2018

Co-occurring conditions	N	Rate per 1,000
Hepatitis B comorbidity in 2018	60	2.1
Hepatitis C comorbidity in 2018	87	3.1
Tuberculosis comorbidity in 2018	10	0.4
Early Syphilis comorbidity in 2018	918	32.4
Gonorrhea comorbidity in 2018	794	28.0
Chlamydia comorbidity in 2018	792	27.9
History of mental illness	1,200	42.3
History of substance use	4,503	158.9
Homeless at year-end 2018	415	14.6
Inmates living with HIV released in 2018	81	2.9

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The top three co-occurring conditions among PLWH with the highest rates in the state of Florida are also history of substance abuse, history of mental illness, and early syphilis. In 2018 the rate of history of substance abuse was the highest among co-occurring conditions at 201.5 per 1,000 PLWH in Florida. The rate of history of mental illness in 2018 reached 42.3 per 1,000 PLWH in Florida, while the rate of early syphilis reached 25.9 per 1,000 PLWH (Table 20).

Table 20: Conditions Co-occurring with HIV/AIDS among PLWH in the State of Florida 2018

Co-occurring conditions	N	Rate per 1,000
Hepatitis B comorbidity in 2018	279	2.3
Hepatitis C comorbidity in 2018	479	4.0
Tuberculosis comorbidity in 2018	53	0.4
Early Syphilis comorbidity in 2018	3,100	25.9
Gonorrhea comorbidity in 2018	2,780	23.2
Chlamydia comorbidity in 2018	2,599	21.7
History of mental illness	5,057	42.3
History of substance use	24,114	201.5
Homeless at year-end 2018	751	6.3
Inmates living with HIV released in 2018	681	5.7

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

People Living with AIDS by Demographics

Table 21 shows the prevalence of people living with AIDS (PLWA) stratified by race and ethnicity for 2014-2018 in Miami-Dade County. From 2014-2018, the highest percentage of PLWA identified as Black Non-Hispanic, followed by Hispanic/Latinxs, White Non-Hispanics, Multi-race Non-Hispanics, and Asian Non-Hispanics, respectively. American Indian/Alaska Native and Native Hawaiian/Pacific Islander (both Non-Hispanic), each accounted for 0.0% of PLWA from 2014-2018.

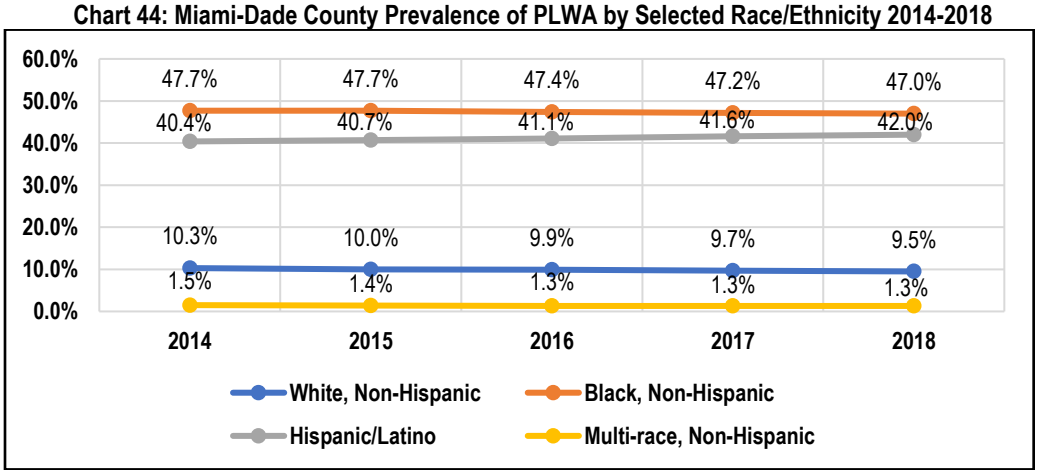
Table 21: Miami-Dade County Prevalence of PLWA by Race/Ethnicity 2014-2018

Race/Ethnicity	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Non-Hispanic/Latinx										
White	1,418	10.3%	1,367	10.0%	1,363	9.9%	1,336	9.7%	1,307	9.5%
Black	6,580	47.7%	6,541	47.7%	6,557	47.4%	6,513	47.2%	6,444	47.0%
Asian	27	0.2%	29	0.2%	29	0.2%	29	0.2%	34	0.2%
American Indian/Alaska Native	0	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%
Native Hawaiian/Pacific Islander	1	0.0%	1	0.0%	1	0.0%	1	0.0%	1	0.0%
Multi-race	201	1.5%	187	1.4%	185	1.3%	175	1.3%	174	1.3%
Hispanic/Latinx										
Hispanic/Latinx	5,571	40.4%	5,587	40.7%	5,688	41.1%	5,736	41.6%	5,756	42.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Following Chart 44, the percentages attributed to each race and ethnicity among PLWA have not changed much over the four-year period in Miami-Dade County. The percentage attributed to Black Non-Hispanics has remained relatively stable from 47.7% in 2014 to 47.0% in 2018, while the percentage attributed to Hispanic/Latinxs has slightly increased from 40.4% in 2014 to 42.0% in 2018. The percentages attributed to White Non-Hispanics and Multi-race Non-Hispanics have decreased slightly from 10.3% and 1.5% in 2014 to 9.5% and 1.3% in 2018, respectively. Asian, American Indian/Alaska Native and Native Hawaiian/Pacific Islander (all Non-Hispanic), are not included in Chart 44, as each accounted for less than 0.3% of PLWA from 2014-2018.

Chart 44: Miami-Dade County Prevalence of PLWA by Selected Race/Ethnicity 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of race and ethnicity among PLWA for the state of Florida differs from the distribution for Miami-Dade County. At the state level from 2014-2018, the highest percentage of PLWA identified as Black Non-Hispanic, followed by White Non-Hispanics, Hispanic/Latinxs, Multi-race Non-Hispanics, and Asian Non-Hispanics, respectively. American Indian/Alaska Native (Non-Hispanic) accounted for 0.1% of PLWA each year, while Native Hawaiian/Pacific Islander (Non-Hispanic) accounted for 0.0% of PLWA each year (Table 22).

Table 22: State of Florida Prevalence of PLWA by Race/Ethnicity 2014-2018

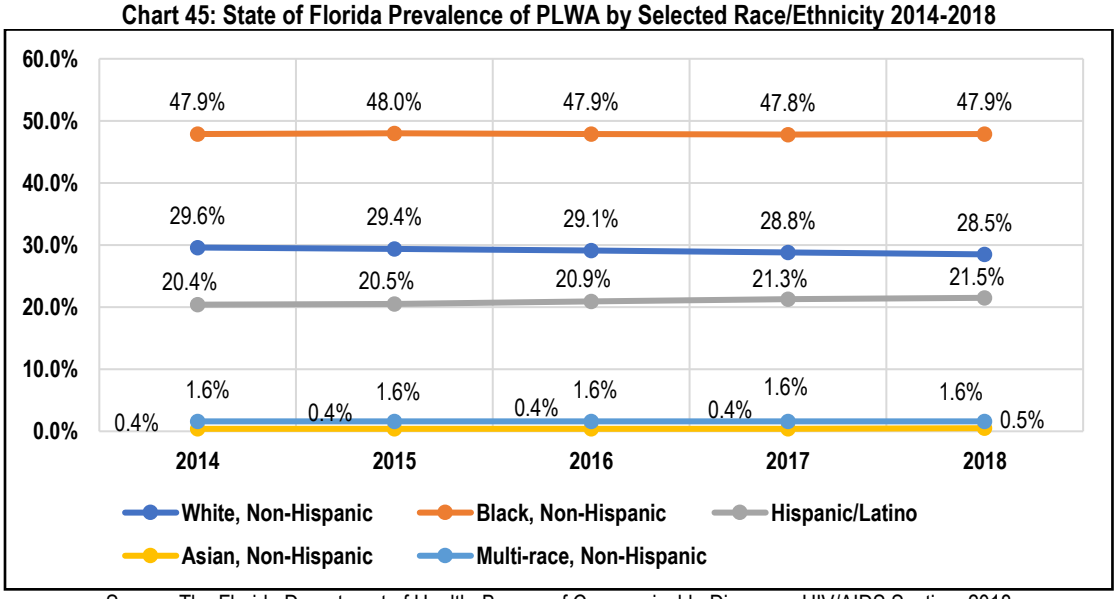
Race/Ethnicity	2014		2015		2016		2017		2018	
	N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
Non-Hispanic/Latinx										
White	18,320	29.6%	18,264	29.4%	18,213	29.1%	18,138	28.8%	17,926	28.5%
Black	29,618	47.9%	29,880	48.0%	29,983	47.9%	30,046	47.8%	30,169	47.9%
Asian	232	0.4%	242	0.4%	267	0.4%	278	0.4%	297	0.5%
American Indian/Alaska Native	35	0.1%	38	0.1%	39	0.1%	47	0.1%	48	0.1%
Native Hawaiian/Pacific Islander	19	0.0%	20	0.0%	21	0.0%	25	0.0%	27	0.0%
Multi-race	1,003	1.6%	992	1.6%	988	1.6%	977	1.6%	980	1.6%
Hispanic/Latinx										
Hispanic/Latinx	12,638	20.4%	12,786	20.5%	13,121	20.9%	13,398	21.3%	13,546	21.5%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Following Chart 45, the percentages attributed to each race and ethnicity among PLWA have remained relatively stable over the four-year period at the state level. In 2018, Black Non-Hispanics accounted for 47.9% of PLWA, followed by White Non-Hispanics at 28.5% and Hispanic/Latinxs at 21.5%. Multi-race and Asian (both Non-Hispanic) each accounted for less than 1.7% of PLWA in 2018. American Indian/Alaska Native and Native Hawaiian/Pacific Islander

(both Non-Hispanic), are not included in Chart 45, as each accounted for less than 0.2% of PLWA from 2014-2018.

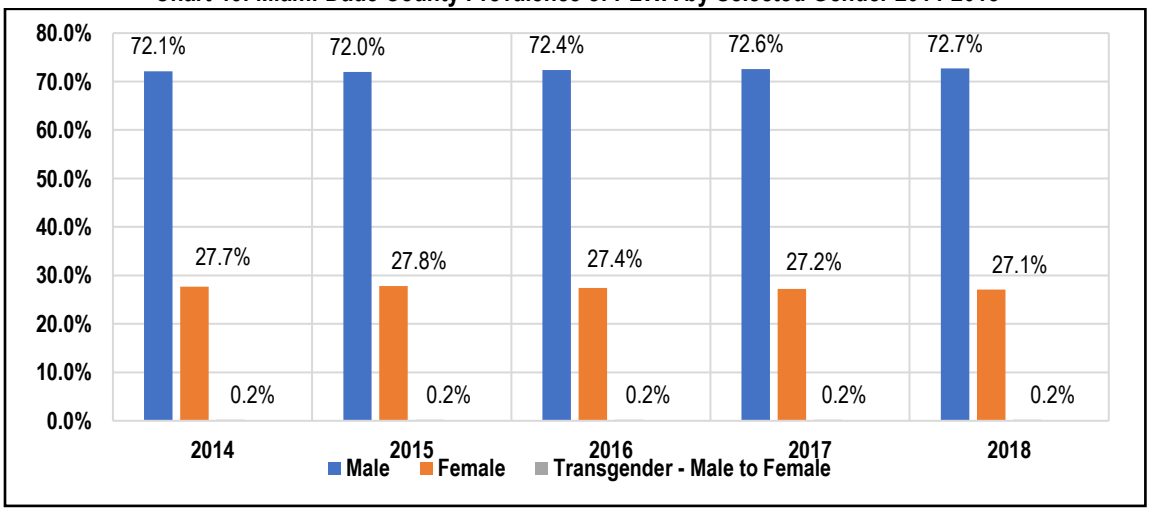
Chart 45: State of Florida Prevalence of PLWA by Selected Race/Ethnicity 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

In 2018 72.7% of PLWA in Miami-Dade County identified as male, while 27.1% identified as female and 0.2% identified as transgender male to female. These percentages remained relatively stable from 2014-2018 (Chart 46). The percentage of PLWA that identified as transgender (female to male) is not included in Chart 46, as there were less than 3 cases each year which accounted for 0.0% of PLWA in Miami-Dade County.

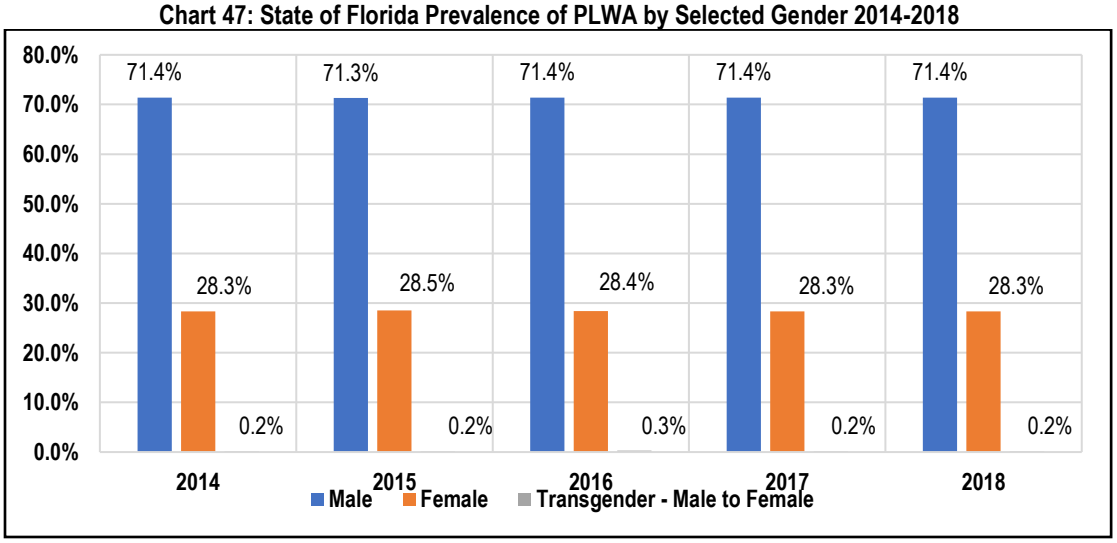
Chart 46: Miami-Dade County Prevalence of PLWA by Selected Gender 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of gender among PLWA for the state of Florida is similar to the distribution for Miami-Dade County. In 2018, 71.4% of PLWA identified as male, while 28.3% identified as female and 0.2% identified as transgender (male to female). These percentages did not change much over the four-year period of 2014-2018 (Chart 47). The percentage of PLWA that identified as transgender (female to male) is not included in Chart 47, as there were less than 5 cases each year which accounted for 0.0% of PLWA in Florida.

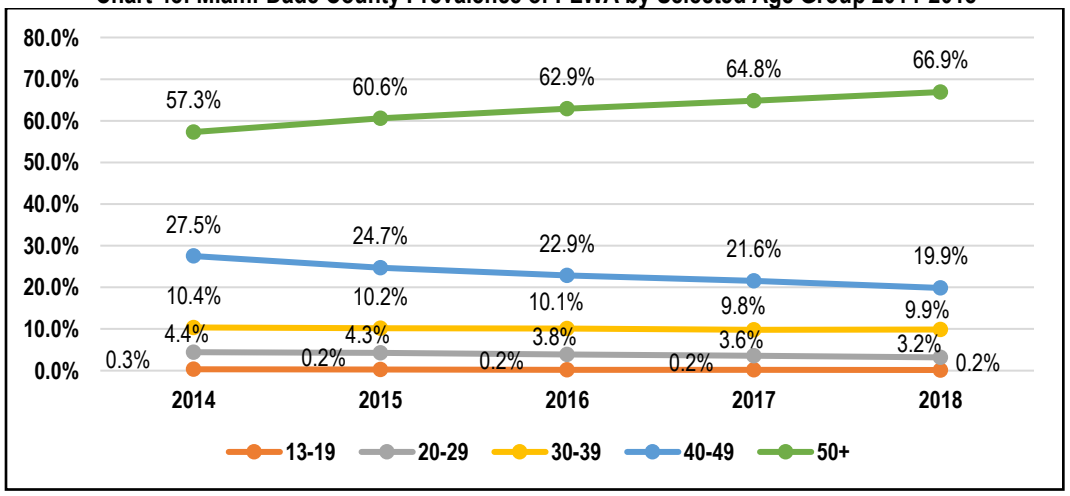
Chart 47: State of Florida Prevalence of PLWA by Selected Gender 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Chart 48 illustrates the age distribution among PLWA in Miami-Dade County. In 2018 the majority of PLWA in Miami-Dade County belonged to the 50+ age group (66.9%), followed by the 40-49 age group (19.9%), the 30-39 age group (9.9%), the 20-29 age group (3.2%), and the 13-19 age group (0.2%). The percentage of PLWA belonging to the 50+ age group has increased from 57.3% in 2014 to 66.9% in 2018, while the percentage of PLWA belonging to the 40-49 age group has decreased from 27.5% in 2014 to 19.9% in 2018. The percentages of PLWA belonging to the 30-39, 20-29, and 13-19 age groups have remained relatively stable over the four-year period. The percentage of PLWA belonging to the 0-12 age group is not included in Chart 48, as it remained below 0.1% over the four-year period, decreasing from 0.06% in 2014 to 0.02% in 2018.

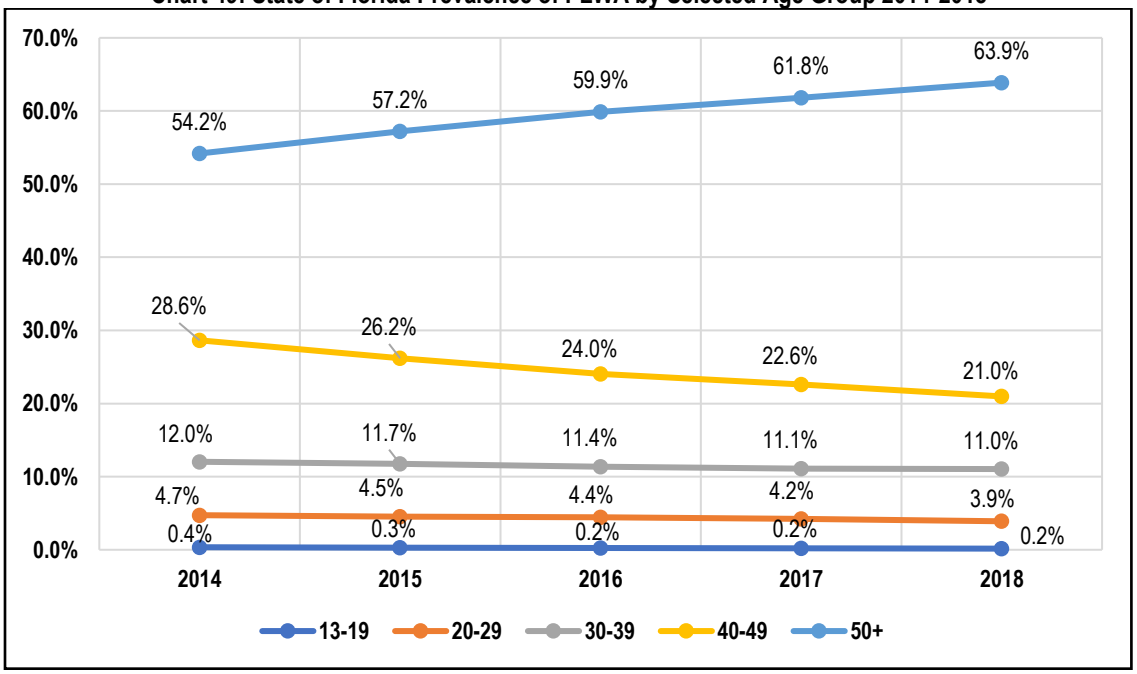
Chart 48: Miami-Dade County Prevalence of PLWA by Selected Age Group 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

The distribution of age group among PLWA for the state of Florida is similar to the distribution for Miami-Dade County. In 2018 the majority of PLWA in the state of Florida belonged to the 50+ age group (63.9%), followed by the 40-49 age group (21.0%), the 30-39 age group (11.0%), the 20-29 age group (3.9%), and the 13-19 age group (0.2%). The percentage of PLWA belonging to the 50+ age group has increased from 54.2% in 2014 to 63.9% in 2018, while the percentage of PLWA belonging to the 40-49 age group has decreased from 28.6% in 2014 to 21.0% in 2018. The percentages of PLWA belonging to the 30-39, 20-29, and 13-19 age groups have remained relatively stable over the four-year period (Chart 49). Not shown in Chart 49, is the 0-12 age group which accounted for 0.1% or less of PLWA in Florida over the four-year period.

Chart 49: State of Florida Prevalence of PLWA by Selected Age Group 2014-2018

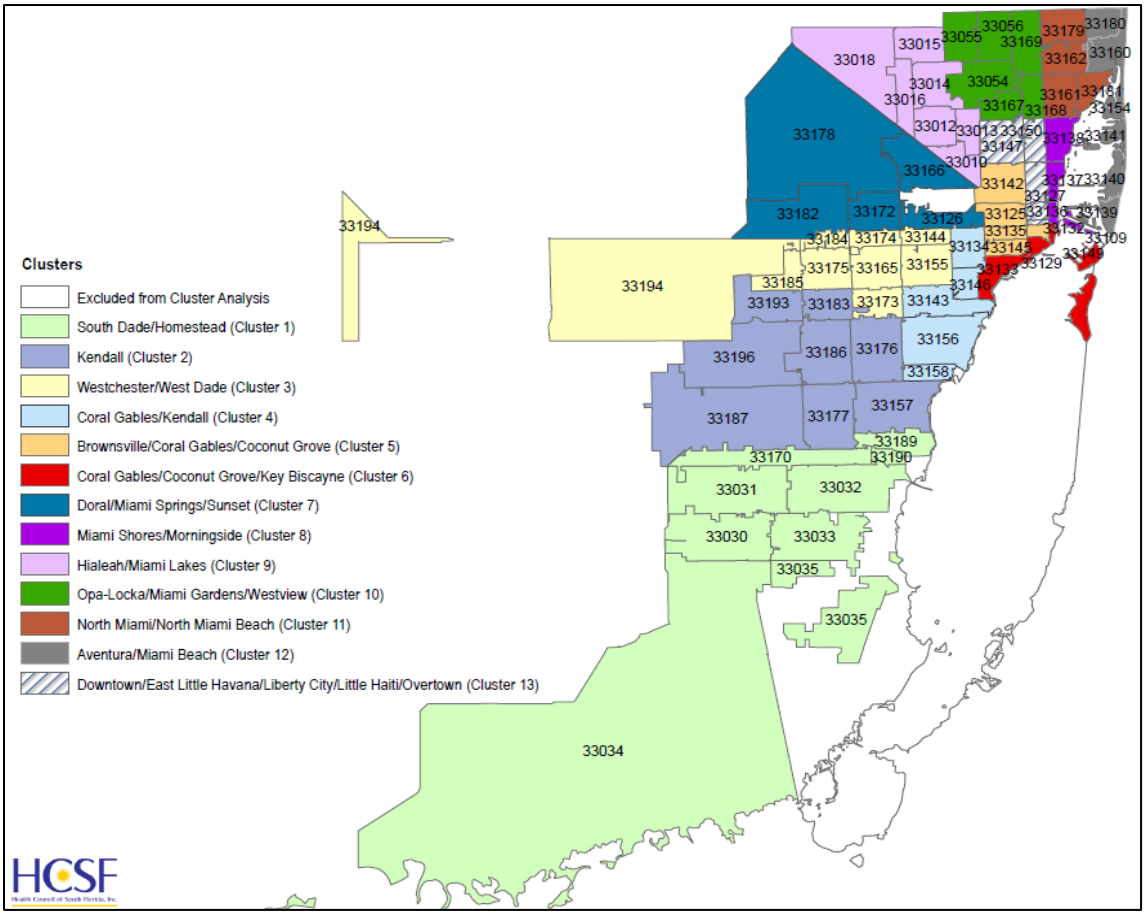


Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

PLWH According to Selected Demographics Across All Clusters in Miami-Dade County

The following section highlights selected demographics of PLWH according to clusters in Miami-Dade County. Cluster information was presented earlier under the sections *Miami-Dade County Demographic Profile by Cluster* and *HIV Newly Diagnosed cases*, as well as earlier in this section. Cluster analysis allows for geographical comparisons of PLWH across the County based on specific socioeconomic and demographic characteristics, useful for health planning (Map 4). Clusters are made up of zip codes linked according to their perceived community identity and geographic contiguity. However, at times these clusters also cross boundaries based upon socioeconomic status or population counts. There are thirteen (13) total clusters, twelve (12) standard clusters and one (1) oversampled cluster. The oversampled cluster consists of contiguous ZIP codes representing the most economically and socially deprived neighborhoods, many of which also suffer from the highest rates of hospitalization for preventable conditions.

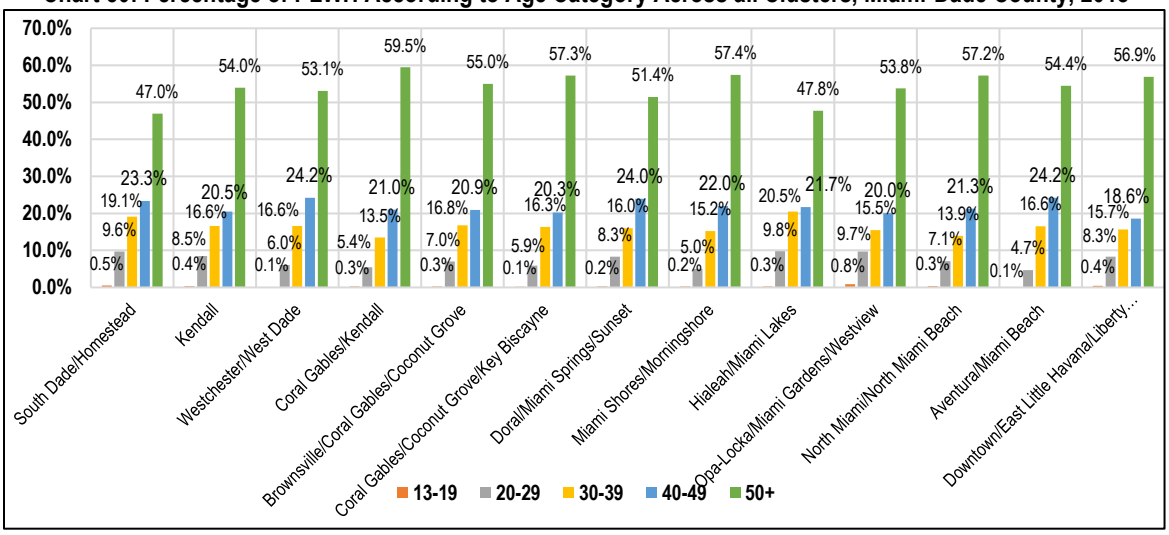
Map 4: Cluster Distribution in Miami-Dade County



Demographics

As noted earlier, PLWH in the 50+ age group account for the greatest proportion of PLWH and this is the case across all clusters in Miami-Dade County (Chart 50). Compared to all clusters and relative to its population size, Cluster 4 (Coral Gables/Kendall) exhibited the highest percentage of PLWH aged 50 and older with approximately 60%, while Cluster 1 (South Dade/Homestead) represented the lowest percentage with 47%. Cluster 2 (Westchester/West Dade) and Cluster 12 (Aventura/Miami Beach) accounted for the highest percentage of PLWH between the ages of 40 and 49 with 24.2% for both geographical areas. The same pattern is observed for all clusters in that the percentage of PLWH increases with age. Please note that the pediatric population under the age of 13 accounted for less than 0.5% across all clusters, as such it has been excluded from the analysis shown in Chart 50 (please refer to Footnote 2 regarding explanation on small populations).

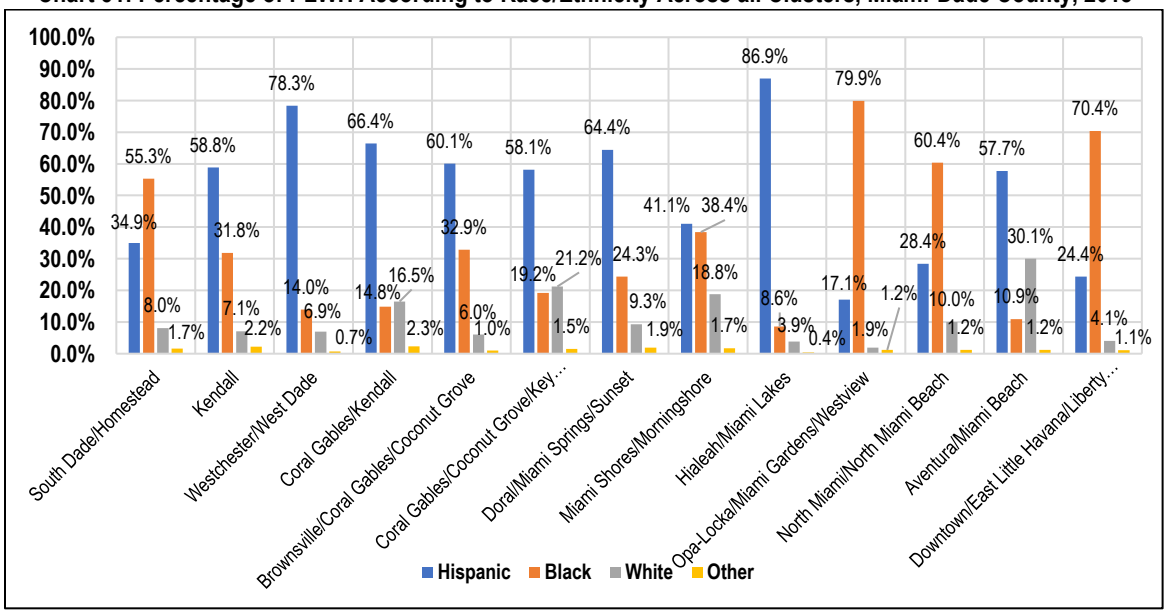
Chart 50: Percentage of PLWH According to Age Category Across all Clusters, Miami-Dade County, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

As depicted in Chart 51, when race/ethnicity is analyzed among PLWH, it is observed that the Hispanic population accounts for the greatest proportion of PLWH across most clusters in Miami-Dade County with the highest percentage observed in Cluster 9 (Hialeah/Miami Lakes) with close to 87%, followed by Cluster 3 (Westchester/West Dade) with 78.3%. Residents who identified as non-Hispanic Black presented the highest percentages of PLWH in four out the 13 clusters, with the highest percentage observed is Cluster 10 (Opa-Locka/Miami Gardens/Westview) with approximately 80%. It is noteworthy that in three clusters (Coral Gables/Kendall, Coral Gables/Coconut Grove/Key Biscayne, and Aventura/Miami Beach), residents who identified as non-Hispanic White exhibited higher percentages of PLWH than non-Hispanic Black residents with the greatest difference observed in Aventura/Miami Beach (30.1% compared to 10.9%, respectively).

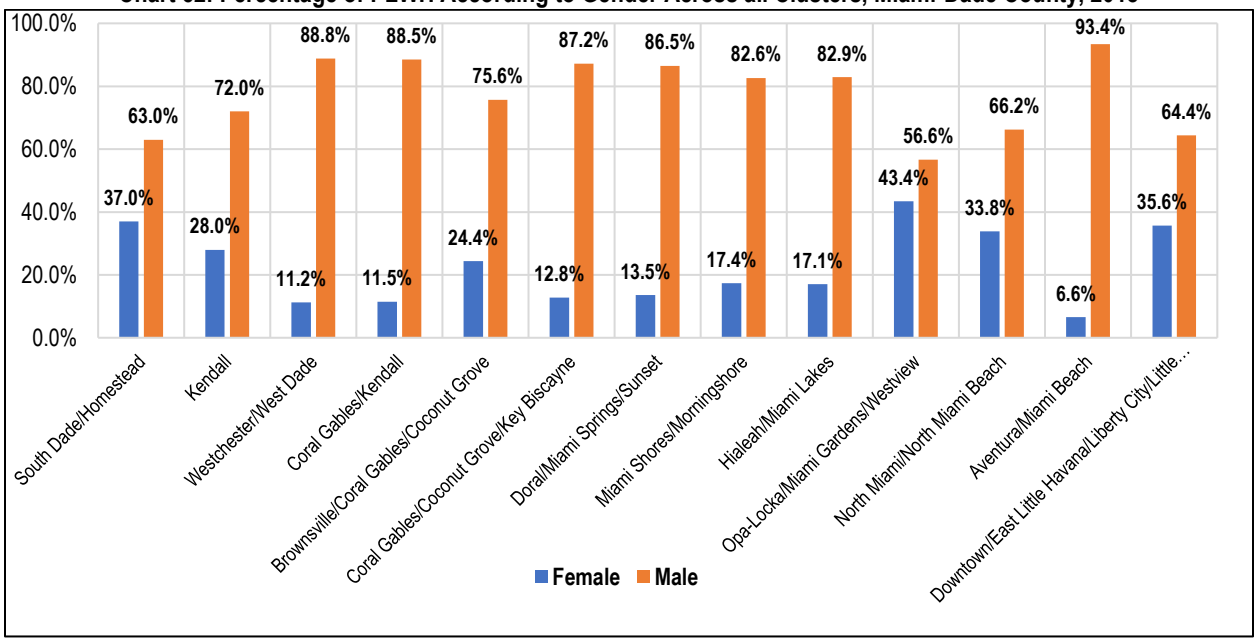
Chart 51: Percentage of PLWH According to Race/Ethnicity Across all Clusters, Miami-Dade County, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

As shown on Chart 52, the male population accounts for the greatest proportion of PLWH across all clusters in Miami-Dade County with the most significant difference observed in Cluster 12 (93.4% of males compared to 6.6% of females living with HIV), followed by Cluster 3 (Westchester/West Dade) with 88.5% compared to 11.2%, respectively. The smallest disparity was observed in Cluster 10 (Opa-Locka/Miami Gardens/Westview) where close to 57% of PLWH were males compared to 43.4% who identified as females.

Chart 52: Percentage of PLWH According to Gender Across all Clusters, Miami-Dade County, 2018



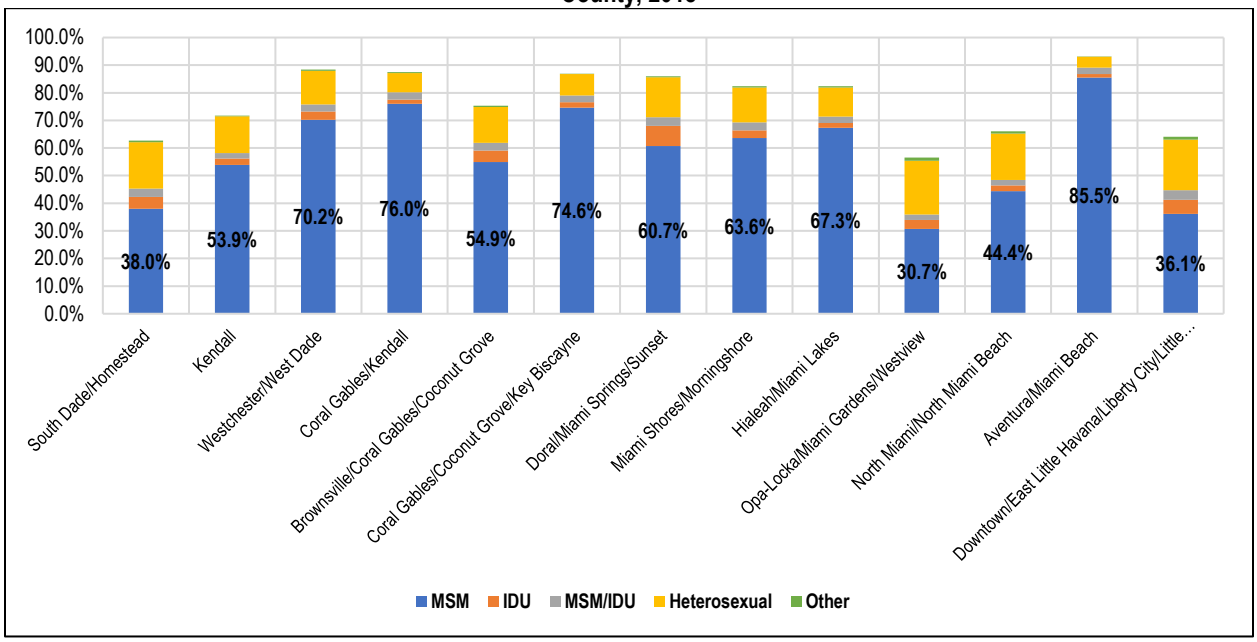
Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Mode of Transmission

Chart 53 depicts the percent distribution of PLWH according to mode of transmission among residents identified as males for all clusters in Miami-Dade County. The most frequent mode of transmission among this population is MSM across all clusters with the highest percentage observed in Cluster 12 (Aventura/Miami Beach) with approximately 86%, followed by Cluster 4 (Coral Gables/Kendall) with 76% of total number of PLWH residing within this cluster (Table 23). Please note that Transgender Sexual Contact as a mode of HIV transmission has been excluded from the analysis represented in Chart 53 due to the small statistic observed which resulted in less than 0.5% of total PLWH residing in each cluster (for specific percentages with respect to this mode of transmission, please refer to Table 23).

The second most frequent mode of transmission is attributed to Heterosexual Contact which ranged between 4% and 19.4% of total number of PLWH across all clusters, in which Cluster 10 (Opa-Locka/Miami Gardens/Westview) exhibited the highest percentage while Cluster 12 (Aventura/Miami Beach) represented the lowest percentage of all clusters.

Chart 53: Percentage of PLWH According to Mode of Transmission among Males Across all Clusters, Miami-Dade County, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Table 23: Percentage* of PLWH According to Mode of Transmission among Males Across all Clusters, Miami-Dade County, 2018

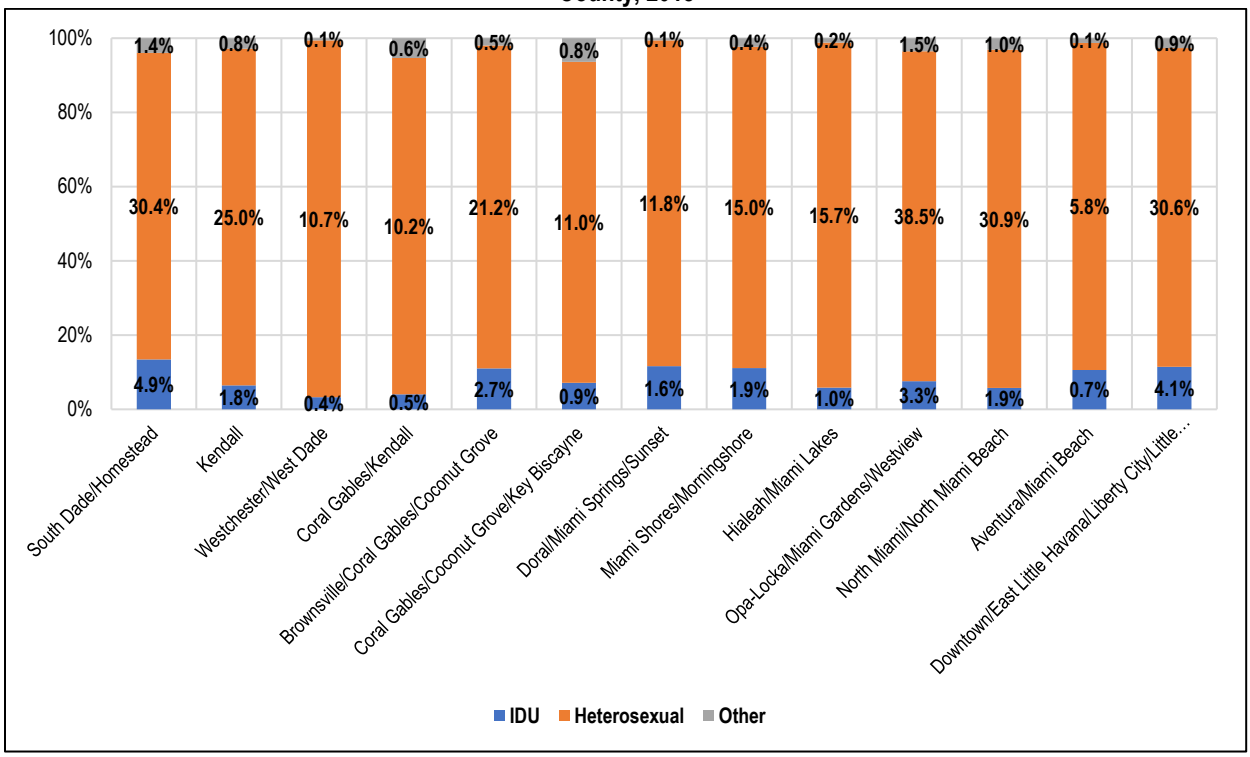
Clusters	MSM	IDU	MSM/IDU	Heterosexual	Transgender Sexual Contact	Other
South Dade/Homestead	38.0%	4.3%	3.0%	16.9%	0.2%	0.6%
Kendall	53.9%	2.3%	1.9%	13.3%	0.1%	0.3%
Westchester/West Dade	70.2%	3.0%	2.6%	12.2%	0.1%	0.4%
Coral Gables/Kendall	76.0%	1.5%	2.6%	7.0%	0.3%	0.3%
Brownsville/Coral Gables/Coconut Grove	54.9%	4.1%	2.8%	13.0%	0.3%	0.4%
Coral Gables/Coconut Grove/Key Biscayne	74.6%	2.0%	2.4%	7.8%	0.1%	0.1%
Doral/Miami Springs/Sunset	60.7%	7.3%	3.1%	14.5%	0.4%	0.4%
Miami Shores/Morningshore	63.6%	2.8%	2.8%	12.7%	0.1%	0.4%
Hialeah/Miami Lakes	67.3%	1.8%	2.3%	10.5%	0.4%	0.5%
Opa-Locka/Miami Gardens/Westview	30.7%	3.3%	2.0%	19.4%	0.1%	1.1%
North Miami/North Miami Beach	44.4%	2.1%	1.9%	16.9%	0.1%	0.8%
Aventura/Miami Beach	85.5%	1.3%	2.3%	4.0%	0.2%	0.1%
Downtown/East Little Havana/Liberty City/Little Haiti/Overtown	36.1%	5.2%	3.4%	18.3%	0.2%	1.1%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

*Data Note: The denominator utilized to calculate percentages represent the total number of PLWH residing within each cluster in Miami-Dade County

Among residents of Miami-Dade County who identified as females, the most frequent mode of transmission is Heterosexual Contact for all clusters, with Cluster 10 (Opa-Locka/Miami Gardens/Westview) presenting the highest percentage with 38.5% of total number of PLWH residing in this cluster, followed by Cluster 11 (North Miami/North Miami Beach), Cluster 13 (Downtown/East Little Havana/Liberty City/Little Haiti/Overtown), and Cluster 1 (South Dade/Homestead) – all three clusters exhibiting close to 31% of total number of PLWH. As observed earlier, mode of transmission as Transgender Sexual Contact has been excluded from the analysis presented in Chart 54 due to the small statistics observed. Except for Cluster 1 (South Dade/Homestead) which experienced 0.2% HIV infections due to Transgender Sexual Contact, there were no reported HIV infection due to Transgender Sexual Contact among the female population across all clusters in Miami-Dade County.

Chart 54: Percentage of PLWH According to Mode of Transmission among Females Across all Clusters, Miami-Dade County, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

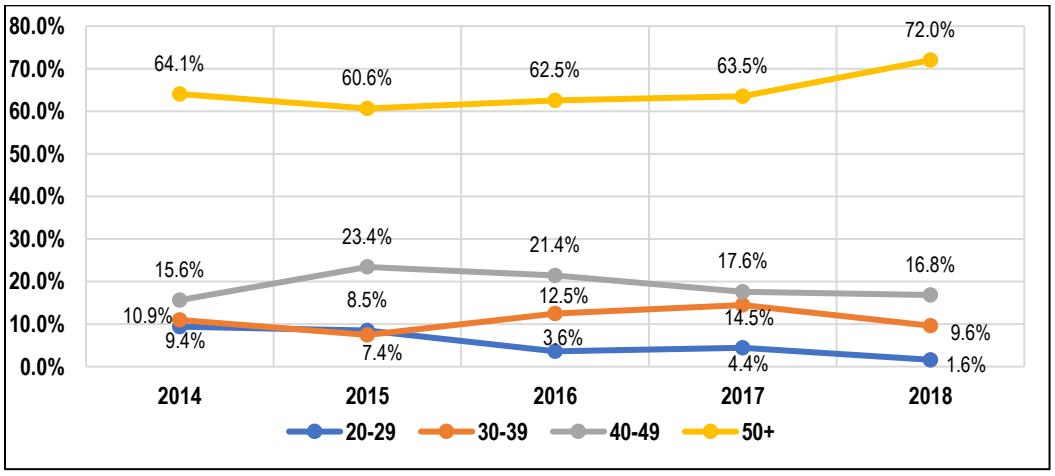
HIV-Related Deaths among People Living with HIV

Demographics

The following section depicts HIV-related deaths among PLWH in Miami-Dade County and the State of Florida according to selected demographics for 2014 through 2018. Based on the trend analysis illustrated in Chart 55, Miami-Dade County residents aged 50 years and older living with HIV exhibited the highest percentage of HIV-related deaths between 2014 and 2018 with the highest percentage observed in 2018 with 72%. The second highest percentage of HIV-related deaths between 2014 and 2018 derived from residents between the ages of 40 and 49, however it is still significantly lower than the statistics observed among residents 50 years of age and older. For instance, in 2018 the percentage of HIV-related deaths among PLWH ages 50 and older was

four times as high as those between the ages of 40 and 49 (72% compared to 16.8%, respectively). Please note that age group 0 through 19 has been excluded from the analysis since there were no HIV-related deaths between 2014 and 2018.

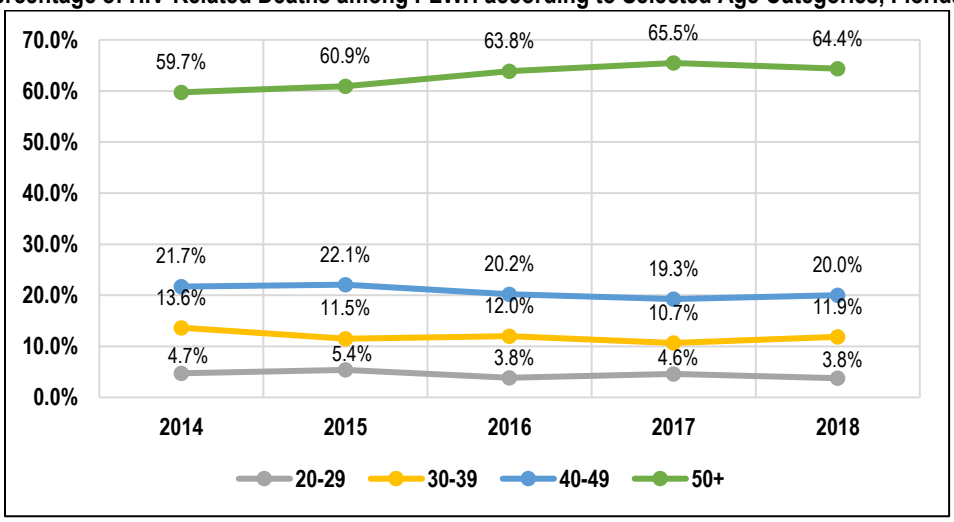
Chart 55: Percentage of HIV-Related Deaths among PLWH according to Selected Age Categories, Miami-Dade County, 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

A similar trend is observed in the State of Florida overall, in which the highest percentage of HIV-related deaths of PLWH is seen among the older populations; and for the State of Florida in particular, a clear distinction is observed among the different age groups presented (please refer to Chart 56). The highest percentage of HIV-related deaths in the State of Florida was observed in 2017 with close to 66%, followed by a slight decrease in 2018 with 64.4%.

Chart 56: Percentage of HIV-Related Deaths among PLWH according to Selected Age Categories, Florida, 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

Table 24 represents HIV-related deaths of PLWH in the State of Florida and corresponding percentages. Please note that PLWH who are younger than 20 years of age were excluded from the trend analysis shown in Chart 56 since their respective percentages were less than 0.5%.

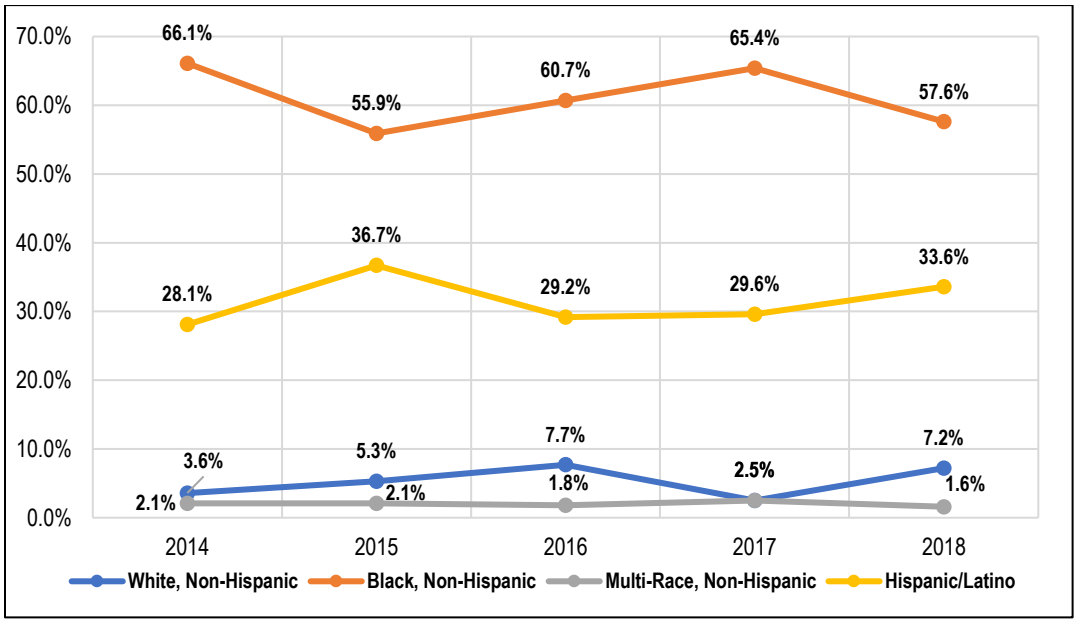
Table 24: HIV-Related Deaths among PLWH according to Age, Florida, 2014-2018

Age Categories	2014		2015		2016		2017		2018	
	n	%	n	%	n	%	n	%	n	%
0-12	0	0.0%	1	0.1%	0	0.0%	0	0.0%	0	0.0%
13–19	2	0.2%	0	0.0%	1	0.1%	0	0.0%	0	0.0%
20-29	42	4.7%	50	5.4%	34	3.8%	36	4.6%	25	3.8%
30-39	122	13.6%	107	11.5%	106	12.0%	83	10.7%	79	11.9%
40-49	194	21.7%	205	22.1%	179	20.2%	150	19.3%	133	20.0%
50+	534	59.7%	566	60.9%	565	63.8%	510	65.5%	428	64.4%
Total	894	100.0%	929	100.0%	885	100.0%	779	100.0%	665	100.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

In Miami-Dade County, non-Hispanic Black residents living with HIV experienced the highest percentage of HIV-related deaths compared to any other racial or ethnic group between 2014 through 2018 (please refer to Chart 57). For instance, in 2018 out of a total of 125 HIV-related deaths 72 or 57.6% derived from non-Hispanic Black residents living with HIV compared to 33.6% among Hispanic/Latinx residents living with HIV. However, it is also important to highlight that between 2017 and 2018 PLWH identified as non-Hispanic Black experienced a 12% decrease in the percentage of HIV-related deaths.

Chart 57: Percentage of HIV-Related Deaths among PLWH according to Selected Race/Ethnicity, Miami-Dade County, 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

Table 25 provides additional information for the racial and ethnic groups that were excluded from the trend analysis shown in Chart 57 due to relatively small statistics observed compared to other racial and ethnic groups.

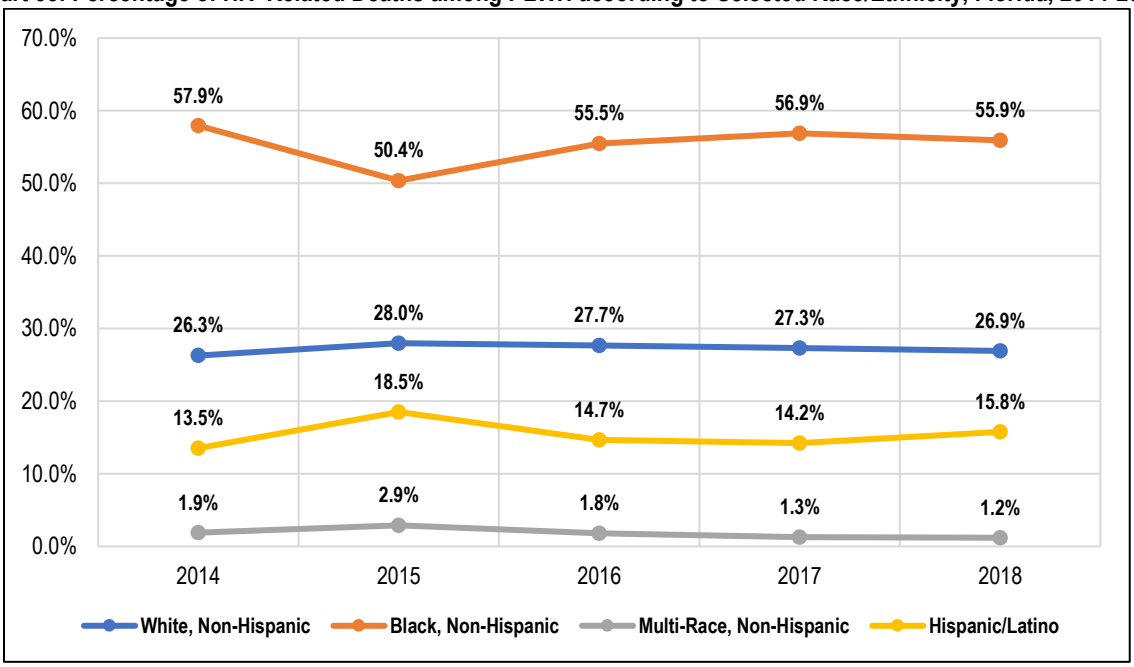
Table 25: HIV-Related Deaths among PLWH according to Race/Ethnicity, Miami-Dade County, 2014-2018

Race/Ethnicity	2014		2015		2016		2017		2018	
	n	%	n	%	n	%	n	%	n	%
Non-Hispanic/Latinx										
White	7	3.6%	10	5.3%	13	7.7%	4	2.5%	9	7.2%
Black	127	66.1%	105	55.9%	102	60.7%	104	65.4%	72	57.6%
Asian	0	0.0%	0	0.0%	1	0.6%	0	0.0%	0	0.0%
American Indian/Alaska Native	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Native Hawaiian/Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Multi-Race	4	2.1%	4	2.1%	3	1.8%	4	2.5%	2	1.6%
Hispanic/Latinx										
Hispanic/Latinx	54	28.1%	69	36.7%	49	29.2%	47	29.6%	42	33.6%
Total	192	100.0%	188	100.0%	168	100.0%	159	100.0%	125	100.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

As observed in Miami-Dade County, non-Hispanic Black residents in Florida who are living with HIV accounted for the greatest proportion of HIV-related deaths between 2014 and 2018 compared to other racial or ethnic groups (Chart 58). In 2018, close to 56% of HIV-related deaths derived from non-Hispanic Black residents living with HIV, followed by non-Hispanic White residents with approximately 27% of total HIV-related deaths. Between 2014 and 2018, the percentage of HIV-related deaths among non-Hispanic White residents have remained relatively stable ranging between 26.3% and 26.9%.

Chart 58: Percentage of HIV-Related Deaths among PLWH according to Selected Race/Ethnicity, Florida, 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

In 2018, HIV-related deaths of Persons Living with HIV who identified as non-Hispanic Asian, American Indian, and Native Hawaiian or Pacific Islander accounted for only 0.2% of total deaths

observed, and this statistic has remained stable since 2014 (please refer to table 26 for additional details).

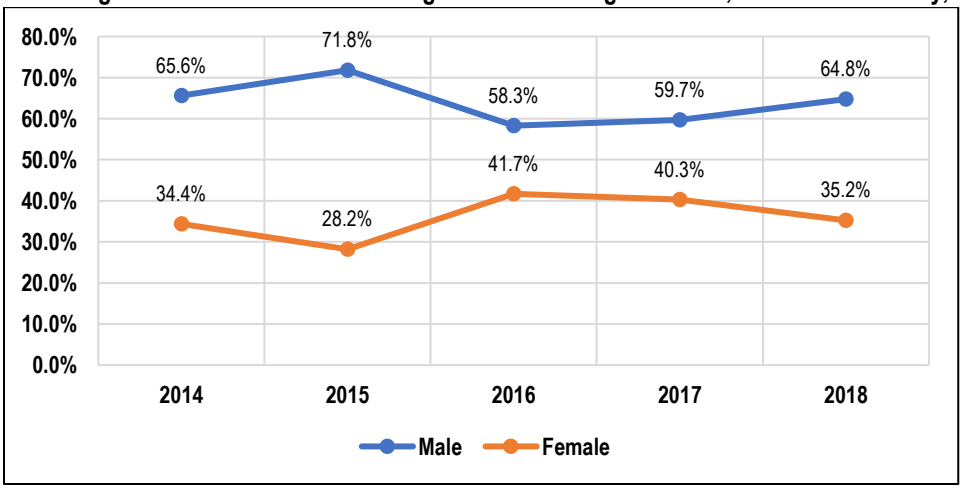
Table 26: HIV-Related Deaths among PLWH according to Race/Ethnicity, Florida, 2014-2018

Race/Ethnicity	2014		2015		2016		2017		2018	
	n	%	n	%	n	%	n	%	n	%
Non-Hispanic/Latinx										
White	235	26.3%	260	28.0%	245	27.7%	213	27.3%	179	26.9%
Black	518	57.9%	468	50.4%	491	55.5%	443	56.9%	372	55.9%
Asian	3	0.3%	2	0.2%	2	0.2%	2	0.3%	1	0.2%
American Indian/Alaska Native	0	0.0%	0	0.0%	1	0.1%	0	0.0%	0	0.0%
Native Hawaiian/Pacific Islander	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Multi-Race	17	1.9%	27	2.9%	16	1.8%	10	1.3%	8	1.2%
Hispanic/Latinx										
Hispanic/Latinx	121	13.5%	172	18.5%	130	14.7%	111	14.2%	105	15.8%
Total	894	100.0%	929	100.0%	885	100.0%	779	100.0%	665	100.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

Based on the trend analysis depicted in Chart 59, between 2014 and 2018, the percentage of HIV-related deaths among males living with HIV in Miami-Dade County was significantly higher compared to females. For instance, in 2018 close to 65% of HIV-related deaths derived from males living with HIV compared to 35.2% among females. Furthermore, between 2015 and 2016 the male population living with HIV experienced a 27.4% decrease in the number of HIV-related deaths, while females experienced a 32% increase during the same time frame. Between 2016 and 2018, however, a steady increase was observed among males living with HIV, while females experienced a steady decrease in the number of HIV-related deaths. Please note that there were no HIV-related deaths reported for data the transgender population (male to female and female to male) between 2014 and 2018.

Chart 59: Percentage of HIV-Related Deaths among PLWH according to Gender, Miami-Dade County, 2014-2018

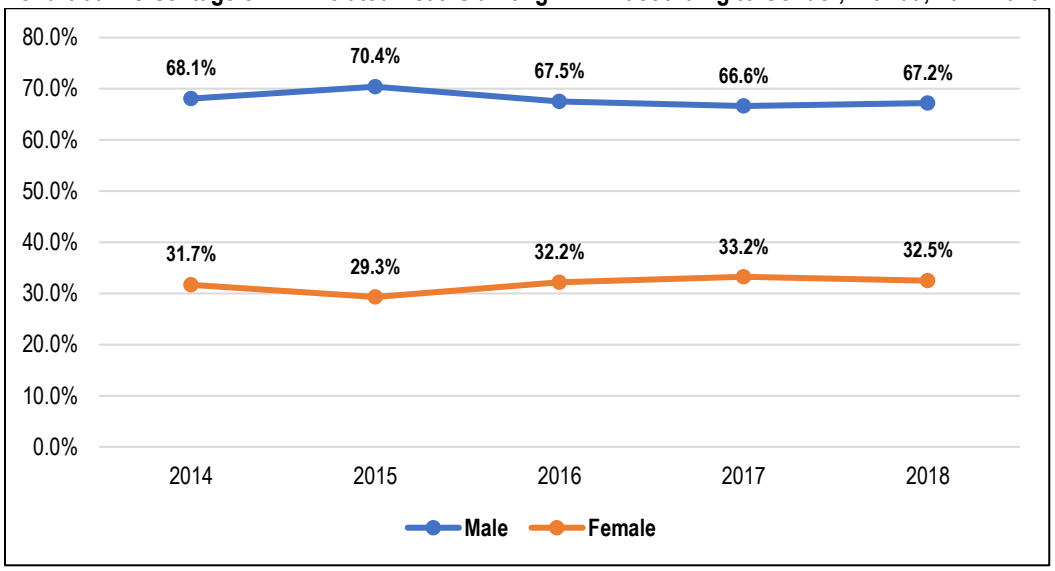


Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

For the state of Florida, similar statistics were observed between 2014 and 2018 with the males living HIV exhibiting a higher percentage of HIV-related deaths compared to females (Chart 60).

For instance, in 2018 slightly over 67% of HIV-related deaths derived from males living with HIV compared to approximately 33% of females living with HIV. Between 2014 and 2018 the percentage of HIV-related deaths have remained relatively stable for both populations.

Chart 60: Percentage of HIV-Related Deaths among PLWH according to Gender, Florida, 2014-2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

Additionally, the total number of HIV-related deaths observed among the transgender population in the state of Florida between 2014 and 2018 was 10 for transgender male-to-female and 1 for transgender female-to-male. These totals represent less than 0.5% of total HIV-related deaths observed during this time frame (please refer to Table 27 for additional details).

Table 27: HIV-Related Deaths among PLWH according to Gender, Florida, 2014-2018

	2014		2015		2016		2017		2018	
Gender	n	%	n	%	n	%	n	%	n	%
Male	609	68.1%	654	70.4%	597	67.5%	519	66.6%	447	67.2%
Female	283	31.7%	272	29.3%	285	32.2%	259	33.2%	216	32.5%
Transgender (Male to Female)	2	0.2%	2	0.2%	3	0.3%	1	0.1%	2	0.3%
Transgender (Female to Male)	0	0.0%	1	0.1%	0	0.0%	0	0.0%	0	0.0%
Total	894	100.0%	929	100.0%	885	100.0%	779	100.0%	665	100.0%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

HIV Continuum of Care

The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, defines PLWH "In Care" as having at least one documented Viral Load (VL) or CD4 lab work, medical visit, or prescription between January 1, 2018 through March 31, 2019; while "Retained in Care" is defined as having two or more documented VL or CD4 lab work, medical visits, or prescriptions at least three months apart from January 1, 2018 through June 30, 2019. The following section describes the HIV continuum of care for PLWH according to selected demographics for Miami-Dade County and the state of Florida.

Demographics

In Miami-Dade County, slightly over 69% of PLWH were in care in 2018 while close to 64% were retained in care in the same year. Residents between the ages of 0 and 12 exhibited the highest percentage of PLWH who are in care as well as retained in care (92.6% in both instances), followed by those between the ages of 13 and 19 (85% and 78%, respectively). Please refer to Table 28.

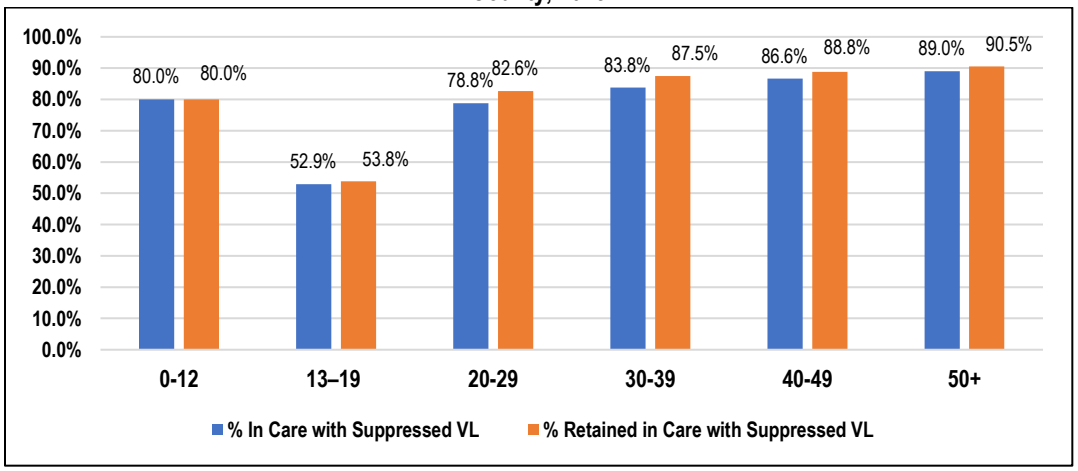
Table 28: HIV Continuum of Care among PLWH according to Race/Ethnicity, Miami-Dade County, 2018

Age Categories	PLWH	In Care	% in Care	Retained in Care	% Retained in Care
0-12	27	25	92.6%	25	92.6%
13–19	100	85	85.0%	78	78.0%
20-29	2,073	1,632	78.7%	1,452	70.0%
30-39	4,578	3,351	73.2%	3,013	65.8%
40-49	6,087	4,196	68.9%	3,881	63.8%
50+	15,480	10,301	66.5%	9,724	62.8%
Total	28,345	19,590	69.1%	18,173	64.1%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

Based on the data collected by the Florida Department of Health, there was a higher percentage of PLWH retained in care with a suppressed viral load for all age groups compared to those only in care. The highest percentage of PLWH who were retained in care with a suppressed viral load derived from residents aged 50 and older with close to 91% compared to 89% who were only in care for the same age group. The lowest percentage, regardless of whether they were in care or retained in care derived from residents ages 13 and 19 (52.9% and 53.8%, respectively) (Chart 61).

Chart 61: PLWH in Care and Retained Care with a Suppressed Viral[11] Load According to Age Category, Miami-Dade County, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

[11] In Care with Suppressed Viral Load: PLWH with at least one documented FL or CD4 lab, medical visit, or prescription from January 1, 2018 through March 31, 2019 that also had a suppressed viral load (<200 copies/mL) on the last viral load during the same time frame.

Retained in Care with Suppressed Viral Load: PLWH with two or more documented VL or CD4 labs, medical visits, or prescriptions at least three months apart from January 1, 2018 through June 30, 2019 that also has a suppressed VL (<200 copies/mL) on the last VL from January 1, 2018 through March 31, 2019

In Florida, the percentage of PLWH who were in care and retained in care was slightly higher than what was observed in Miami-Dade County with 75.1% and close to 69%, respectively (Table 29). As observed in Miami-Dade County, residents younger than 20 years of age accounted for the greatest proportion of PLWH who were in care and retained in care in 2018 for their respective age groups (i.e. 0-12 and 13-19).

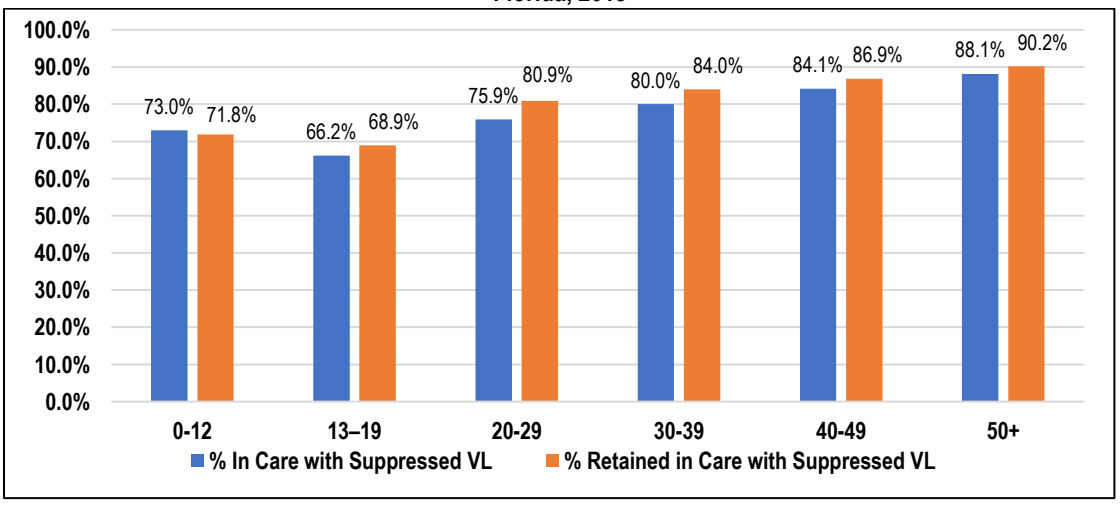
Table 29: HIV Continuum of Care among PLWH according to Age, Miami-Dade County, 2018

Age Categories	PLWH	In Care	% in Care	Retained in Care	% Retained in Care
0-12	159	148	93.1%	142	89.3%
13–19	491	441	89.8%	402	81.9%
20-29	9,951	7,919	79.6%	6,848	68.8%
30-39	19,417	14,505	74.7%	12,863	66.2%
40-49	25,727	19,007	73.9%	17,326	67.3%
50+	63,916	47,905	74.9%	44,841	70.2%
Total	119,661	89,925	75.1%	82,422	68.9%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

When suppressed viral load is analyzed based on the continuum of care (i.e. in care and retained in care), it is observed that in Florida there was a higher percentage of PLWH with a suppressed viral load who were retained in care compared to those who were only in care for all age groups except for residents younger than 13 years of age (71.8% compared to 73%, respectively). Please refer to Chart 62. The highest percentage of PLWH with a suppressed viral load who were retained in care was observed among residents 50 years of age and older with 90.2% compared to 88.1% of residents under the same age group who were only in care.

Chart 62: Percentage of PLWH in Care and Retained Care with a Suppressed Viral Load According to Age Category, Florida, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

In Miami-Dade County, residents identified as non-Hispanic multi-race exhibited the highest percentage of PLWH who were in care and second highest percentage among those retained in care (74.3% and 68.8%, respectively). The second highest percentage observed among PLWH

who were in care derived from non-Hispanic American Indian or Alaska Native with 71.4%.[12] Compared to non-Hispanic White residents, residents identified as non-Hispanic Black presented a higher percentage of PLWH who were in care or retained in care. For instance, 66% of non-Hispanic Black residents living with HIV are in care compared to approximately 65% of non-Hispanic White residents (Table 30).

Table 30: HIV Continuum of Care among PLWH according to Race/Ethnicity, Miami-Dade County, 2018

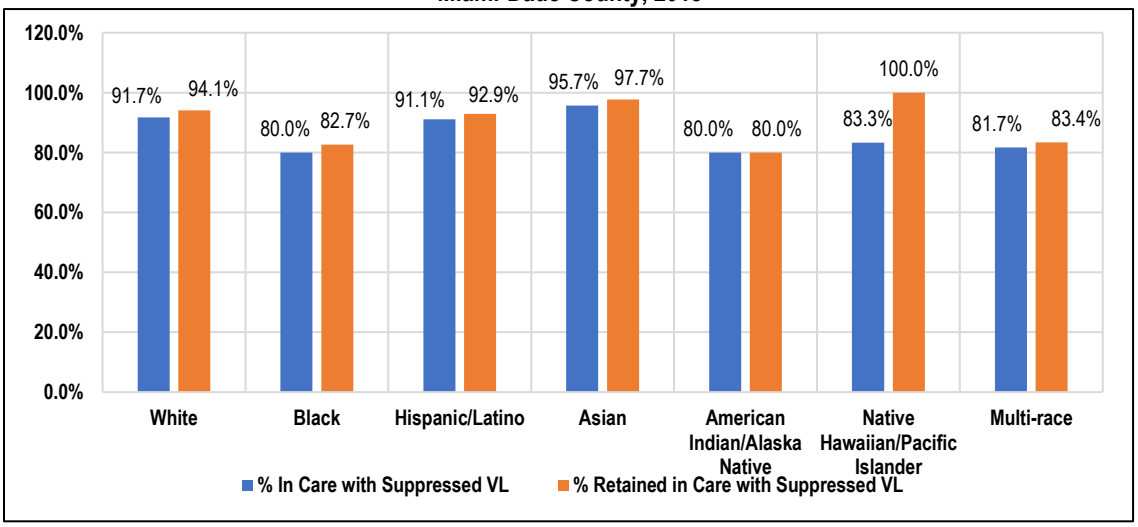
Race/Ethnicity	PLWH	In Care	% in Care	Retained in Care	% Retained in Care
Non-Hispanic/Latinx					
White	3,047	1,972	64.7%	1,781	58.5%
Black	11,894	7,847	66.0%	7,229	60.8%
Asian	86	46	53.5%	43	50.0%
American Indian/Alaska Native	7	5	71.4%	5	71.4%
Native Hawaiian/Pacific Islander	9	6	66.7%	3	33.3%
Multi-Race	272	202	74.3%	187	68.8%
Hispanic/Latinx					
Hispanic/Latinx	13,030	9,512	73.0%	8,925	68.5%
Total	28,345	19,590	69.1%	18,173	64.1%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

As suppressed viral load is compared based on continuum of care according to race and ethnicity, it is observed, as stated earlier, that there is a higher percentage of PLWH with a suppressed viral load who were in retained care than those who were only in care (please refer to Chart 63) for most racial and ethnic groups presented. All PLWH identified as Native Hawaiian or Pacific islander (3) who were in retained care had a suppressed viral load (100%), compared to 83.3% of the same ethnic identity who were only in care. Among the three racial or ethnic groups with the highest number of PLWH (non-Hispanic White, non-Hispanic Black, and Hispanic residents), non-Hispanic White residents experienced the highest percentage of suppressed viral load regardless of whether they were in care or retained in care (91.7% and 94.1%, respectively).

[12] It is important to point out that non-Hispanic American Indian and Alaska Native residents represent a small proportion of total population living with HIV, as such a slight increment in the number of persons in care or retained in care would dramatically affect the respective percentages when compared to other racial or ethnic groups. The same would apply for non-Hispanic Native Hawaiian/Pacific Islander.

Chart 63: Percentage of PLWH in Care and Retained Care with a Suppressed Viral Load According to Race/Ethnicity, Miami-Dade County, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

In the state of Florida, as it was observed in Miami-Dade County, residents who identified as non-Hispanic Multi-Race presented the highest percentage of PLWH who were in care and retained in care (79.6% and 72.9%, respectively), followed by non-Hispanic White residents with 78.5% and 72%, respectively (Table 31).

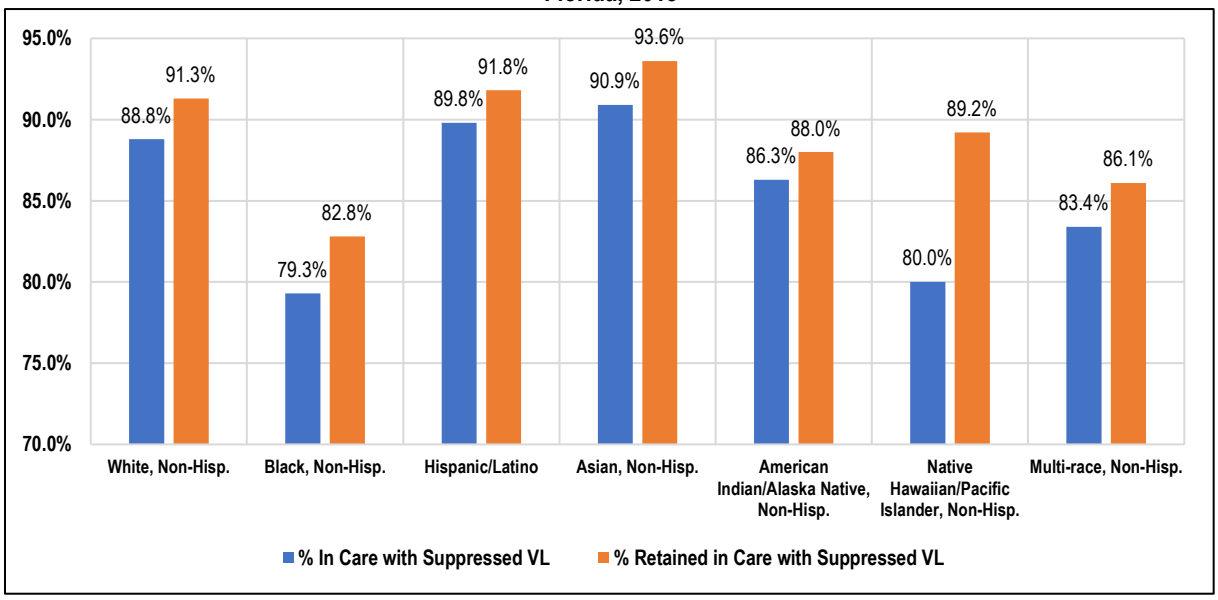
Table 31: HIV Continuum of Care among PLWH according to Race/Ethnicity, Florida, 2018

Race/Ethnicity	PLWH	In Care	% in Care	Retained in Care	% Retained in Care
Non-Hispanic/Latinx					
White	34,475	27,053	78.5%	24,821	72.0%
Black	54,117	39,671	73.3%	36,079	66.7%
Asian	678	497	73.3%	453	66.8%
American Indian/Alaska Native	105	80	76.2%	75	71.4%
Native Hawaiian/Pacific Islander	66	50	75.8%	37	56.1%
Multi-Race	1,634	1,300	79.6%	1,192	72.9%
Hispanic/Latinx					
Hispanic/Latinx	28,586	21,274	74.4%	19,765	69.1%
Total	119,661	89,925	75.1%	82,422	68.9%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

Non-Hispanic Asian residents of the State of Florida exhibited the highest percentage of PLWH with a suppressed viral load in their continuum of care (in care and retained care) with 90.9% and 93.6%, respectively (Chart 64). Compared to other racial and ethnic groups, non-Hispanic Black residents experienced the lowest percentage of PLWH with a suppressed viral load whether in care or in retained care (79.3% and 82.8%, respectively).

Chart 64: Percentage of PLWH in Care and Retained Care with a Suppressed Viral Load According to Race/Ethnicity, Florida, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

In Miami-Dade County, close to 70% of the female population living with HIV were in care in 2018 while 65% were retained in care (Table 32). These statistics are slightly higher than the male population living with HIV, in which close to 69% were in care compared to 63.8% who were retained in care. The transgender population (male to female and female to male) represent a small proportion of PLWH, as such it is suggested to exercise caution when interpreting the HIV continuum of care statistics. For instance, there were three residents who identified as transgender - female to male living with HIV, in which all (100%) were in care in 2018. However, there was only one resident identified as such who was retained in care, and as a result the respective percentage is reduced significantly at 33.3%.

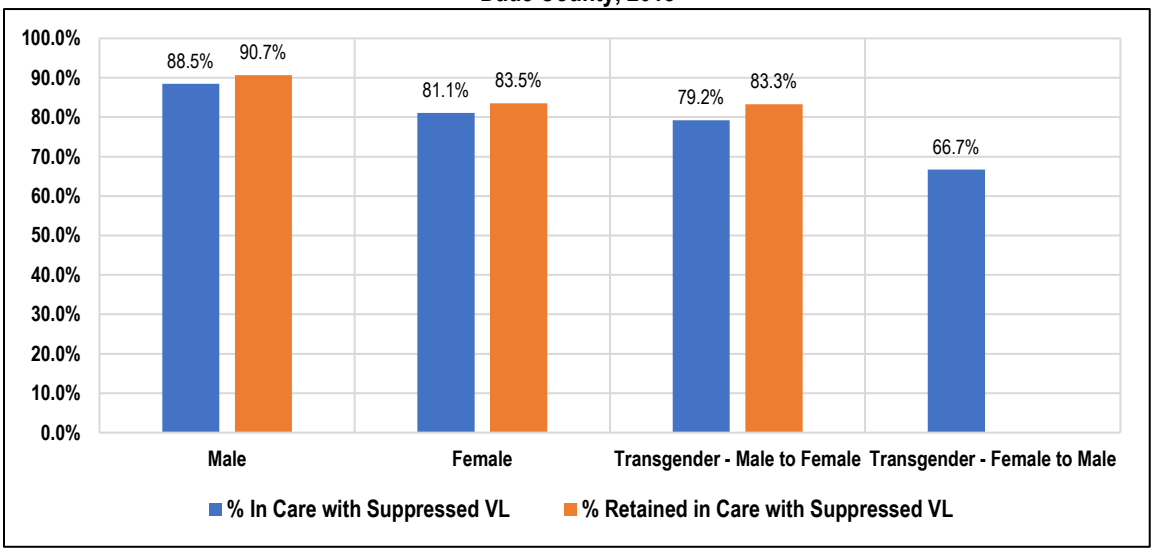
Table 32: HIV Continuum of Care among PLWH according to Gender, Miami-Dade County, 2018

Gender	PLWH	In Care	% in Care	Retained in Care	% Retained in Care
Male	21,150	14,556	68.8%	13,491	63.8%
Female	7,129	4,978	69.8%	4,633	65.0%
Transgender (Male to Female)	63	53	84.1%	48	76.2%
Transgender (Female to Male)	3	3	100.0%	1	33.3%
Total	28,345	19,590	69.1%	18,173	64.1%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

Furthermore, among the male population living with HIV who were retained in care close to 91% had a suppressed viral load, compared to 89% who were in care. These statistics are higher than those observed among the female population living with HIV (81.1% and 83.5%, respectively). There were no residents living with HIV in Miami-Dade County who identify as transgender (female to male) with a suppressed viral load while retained in care (Chart 65).

Chart 65: Percentage of PLWH in Care and Retained Care with a Suppressed Viral Load According to Gender, Miami-Dade County, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2014-2018

In the State of Florida, as observed in Miami-Dade County, a higher percentage of females living with HIV were in care and retained in care compared to the males (Table 33). For instance, slightly over 70% of females living with HIV were retained in care compared to 68.4% of the male population living with HIV. As observed earlier, caution is advised when interpreting statistics for significantly smaller populations living with HIV. This is the case for residents who identify as transgender (female to male), as they exhibited the highest percentage of PLWH who were in care with 92.3% (one increment or reduction of PLWH in care for this population would affect the respective percentage significantly).

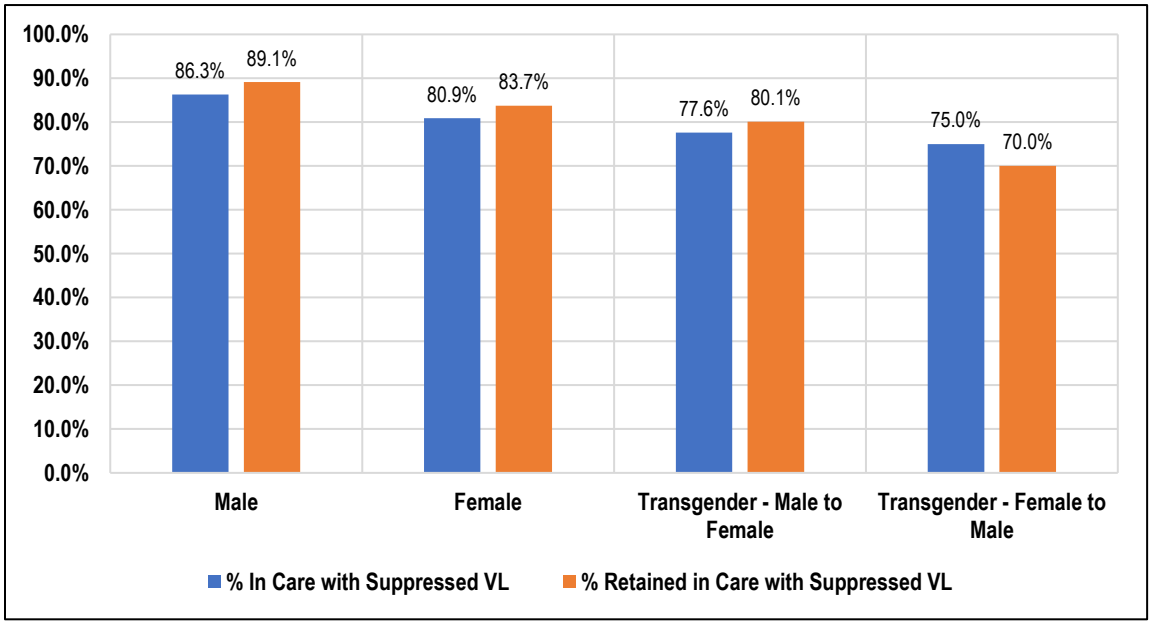
Table 33: HIV Continuum of Care among PLWH according to Gender, Florida, 2018

Gender	PLWH	In Care	% in Care	Retained in Care	% Retained in Care
Male	86,949	64,993	74.7%	59,442	68.4%
Female	32,363	24,652	76.2%	22,734	70.2%
Transgender (Male to Female)	336	268	79.8%	236	70.2%
Transgender (Female to Male)	13	12	92.3%	10	76.9%
Total	119,661	89,925	75.1%	82,422	68.9%

Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Similar statistics are observed for the State of Florida compared to Miami-Dade County as suppressed viral load is analyzed according to gender for PLWH. Compared to other gender identification category, males presented the highest percentage of PLWH with a suppressed viral load while in care and retained in care (86.6% and 89.1%, respectively). Please refer to Chart 66. The second highest percentages of suppressed viral load according to PLWH in care and retained in care derived from the female population with approximately 81% and 84%, respectively.

Chart 66: Percentage of PLWH in Care and Retained in Care with a Suppressed Viral Load According to Gender, Florida, 2018



Source: The Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section, 2018

Statewide 2019 HIV Care Needs Survey

Introduction

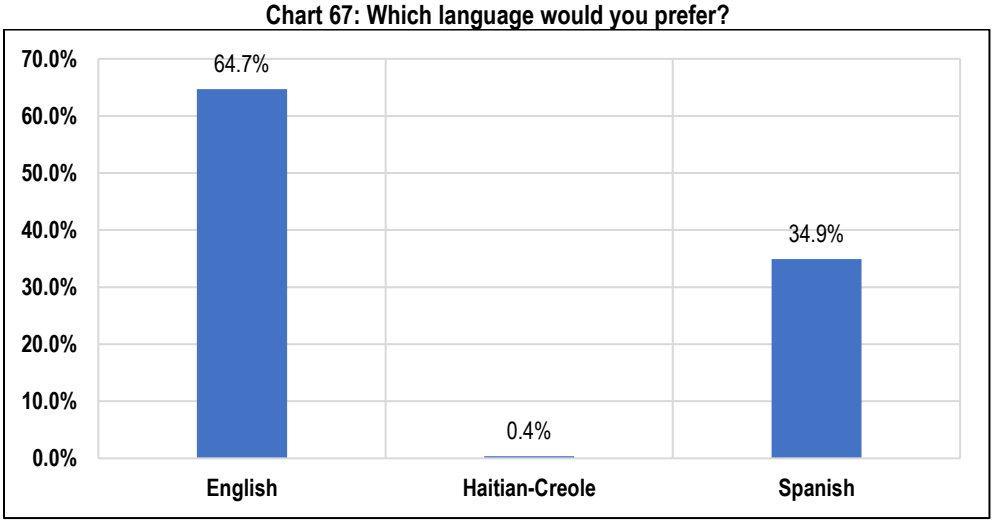
Data from the *Statewide 2019 HIV Care Needs Survey* was utilized to capture the perspective of consumers of HIV services in Miami-Dade County. The *Statewide 2019 HIV Care Needs Survey* was administered by the Florida Department of Health (FDOH) throughout the entire state of Florida in 2019. To administer the statewide survey, the FDOH first calculated a sample size for each county based on the number of persons living with HIV. Each county was provided the minimum number of surveys to be sent to reach 25% of PLWH, at a ten percent response rate. Ryan White Part B Lead Agencies and Ryan White Part A recipients collaborated to work with local providers, community members, and other stakeholders to obtain the survey responses. The survey was made available in paper and online through SurveyGizmo in three languages, including; English, Haitian-Creole, and Spanish. Paper surveys were collected locally and mailed to the Florida Department of Health, Bureau of Communicable Diseases, HIV/AIDS Section for data entry and analysis. While this was a statewide survey, this report only analyzes the data from survey participants in Miami-Dade County.

Survey Demographics

The number of participants who took the 2019 Miami-Dade County HIV care needs survey totaled 765 people, of which 728 completed the entire survey (95.2%), 20 completed it partially (2.6%), and 17 were disqualified (2.2%). Of those who completed and partially completed the survey, the majority of respondents preferred to take the survey in English (64.7%) while other respondents preferred to take it in Spanish (34.9%), and only a few respondents preferred to take it in Haitian-

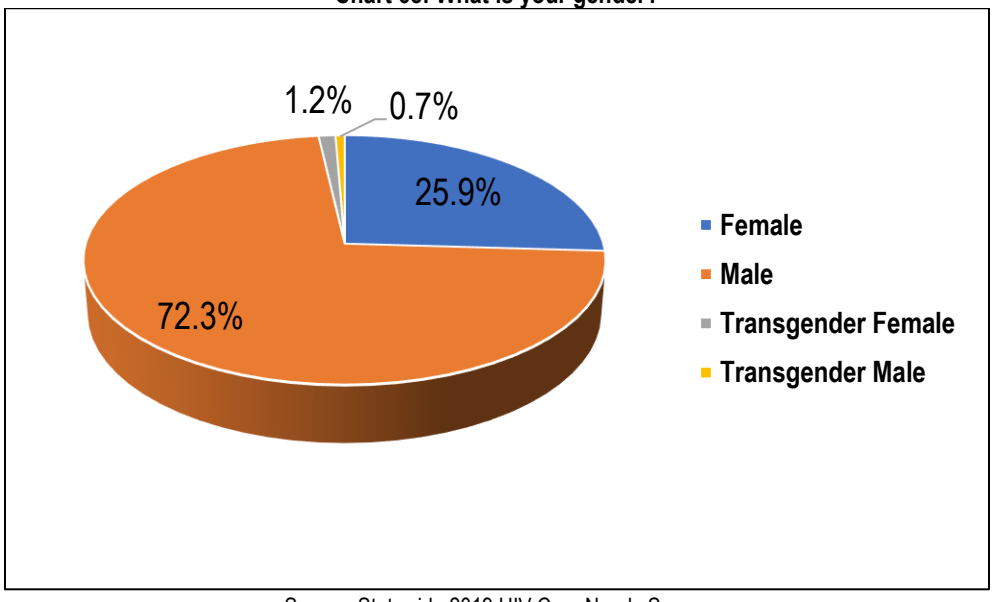
Creole (0.4%) (Chart 67). Although most respondents preferred the survey in English, the prevalence of Spanish speakers was considerable (N=267 respondents). Respondents included females, males, transgender females, and transgender males, with 25.9% being females, 72.3% males, 1.2% transgender females, and 0.7% transgender males, denoting the predominance of HIV cases in males (Chart 68).

Chart 67: Which language would you prefer?



Source: Statewide 2019 HIV Care Needs Survey

Chart 68: What is your gender?

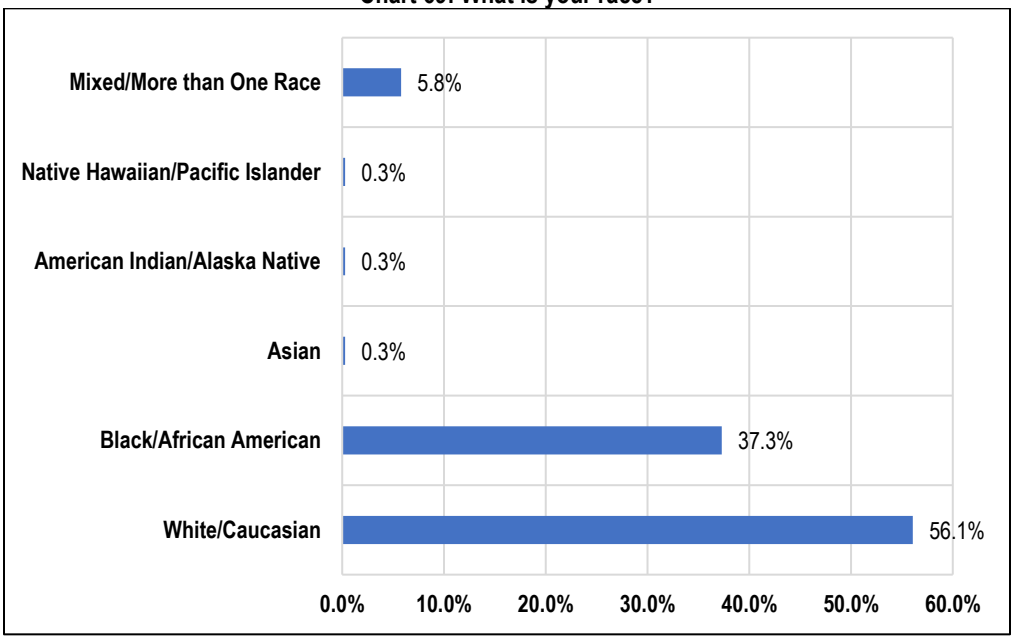


Source: Statewide 2019 HIV Care Needs Survey

Most respondents identified themselves as being White/Caucasian (56.1%), followed by the second largest race group of Black/African Americans (37.3%). Only a scarce representation of Asians (0.3%), American Indians/Alaska Natives (0.3%), and Native Hawaiians/Pacific Islanders (0.3%), were observed, while 42 (5.8%) respondents identified as belonging to a mixed race

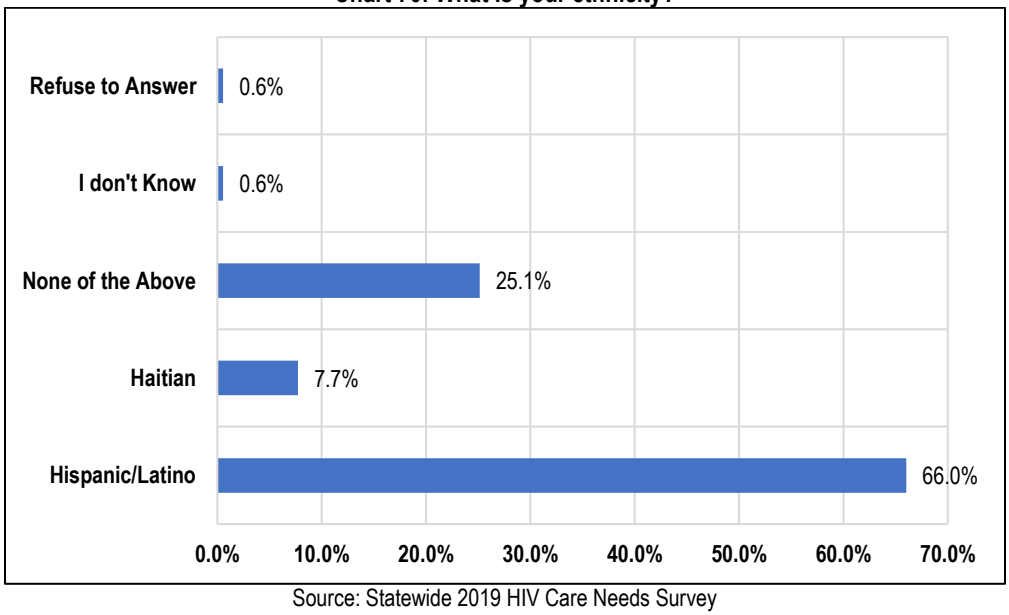
(more than one race) (Chart 69). Also, in ethnicity terms, most respondents identified as Hispanic/Latinx (66.0%), a few respondents identified as Haitians (7.7%), and one fourth of respondents neither identified themselves as Hispanic/Latinx nor Haitians (25.1%). A small percentage of respondents did not know their ethnicity (0.6%) or refused to identify to any ethnicity (0.6%) (Chart 70). This indicates the prevalence of the Hispanic/Latinx community for HIV infection cases.

Chart 69: What is your race?



Source: Statewide 2019 HIV Care Needs Survey

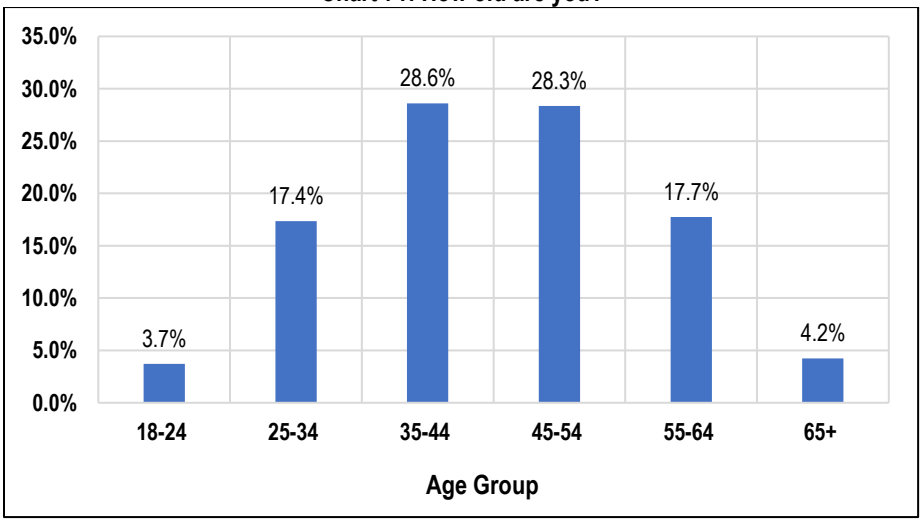
Chart 70: What is your ethnicity?



Source: Statewide 2019 HIV Care Needs Survey

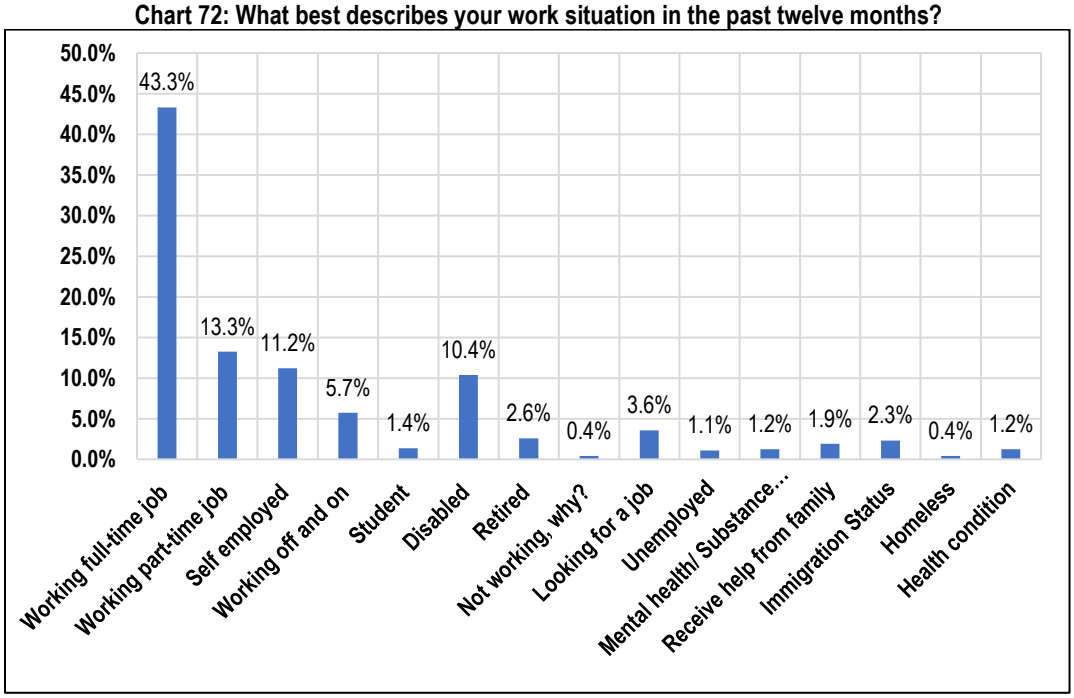
Respondents to the survey were mostly between 35 and 44 years of age (28.6%) and between 45 and 54 years of age (28.3%). The 25 to 34 age group accounted for 17.4% of respondents, followed by the 55 to 64 age group which accounted for 17.7% of respondents. Few respondents belonged to the 18 to 24 category (3.7%) and the 65 and older category (4.2%) (Chart 71). In the previous 12 months, most survey respondents had a full-time job (43.3%), while some of them had part-time jobs (13.3%), were self-employed (11.2%), or were disabled (10.4%). Few of the survey respondents were working off and on (5.7%), looking for a job (3.6%), were retired (2.6%), or were under a type of immigration status (2.3%). Very few of the survey respondents were receiving help from their families (1.9%), were students (1.4%), were under mental health/substance abuse conditions (1.2%), or a health condition (1.2%), or were unemployed (1.1%), not working (0.4%), or were homeless (0.4%) (Chart 72).

Chart 71: How old are you?



Source: Statewide 2019 HIV Care Needs Survey

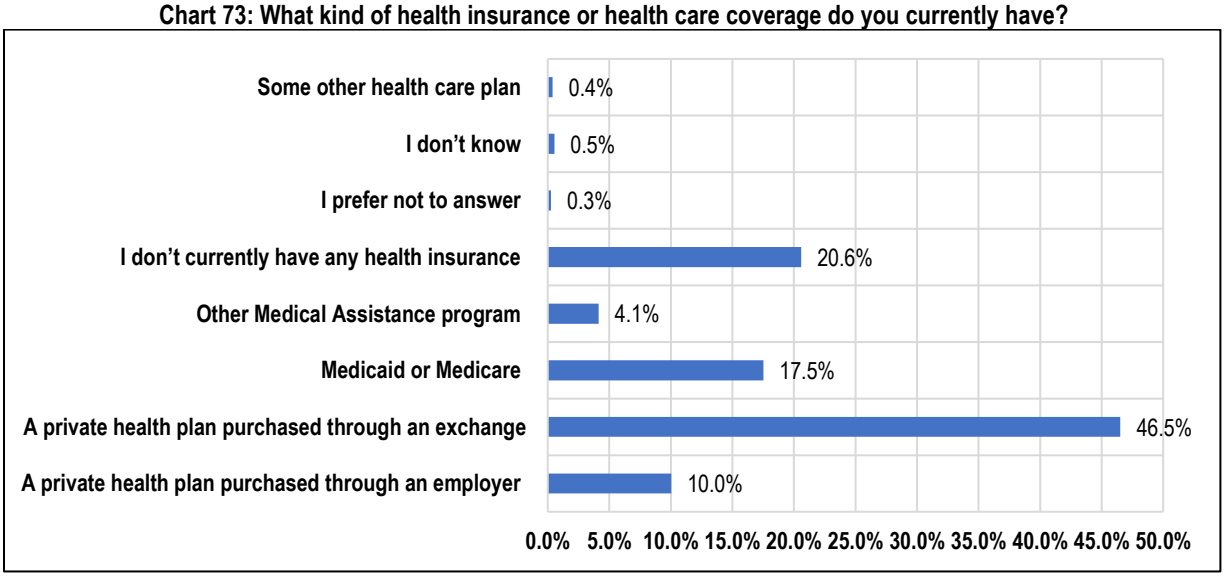
Chart 72: What best describes your work situation in the past twelve months?



Source: Statewide 2019 HIV Care Needs Survey

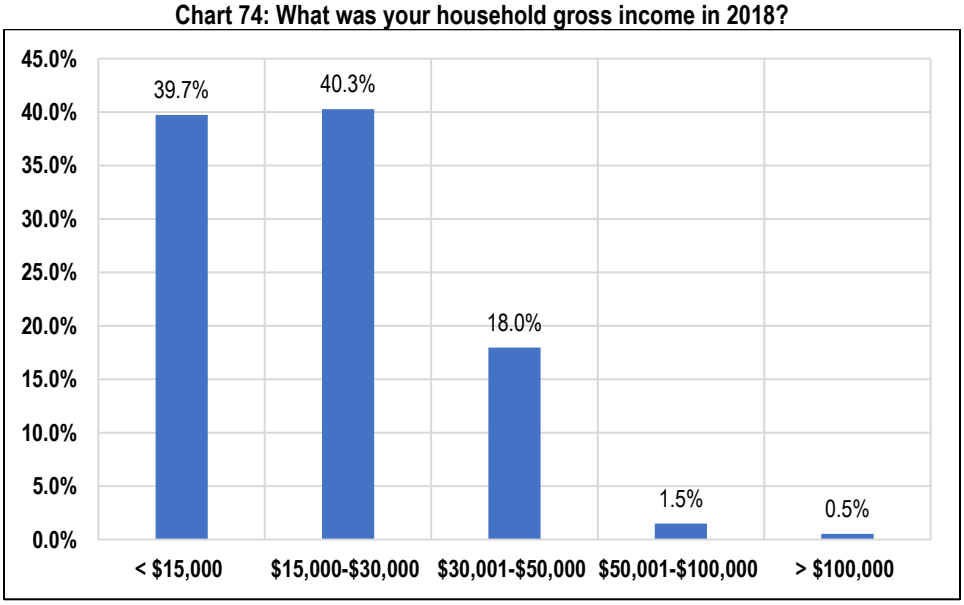
Most survey respondents had a private health insurance purchased through an exchange (46.5%) or did not have any health insurance (20.6%), while some were insured through Medicaid or Medicare (17.5%), had a private health plan through an employer (10.0%), or had a different medical assistance program (4.1%). Very few of the respondents did not know what health insurance they had (0.5%), had some other health care plan (0.4%), or preferred not to answer about their insurance (0.3%) (Chart 73). This result indicates that 154 survey respondents did not have health insurance, which sets a contextual precedence for the HIV-related questions asked in this survey. The gross income category with the highest percentage of survey respondents was the $15,000-$30,000 category with 40.3%, immediately followed by the less-than-$15,000 category with 39.7%. This indicates that most of the respondents were below the poverty line if the respondent's families were in the range of having one to five family members (Chart 74).

Chart 73: What kind of health insurance or health care coverage do you currently have?



Source: Statewide 2019 HIV Care Needs Survey

Chart 74: What was your household gross income in 2018?



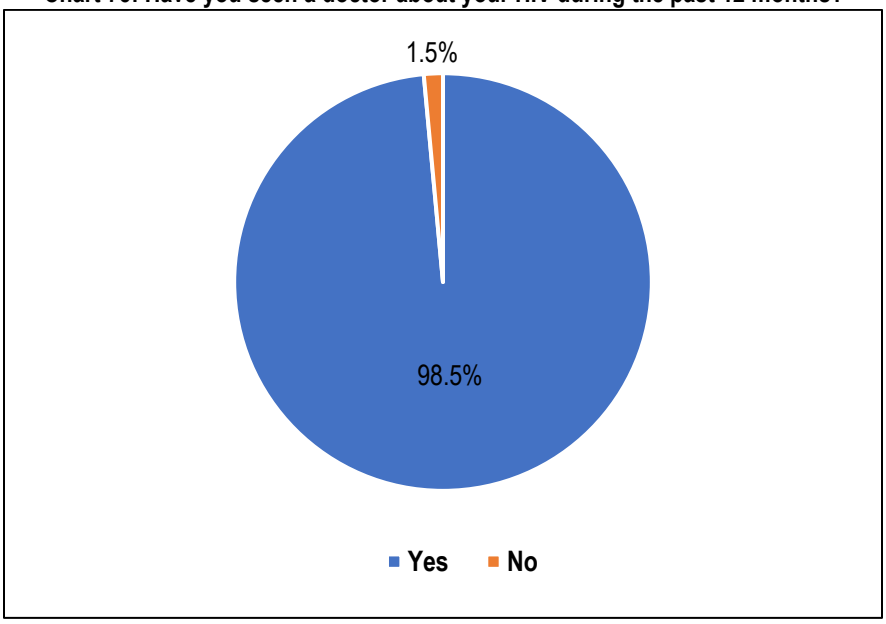
Source: Statewide 2019 HIV Care Needs Survey

HIV-Related Care

Survey respondents had a variety of responses regarding HIV-related care questions. Respondents were often aware of their status as individuals with HIV and the services they could receive, however the survey also indicated some mixed results with respect to respondents acting to obtain treatment due to perceived individual and societal level barriers. For example, most survey respondents (98.5%) have gone to the doctor during the past 12 months, suggesting that many individuals with HIV do not shy away from their condition (e.g., shame, secrecy, etc.) and instead want or desire medical attention and treatment (Chart 75). Also, most survey respondents

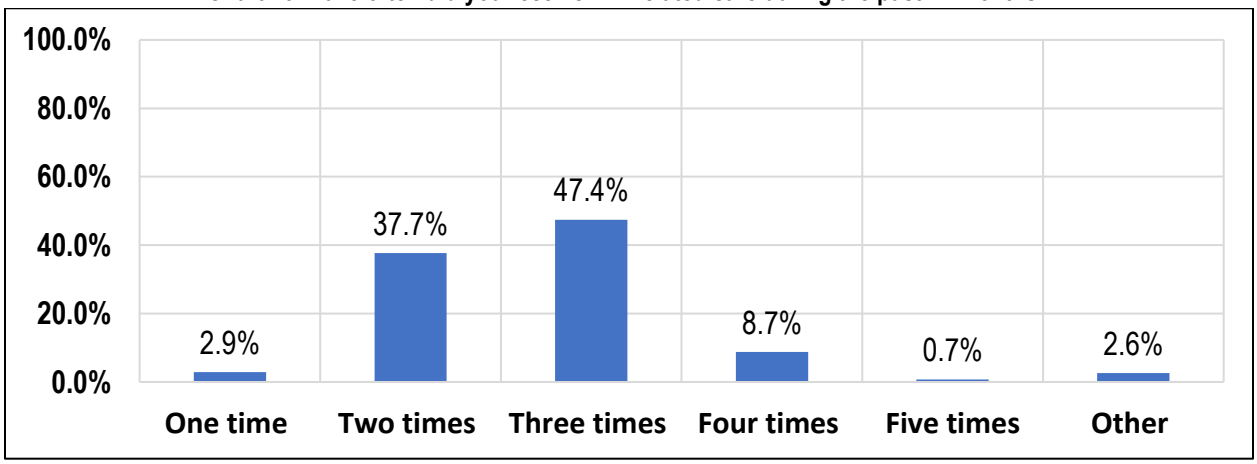
indicated that they were receiving HIV-related care during the past 12 months twice (37.7%) or three times (47.4%) in that time period (Chart 76).

Chart 75: Have you seen a doctor about your HIV during the past 12 months?



Source: Statewide 2019 HIV Care Needs Survey

Chart 76: Have often did you receive HIV-related care during the past 12 months?

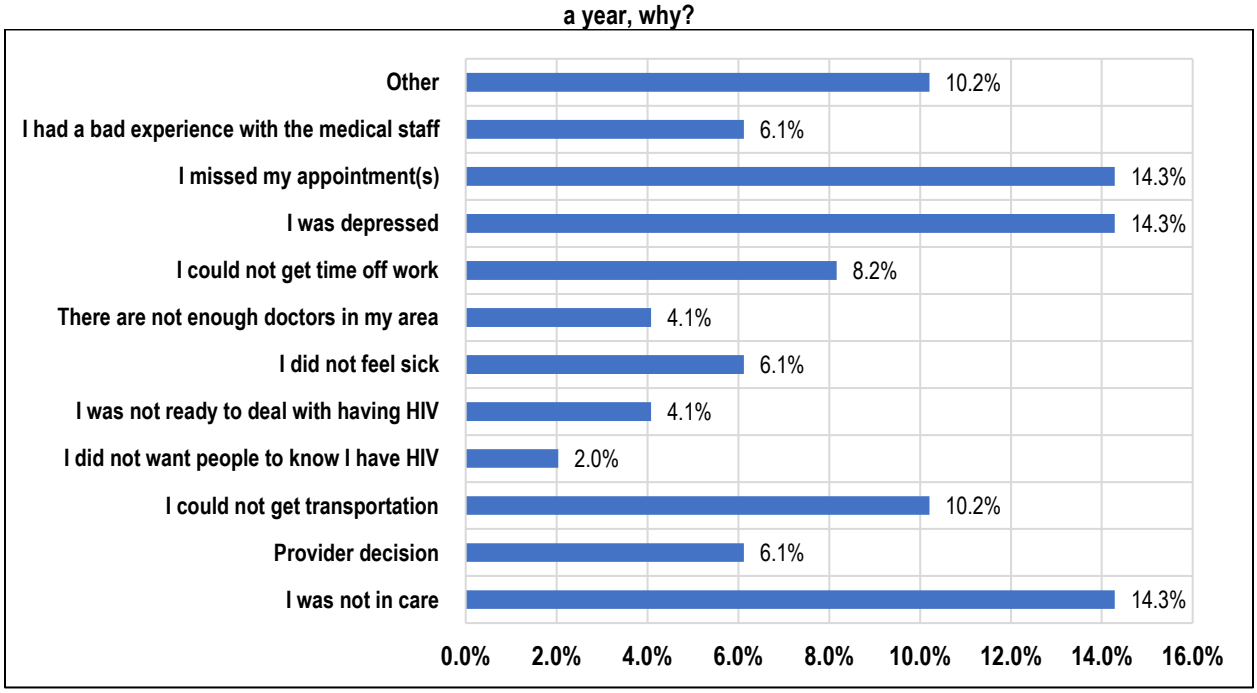


Source: Statewide 2019 HIV Care Needs Survey

Survey respondents had a highly diverse set of responses to the question of why they did not receive HIV-related medical care in the past 12 months or why they received it less than twice a year. Roughly half of all respondents (43%) indicated that the reason this happened was because they were not in medical care (14.3%), were depressed (14.3%), or missed their appointment (14.3%). Some of the survey participants indicated that they could not get transportation (10.2%) or could not get time off work (8.2%), while less respondents indicating that this was their

provider's decision (6.1%), they did not feel sick (6.1%), or had a bad experience with medical staff (6.1%). Fewer of the respondents indicated that the reason for this was that they were not ready to deal with having HIV (4.1%), stated that there were not enough doctors in their areas (4.1%), or did not want people to know that they have HIV (2.0%) (Chart 77). Overall, it seems as if this varied set of conditions for why they did not receive medical care in the past 12 months or less than twice in a year is based upon their personal cases and some societal level or health system barriers such as not being in medical care, following providers' decisions, not enough doctors in the area, and poor experiences with medical staff.

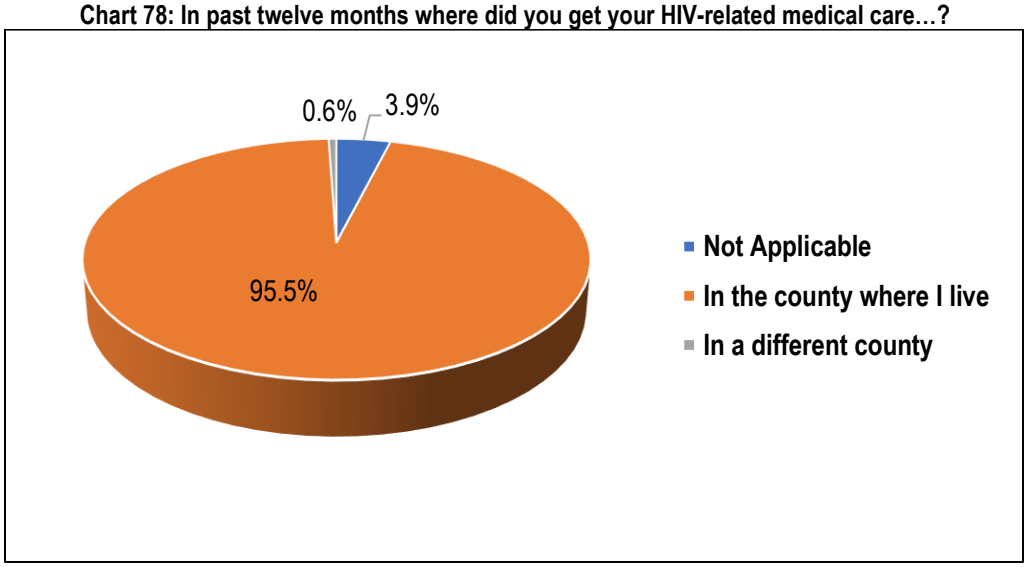
Chart 77: If you have not been in care during the past 12 months or received HIV-related medical care less than 2 times a year, why?



Source: Statewide 2019 HIV Care Needs Survey

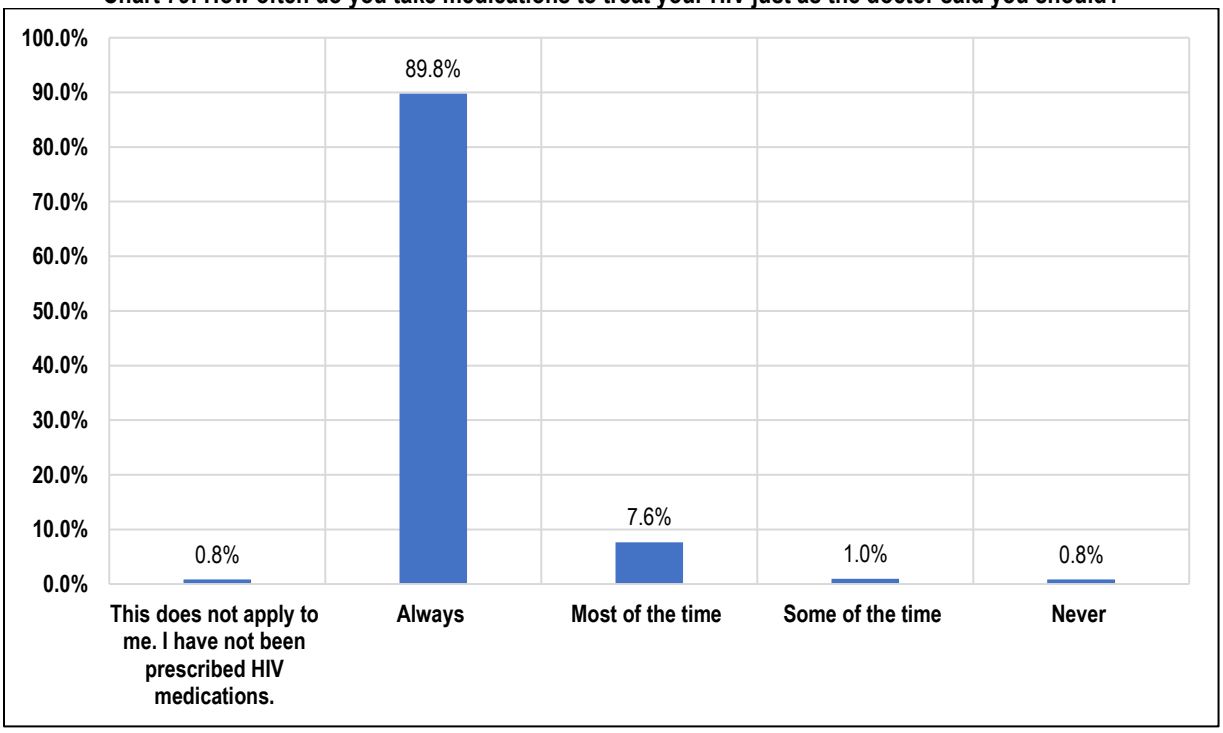
Most survey respondents (95.5%) indicated that they were receiving HIV-medical care in Miami-Dade County instead of in a different county (3.9%), suggesting that there is a level of county circumscription that could be related to the probable amount and efficacy of services provided by Miami-Dade County (Chart 78). Also, most survey respondents are adhering to their medication, as 89.8% of them indicated (659 respondents) that they always take their HIV treatment medications as prescribed by their doctors, with 7.6% of them (56 respondents) indicating that they take their medications most of the time, and 1.0% of them (7 respondents) taking them some of the time (Chart 79).

Chart 78: In past twelve months where did you get your HIV-related medical care…?



Source: Statewide 2019 HIV Care Needs Survey

Chart 79: How often do you take medications to treat your HIV just as the doctor said you should?

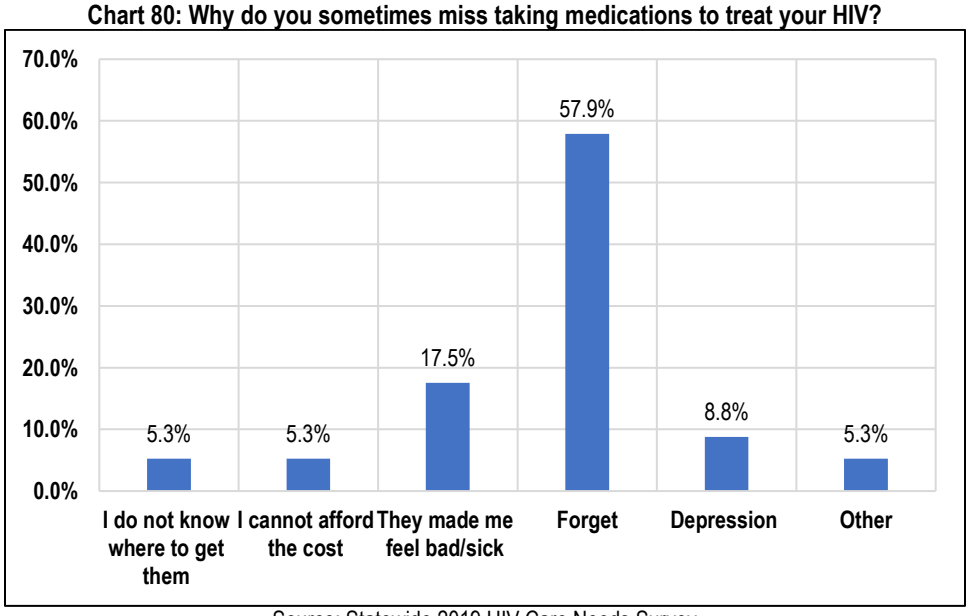


Source: Statewide 2019 HIV Care Needs Survey

Even though as previously noted, 89.8% of respondents claimed to always take their HIV treatment medications as prescribed by their doctors, more than half (57.9%) of the respondents also cite “forget(ting)” as the reason why they miss taking their medications. Fewer survey participants indicated that missed doses are due to unwanted side effects (17.5%), or due to depression (8.8%) (Chart 80). Very few of the survey respondents did not know where to get their medications (5.3%) or could not afford the cost of medications (5.3%). Also, the majority of the survey participants (75.7%) were able to obtain the services they needed in the past 12 months,

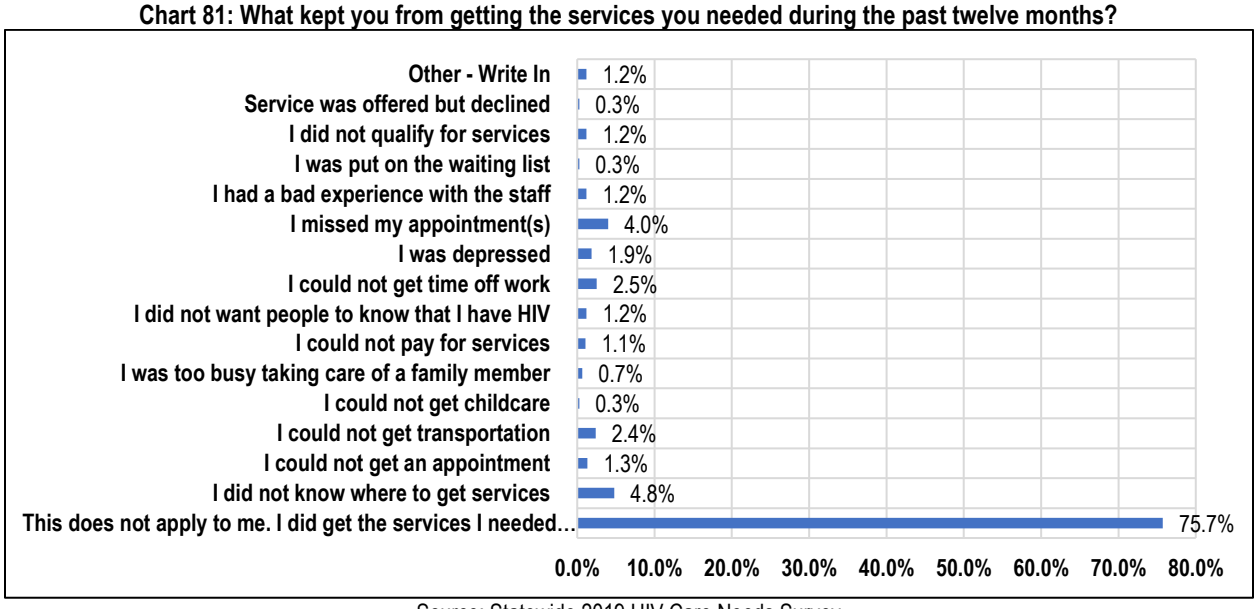
while few respondents did not know how to get their services (4.8%) or could not pay for the services (4.0%) in the past 12 months (Chart 81). These latter responses moderately reveal that lack of information and costs are barriers to accessing HIV-related medical care.

Chart 80: Why do you sometimes miss taking medications to treat your HIV?



Source: Statewide 2019 HIV Care Needs Survey

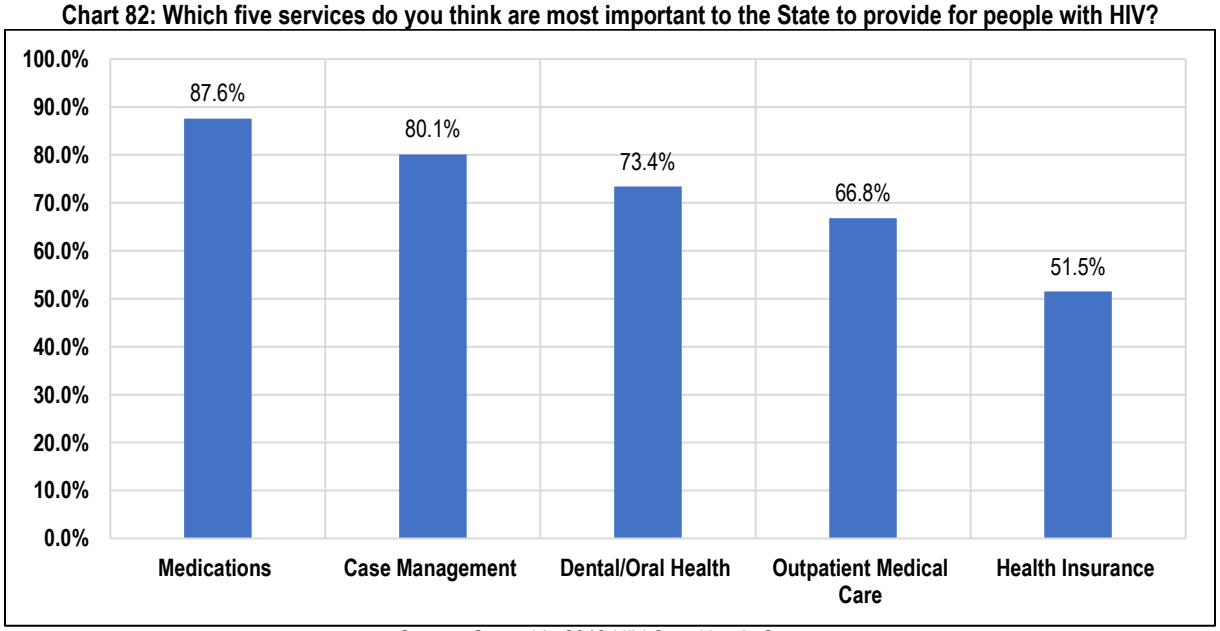
Chart 81: What kept you from getting the services you needed during the past twelve months?



Source: Statewide 2019 HIV Care Needs Survey

Survey participants ranked the five most important services for the State to provide for PLWH, resulting in the following top services; medication (87.6%), case management (80.1%), dental/oral health (73.4%), outpatient medical care (66.8%), and health insurance (51.5%) (Chart 82).

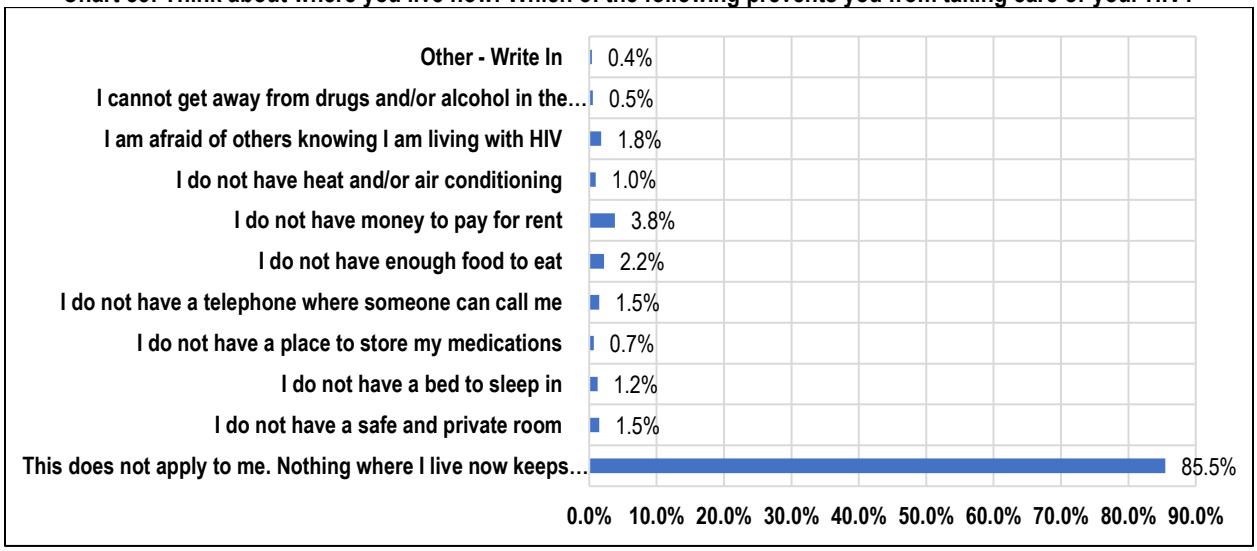
Chart 82: Which five services do you think are most important to the State to provide for people with HIV?



Source: Statewide 2019 HIV Care Needs Survey

85.5% of respondents do not see their place of residence as a barrier to taking care of their HIV. However, 10.5% of respondents indicated that their place of residence acts a barrier in some way. These reasons included; not having money to pay for rent (3.8%), not having enough food to eat (2.2%), being afraid of others knowing they live with HIV (1.8%), not having a telephone (1.5%), and not having a bed to sleep in (1.2%) (Chart 83).

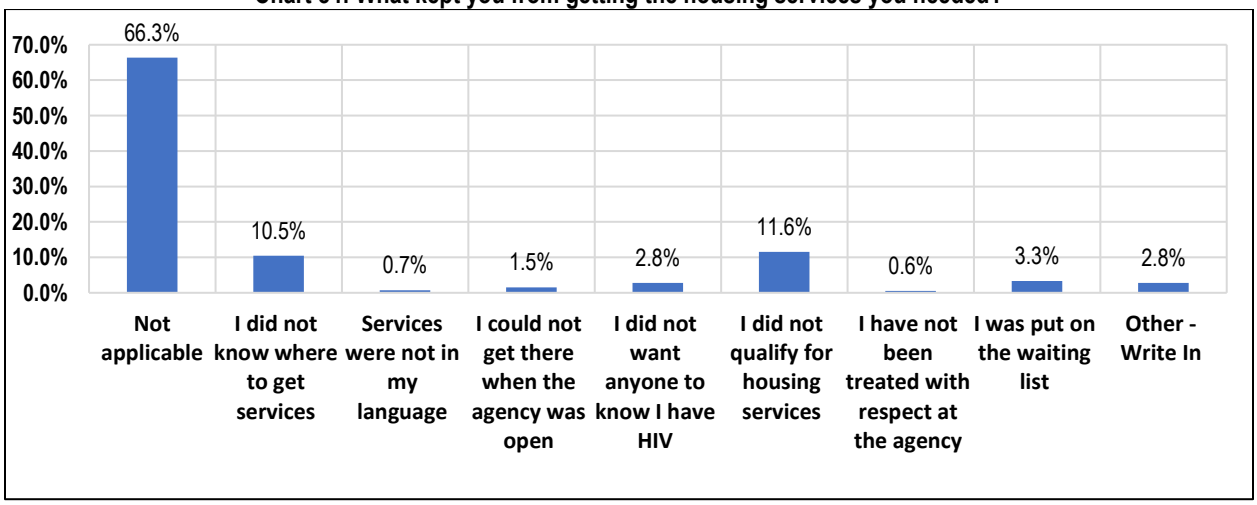
Chart 83: Think about where you live now: Which of the following prevents you from taking care of your HIV?



Source: Statewide 2019 HIV Care Needs Survey

For most survey respondents, the question of what prevented them from getting housing services did not apply (66.3%). However, some of the respondents indicated that not qualifying for housing services (11.6%) and not knowing where to get housing services (10.5%) prevented them from obtaining housing services. Some survey respondents faced other barriers to obtaining housing services, including; language barriers (0.7%), waiting lists (3.3%), not being treated with respect (0.6%), hours of operation (1.5%), stigma (2.8%), and "other" (2.8%) (Chart 84).

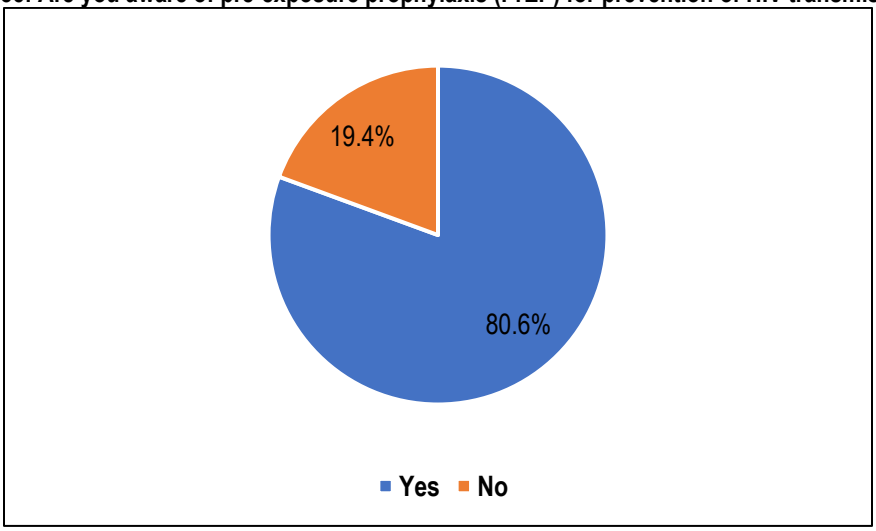
Chart 84: What kept you from getting the housing services you needed?



Source: Statewide 2019 HIV Care Needs Survey

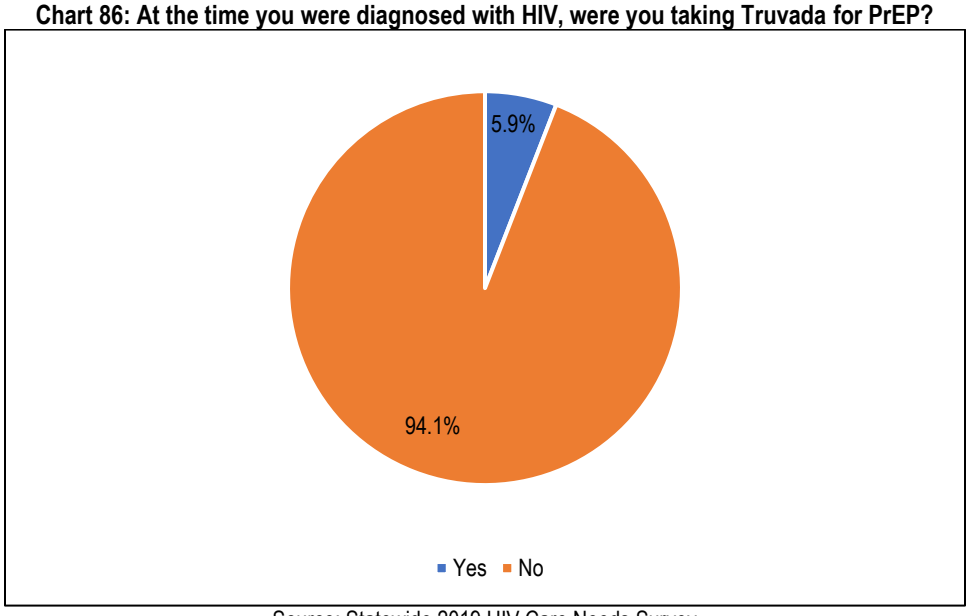
Most survey respondents (80.6%) were aware that pre-exposure prophylaxis (PrEP) is used to prevent HIV transmission, however, the great majority of them were not taking the medicine Truvada for PrEP (94.1%) when they were diagnosed with HIV. It is important to indicate that despite most respondents being aware of PrEP to prevent HIV transmission (80.6%), a considerable number of them (19.4% or 82 respondents) were not aware of PrEP (Charts 85 and 86).

Chart 85: Are you aware of pre-exposure prophylaxis (PrEP) for prevention of HIV transmission?



Source: Statewide 2019 HIV Care Needs Survey

Chart 86: At the time you were diagnosed with HIV, were you taking Truvada for PrEP?

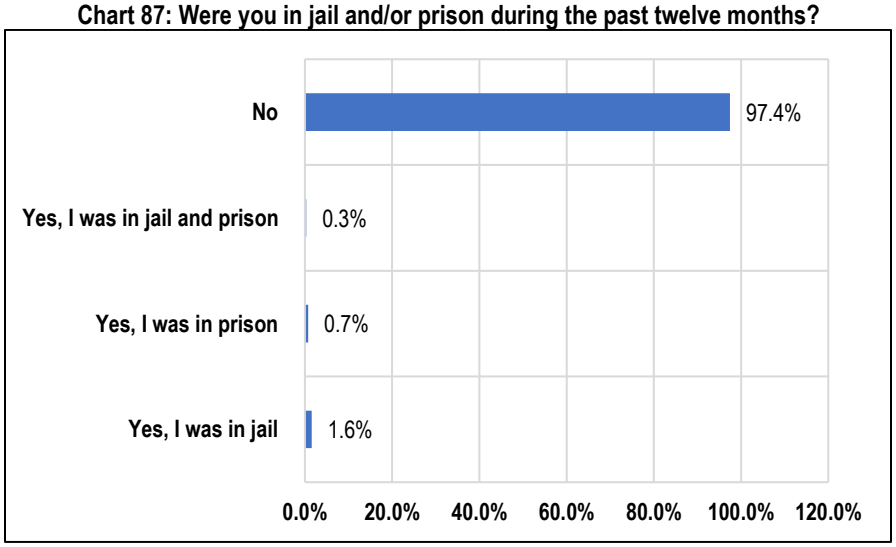


Source: Statewide 2019 HIV Care Needs Survey

HIV Respondents with Past Jail or Prison Time

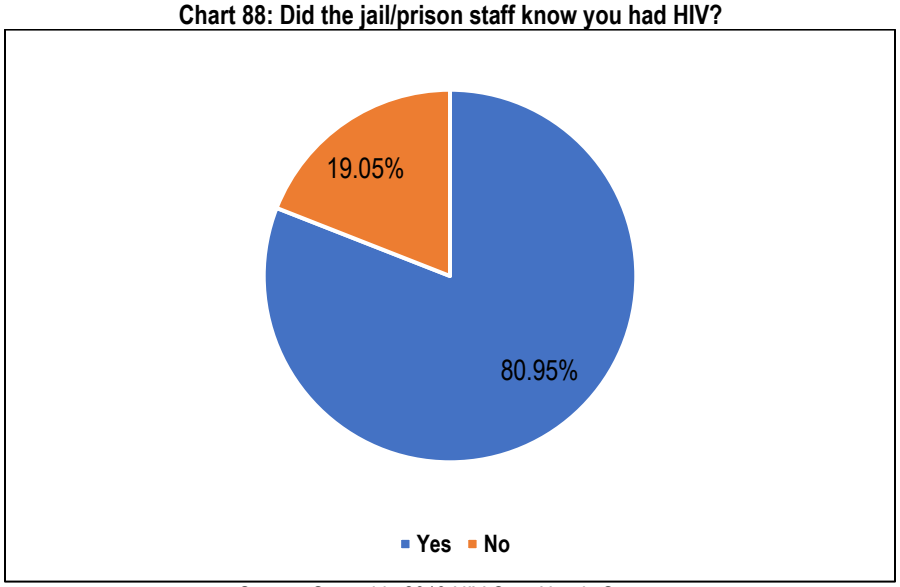
Few survey respondents were in jail, prison, or both in the previous 12 months of the survey (2.6% or 18 respondents) (Chart 87). 81% of those survey participants who specified they were in jail, prison, or both, indicated that the staff working on those jails or prisons knew that these respondents were infected with HIV, while 19.1% indicated this staff did not know of their HIV condition (Chart 88). Out of these few respondents, 68.2% indicated that they received HIV-related medical care while they were in jail, prison, or both, while 31.8% of them did not (Chart 89).

Chart 87: Were you in jail and/or prison during the past twelve months?



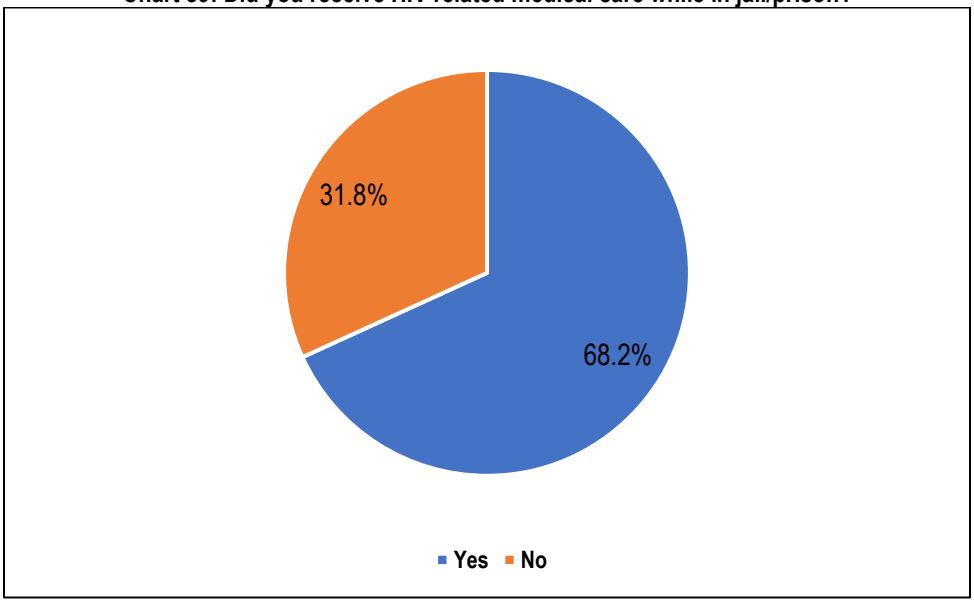
Source: Statewide 2019 HIV Care Needs Survey

Chart 88: Did the jail/prison staff know you had HIV?



Source: Statewide 2019 HIV Care Needs Survey

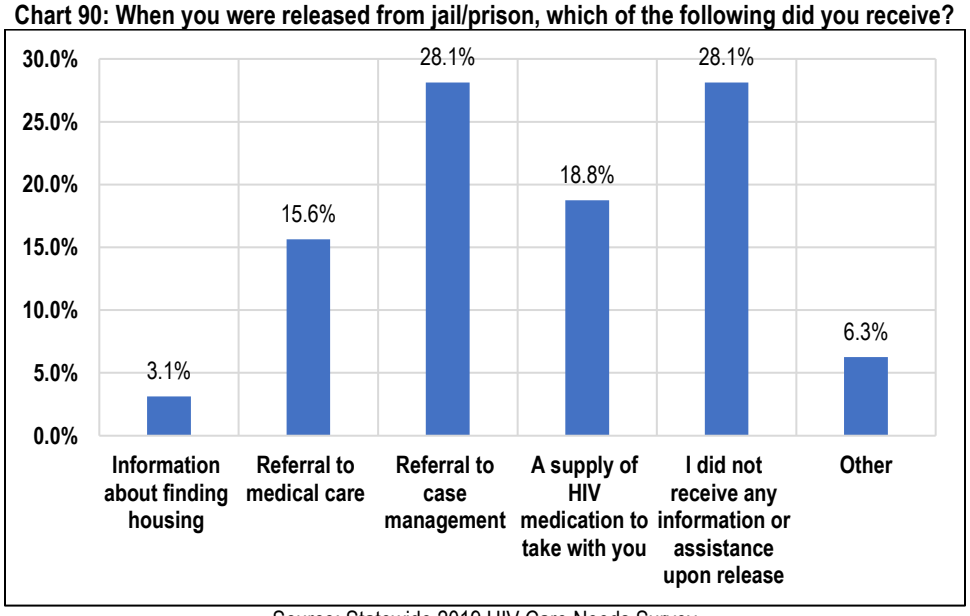
Chart 89: Did you receive HIV related medical care while in jail/prison?



Source: Statewide 2019 HIV Care Needs Survey

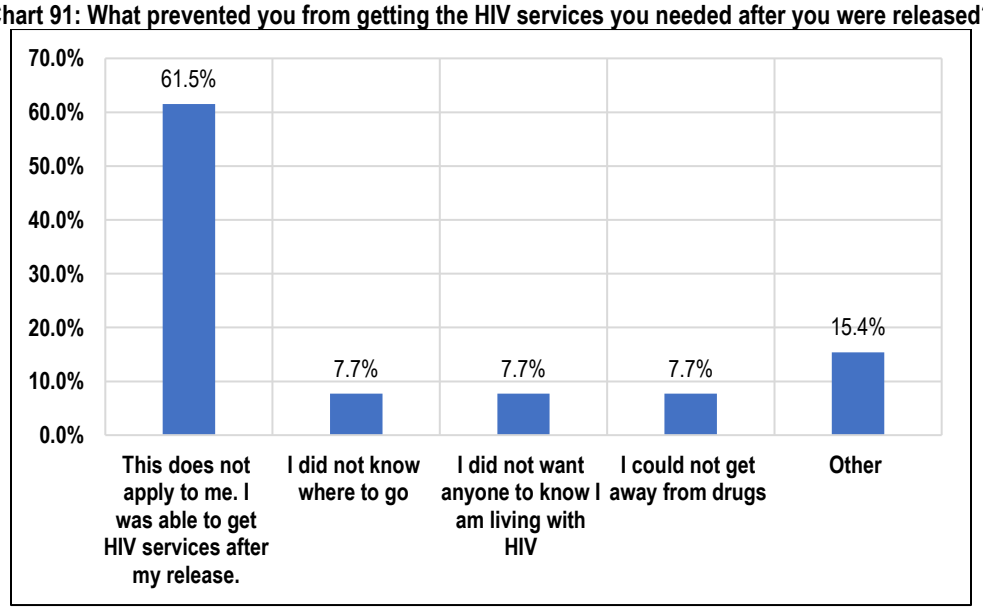
After release from jail, prison, or both, survey participants indicated that 28.1% of them received a referral for case management, 28.1% of them did not receive any information or assistance, 18.8% of them got a supply of HIV medication to take with them, 15.6% of them got a referral to medical care, and 3.1% of them got information about finding housing (Chart 90). Most survey respondents who were in jail, prison, or both were able to get HIV services after their release (61.5%), but few of them did not know where to go to get these services (7.7%), did not want anybody to know they had HIV (7.7%), or could not get away from drugs (7.7%) (Chart 91). Survey participants seem to have vacillated in responding to questions related to jail or prison time as respondent numbers change slightly from question to question related to jail or prison time, or both.

Chart 90: When you were released from jail/prison, which of the following did you receive?



Source: Statewide 2019 HIV Care Needs Survey

Chart 91: What prevented you from getting the HIV services you needed after you were released?



Source: Statewide 2019 HIV Care Needs Survey

Summary of Survey Results

The 2019 Miami-Dade County HIV care needs survey was taken by more than 700 respondents and most preferred to take it in English but with a sizable representation of Spanish-language takers. Most respondents were male, and most respondents' ages were in between 35 and 54 years of age. Most respondents were White/Caucasians and Black/African Americans, and there was a preponderance of respondents that identified as Hispanic as opposed to Haitians and others. Most survey participants were either employed full time, part time, or self-employed. Most participants had medical insurance through private exchanges or Medicare and Medicaid, while about one fifth of them did not have health insurance. Also, most participants earned between $15,000 per year and $30,000 per year.

Most survey participants went to see their doctors in the last 12 months and most of them were receiving medication two to three times a year. Respondents did not receive medical care in the previous 12 months or less than twice a year for a variety of reasons, with roughly half of the participants responding that they were not in medical care, were depressed, or missed their appointment. Most survey participants received their medical attention within Miami-Dade County and most of them indicated that they were taking their HIV medications and treatments as prescribed by their doctors. In contradiction to the previous findings, more than half of the respondents forgot to take their HIV medications. Most participants responded that they had received medical services in the last 12 months.

Survey participants ranked the five most essential services for the State to provide, which were for medication, case management, dental/oral health, outpatient medical care, and health insurance. Also, survey respondents' place of residence did not seem to be a robust determinant factor that prevents them from taking care of their HIV-related medical condition. More than half of survey respondents have access to housing services provided by the government, but some of them did not know about these services or did not qualify for these services. Most respondents were aware of PrEP but, surprisingly, most of them were not taking this medication (Truvada for PrEP) when they were diagnosed with HIV. Finally, very few of the survey respondents were in jail, prison, or both. While in jail, prison or both, staff were mostly informed of their HIV condition, and most respondents received HIV-related medical care and received referrals to case management, medical care, and HIV medication.

Local Needs Assessments Review

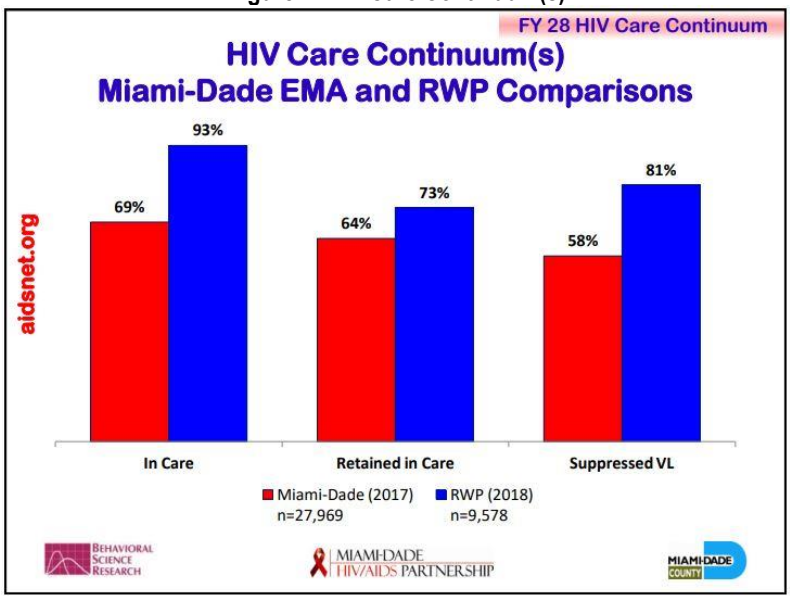
2019 Miami-Dade HIV/AIDS Partnership Needs Assessment

The 2019 Miami-Dade HIV/AIDS Partnership Needs Assessment (hereby referred to as PNA) was completed as part of a yearly, ongoing needs assessment process by the Care and Treatment Committee of the Partnership. Behavioral Science Research Corporation (BSR) prepared the needs assessment in partnership with FDOH-MD, Ryan White Part A, and other Committee members. The PNA is completed yearly to determine how funding will be allocated for Ryan White Part A services across Miami-Dade County. The findings below are summarized from the complete PNA, accompanied by charts that were also extracted from the PNA.

The HIV Care Continuum consists of the steps that a newly diagnosed person with HIV would take in order to eventually achieve viral suppression.[13] This standard process is in place across the United States in different Ryan White programs (RWP), and the same applies to the RWP in MDC. Comparing clients in the Miami-Dade RWP to the overall PLWH population in the Miami-Dade EMA, RWP clients perform better along the HIV Care Continuum (Figure 1). 93% of clients in the RWP are in care compared to 69% of the Miami-Dade PLWH population, and 81% of RWP clients have suppressed viral loads compared to 58% of the broader Miami-Dade PLWH population. Consistent viral suppression is the final goal of the HIV Care Continuum, and the increased rates of viral suppression in the RWP population suggest that RWP services are effective at keeping PLWH engaged in their care. Still, there does exist a large gap between clients who enter care (“In Care”) and those retained in care (“Retained in Care”). Note that “In Care” is defined as having one documented lab or medical visit in the fiscal year (FY), while “Retained in Care” is defined as having at least 2 or more of these labs or visits within the year (at least three months apart).

[13] https://hab.hrsa.gov/about-ryan-white-hivaids-program/hiv-care-continuum

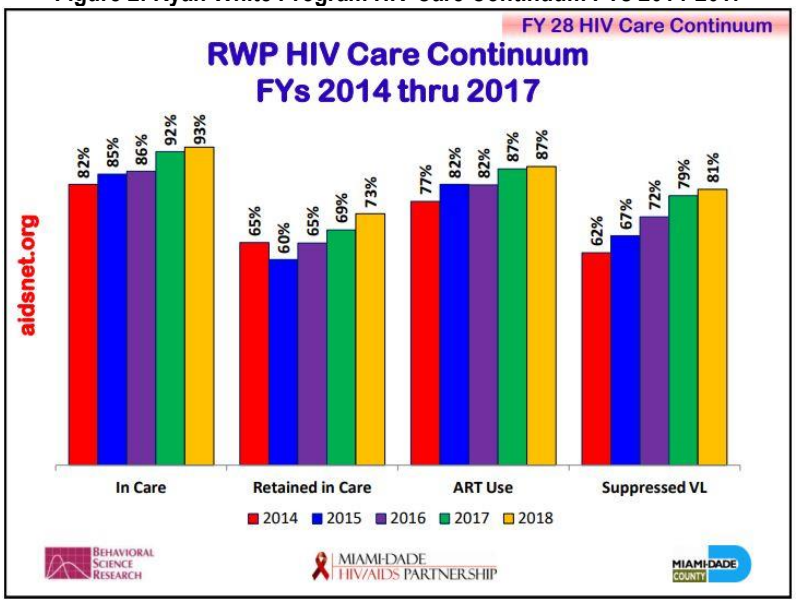
Figure 1: HIV Care Continuum(s)



Source: Behavioral Science Research Corporation
Extracted from http://aidsnet.org/wp-content/uploads/2019/08/FY28-Care-Continuum.pdf

The RWP clients have also seen progress in recent years across all steps of the HIV Care Continuum. From 2014 to 2018, much progress has been made especially as it relates to achieving suppressed viral loads (Figure 2). There have also been increases in ART use, retention in care, and in care.

Figure 2: Ryan White Program HIV Care Continuum FYs 2014-2017



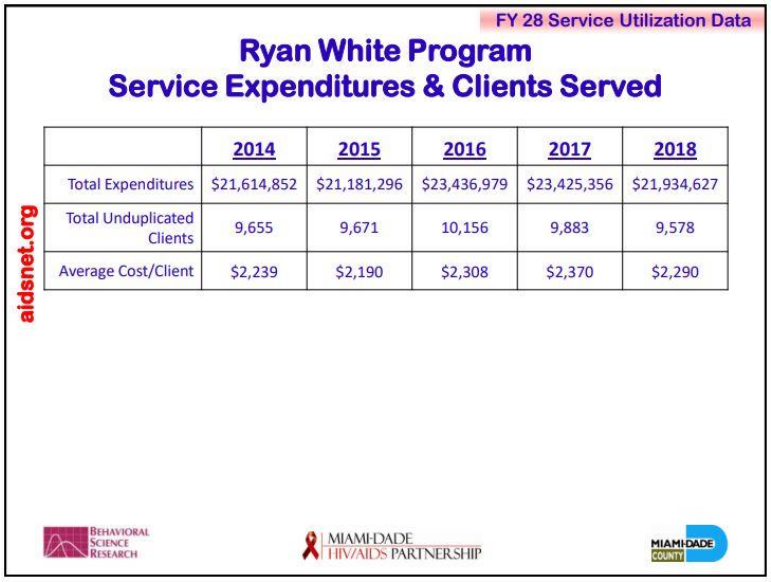
Source: Behavioral Science Research Corporation.
Extracted from http://aidsnet.org/wp-content/uploads/2019/08/FY28-Care-Continuum.pdf

Health disparities exist within the RWP client population. Black non-Hispanics are less retained in care, use ART less, and achieve viral suppression at lesser rates when compared to their other

racial counterparts. Female clients also use ART slightly less when compared to the male and transgender populations.[14]

Service expenditures and clients served have changed slightly over the period of 2014-2018, with 2018 levels decreasing from 2016-17 levels (Figure 3). In 2018, about $21.9 million was spent by the RWP for a total of 9,578 clients. These values closely resemble 2014 values, when the RWP spent $21.6 million on 9,655 clients.

Figure 3: Ryan White Program Service Expenditures and Clients Served



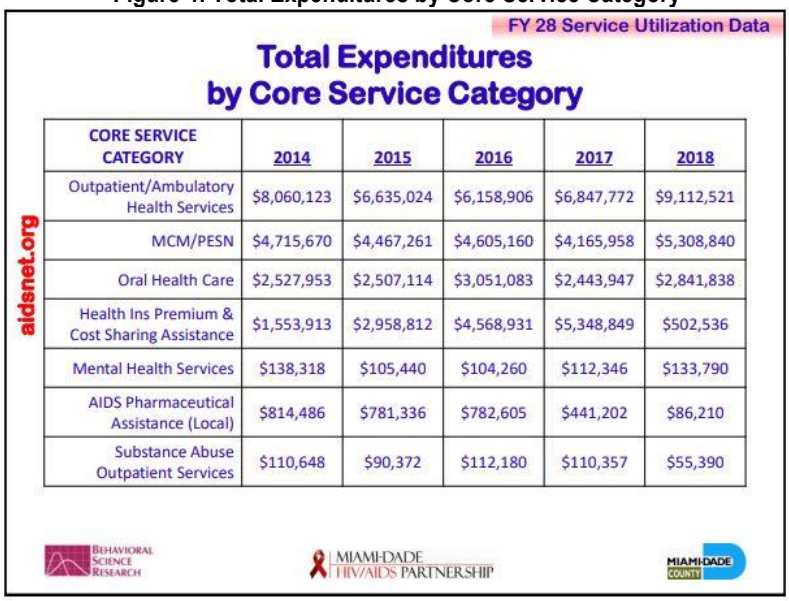
	2014	2015	2016	2017	2018
Total Expenditures	$21,614,852	$21,181,296	$23,436,979	$23,425,356	$21,934,627
Total Unduplicated Clients	9,655	9,671	10,156	9,883	9,578
Average Cost/Client	$2,239	$2,190	$2,308	$2,370	$2,290

Source: Behavioral Science Research Corporation.
Extracted from http://aidsnet.org/wp-content/uploads/2019/08/FY28_RW-NA_Service-Utilization.pdf

Figures 9 and 10 outline total expenditures by core and support service categories. Outpatient/ambulatory health services account for the highest proportion of spending in the core service category, with $9.1 million spent in 2018 (Figure 4). This represents an increase from spending in 2017 for this same category, which was $6.8 million. In the support service categories, substance abuse services (residential) and the food bank accounted for most of spending in these services (Figure 5).

[14] http://aidsnet.org/wp-content/uploads/2019/08/FY28-Care-Continuum.pdf

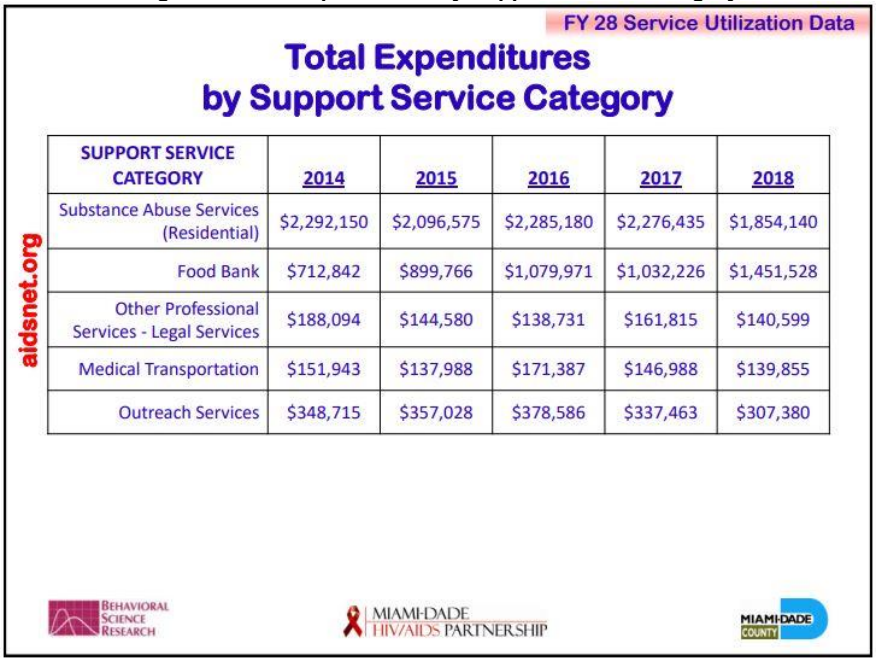
Figure 4: Total Expenditures by Core Service Category



CORE SERVICE CATEGORY	2014	2015	2016	2017	2018
Outpatient/Ambulatory Health Services	$8,060,123	$6,635,024	$6,158,906	$6,847,772	$9,112,521
MCM/PESN	$4,715,670	$4,467,261	$4,605,160	$4,165,958	$5,308,840
Oral Health Care	$2,527,953	$2,507,114	$3,051,083	$2,443,947	$2,841,838
Health Ins Premium & Cost Sharing Assistance	$1,553,913	$2,958,812	$4,568,931	$5,348,849	$502,536
Mental Health Services	$138,318	$105,440	$104,260	$112,346	$133,790
AIDS Pharmaceutical Assistance (Local)	$814,486	$781,336	$782,605	$441,202	$86,210
Substance Abuse Outpatient Services	$110,648	$90,372	$112,180	$110,357	$55,390

Source: Behavioral Science Research Corporation.
Extracted from http://aidsnet.org/wp-content/uploads/2019/08/FY28_RW-NA_Service-Utilization.pdf

Figure 5: Total Expenditures by Support Service Category

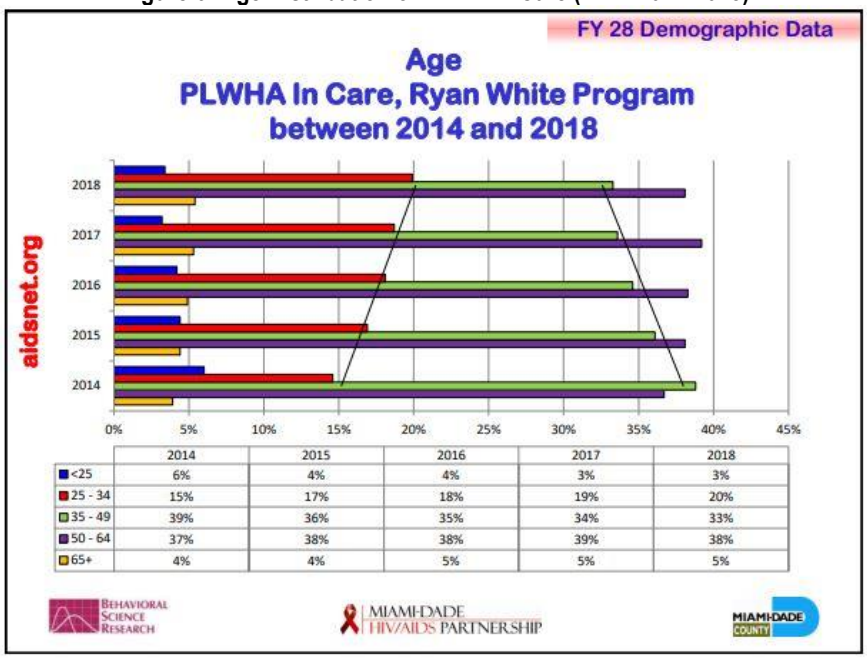


SUPPORT SERVICE CATEGORY	2014	2015	2016	2017	2018
Substance Abuse Services (Residential)	$2,292,150	$2,096,575	$2,285,180	$2,276,435	$1,854,140
Food Bank	$712,842	$899,766	$1,079,971	$1,032,226	$1,451,528
Other Professional Services - Legal Services	$188,094	$144,580	$138,731	$161,815	$140,599
Medical Transportation	$151,943	$137,988	$171,387	$146,988	$139,855
Outreach Services	$348,715	$357,028	$378,586	$337,463	$307,380

Source: Behavioral Science Research Corporation.
Extracted from http://aidsnet.org/wp-content/uploads/2019/08/FY28_RW-NA_Service-Utilization.pdf

It is also important to include the demographics of the RWP client population in this review. Figure 11 shows the age distribution of the RWP clientele, from 2014 to 2018. There has been a slight increase in the proportion of clients ages 25-34, along with a slight decrease in the 35-49 age group. The 50-64 age group accounts for the largest proportion of the RWP client population, with 38% belonging to this age group in 2018 (Figure 6).

Figure 6: Age Distribution of PLWH In Care (RWP 2014-2018)



	2014	2015	2016	2017	2018
<25	6%	4%	4%	3%	3%
25 - 34	15%	17%	18%	19%	20%
35 - 49	39%	36%	35%	34%	33%
50 - 64	37%	38%	38%	39%	38%
65+	4%	4%	5%	5%	5%

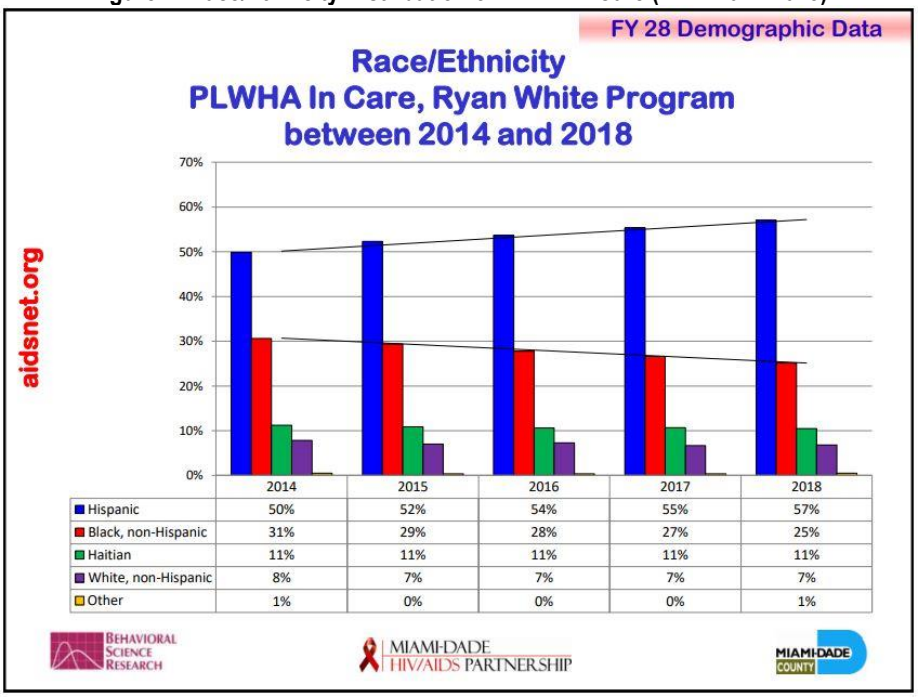
Source: Behavioral Science Research Corporation.
Extracted from http://aidsnet.org/wp-content/uploads/2019/08/FY28_RW-NA_Demographics.pdf

Gender has stayed virtually the same in the RWP clientele across the 2014-2018 period. In 2018, 77% of the RWP clientele were males, 23% females, and 1% identified as transgender[15].

The RWP client population is racially and ethnically diverse, as is the general Miami-Dade population. 57% of the RWP clientele is Hispanic, with 25% identifying as Black non-Hispanic and 11% as Haitian (Figure 7). White non-Hispanics make up 7% of the RWP clientele. There has also been a slight increase in the Hispanic RWP population from 2014-2018, associated with a slight decrease in the Black non-Hispanic population.

[15] http://aidsnet.org/wp-content/uploads/2019/08/FY28_RW-NA_Demographics.pdf

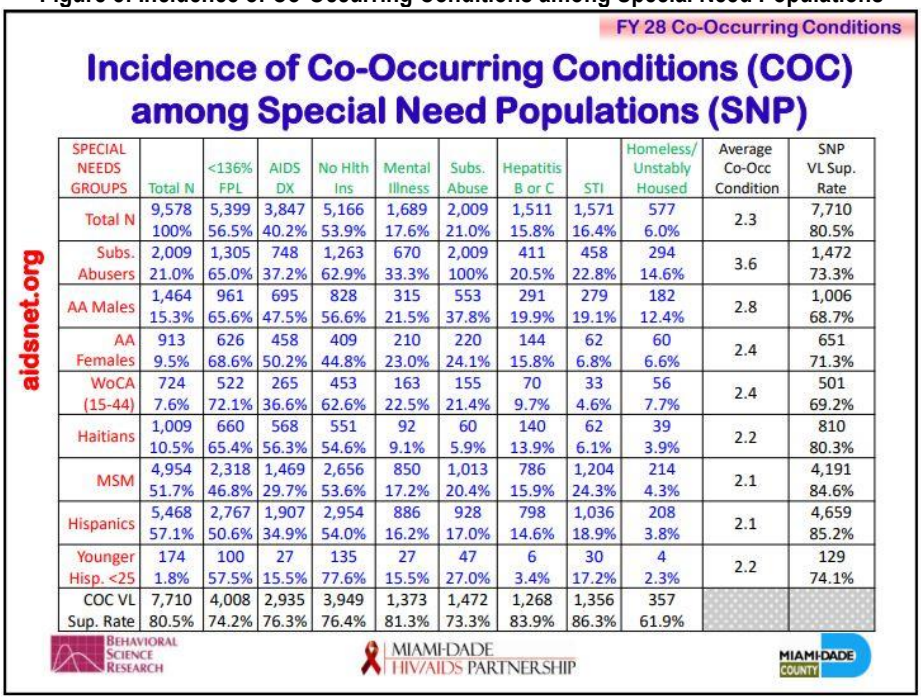
Figure 7: Race/Ethnicity Distribution of PLWH In Care (RWP 2014-2018)



Source: Behavioral Science Research Corporation.
Extracted from http://aidsnet.org/wp-content/uploads/2019/08/FY28_RW-NA_Demographics.pdf

There are also specific co-occurring conditions within the RWP client population that affect their overall well-being, as well as program expenditures and services. Specifically, those within special needs populations (SNPs) are affected greatly by the existence of these co-occurring conditions. The eight co-occurring conditions of interest to the Miami-Dade RWP include: poverty (<136% of FPL), current AIDS diagnosis, lack of health insurance, mental illness, substance abuse, Hepatitis B/C co-infection, other STI co-infection, and homelessness. These co-occurring conditions have various effects on viral suppression, depending on the specific condition in question (Figure 8).

Figure 8: Incidence of Co-Occurring Conditions among Special Need Populations



FY 28 Co-Occurring Conditions

Incidence of Co-Occurring Conditions (COC) among Special Need Populations (SNP)

aidsnet.org

SPECIAL NEEDS GROUPS	Total N	<136% FPL	AIDS DX	No Hlth Ins	Mental Illness	Subs. Abuse	Hepatitis B or C	STI	Homeless/ Unstably Housed	Average Co-Occ Condition	SNP VL Sup. Rate
Total N	9,578	5,399	3,847	5,166	1,689	2,009	1,511	1,571	577	2.3	7,710
	100%	56.5%	40.2%	53.9%	17.6%	21.0%	15.8%	16.4%	6.0%		80.5%
Subs. Abusers	2,009	1,305	748	1,263	670	2,009	411	458	294	3.6	1,472
	21.0%	65.0%	37.2%	62.9%	33.3%	100%	20.5%	22.8%	14.6%		73.3%
AA Males	1,464	961	695	828	315	553	291	279	182	2.8	1,006
	15.3%	65.6%	47.5%	56.6%	21.5%	37.8%	19.9%	19.1%	12.4%		68.7%
AA Females	913	626	458	409	210	220	144	62	60	2.4	651
	9.5%	68.6%	50.2%	44.8%	23.0%	24.1%	15.8%	6.8%	6.6%		71.3%
WoCA (15-44)	724	522	265	453	163	155	70	33	56	2.4	501
	7.6%	72.1%	36.6%	62.6%	22.5%	21.4%	9.7%	4.6%	7.7%		69.2%
Haitians	1,009	660	568	551	92	60	140	62	39	2.2	810
	10.5%	65.4%	56.3%	54.6%	9.1%	5.9%	13.9%	6.1%	3.9%		80.3%
MSM	4,954	2,318	1,469	2,656	850	1,013	786	1,204	214	2.1	4,191
	51.7%	46.8%	29.7%	53.6%	17.2%	20.4%	15.9%	24.3%	4.3%		84.6%
Hispanics	5,468	2,767	1,907	2,954	886	928	798	1,036	208	2.1	4,659
	57.1%	50.6%	34.9%	54.0%	16.2%	17.0%	14.6%	18.9%	3.8%		85.2%
Younger Hisp. <25	174	100	27	135	27	47	6	30	4	2.2	129
	1.8%	57.5%	15.5%	77.6%	15.5%	27.0%	3.4%	17.2%	2.3%		74.1%
COC VL Sup. Rate	7,710	4,008	2,935	3,949	1,373	1,472	1,268	1,356	357		
	80.5%	74.2%	76.3%	76.4%	81.3%	73.3%	83.9%	86.3%	61.9%		

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Source: Behavioral Science Research Corporation.
Extracted from http://aidsnet.org/wp-content/uploads/2019/08/FY28_NA_CoMorbidities.pdf

2017 City of Miami HOPWA Housing Gap Analysis

The City of Miami Housing Opportunities for Persons with AIDS (HOPWA) program offers housing and housing-related services to meet the housing needs of low-income PLWH in Miami-Dade County.[16] The HOPWA Housing Gap Analysis is conducted by the City of Miami HOPWA program to assess the gap between estimated need and available housing resources for this population. The Gap Analysis is attached in Appendix I.

The Housing Gap Analysis (HGA) estimates that there is a gap of 10,116 between existing housing resources and total number of PLWH in need of housing assistance (Appendix I). The HGA used a similar methodology utilized by the Chicago Eligible Metropolitan Area (EMA) and utilizes data from FDOH-MD and the RWP in Miami-Dade. The calculation made by the HGA is below on Figure 9.

[16] : https://www.miamigov.com/Government/Departments-Organizations/Housing-Community-Development/Housing-Opportunities-for-Persons-with-AIDS-HOPWA

Figure 9: PLWH in Need of Housing Assistance in Miami-Dade Metropolitan Division

Estimated Number of Individuals Living with HIV/ AIDS in Need of Housing Assistance within the Miami-Dade Metropolitan Division	
1. HIV-Positive Individuals Receiving Ryan White Services Living at or Below Poverty Level and in Need of Housing Assistance	4,422
2. Remaining Individuals Living with HIV/ AIDS in Need of Housing Assistance	+ 6,576
3. Total Number of Individuals Living with HIV/ AIDS in Need of Housing Assistance.	= 10,998
4. Existing Housing Resources— Units and Subsidies Dedicated to Individuals Living with HIV/ AIDS	– 882
TOTAL: Estimated Gap Between Existing Housing Resources and Total Number of Individuals Living with HIV/ AIDS in Need of Housing Assistance	= 10,116

Source: City of Miami HOPWA Program. 2017 Housing Gap Analysis. Appendix I.

The HGA calculation includes individuals who are utilizing RWP services and under the Federal Poverty Level (4,422), as well as a conservative estimate of 6,576 PLWH who need some form of housing assistance. The major gap comes from the limited resources available under the City of Miami HOPWA program. The program has 850 units for long-term tenant-based rental subsidies, as well as 32 project-based units with HOPWA support and/or subjected to rent regulatory agreements. There was a decrease of 150 long-term units from 2016 to 2017 (Appendix I), and an increase of 159 individuals in poverty from the RWP. The gap determined by the HGA increased from 2016 to 2017 by 361, also accounting for a slight increase in need from the PLWH population (52). Figure 10 outlines the number of individuals in the RWP living at or below FPL.

Figure 10: Ryan White Program Clients at or below Poverty in Miami-Dade County

NUMBER OF MIAMI-DADE COUNTY RYAN WHITE PROGRAM CLIENTS (HIV & AIDS) AT OR BELOW POVERTY BASED ON NUMBER OF PERSONS IN FAMILY UNIT REPORTING PERIOD 3/1/16-2/29/17			
Persons in Family Unit	**100% of Poverty**	**Clients Living at 100% Poverty Level**	
1	$11,880	3,722	84.2%
2	$16,020	362	8.3%
3	$20,160	160	3.6%
4	$24,300	104	2.4%
5	$28,440	51	1.2%
6	$32,580	13	0.3%
7	$36,730	3	0.1%
8+**	$40,890+	2	0.0%
GRAND TOTAL		**4,422***	

Source: City of Miami HOPWA Program. 2017 Housing Gap Analysis. Appendix I.

FDOH-MD EHE Survey

As part of EHE efforts, FDOH-MD is undertaking a comprehensive needs assessment and strategic planning project to determine the most effective and efficient mechanisms to bring the number of new HIV cases to zero. A key instrument in this effort is a consumer and stakeholder survey. The survey was a key effort for community engagement and feedback from the community at large on all EHE pillars.

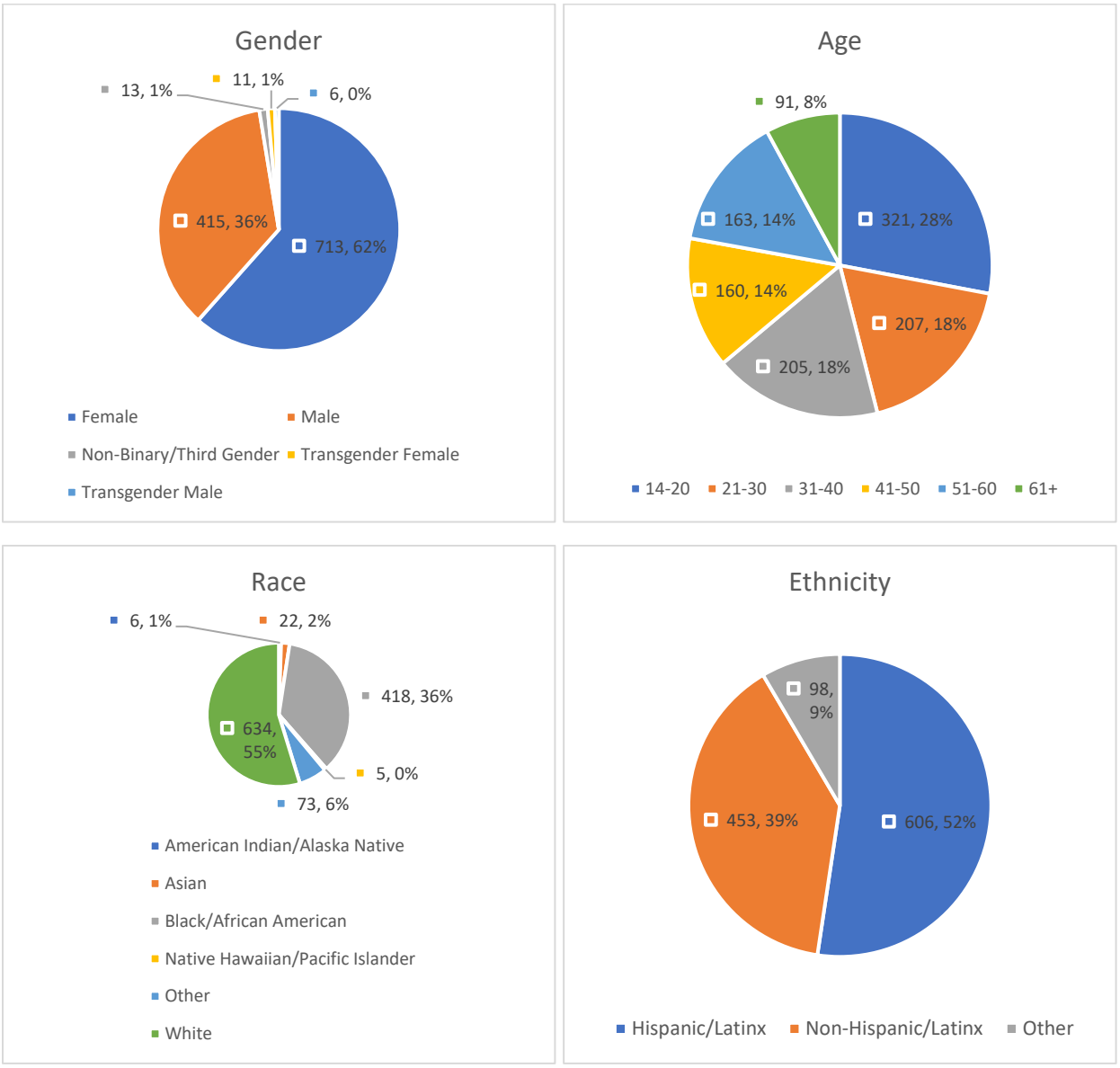
EHE community survey was launched in English, Spanish and Creole via SurveyMonkey. The survey was administered from October 22nd, 2019, to November 15th, 2019, with a total of 1,158 respondents. Respondents include people living with HIV/AIDS (PLWH), professionals working in HIV/AIDS prevention and care, research, advocacy, and members from the community at large. A total of 18 questions were asked that included community demographics, and recommendations for each of the pillars. Online and paper formats were made available for the community and the survey was disseminated via various online venues, including the FDOH TestMiami website, Consortium for a Healthier Miami-Dade website, Health Council of South Florida website, Miami-Dade HIV/AIDS Partnership website, and contracted providers made it available via their websites. A flyer with a QR code was created as well as survey images for social media platforms. Over 2,000 paper copies were printed and distributed. Additionally, it was shared via social media platforms through HIV service providers. FDOH purchased 3 iPads to assist in data collection. The FDOH prevention team collected surveys from FDOH clinics and conducted outreach days with the support of the Office of Community Advocacy. Days of Action were also conducted in partnership with community agencies in order to assure that the community provided feedback on the EHE plan.

The EHE Survey was promoted in over 40 outreach and testing events. It was also shared with FDOH staff via postings, FDOH intranet, and emails to encourage participation and distribution. The survey was also shared with condom providers (BRTA sites) and community mobilization listservs. Additionally, it was included in the Miami-Dade County Employee Newsletter on October 28th, 2019, that reached over 26,000 employees. The EHE survey image created was also placed on the digital screens in the main train station of Miami-Dade. The survey utilized validated clustering mechanisms from county-wide surveys administered by the FDOH in 2013 and 2018. Overall and by cluster sample size calculations were completed with a 95% confidence level and 5% confidence intervals.

Demographic Profile

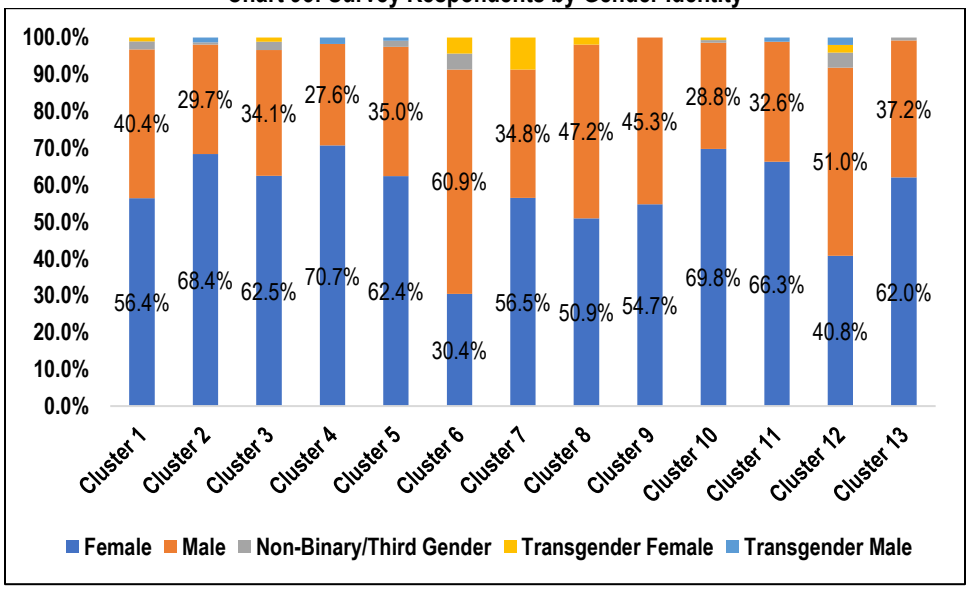
Chart 92 provides a demographic snapshot of all the survey respondents by gender, age, race, and ethnicity. Total counts for each group as well as percentages are included. A large majority of the respondents were female (62%) and over half of the respondents identified as Latinx. Different age groups are represented in this sample, with similar percentages across multiple age ranges. There was also considerable representation from the Black/African-American community in this sample (36%).

Chart 92: Snapshot of EHE Survey Respondents



Survey respondents were categorized into thirteen (13) clusters representing neighborhoods in Miami-Dade. Of those who answered, the majority identify as female across each cluster, except for Clusters 6 and 12. Cluster 4 had the highest percentage of females respond (70.7%) while Cluster 6 had the smallest (30.4%) and conversely the highest of male (60.9%). Additionally, Cluster 6 had the highest percentage of non-binary/third gender respondents (4.3%), Cluster 7 had the highest percentage of transgender female respondents (8.7%), and Cluster 12 the highest percentage of transgender male respondents (2.0%) (Chart 93).

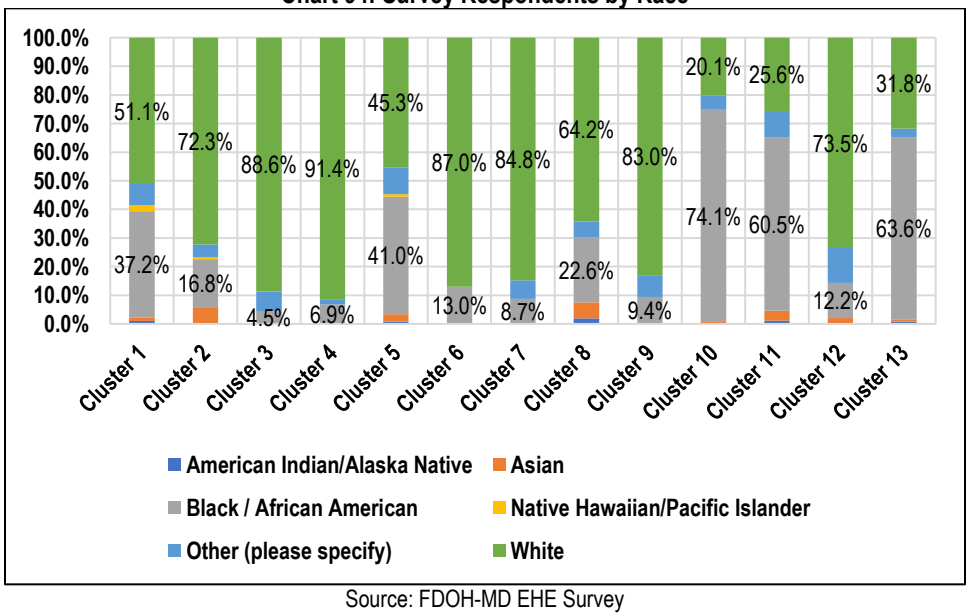
Chart 93: Survey Respondents by Gender Identity



Source: FDOH-MD EHE Survey

Most respondents were White with the largest percentage arising from Cluster 3 (88.6%) and Cluster 6 (87.0%). Cluster 10 has the largest percentage of respondents who identify as Black/African-American (74.1%) followed by Cluster 13 (63.6%) and Cluster 11 (60.5%). Cluster 2 and Cluster 8 also had measurable percentages of Asian respondents (5.8% and 5.7%, respectively) (Chart 94).

Chart 94: Survey Respondents by Race

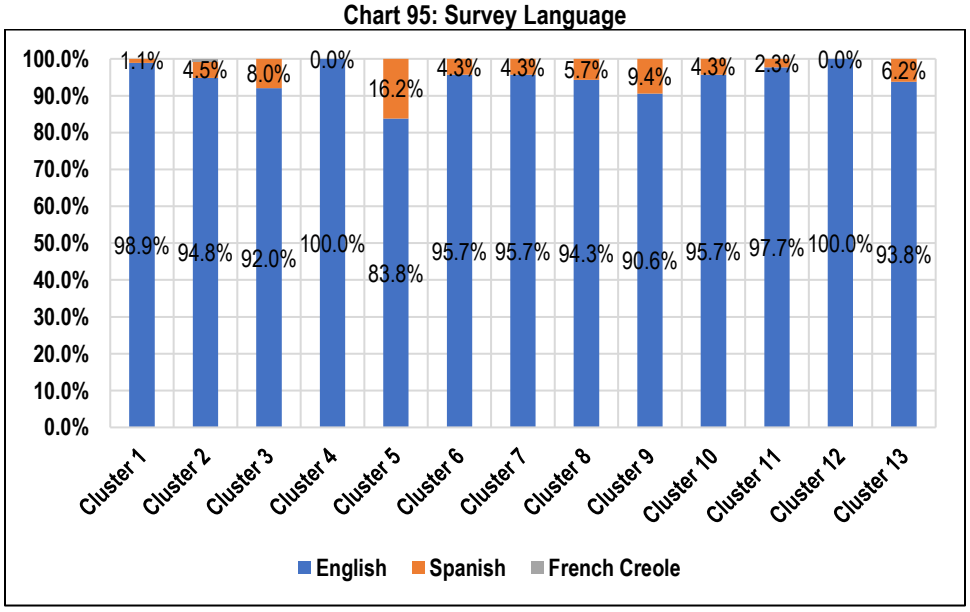


Source: FDOH-MD EHE Survey

English was the predominant language for survey completion accounting for over 90% in each cluster except Cluster 5 (83.8%). Cluster 5 also had the largest percentage of surveys completed

in Spanish (16.2%). Cluster 2 was the only cluster with a survey completed in French Creole (0.6%) (Chart 95).

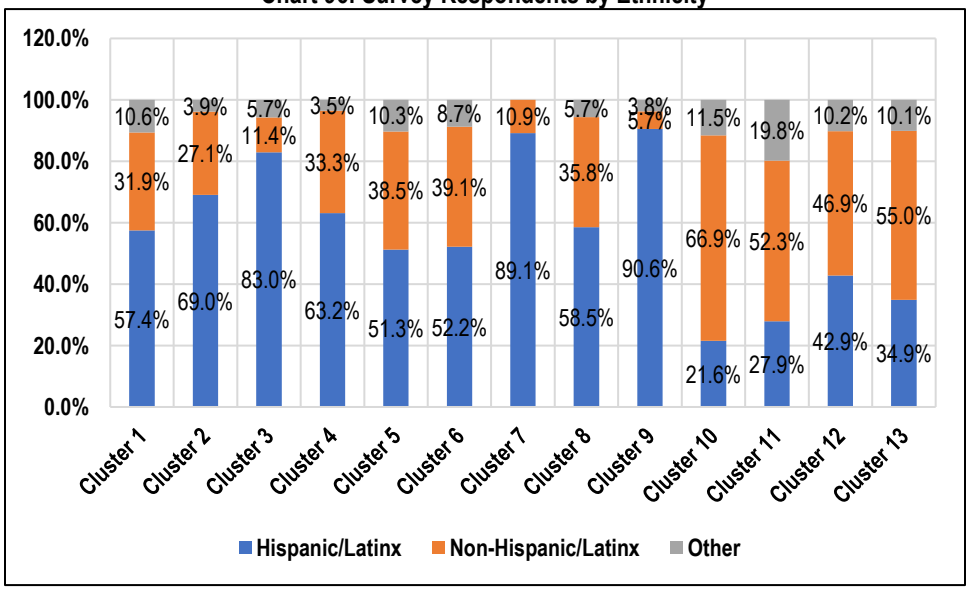
Chart 95: Survey Language



Source: FDOH-MD EHE Survey

Finally, like Miami-Dade County, most respondents consider themselves Hispanic/Latinx with the largest percentage represented in Cluster 9 (90.6% and the smallest in Cluster 10 (21.6%). Additionally, many clusters had between 5%-10% who identified as “Other” or other than Hispanic/Non-Hispanic. Cluster 11 had the largest percentage at 19.8% while Cluster 7 had no “Other” respondents. Other primarily represented persons from Haiti or another Caribbean Island (Chart 96).

Chart 96: Survey Respondents by Ethnicity



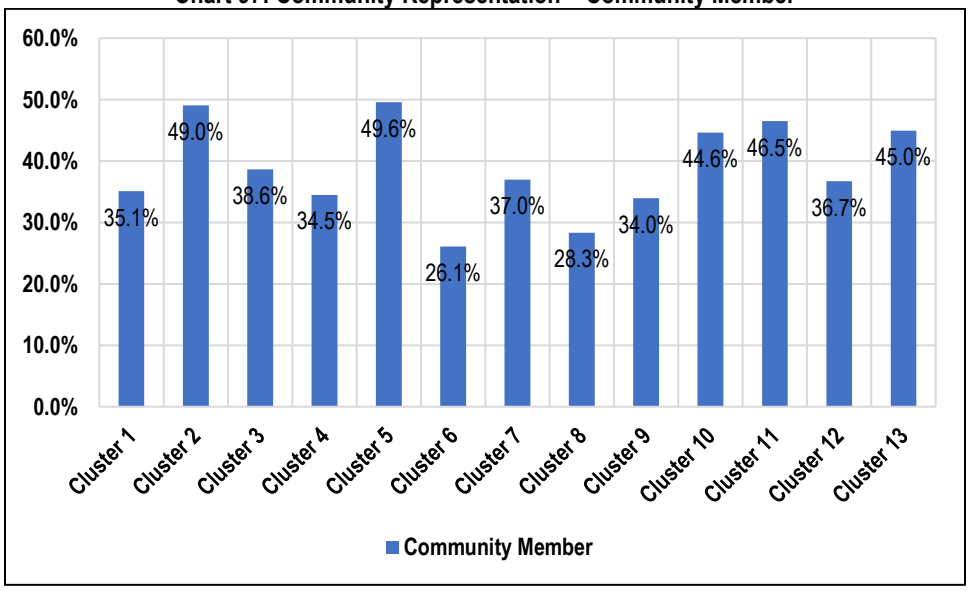
Source: FDOH-MD EHE Survey

Community Representation

Respondents were asked what community they represented but answer choices were not mutually exclusive. For example, a respondent could be both a Person Living with HIV/AIDS and a member of the Local Miami-Dade HIV/AIDS Planning Council.

For those who answered they are a Community Member, representation was distributed from 26.1% in Cluster 6 to 49.6% in Cluster 5. Most clusters had approximately 35-40% of respondents who identify as a Community Member (Chart 97).

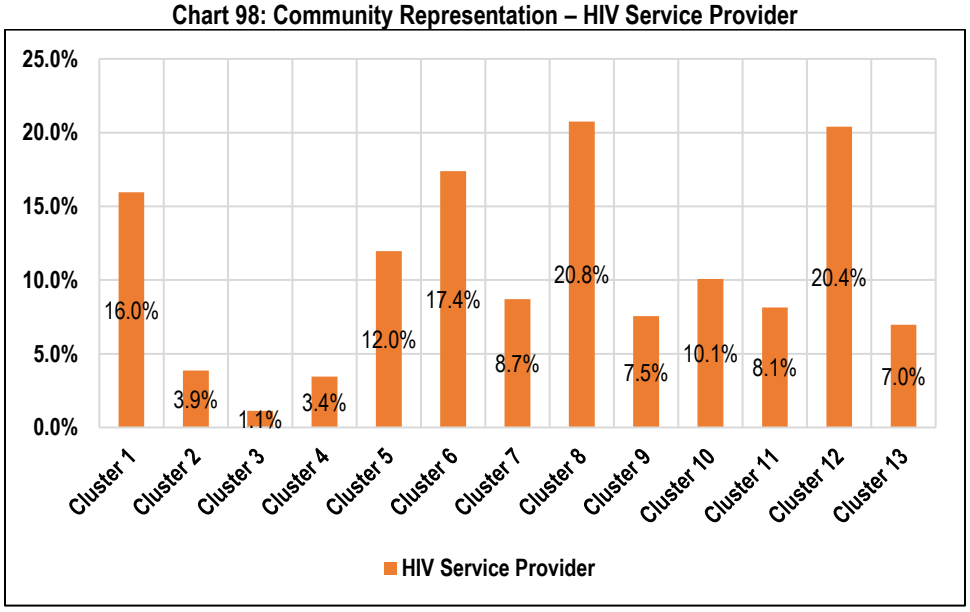
Chart 97: Community Representation – Community Member



Source: FDOH-MD EHE Survey

There was quite an expanse of respondents who answered that they are an HIV Service Provider. Only 1.1% of respondents from Cluster 3 said they are an HIV Service Provider, while 20.8% of Cluster 8 said they are an HIV Service Provider (Chart 98).

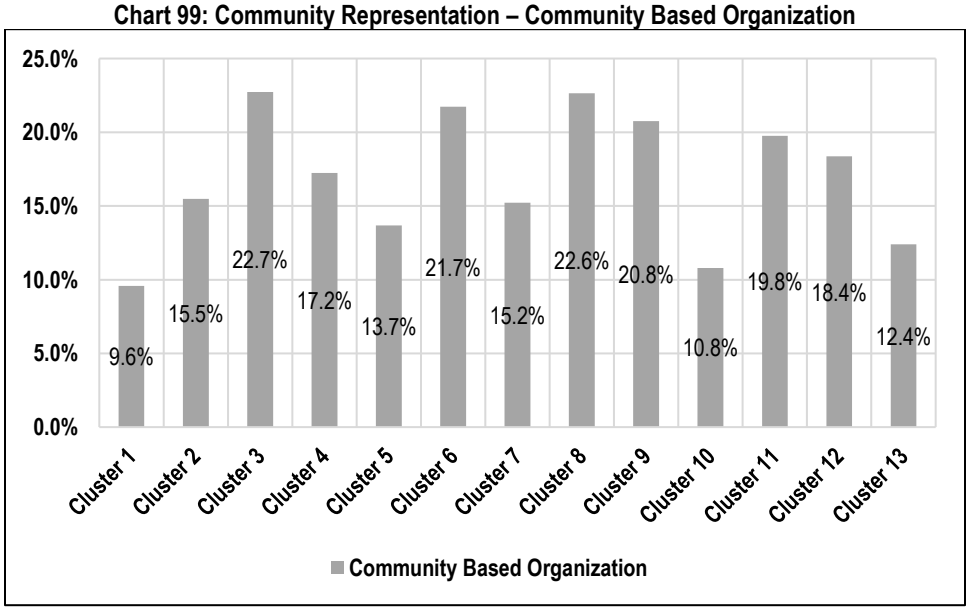
Chart 98: Community Representation – HIV Service Provider



Source: FDOH-MD EHE Survey

There were between 9.6% and 22.7% of respondents who answered they represent a Community Based Organization. The smallest percentage was seen in Cluster 1 (9.6%) while the largest percentage was seen in Cluster 6 (21.7%) and Cluster 8 (22.6%) (Chart 99).

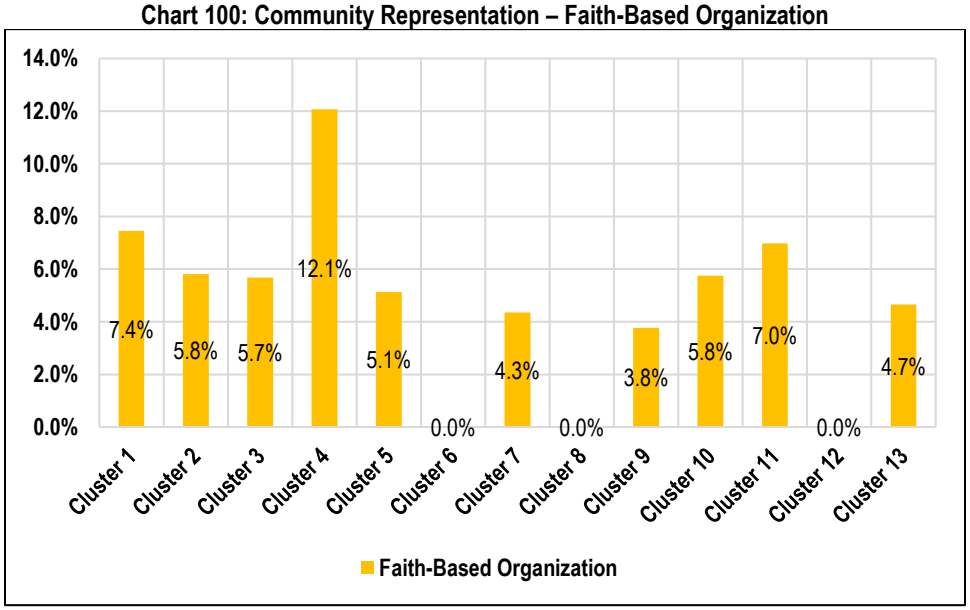
Chart 99: Community Representation – Community Based Organization



Source: FDOH-MD EHE Survey

There were much smaller percentages of respondents who answered that they represent a faith-based organization. Clusters 6, 8, and 12 all had 0.0% of respondents say that they represent a faith-based organization, while Cluster 4 had 12.1% (Chart 100).

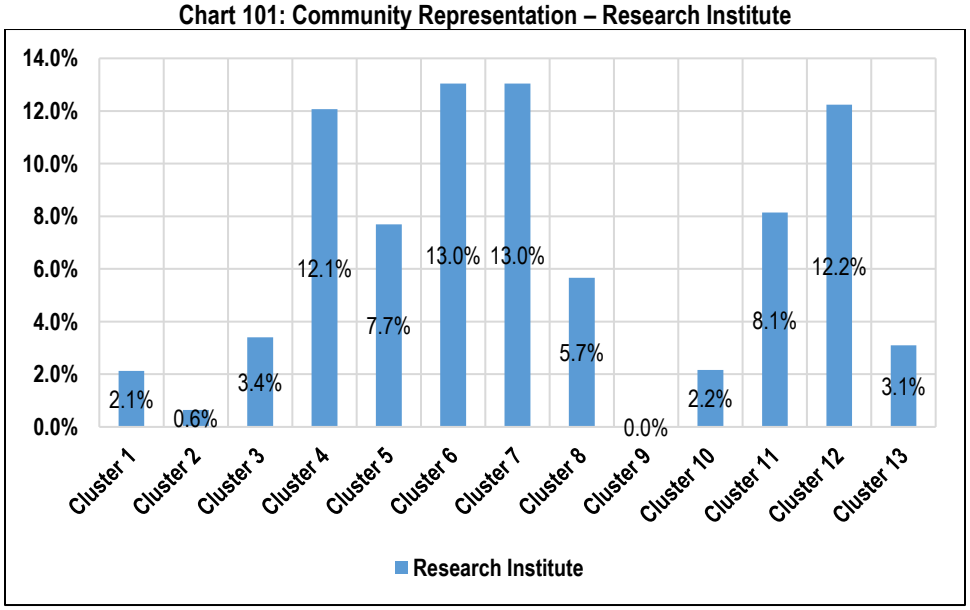
Chart 100: Community Representation – Faith-Based Organization



Source: FDOH-MD EHE Survey

There were also, generally, small percentages that represent Research Institutes. Cluster 9 had 0.0% and Cluster 2 had only 0.6% of respondents identify as working for a Research Institute. However, Cluster 4 (12.1%), Cluster 12 (12.2%), Cluster 6 (13.0%), and Cluster 7 (13.0%) had much higher percentages (Chart 101).

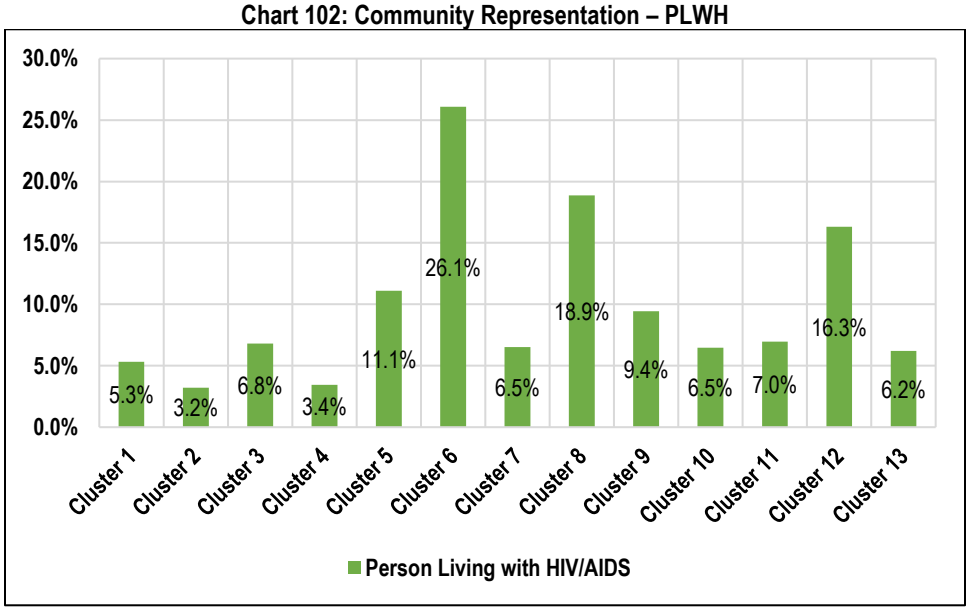
Chart 101: Community Representation – Research Institute



Source: FDOH-MD EHE Survey

Interestingly, most clusters had between 3%-7% who said they are a Person Living with HIV/AIDS (PLWH). However, Cluster 6 had 26.1%, Cluster 8 had 18.9%, and Cluster 12 had 16.3% (Chart 102).

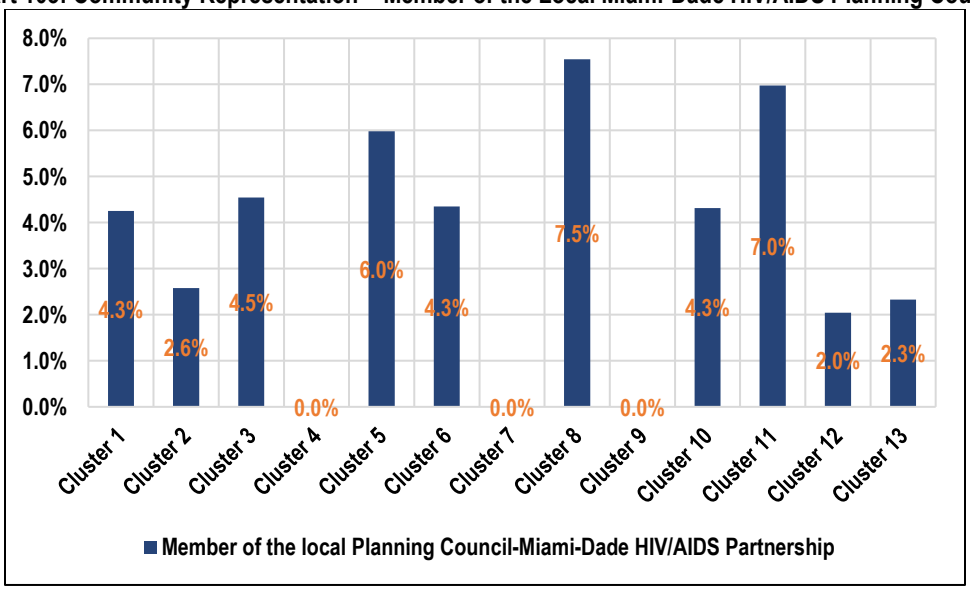
Chart 102: Community Representation – PLWH



Source: FDOH-MD EHE Survey

There were small percentages who responded that they are a Member of the Local Miami-Dade HIV/AIDS Planning Council (Partnership). Cluster 4, Cluster 7, and Cluster 9 all had 0.0% while Cluster had 7.0% and Cluster 8 had 7.5%) (Chart 103).

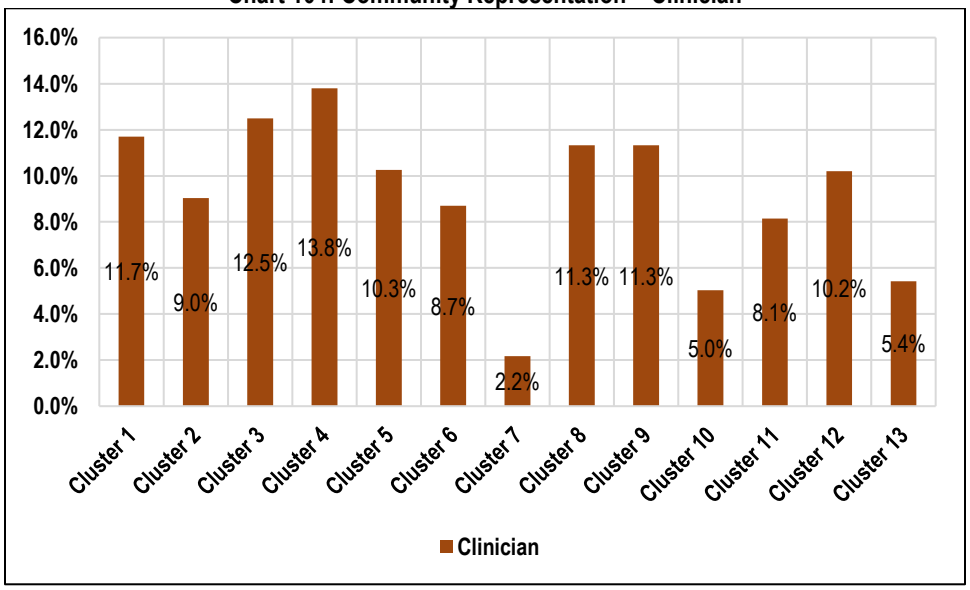
Chart 103: Community Representation – Member of the Local Miami-Dade HIV/AIDS Planning Council



Source: FDOH-MD EHE Survey

There were moderate percentages of respondents who said they are a Clinician. Roughly 10%-11% of respondents in all Clusters answered they are a Clinician with the highest rate in Cluster 4 (13.8%) and the lowest in Cluster 7 (2.2%) (Chart 104).

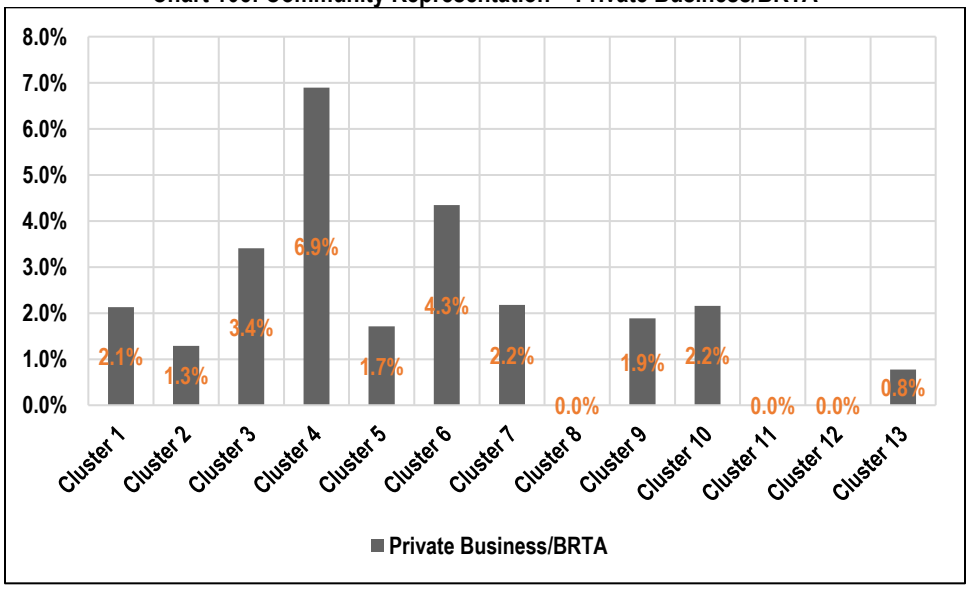
Chart 104: Community Representation – Clinician



Source: FDOH-MD EHE Survey

There were also small percentages that claimed they represent a Private Business or are a Business Responds to AIDS (BRTA) organization. There were no respondents in Cluster 8, Cluster 11, and Cluster 12 who are Private Business or BRTA representatives, while there were 6.9% in Cluster 4 (Chart 105).

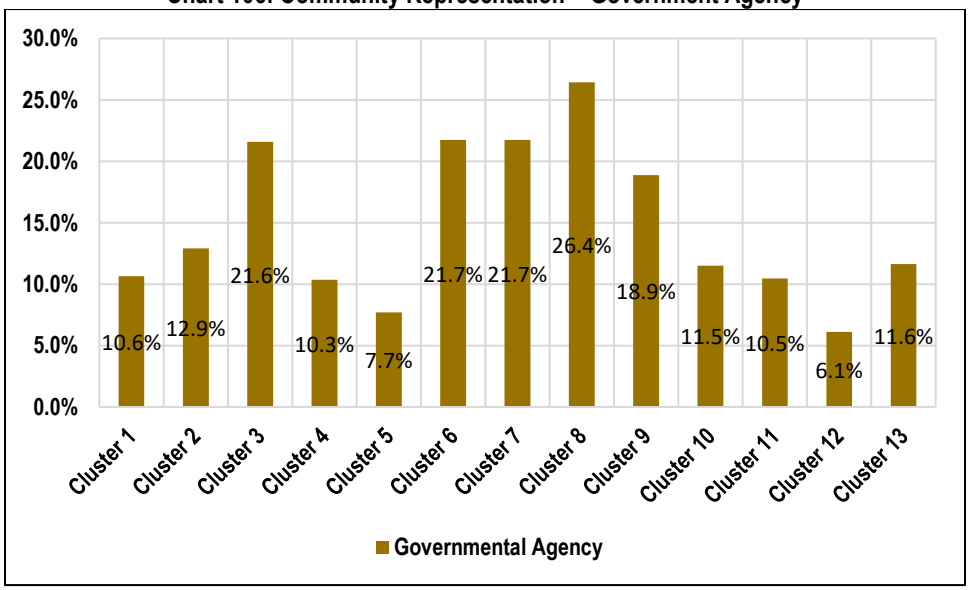
Chart 105: Community Representation – Private Business/BRTA



Source: FDOH-MD EHE Survey

Lastly, there were sizable percentages that answered that they represent a Governmental Agency, but with ample variance between clusters. Clusters 3, 6, 7, and 8 all had greater than 20% of respondents answer they represent a Governmental Agency, while less than 10% of Clusters 5 and 12 answered so (Chart 106).

Chart 106: Community Representation – Government Agency



Source: FDOH-MD EHE Survey

Results

Pillar 1: Diagnose

The respondents were asked about how HIV testing services and outreach could be improved in Miami-Dade County. The word-cloud below (Figure 11) illustrates the most common words and phrases used in the answers.

"Testing has to be part of the annual medical evaluation."

"Place ads on social media as part of outreach."

"Make people more aware of the benefits of knowing your status."

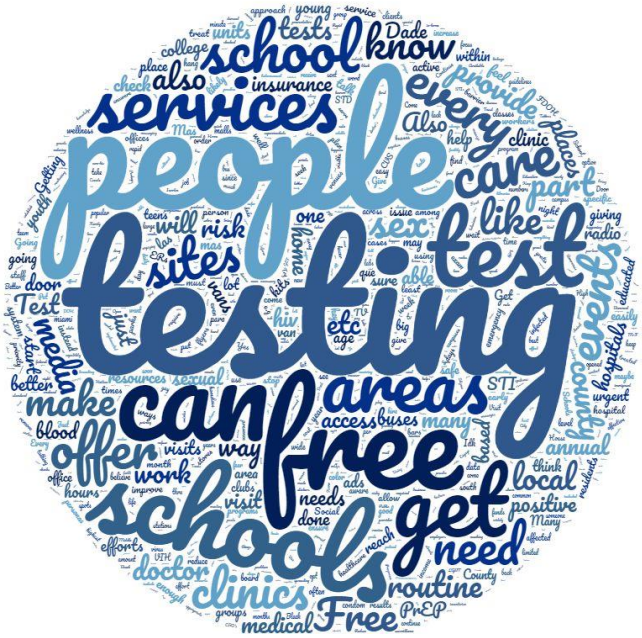
"Allow easy access to people who do not have medical insurance."

"Testing should be available in schools."

A large portion of the respondents mentioned the expansion of testing would be quite helpful, mainly free testing, which is already available through most testing sites. Additionally, testing at

schools, education about risk factors, expanded access to hard-to-reach areas such as South Miami-Dade, and respondents also proposed greater use of mobile units/buses.

Figure 11: How can HIV testing services and outreach be improved in Miami-Dade County so that everyone can know their HIV status?



Pillar 2: Treat

Respondents were also asked how can PLWH get timely, accessible HIV treatment and continued care. Many responded that it is important to have general access and availability. This is particularly important in dually burdened communities with high incidence of HIV/AIDS and low access to care. Additionally, many mentioned the need for more physicians who offer or are knowledgeable about HIV and treatment, general awareness, and more access to testing.

"I would say that expedited processes and catering to individual clients needs would help immensely."

"Provide transportation to those in need."

"Educate medical personnel."

"Allocate more funding to organizations that provide care to HIV newly diagnosed clients."

Figure 12: How can people living with HIV/AIDS get timely, accessible HIV treatment, and continued care in order to improve their health?

Pillar 3: Prevent

When asked how Miami-Dade can improve PrEP awareness, access, and use, many responded that education about PrEP is vital. Furthermore, awareness at schools, utilizing the media to raise awareness, and social media were all identified as important. A common theme was ensuring that PrEP is or remains affordable and that there is access at clinics across the county. Finally, some respondents indicated that utilizing vans to both advertise and to provide PrEP access could be useful in improving PrEP utilization. Respondents also discussed the need to address stigma and educate populations on overall HIV issues.

"Provide materials to the community that are easy to understand."

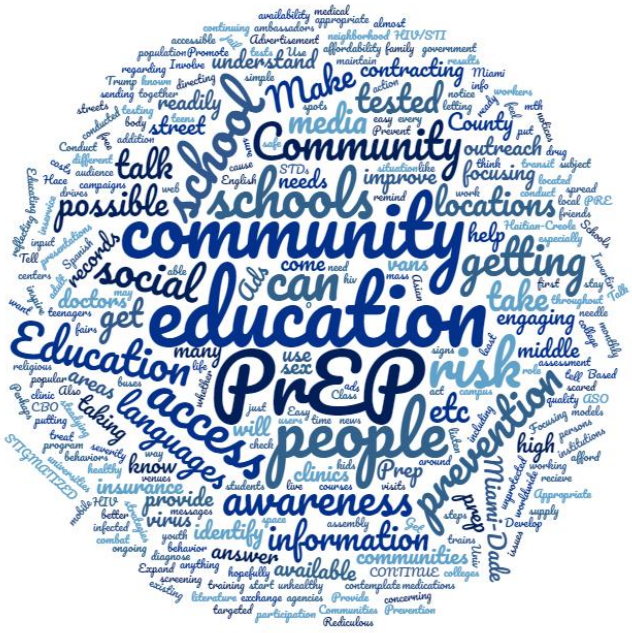
"Advertise at public places."

"Reach out to underserved populations with people that look like them."

"Tackle the stigma and provide culture-appropriate information."

"Talking helps reduce the stigma and normalize that it is a health condition like chronic conditions are."

Figure 13: Questions on PrEP and prevention efforts



Pillar 4: Respond

An important aspect of the response to HIV/AIDS in Miami-Dade County is the collaboration between health departments, community partners and others to respond to HIV outbreaks. Many mentioned the importance of a community response, providing affordable/free testing and treatment, and educating the community about risks. Emphasis was also given to the importance of knowledgeable professionals to be "on the ground" to explain the risks, prevention mechanisms, and testing to community members. There was also significant stress given to the immediacy needed in the case of an outbreak and that collaboration between partners could provide a more coordinated and improved response.

"Do more community outreach and events through community mobilization groups."

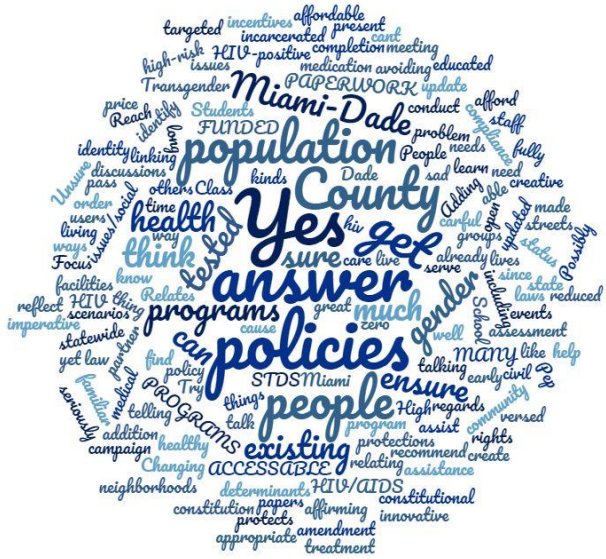
"Make a plan in advance with designated roles for each organization and ensure funding meets the requirements."

"Talk to people and let them know what's going on."

Figure 14: How can health departments, community partners, and members collaborate in response to an HIV outbreak?

Lastly, respondents were asked if they gave any recommendations that would require a change to an existing policy/program or the creation of a new policy or program. A significant portion responded yes, with further details given. Many mentioned the continued importance of ensuring there is minimal risk of incarceration for PLWH, along with recognizing gender identity as a civil right and requiring medical facilities to recognize and treat transgender persons appropriately. Additionally, several respondents mentioned the continued need for affordable treatment and prevention mechanisms, meeting at-risk populations where they are (in their neighborhood, school, etc.), and a better understanding of the social determinants affecting the HIV/AIDS population.

Figure 15: Do any of your recommendations above require a change to an existing policy or program or the creation of a new policy or program?



Social Determinants of Health

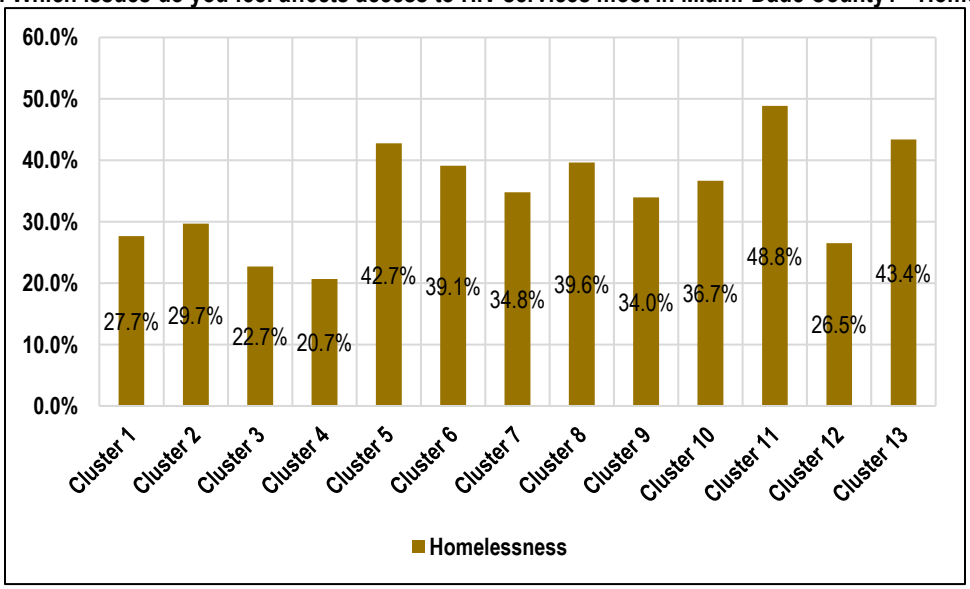
To gain an understanding of the social determinants that most affect access to HIV-related services in Miami-Dade County, respondents were asked to choose their top five issues. The top issue was Homelessness with 404 total respondents. This was followed by Mental Health (370), Substance Use (363), Immigration Status (318), and the Uninsured/Underinsured Population (317) (Table 34). These factors have been linked to increasing HIV incidence when they are not properly addressed in the impacted communities. The following charts are ordered according to the choices most prevalent within the respondent group.

Table 34: Top 5 Issues that Most Affect Access to HIV Services

Rank	Issue	Count
1	Homelessness	404
2	Mental Health	370
3	Substance Use	363
4	Immigration Status	318
5	Uninsured/Under insured	317
6	Discrimination	284
7	Transportation	232
8	Underemployment/Unemployment	215
9	Domestic Violence/Inter-Partner Violence/Sexual Assault	212
10	Human Trafficking	207
11	Affordable Housing	206
12	Living Wage	169
13	Incarceration	122

Homelessness is the top issue for respondents overall. Cluster 4 had the smallest percentage of respondents indicate it is a top-5 issue at 20.7% while Cluster 11 had the largest 48.8%. Most clusters had between 25-35% indicate it as a top-5 issue (Chart 107).

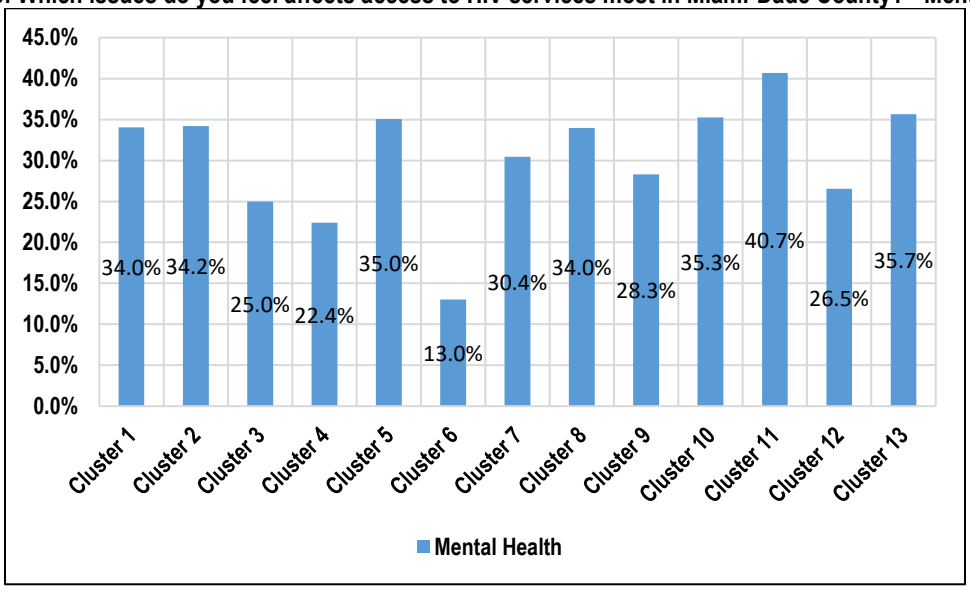
Chart 107: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Homelessness



Source: FDOH-MD EHE Survey

Mental Health had roughly 30% support across clusters. Cluster 11 responded with 40.7% indicating mental health as a top-5 issue for them, while Cluster 6 only had 13.0%. All other clusters had between 22.0% and 36% respond that mental health is a top-5 issue (Chart 108).

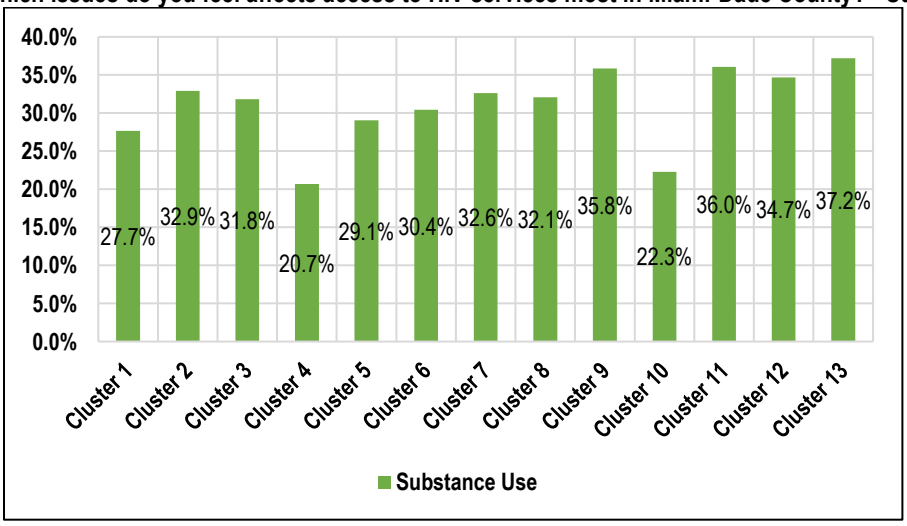
Chart 108: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Mental Health



Source: FDOH-MD EHE Survey

Substance use is a growing concern nationwide in HIV/AIDS prevention and treatment. Particularly with the opioid epidemic plaguing much of the United States and HIV outbreaks because of needle sharing everywhere from Indiana to Miami-Dade, substance use is no doubt a key driver of the current HIV epidemic. It should be no surprise that Substance Use is a top-5 issue overall and that it garnered strong support as a key issue across clusters. Every cluster indicated that at least 20% believe that substance use is a top-5 issue with Cluster 13 indicating up to 37.2% (Chart 109).

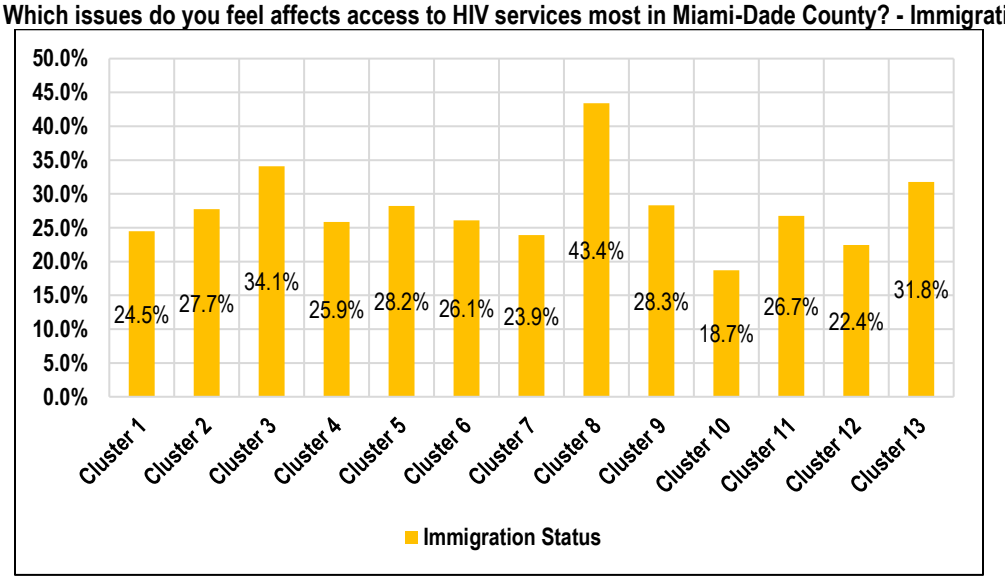
Chart 109: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Substance Use



Source: FDOH-MD EHE Survey

Immigration Status, a pressing issue in Miami-Dade County as a minority-majority county, garnered 20%-30% support as a top-5 issue across clusters. However, Cluster 8 responded with 43.4% as a top-5 issue, compared to a low 18.7% in Cluster 10.

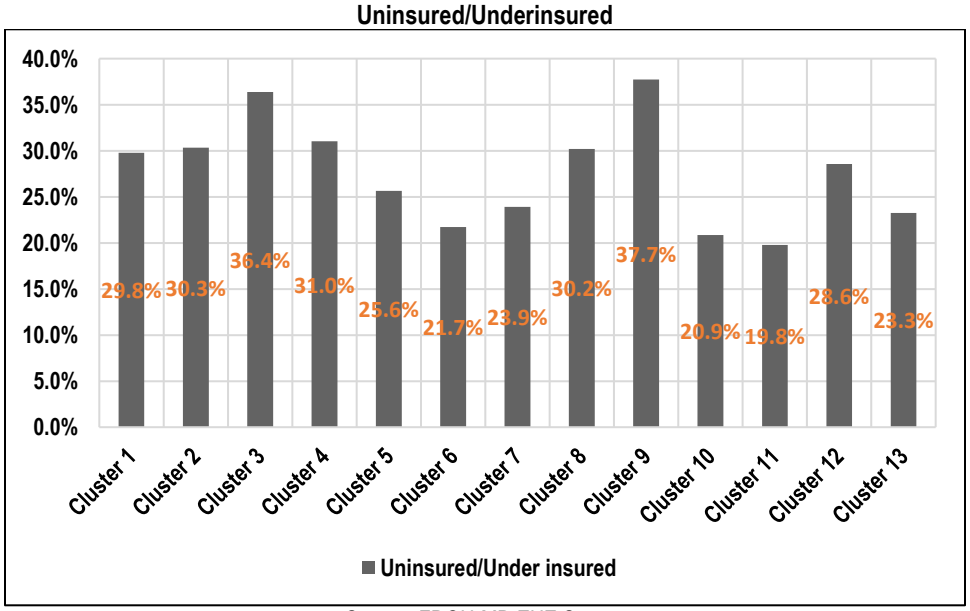
Chart 110: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Immigration Status



Source: FDOH-MD EHE Survey

The Uninsured/Underinsured population remains a chief concern in HIV/AIDS prevention and treatment as well. Considered a top-5 issue overall, uninsured/underinsured persons have roughly 20% to 38% of respondents across clusters with Cluster 11 having the smallest percentage (19.8%) and Cluster 9 having the largest (37.7%) (Chart 111).

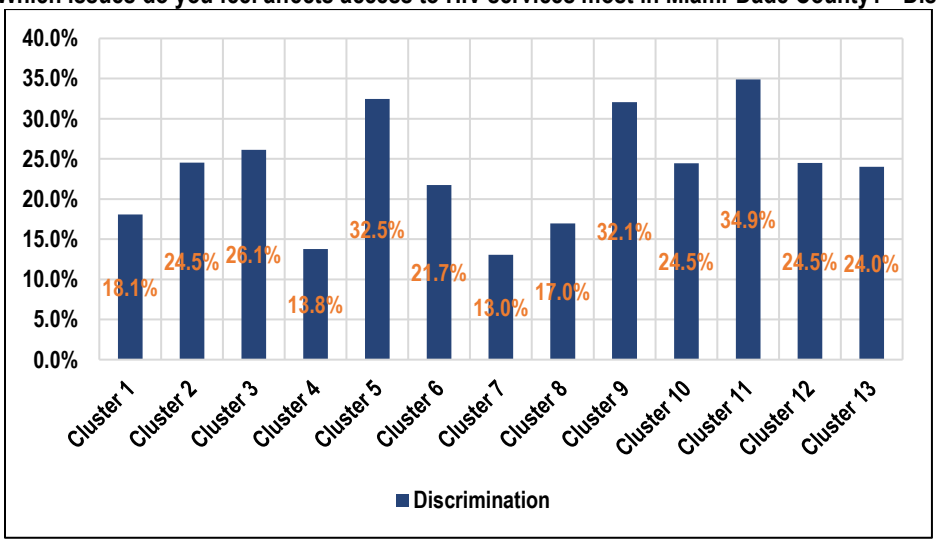
Chart 111: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Uninsured/Underinsured



Source: FDOH-MD EHE Survey

While stigma remains an issue for PLWH, discrimination did not register as a top-5 issue overall. However, in certain clusters, a large portion responded that discrimination is a top-5 issue for their area. Clusters 5, 9, and 11 garnered over 30% support as a top-5 issue (32.5%, 32.1%, and 34.9%, respectively) while Cluster 4 and Cluster 7 only have 13.8% and 13.0% (Chart 112).

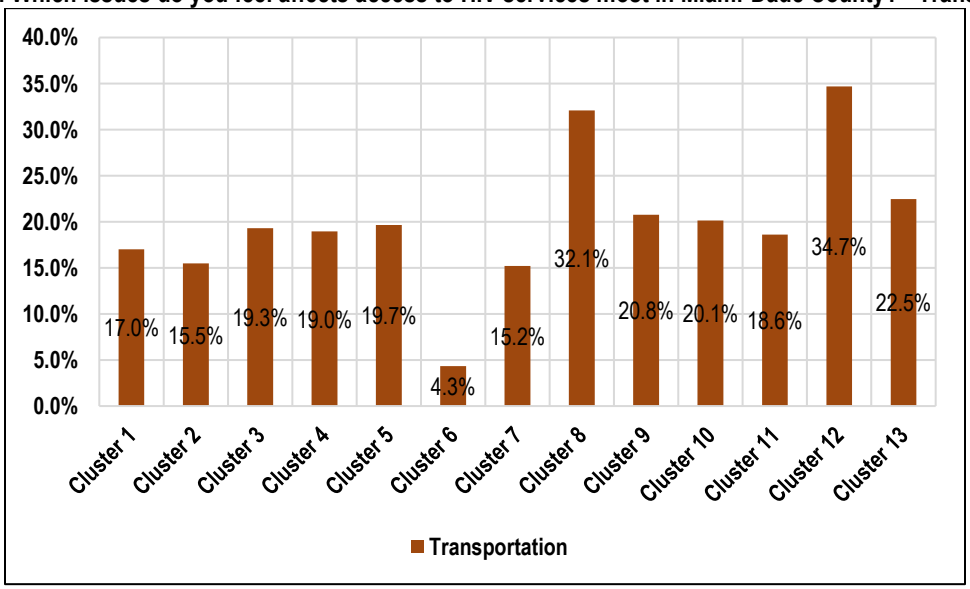
Chart 112: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Discrimination



Source: FDOH-MD EHE Survey

Transportation had consistent support of around 15%-20% across clusters. However, Cluster 6 had only 4.3% indicate transportation is a top-5 issue for them, and Cluster 8 indicated that 32.1% believe it is a top-5 issue.

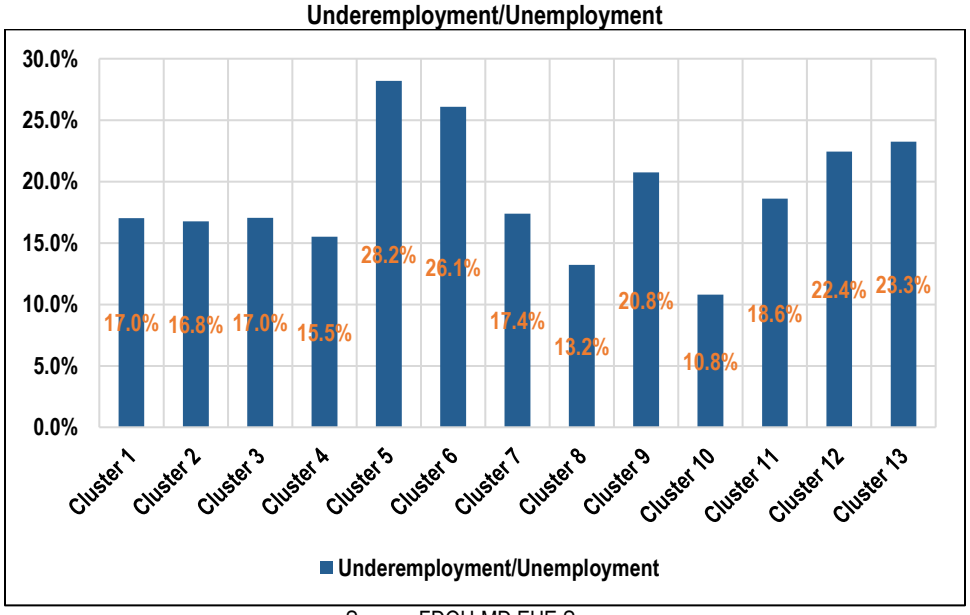
Chart 113: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Transportation



Source: FDOH-MD EHE Survey

Unemployment/underemployment is not a top-5 issue overall but did moderate significant support across clusters. In a time where unemployment in Miami-Dade County is only 4.1%, it could be that unemployment/underemployment is not front of mind when considering issues facing access to HIV services. Most clusters recorded less than 20% of the respondent believe unemployment/underemployment is a top-5 issue. Cluster 5 and Cluster 6, however, recorded 28.2% and 26.1% that believe it is a top-5 issue (Chart 114).

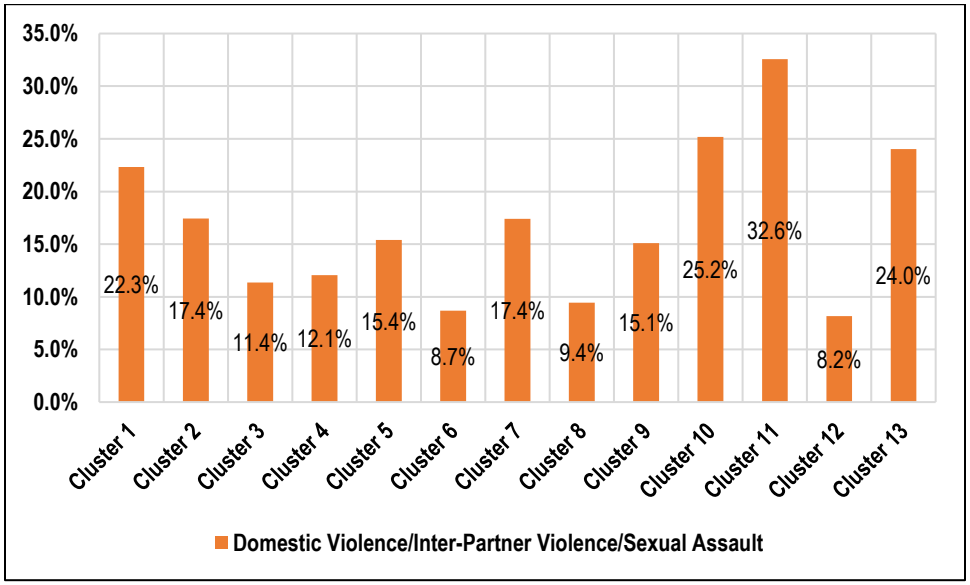
Chart 114: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Underemployment/Unemployment



Source: FDOH-MD EHE Survey

Roughly 10-20% of most clusters consider domestic violence/inter-partner violence/sexual assault to be a top-5 issue. There are dramatic differences between clusters, however; Cluster 11 had 32.6% of their respondents indicate domestic violence/ inter-partner violence/sexual assault are a top-5 issue, while Cluster 6 and Cluster 12 had significantly lower percentages (8.7% and 8.2%, respectively) (Chart 115).

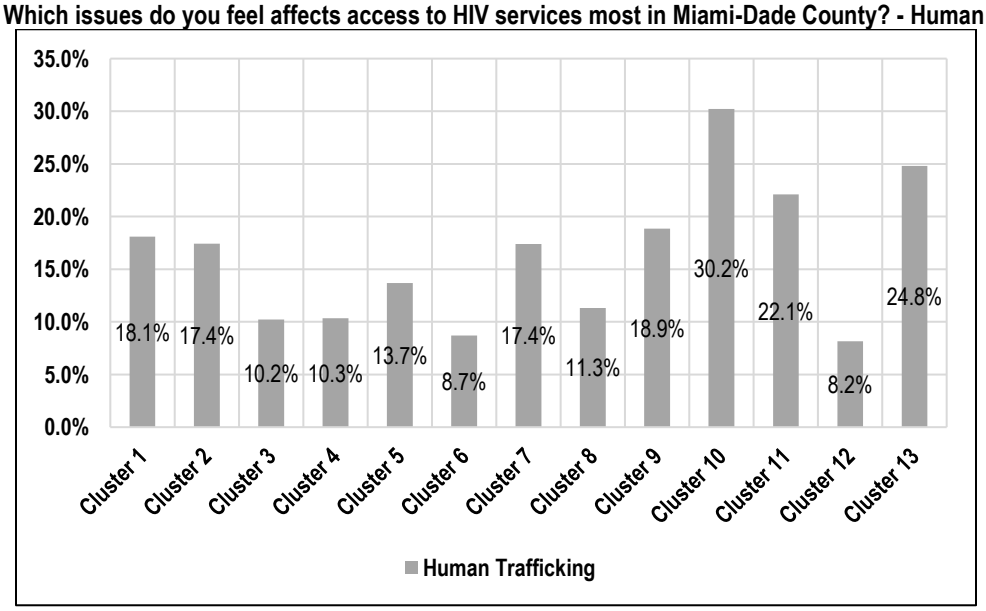
Chart 115: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Domestic Violence/Inter-Partner Violence/Sexual Assault



Source: FDOH-MD EHE Survey

Human trafficking had moderate support as a top-5 issue among respondents with few exceptions. Clusters 12 and 6 had the lowest percentages with 8.2% and 8.7%, respectively. Cluster 13 and Custer 10 had the largest percentages at 24.8% and 30.2% (Chart 116).

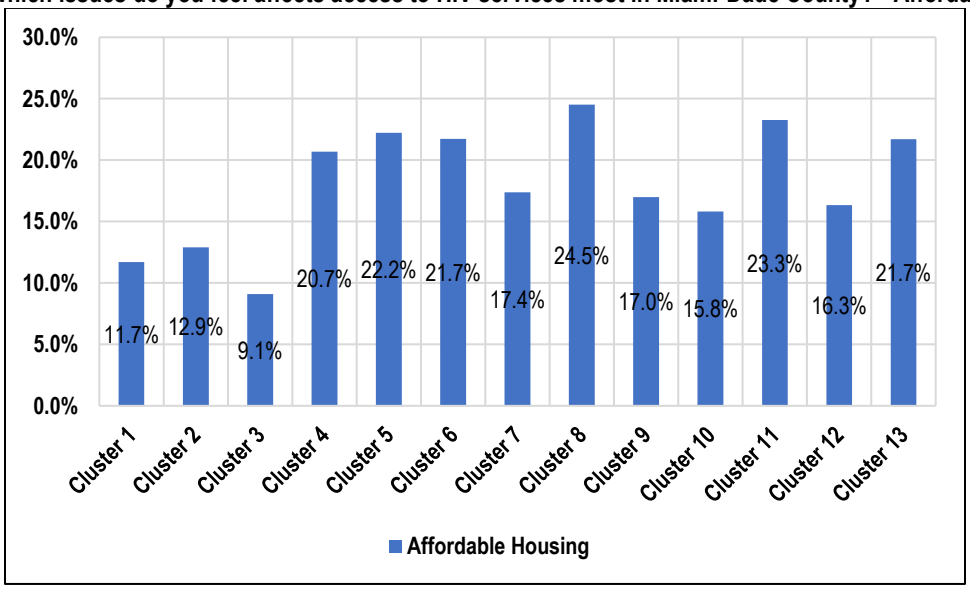
Chart 116: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Human Trafficking



Source: FDOH-MD EHE Survey

When considered on a cluster by cluster basis, there were some differences for each issue on the importance given to each issue. Of those who consider Affordable Housing to be a top-5 issue, approximately 15%-20% of each cluster agreed. Cluster 8 had the largest percentage (24.5%) and Cluster 3 having the lowest (9.1%) (Chart 117).

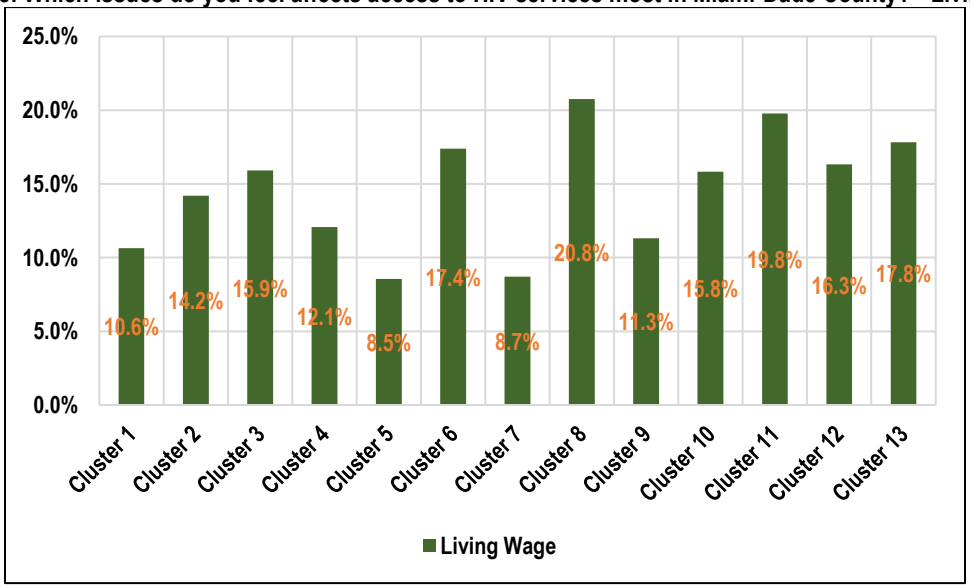
Chart 117: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Affordable Housing



Source: FDOH-MD EHE Survey

Like unemployment/underemployment, a living wage isn't considered a top-5 issue among respondents. All clusters had less than 20% of their respondents indicate that living wage is a top-5 issue for them except for Cluster 8 with 20.8% (Chart 118).

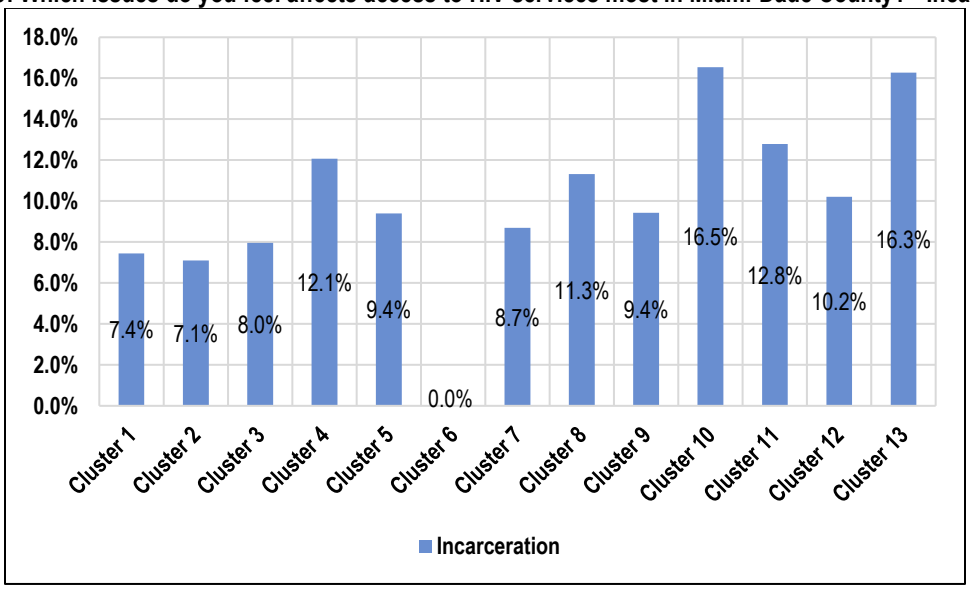
Chart 118: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Living Wage



Source: FDOH-MD EHE Survey

Lastly, incarceration received the lowest overall count of respondents indicating that it is a top-5 issue. No cluster responded with greater than 17% of their population believing that incarceration is a top-5 issue. Cluster 6 had no respondents indicate that it is a top-5 issue, while Cluster 10 and Cluster 13 had the largest percentages with 16.5% and 16.1%, respectively (Chart 119).

Chart 119: Which issues do you feel affects access to HIV services most in Miami-Dade County? - Incarceration



Source: FDOH-MD EHE Survey

Ending the HIV Epidemic Provider Survey

Introduction

The *Ending the HIV Epidemic Provider Survey* aimed to capture the input of providers that deliver HIV care in Miami-Dade County. The survey included 19 questions, two that were related to participants' demographics and two associated with participants' job title and category in their organization (e.g., Peer Educator under the category of Community Outreach/Service Delivery). The remaining of the questions asked participants about services being provided, barriers and challenges to receiving and providing services, and possible changes to address the needs of clients more efficiently.

There were 37 participants that responded to the provider survey representing 9 out of 13 Clusters in Miami-Dade County. Cluster 13 (Downtown/East Little Havana/Liberty City/Little Haiti/Overtown) was the most represented cluster and included participants from three different zip codes: 33127, 33136, and 33147. The greatest percentage of participants represented Community Health of South Florida from its two locations - Cutler Bay and Homestead - with approximately 19% of the total (7 out of 37), followed by Pridelines, a non-for-profit organization, with six out of 37 total participants, or 16.2%. Miami Beach Community Health Center had four participants, accounting for 10.8% of the total respondents. Care Resource, AIDS Healthcare Foundation (AHF), and University of Miami (UMH) had equal representation, each with 3 out of 37 participants or 8.1% of the total, however participants from AHF and UMH derived from different locations. Additionally, there were two participants that derived from Better Way of Miami.

The remaining participants derived from CAN Community Health, Center of Information and Orientation, Clear Health Alliance, Empower U, Florida Department of Health (FDOH), Food for Life Network, Jessie Trice Community Health System, Legal Services of Greater Miami, and UF Hialeah Dental Center.

The largest group of participants were Medical Case Mangers (15 out of 37), six participants indicated the category Community Outreach/Service delivery, while three participants are clinical staff, and four are in administration. Among participants that indicated "Other" as their response, their employment category ranged from HMO plans, pharmacy, and dental to housing and education.

The length of respondents' professional experience in the field of HIV ranged between 1 year to 30 years.

Services

The following services are the most commonly provided services at respondents' organizations:

- Case Management Services
  - HIV testing and counseling
  - Linkage to care
    - Heath-related and legal services
  - Support groups
  - Housing assistance
  - Food service for those in need

- Oral healthcare Services
    - Ryan White dental care
- Primary care services
    - Specific to CHI
- Behavioral Health
    - Psychological counseling and treatment
- Pharmacy
    - Medication delivery and prescription drugs
- Laboratory services
- Women and children HIV care
- Education
    - Transgender
    - Safe sex practices

In terms of services being utilized by most clients, respondents stated the following:

- Primary care
- HIV care
    - Testing, linkage to care, Ryan White pharmacy, Medical case management
- Social services
    - Assistance with housing needs
    - Support services

By contrast, respondents felt that the following services are being utilized the least by clients:

- Nutrition
- Vision
- Psychological services, such as counseling

It is important to highlight that even though participants from Miami Beach Community Health Center indicated that mental health services are the least utilized services among their affiliates, they serve most of Cluster 12 (Aventura/Miami Beach), a cluster that exhibits a high number of PLWH that could benefit from mental health services especially among residents recently diagnosed with HIV.

Additionally, transportation, behavioral health (e.g., substance and drug abuse), and housing were also shared by respondents as the least frequently utilized services within their organizations, however their comments did not surface as themes.

Barriers

The following are themes that were identified regarding specific barriers that respondents' organizations face that hinder the provision of HIV services to their community, including:

- Wait times
    - The long wait times to see a doctor which causes patients to leave before being seen and treated
- Limited funding
    - Limited HIV providers available that deliver much needed services to PLWH

        - Housing challenges faced by PLWH not being addressed
        - Limited funds does not allow for a strong infrastructure to deliver services effectively and efficiently
            - Limited location space to deliver services
            - Transportation systems not accessible
- Stigma and low utilization of services
    - Discrimination of the transgender population

Although not identified as a theme, respondents also felt that the low cost paid by consumers does not allow for the provision of additional services.

Challenges

In this section of the survey, the following themes surfaced, which at times were common within and between respondents affiliated with the different organizations that participated in the survey. These included:

- Hours of operation not suitable for consumers that work regular hours (i.e. 9am to 5pm) that seek and need HIV services
- Adherence to treatment and medication and retention in care
    - Lack of incentives to motivate people to test for HIV
    - Limited locations for consumers to conduct their lab work (e.g., University of Miami Hospital, Jackson Memorial Hospital)
- Resources
    - Limited housing resources for consumers
        - With an increasing cost to rent in Miami-Dade County, options for consumers become limited
    - Outdated office equipment for staff members
        - Improved software that would allow staff to access patients' electronic records

Furthermore, respondents also shared the following challenges faced by the staff, that although not identified as themes, are noteworthy:

- Awareness of services available among consumers and staff
- Services need to align with the needs of the HIV aging population which experience comorbidities
- The need to increase the number of HIV providers who are "adept" in HIV care

Populations Served

Most respondents shared that consumers from different racial and ethnic backgrounds, and age groups are served in their organizations, however some respondents indicated that there are some populations that are served more than others.

- In Miami Beach Health Center, respondents indicated that consumers identified as Black or African Americans are served the least, however at the Community Health South Florida (Cutler Bay), this population comprises the largest percentage of their consumers

- Pridelines shared that the LGBTQ community 13 years of age and older and served in their organization
- UMH serve women, infants, children and youth (Ryan White Part D), however UMH Comprehensive AIDS Program serve adults of all ages, gender, and racial and ethnic background
- Empower U serves mainly residents identified as Black or African American and Hispanic
- AHF Pharmacy addresses the needs of the homeless, elderly, Black or African American, Haitian-Creole, Hispanic, and residents identified as White.

Challenges Among Populations Served

Although a significant number of respondents felt that patients' needs are met at their respective health centers, there were two major themes regarding challenges that certain populations face at respondents' health centers, including:

- Culture
  - Although the English language is a challenge for consumers, respondents also shared that there are always staff members who could help translate during patient visits
    - Frustration experienced by Haitian-Creole consumers due to the language barrier compounded by the lack of printed materials in their language
  - Different beliefs
- Transportation
  - Respondents from most organizations shared that this is the biggest challenge faced by patients
    - For instance, respondents voiced that the location of the Miami Beach Health Center makes it difficult for patients to receive care due the nature of the city which is highly congested with traffic
- Financial
  - Poverty
  - Lack of health insurance
  - Transportation costs
  - Lab costs
- Stigma
  - Fear by consumers of being stigmatized as knowing HIV status
    - Perception of HIV as a "death sentence"
- Legal
  - Undocumented not seeking services
  - Misunderstanding of the legality of certain issues that prevents certain populations from seeking care

Adherence

This question aimed to capture participants' views on consumers' adherence to medications and missed medical and case management appointments by consumers. The following themes were noted:

- Transportation
  - Deficient public transportation system
  - Unreliable means of transportation to make scheduled medical appointments
- Stigma
  - Consumers stop taking their medications to avoid revealing their status to family and friends
  - Consumers miss their appointments for fear to someone would recognize them at the clinic
- Education
  - Limited access to information about the importance of adherence
  - Limited access to information about substance abuse addiction and/or recreational drug use
  - Limited knowledge on the appropriate amount of prescribed medications and refills
  - Low HIV health literacy proficiency
- Forgetfulness – adherence and missed appointments
  - Due to drug use or simply believing that adhering to prescribed medications is not necessary (education)
  - Due to mental health issues
- Scheduling conflicts
  - The health center's hours of operation conflicting with consumers' work schedule

Although it did not surface as a theme, some respondents shared that the perinatally-infected youth and young adults are simply "burnt out" from taking medications, as such do not adhere to the treatment plan.

Unmet Needs

Many of the themes identified in this section and in previous sections are overarching themes that participants felt are important to consider when discussing barriers and challenges to receiving care, and adherence to medications and medical appointments. In terms of consumers' greatest unmet needs, most respondents indicated housing as the greatest unmet need for PLWH. The following highlights all themes identified in this section:

- Housing
  - E.g., long-term housing for adult transgender women
- Transportation
  - An issue also identified in previous sections (*Barriers* and *Challenges among Populations Served*)
- Quality of Care
  - Consolidated and streamlined process of care

        - More flexibility with ADAP, the ability to utilize different approved pharmacies
    - Importance of continuity of care among PLWH
        - High level of bureaucracy leads to a complex system that hinders consumers' access to prescriptions leading to low-level of adherence to treatment plans
- Support Groups
    - Family involvement
    - Fear of HIV-related stigma
    - Mental health care
    - Financial instability

Homelessness is an issue that was previously mentioned by respondents in other sections of the survey, and even though it was not identified as a theme in this section one respondent indicated that this is an unmet need among the population served by his or her organization and it correlates with the housing component mentioned above.

Expanded Services

There were three main themes identified as respondents shared some aspects of their organization that could be either expanded or strengthened (e.g., programs, services). Housing and transportation continue to be overarching themes for survey respondents, as they voiced the need to expand housing options and strengthened or improve the transportation system for their clients.

- Housing and transportation
- AIDS Drug Assistance Program (ADAP)
    - More flexibility needed with pharmacies that work with ADAP
    - More efficient approach to increase access to medications for consumers that, due to their work schedules, are unable to receive them in time
    - Services and guidelines need to be revised
        - Injectable medications are included in ADAP's formulary, yet syringes are not provided to consumers leading to the reuse and, in some case, the sharing of needles
        - Needle exchange program
    - Convenient medication pick-up
- Increase the number of HIV providers
    - Not identified as a theme in this section, however this concern also surfaced as a barrier or challenge in the provision of HIV services

Respondents also felt that increasing the number of HIV providers and reducing restriction of legal services to those in need are two issues that need to be addressed that would in turn strengthened their organization in providing much needed services to PLWH.

Added Services/Programs

There were three themes that were identified regarding the types of programs or services respondents would like to see being introduced in their organizations. These include:

- Support groups to improve the delivery of care
- Transportation services
    - Bus passes, Ride Share, Lyft, Uber
- Mental Health
    - Providing this service in the health center as oppose to referring these services to other providers

Although not identified as themes, the following information was shared by respondents when asked about services or programs that they would like to see introduced in their organization:

- More education
    - Sexual health counseling for residents with repeating STI diagnoses, social workers, staff
- Natural holistic healing methods holistic (e.g., Yoga)
- Urology as a service being provided as many of their patients are 50 years of age and older
- Housing resources and job fairs for their clients
- Transportation services
- Re-introduction of the Partnerships for Care Program (P4C)[17]
- Full-service pharmacy that provides not just HIV-related prescriptions but addresses all of the consumers' needs, especially among HIV aging population
- Needle exchange program

Changes to Services

The response rate for this section of the survey was low compared to other sections, however among participants that provided a response, there were two themes identified. These included: the importance to introduce or expand HIV services based on the needs of the population, and the need to expand efficient outreach efforts in more geographical areas of the County.

The following information was also shared by respondents, some of which overlap with information provided in other sections of the survey:

- Support groups
    - Respondents felt that this help address the mental health of patients living with HIV
- Provide incentives for case managers (e.g., increased salaries)
- Extent the organizations' hours of operation after 5 PM and on Saturdays
- Increase the number of the following staff members: clinicians, counselors, Disease intervention Specialists, nurses, linkage and outreach personnel

[17] Partnerships for Care was a three-year project (2014-2017), in which health centers partnered with CDC-funded State Health Departments in Massachusetts, New York, Maryland, and Florida to improve the delivery of HIV services. Available from https://bphc.hrsa.gov/qualityimprovement/clinicalquality/hivprimarycare-resources.html

- Allocate funding to treat residents without the ability to pay for services

Training/Technical Assistance/Tools Needed

Three themes were noted among respondents with respect to different trainings that are needed to better serve their clients. These included:

- How to effectively access various needed resources and share with clients
    - Food services (e.g., food vouchers)
    - Housing assistance (e.g., emergency housing)
    - Mental health services
- Cultural competency
    - E.g., better strategies to work with the Haitian-Creole communities
- Infectious diseases
- Effective outreach strategies

Regarding different tools needed, respondents mentioned the need to install specific software to better tract and manage client services (e.g., Casewatch).

The following information shared by respondents did not come up as themes, but are rather notable mentions:

- The ability to obtain a nursing degree
- Monthly trainings to assist Medical Case Managers (MCMs) in their work with clients
    - Trainings on formulary

Additional Information

Most participants felt that there was nothing else to add to the to the Ending the HIV Epidemic Provider Survey, however the following was provided by respondents that reiterates what has already been shared in other sections of the survey that could be considered overarching themes:

- Education
    - Informing clients about services available and how to access these services
    - Conducting HIV-related events (e.g., educational sessions) in communities with a high prevalence of HIV associated with safe sex, PrEP
    - Utilizing education as a tool to address stigma surrounding HIV
- A more efficient SDIS software that stores client information related to their HIV care
- Streamline access to necessary medications
- The need to “normalize” HIV with respect to its treatment and regard it as any other chronic condition
    - Consumers should be able to access the treatment of HIV effectively without any delays, and providers should have the services/programs available to deliver HIV care

FDOH-MD EHE Listening Sessions

A key aspect of HIV/AIDS prevention and treatment planning is mining the institutional knowledge of stakeholders and persons who live with HIV/AIDS. As a part of the Ending the HIV Epidemic (EHE) call to action, Miami-Dade County conducted six focus groups with stakeholder collaboratives. These focus groups included input from the Black Treatment Advocates Network (BTAN), Iniciativa Hispana, the Miami Collaborative, the Prevention Committee (part of the Miami-Dade HIV/AIDS planning body), the PrEP Workgroup, and with members of the Transgender community.

Each focus group lasted two hours and covered a host of questions pertinent to the prevention of HIV/AIDS in Miami-Dade County. The focus groups were organized by the Florida Department of Health in Miami-Dade County (FDOH-MD) and took place from September 2019 – October 2019.

Black Treatment Advocates Network (BTAN)

The Black Treatment Advocates Network (BTAN) is a collective of people that aim to address systematic barriers that perpetuate health disparities, particularly among the Black community, by ensuring that here are ample Black-serving institutions and leaders with the skills, capacity, and social capital to ensure equitable access and utilization of HIV prevention and treatment strategies.[18]

The BTAN focus group in Miami-Dade County was completed on September 19, 2019 and covered four key aspects of HIV/AIDS prevention and treatment among the Black community, which align with the four EHE pillars.

Pillar One: Diagnose all people with HIV as early as possible after infection.

BTAN members highlighted the need for routinized testing at private doctor's offices, through education efforts and getting their buy-in. Participants also suggested involving faith-based organizations to spread messages on testing in order to reduce stigma within congregations. The stigma around testing also affects parents of school-aged youth, which can make it difficult to offer tests at health fairs, schools, etc. One BTAN member believed that many populations simply do not feel like they are at risk, especially those coming from higher-SES backgrounds. Largely, participants believed the community has become "complacent" with HIV and do not see it as an issue that affects them.

Pillar Two: Treat the infection rapidly and effectively to achieve sustained viral suppression.

In the BTAN focus group, cultural competency became the focus of the conversation under pillar two. Cultural competency was recommended as beneficial for both peers and providers. It is important to "meet people where they are at," and to be cognizant of clients' varying cultures and backgrounds. BTAN members discussed how a client might not speak the same language of the

[18] https://blackaids.org/programs/black-treatment-advocates-network/btan-overview/

provider, so the provider should take steps not to further alienate the client. Trainings should also include lessons on how to keep the provider's religious beliefs and ideas away from treatment. Staff at all levels should receive training, especially in multi-level institutions such as hospitals.

BTAN members also discussed the importance of providing adequate care for PLWH who are incarcerated, as well as providing treatment within transitional housing settings. One suggestion for those in transitional housing was to make adherence to treatment a condition of housing, in order to encourage PLWH to stay in care.

Pillar Three: Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs.

Participants at the BTAN focus group advocated for increased access to PrEP as a means for "controlling one's own sexual health." It would also help in decrease the stigma around using PrEP. BTAN members suggested increasing advertising in various communities and using positive social media messages. Those dealing with substance abuse issues were also mentioned as possibly benefiting from the use of PrEP. One member also commented on the benefits of encouraging pharmaceutical companies to create better and cheaper options through research.

Participants also had three topics of interest to focus on for risk education purposes: highlighting the fact that Miami-Dade is one of the top areas in the country for new infections, promoting the use of condoms, and increasing awareness on the link between STIs and HIV.

Pillar Four: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

For this pillar, BTAN participants discussed key players that they would want to see involved in a response to potential outbreaks. This includes identifying group leaders, local agencies, testing sites, and stakeholders. The players they identified as important include the following: churches, business owners, political leaders, nightclubs, civic leaders, and schools.

Iniciativa Hispana (The Hispanic Initiative)

Iniciativa Hispana (IH) was developed to reduce the incidence of HIV/AIDS within the Hispanic community in Miami-Dade County. Their objective is to plan, develop, and implement innovative strategies on HIV/AIDS education and prevention through culturally appropriate and sensitive approaches, meeting the needs of the community through service provider's referrals, community referrals, and community building.

The feedback from IH was given on October 8, 2019 and is presented below.

Pillar One: Diagnose all people with HIV as early as possible after infection.

When asked about pillar one, IH focus group members highlighted the importance of rapid linkage to services for those who test positive. Miami "needs to work together and not in silos" so that community partners know where to refer those who test positive immediately. For this group, the building of these relationships between partners seemed most important regarding HIV testing.

Pillar Two: Treat the infection rapidly and effectively to achieve sustained viral suppression.

In order to effectively treat and care for PLWH, IH participants discussed providing more information on the resources available for PLWH. According to one participant, "many are unaware of HIV programs that exist" and could be missing out on services. Social needs also affect this pillar, as one might not have adequate transportation to services, or one might be undocumented and fear accessing any services. Participants also discussed the need for "integrated medicine" and getting clinical staff, especially providers, on board with HIV efforts in order to increase comfort with PLWH.

In the Latinx community, certain issues are also specific to them that can hinder care efforts. For example, there is a "hierarchy of needs" in many Latinx families that can take priority over healthcare: children, spouses, traditional family roles, etc. IH members also wanted to see more group facilitation in areas like Homestead and other areas with high concentrations of Latinx people.

Pillar Three: Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs.

Participants at the IH focus group spent most of the conversation on pillar three, specifically on PrEP and HIV education efforts. Participants highlighted the need for increased education on PrEP through extensive media coverage that showcases a variety of people from different backgrounds using PrEP. Diversity and inclusion are necessary in messages on PrEP in order to increase comfort with PrEP in more at-risk communities. This includes the use of community meetings in Spanish for Latinx communities and more social media content in Spanish. Messaging should be targeted especially at clubs where there is a lot of people and activity.

Participants also discussed how to better assist those who are undocumented or uninsured with accessing PrEP, by focusing on hard-to-reach areas like South Dade and Homestead where many in this population live. Additional support groups for Latinx communities were recommended, as well as having FDOH-MD do more listening tours to get better information from the community. One participant also noted that the cost of labs is a barrier to widespread use of PrEP, as well as the lack of knowledge in the community regarding side effects.

HIV education was a prominent theme in the IH conversation. Participants took a community-focused approach to education, with ideas on involving community leaders and empowering community members to know their status. Overall the participants believed "there is not enough being done about spreading the message of HIV on PSAs, radio, social media, and TV." They suggested a multi-faceted approach with messages at different times of the day would be needed to adequately educate communities.

The need for increased education and training for providers was apparent within these conversations. IH members wanted to see a more bilingual, culturally competent healthcare workforce, especially medical providers. Education regarding testing, PrEP, and other HIV-related issues can help in decreasing the stigma around HIV in the healthcare setting and empower more people to protect themselves. Participants recommended that any messages and campaigns be positively delivered and focused on human relationships.

Top Priorities for Latinx Strategy

When asked about top priorities for the Latinx community regarding HIV, participants shared a variety of community engagement ideas. IH members suggested using more Facebook live events to keep the conversation going and decrease stigma around HIV. Engaging and mobilizing professionals in the Latinx community was also discussed as important for the overall community. Participants wanted to see sexual health normalized and integrated as part of one's physical health, as well as normalizing HIV as more of a chronic and manageable disease. Testing efforts should also be increased and included at health fairs as part of general checkups that test for blood pressure, cholesterol, etc. Mobile units were also discussed as an opportunity for community engagement, by making them more inviting and thinking about "creative spaces" to utilize.

The Miami Collaborative: An MSM Workgroup

The Miami Collaborative MSM Workgroup focus group was completed on October 16, 2019. Feedback was given both via verbal answers and through written responses. The Collaborative is a network of men who have sex with men (MSM) and men's health coordinators around the state of Florida who work together for optimal uses of resources. The Miami Collaborative engages MSM community members and allies to reduce new HIV infections. The goal is to reinvigorate HIV prevention efforts, align with the National HIV/AIDS Strategy, and mobilize leaders to support the reduction of risky behaviors. The Collaborative serves as the link between members of the Gay Men's Workgroup and other advisory councils as necessary and specifically works with community partners and governments to enhance stakeholder engagement. Results in this section are presented by pillar.

Pillar One: Diagnose all people with HIV as early as possible after infection.

For this pillar, participants focused largely on how to supplement traditional HIV tests and educating individuals important for the increased dissemination of testing. One participant discussed the need to add mental health and drug use screening to HIV tests, which can help identify other possible risk factors for someone who is in a vulnerable population. Participants also wanted to see HIV tests be a regular part of routine lab work done at doctor's visits. Sexual health education should also be improved and implemented more broadly in the school system. The needs of trans people were also identified, as people wanted to see more trans-competent testing sites and having more trans health coordinators at testing sites. Working with "sex party organizers" was also mentioned to increase HIV testing in the communities that need it.

Pillar Two: Treat the infection rapidly and effectively to achieve sustained viral suppression.

The centralization, integration, and updating of care systems was the main topic of discussion within this pillar. Participants wanted to see "up-to-date" tech care and the provision of "comprehensive medical & social services at one-stop-shops." One participant also described the need to expand pharmacy services and engagement for care purposes. Medical scribes and peers were mentioned as two ideas for addressing general challenges in the treatment and care systems.

Pillar Three: Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs.

The Miami Collaborative members had multiple suggestions regarding PrEP engagement and usage. Overall, there is a need to "eliminate roadblocks," including those associated with stigma and cost. To address stigma, participants suggested using Facebook commercials and ads to promote PrEP. Educating the community through faith-based organizations, public schools, legal status organizations, influencers, social media, and support groups were additional ways identified to address stigma. The U=U campaign has also proven useful in fighting stigma and having PLWH as "PrEP champions" can also put PLWH at the forefront of PrEP and HIV-related media.

Participants mentioned that the cost of labs can be a barrier to using PrEP. Using the state lab was one recommendation, as it has a 69% drop-off at payment. Using 340B funds to lower copays was another suggestion made to address the cost barrier. Participants would also like to see more providers knowledgeable and involved in PrEP, as there is currently a "lack of knowledge" from providers. Using "tele-PrEP" – or telemedicine for PrEP – can address this issue by connecting patients to providers who know about PrEP. Participants suggested a mechanism to share best practices on PrEP between providers and agencies so that more people can have access.

Pillar Four: Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

Participants at this session highlighted that the tourism industry makes Miami's situation unique and complicated. Regarding potential outbreaks, the participants wanted to see a focus on possible infections coming from other countries and promoting HIV-related information at major ports of entry. One participant wanted to see a representative from a tourism-related agency directly involved in HIV work.

Suggestions also included using newer and more relevant media messages in spreading messages to the public on outbreaks. Participants also discussed potential parties that would need to be involved in such cases: schools, faith-based organizations, providers, the local health department, and CBOs.

PrEP Workgroup

The Miami PrEP Workgroup met on Wednesday, September 25th, 2019 to discuss the new EHE plan. The Miami PrEP Workgroup meeting is a platform for community advocates and providers to collaborate and use capacity-building to create a local service model for PrEP/nPEP in Miami-Dade County.[19] As part of the planning for the creation of the EHE plan, the PrEP Workgroup was divided into three groups to provide input regarding the third pillar, Prevent. Each group had a different topic within the umbrella of prevention with PrEP. The topics were Awareness, Access and Adherence.

Awareness

HIV prevention education should start at adolescence (or earlier). The sexual health education should be comprehensive, sex positive, scientific, inclusive, and tailored (MDC centric).

- The sexual health education should be reinforced by providing information of how high STD incidents are on adolescents in Miami Dade County.
- Increase collaboration between community mobilizing workgroups so that services would not be duplicated, and more areas could be covered. For example, instead of one event having five providers, these providers could select other locations nearby to have a greater impact in the area and community.
- Different policies regarding PrEP, health education, sexual health education and testing and treatment should be modified and improved. Some policies include:
    a) Sexual health in schools does not allow to educate about different prevention methods like condoms, PrEP nor sexual behaviors. It is also not allowed to provide condom demonstration nor distribution.
- Work and educate to change community attitudes towards PrEP. (ex. Parents, teens, incarceration population, party and play (PNP) people, men, women, policy people, doctors).
    a) Clarify the community knowledge about what PrEP and what PrEP is not. PrEP is for every individual incurring sexual behaviors (e.g. not a “gay man’s drug”).
    b) Biomedical prevention is an additional method available to everyone, besides the condoms. Educating about future prevention methods being studied is important for the community to be open-minded, be able to plan, and look to prevention as long term.
    c) Improve information of PrEP in health care providers (HCP) including marketing (HIV & PrEP) on television and other powerful media.
    d) Incarcerated people should also have information of PrEP so they can access the services once they are released. Their case managers or parole officer should also

[19] http://miamidade.floridahealth.gov/programs-and-services/infectious-disease-services/hiv-aids-services/Prevention.html

have the education of PrEP to be able to provide the newly released with the most accurate information and referral.

e) Change community attitude towards HIV/STD prevention and treatment. Reinforcement is needed regarding the condom use and other preventive methods. Stigma and myths must be included in the conversations to be able reduce and desist misinterpretations.

f) The side effects of PrEP that could take a percentage of bone density needs to be better explained to the clients and the community.

- Policy in Florida regarding HIV prevention & PrEP for immigrants.
- Make PrEP available for teens without parental consent.
- Increase information about PrEP, HIV and STDs prevention to most high-risk groups and area codes.
- Counteract information regarding Truvada lawsuits. Lawyers in Florida can market themselves in television, radio, billboards and social media to recruit clients to be part of a lawsuit against the pharmaceutical company Gilead because of the side effects the medication can cause. This is impacting the recruitment, adherence and prevention efforts to end new HIV transmission.
- Within the education component, reinforce to empower the patient's decision to be on PrEP and that it is not the provider's decision. Many HCP are not well educated and not comfortable prescribing PrEP.
- There is a need to expand and use more and different media outlets. Also, more funding needs to be brought to provide marketing and promotion.
- Address to cover the cost of transportation, laboratory fees and visit costs.
- Provide more information for PrEP for women and increase outreach efforts for women. More educational pamphlets and brochures are needed for females.
- Match PrEP prescriptions with other HIV policies.
- Increase awareness of other upcoming HIV prevention tools like the vaginal ring and injectable PrEP.
- Hospitals need better protocols surrounding teens and PrEP.
- Pediatricians should be included in the efforts of education for prevention methods as they also see teenagers and young adults. They can provide prevention methods before adolescent starts in sexual behaviors.
- More pamphlets, brochures and education materials focusing in all communities are needed; not just men. There is a high demand of request for educational material that not only address the LGBTQ and/or Men who have Sex with Men community, but that are focused on women, heterosexual community, adult and elderly, youngsters, and different ethnicity and racial backgrounds.

- Training for HCP. The providers need to ask more questions regarding sexual health and not only the question to fill or check mark requirements. HCP should not only receive continued education regarding HIV and PrEP, but also about sexual health. Make mystery shopping visits to HCP was also recommended.
- More research is needed on how PrEP information travels in social and personal networks (ex. from doctors to patients, teachers to students, social media, friends, etc.)

Access

- Provide availability for walk in appointments. When calling for an appointment, the person on the phone must know what PrEP is, how to do an appointment and the costs, if any.
- Make sure the laboratory tests and visit are low-cost. In some agencies, the costs and fees are waived because of the profit that 340B provides.
- Review the scheduling and hours of clinic. Besides the time the client is in the clinic, agencies must be aware what it takes and how long it takes the client to get to the clinic. Also, the time and process it takes the client to receive the medication. All factors must be considered.
- Besides the service hours offered by the clinic, agencies must consider how much time the clients spend in the clinic.
- Being insured and uninsured is still causing confusion. The communication and marketing should be integrated and well explained.
- HIV screening and testing should be integrated along with PrEP.
- The process of navigation should be clear. Not only refer to an agency and a phone number that takes you to a system, but referend to specific team with names. Referrals also must be tailored to a client's needs.
- Provide rapid access to PrEP. This empowers patients and increases adherence. Also, direct access can potentially increase the intake because the clients will have more confidence to refer others to a good and easy service.
- Transportation is one of the main barriers that affects the adherence and retention of the clients. How can the agencies provide transportation tickets, i.e. Uber or Lyft for the clients? Mobile clinics can also compensate for the transportation issue and can also provide a rotation of services in different at-risk areas. Mobile clinics visits are shorter and would work best for some clients.
- Housing and food are also barriers for access as clients prioritize their basic needs. Clients whom are homeless or are in an unstable housing are very difficult to reach for their follow ups and even for the pharmacy to get confirmation to send their medication.
- Privacy arise regarding the concern of clients keeping their PrEP stored or hidden. Another issue regarding privacy has been clients that are insured under their parents, don't want their parents to know they are in PrEP. However, the parents will receive notification of all that it is process on the insurance.

- To increase uptake of PrEP in communities, HCPs need to receive the education to refer their clients. Besides receiving the information, the HCP need accurate information to be comfortable for prescribing PrEP and to follow the correct protocols.
- PrEP continues to have a stigma that is for the LGBTQ community. This stigma needs to be destructed so that all communities can become aware and receptive to receive services for PrEP.
- Community should be educated about all components of PrEP and not only what it is for. Does the community know about prep? Although the first phase of PrEP was to increase PrEP awareness, there is still much to do to reach other communities unaware of PrEP.
- Besides the awareness of PrEP, the community needs to have knowledge regarding the organizations and agencies other services and offerings. Some clients can become more receptive when they see the services as comprehensive or multi-serviced.
- Other states allow pharmacies to have access to laboratory results, EMR and medical records. By allowing this, providers inside pharmacies can prescribe PrEP and would eliminate intermediaries.
- Changes in law and policies:
    a. Pharmacist should be able to prescribe PrEP with a standard form after corroborating laboratory results. Pharmacies can easily continue the follow ups.
    b. Health hubs can facilitate provided PrEP to multiple clients at the same time. It would also break the stigma as it would be a positive social activity.
    c. Building confidence that this works. Community trust the pharmacies. build confidence for the pharmacist to prescribe PrEP.
    d. Reduce barriers of access for PrEP.

Adherence

- Regarding clinic hours,
    a. Extend one or more days to 9 pm and provide availability on weekends.
    b. Provide telemedicine, telehealth or telePrEP for follow up visits.
    c. Provide clients with first bottle of PrEP the same day they start.
    d. Mobilize pop-up locations which will reach more communities and would provide extra-office hours. Have available (scale up) more mobile units in strategic areas of high incidence.
    e. Persistence of PrEP Navigators and Case Managers for follow up reminders.
- Provide free rides to the medical visits with Uber, Lyft or other transportation mobile apps.
- Lower the cost of laboratory tests and visit fees by:

    a. Partnering with laboratory companies like Quest and LabCorp to mediate a low or no-cost.
    b. Providing “Drop-in” laboratory programs.
    c. Accepting self-administered testing and home laboratory testing.
    d. “Cutting out middle people” or eliminating intermediaries so that laboratory results can be provided with rapid access.

- Make improvements on pharmacies like:
    a. Establishing pharmacist-driven PrEP protocols. If pharmacist would be able to see the laboratory results, they would be able to provide PrEP.
    b. Allowing a standing PrEP script for Florida (No doctor required, pharmacist can provide) like Naloxone for example. Some pharmacies have standing orders for PEP but not for PrEP.
    c. Provides same day PrEP.
- Offer clients the alternative of non-daily dosing (2-1-1) if client has medication side effects.
- Additional points regarding adherence mentioned were:
    a. Provide couples appointments.
    b. STD testing being recommended but not required to get PrEP.
    c. Implement a smooth transition from PEP to PrEP.

Transgender Focus Groups

There were four separate focus groups across Miami-Dade County for transgender persons. Transgender people are at a significantly higher risk of contracting HIV, and efforts are continuing to engage the transgender population. In total, 15 people attended the focus groups, which took place from October 11 – October 29, 2019. The locations for the focus groups include a collegiate setting, two clinical settings, and a nonprofit organization. Table 35 below includes basic demographic data on attendees at the focus groups, and Table 36 includes data on HIV/STD testing, PrEP use, and care within this group.

Table 35 – Transgender Focus Groups Demographics

Age Group	Total	%		**Race**	Total	%
13-18	0	0.0%		Black	0	0.0%
18-24	2	13.3%		White	9	60.0%
25-34	3	20.0%		Asian	0	0.0%
35-44	2	13.3%		Mixed Race	4	26.7%
45+	8	53.3%		Other	1	6.7%
	15	100.0%		N/A	1	6.7%
					15	100.0%
Sexual Orientation	Total	%				
Gay	3	20.0%		**Gender Identity**	Total	%
Lesbian	1	6.7%		Trans Women	10	66.7%
Bisexual	1	6.7%		Trans Man	4	26.7%
Pansexual	1	6.7%		Non-Binary	1	6.7%
Asexual	2	13.3%			15	100.0%
Heterosexual	4	26.7%				
Other	2	13.3%		**Ethnicity**	Total	%
N/A	1	6.7%		Hispanic	10	66.7%
	15	100.0%		Non-Hispanic	5	33.3%
					15	100.0%
Employment Status	Total	%				
Unemployed	7	46.7%		**Education Status**	Total	%
Part Time	1	6.7%		Less than HS	2	13.3%
Temporary	0	0.0%		HS Diploma/GED	6	40.0%
Multiple Jobs	2	13.3%		Associate Degree	2	13.3%
Sex Work	1	6.7%		Voc Training/Trade	1	6.7%
Self Employed	1	6.7%		Bachelor's Degree	2	13.3%
Full time	3	20.0%		Master's Degree	1	6.7%
	15	100.0%		PhD or Post Doc	1	6.7%
					15	100.0%
Yearly Income	Total	%				
10K or less	9	60.0%		**Health Insurance**	Total	%
15K to 25K	0	0.0%		No insurance	3	20.0%
25K to 40K	2	13.3%		Employer Insurance	3	20.0%
40K to 100K	3	20.0%		ACA Marketplace	4	26.7%
100K +	0	0.0%		Medicare	3	20.0%
N/A	1	6.7%		Medicaid	2	13.3%
	15	100.0%		Ryan White	0	0.0%
				ADAP	0	0.0%
					15	100.0%

Table 36 – Transgender Focus Groups Additional Data

STD Testing	Total	%		**What STD's tested for**	Total	%
Every six months	12	80.0%		All 6 STDs	8	53.3%
Every year	0	0.0%		5 out of 6	1	6.7%
Every 2 years	1	6.7%		4 out of 6	1	6.7%
Don't remember	2	13.3%		3 out of 6	1	6.7%
Never	0	0.0%		2 out of 6	0	0.0%
	15	100.0%		1 out of 6	1	6.7%
				None	3	20.0%
Tested Positive STD	Total	%			15	100.0%
Never	9	60.0%				
Once	2	13.3%		**HIV Testing**	Total	%
Twice	1	6.7%		Every six months	12	80.0%
More than two times	2	13.3%		Every year	0	0.0%
N/A	1	6.7%		Every two years	0	0.0%
	15	100.0%		Don't remember	2	13.3%
				N/A	1	6.7%
HIV/STD Rank	Total	%			15	100.0%
Top Concern	5	33.3%				
Very Concerned	4	26.7%		**Care Continuum**	Total	%
Somewhat Concerned	2	13.3%		Never in Care	8	53.3%
Not Concerned	4	26.7%		Went to one appointment	1	6.7%
	15	100.0%		Go every three months	3	20.0%
				On ART/Virally suppressed	0	0.0%
PrEP Use	Total	%		N/A	3	20.0%
Never	9	60.0%			15	100.0%
Started but discontinued	0	0.0%				
Yes, but not consistently	0	0.0%				
Take PrEP daily	6	40.0%				
	15	100.0%				

The following results are organized by major themes identified throughout the focus groups. The four main themes in these discussions are: training & education, social determinants, engagement, and exclusion.

Training & Education

In all the transgender focus groups, participants identified additional training and education as a necessity for providers and staff working with trans people. Rather than being optional, many participants want to see mandatory trainings on LGBTQ+ competencies for "all current and future providers working in the HIV/STD field." This includes changes in higher education settings, where, for example, medical schools can have classes focused on how to provide appropriate care for trans people. In other disciplines, requiring a gender and sexuality course could also help familiarize students with transgender issues and topics.

One participant sees the issue as providers being "out of date" on transgender health issues and not knowing how to administer "transition-related services." Integrating educational components into the medical training of providers and staff can help address these gaps and bring providers up to date on best practices for providing care to trans people, especially as it relates to HIV. Suggestions also included having a medical certification process for providers who specifically wish to work with the Trans community. The local health department can also include transgender and GNC health competencies in the HIV 500/501 CTL trainings.

Social Determinants

Multiple issues relating to social determinants were raised at the transgender focus groups. For example, job insecurity in the trans community is a concern and participants expressed an interest in additional resources for job training and professional development. Healthy food access is another social factor that participants wanted to see addressed in HIV counseling. A large area of concern for participants is transportation, given the fact that they "fear using public transit" as it is an area where they are "vulnerable to attacks and discrimination by strangers." A lack of access to affordable transportation gives them little options regarding safe transportation.

Immigration status was also a topic of concern for participants in these sessions. Several spoke about a distrust of healthcare systems and law enforcement, raising fears that healthcare professionals could share their HIV status with local immigration authorities. They were also worried that information collected by "intrusive" intake forms could be shared with immigration authorities and jeopardize their situations.

Health insurance and housing were mentioned in these conversations as additional issues. Those without health insurance could not easily access transition-related services, and participants wanted to see additional efforts to provide trans people with secure and safe housing. One participant spoke about a need to change laws and/or policies regulating shelters so that trans people experiencing homelessness can be sheltered according to their gender identity.

Engagement

Participants had several recommendations regarding engagement with the trans community. One way to better engage and support the community would be to "increase efforts in hiring trans PrEP ambassadors" as well as people with proven experience working with the trans community. This would be especially helpful for increasing PrEP usage in the trans community, offering counseling

and education on PrEP benefits and myths. Suggestions also included having PrEP ads placed where trans people are known to be around.

In most engagement efforts by agencies, participants expressed that they often see engagement efforts focused on gay and bisexual men and not so much the T part of LGBTQ+. They believe efforts by the local health department to create a "community mobilization group" led by trans community members would be beneficial and productive. Such a group could be involved in various efforts such as "dispelling myths about gender identity, have LGBT-led potlucks, identify Trans-friendly employers," and other activities that increase HIV prevention and care for the trans community while also improving their overall quality of life.

Exclusion

Lastly, participants spoke often about the discrimination and exclusivity faced within the healthcare system. Intake forms will often have only binary options for gender available (male/female) and no options for persons identifying as they/them or a third gender. Similarly, health service employees will often misgender transgender people or call them by their "deadnames," which are names they no longer identify with. Generally, participants expressed a sense of trans people "not being accepted or welcome" in medical settings. One solution proposed was to have a state or local policy that could somehow hold private practices accountable that discriminate against trans people.

HIV/AIDS Planning Council Sessions

A handful of sessions were coordinated with sitting members of the local HIV/AIDS planning council. This includes the overall Partnership (Miami-Dade HIV/AIDS Partnership), the Strategic Planning Committee, the Prevention Committee, and former members from the Getting 2 Zero Task Force. The following results encompass data gathered from all these sessions and are presented by pillar, as well as a section on additional issues.

Pillar One: Diagnose all people with HIV as early as possible after infection.

Across the sessions, participants supported the testing efforts by FDOH-MD and other agencies, especially the TTRA protocol. Participants suggested increasing testing efforts in hospital settings and easing the transition for a patient between a hospital setting and the Ryan White Program (RWP). Workforce agencies can also be involved in testing efforts by partnering with local CBOs and providing HIV testing and education to employees. The increased dissemination of HIV/STD testing kits was also discussed, as well as including faith-based leaders and communities as key players in increasing HIV testing.

Pillar Two: Treat the infection rapidly and effectively to achieve sustained viral suppression.

Given that the local HIV/AIDS Partnership addresses mostly Ryan White Part A matters, most of the content derived from these conversations related to pillar two. Access to care was a top concern for participants; the 6-month re-certification process was cited as a possible barrier for clients staying in care. One participant suggested that RW and ADAP become more "integrated" so that clients only have to renew once, in order to avoid this "drop-off" point. Additional ADAP locations would be beneficial as well, according to participants, and extended hours could help clients with getting their medications. One current disparity that exists between ADAP clients and insured clients is that ADAP clients do not have the option for home delivery; this would be a possible point where disparities in access can be addressed.

Provider education regarding HIV issues is currently lacking. Participants wanted to see increased efforts to provide cultural competency training for providers and staff, training on PEP/PrEP, and "trauma-informed care" since dealing with HIV can be traumatic for newly diagnosed individuals. Capacity building in the provider workforce can help them better connect PLWH to services outside of general medical care and understand the "entire client profile." The goal would be to "re-define what network of care means" for PLWH and create a system that is more holistic and looks at the entire picture, especially as it relates to addressing social needs. Housing was the social determinant most often referenced when discussing social needs.

Pillar Three: Prevent new HIV transmissions by using proven interventions, including PrEP and SSPs.

Participants had several ideas on how to increase prevention efforts in the Miami-Dade area. Regarding the implementation of PrEP, there still seems to be a "stigma" around PrEP and a perception that it is only supposed to be for LGBTQ+ individuals. To address stigma related to PrEP as well as HIV, participants suggested to "identify the root causes of stigma" and reduce it through "educational and communication programs directed towards providers and the general public." Using social media, involving local politicians, and non-traditional agencies like tourism-related government agencies can help in prevention efforts and destigmatize HIV. "Real and pretty marketing" can go a long way, according to participants.

Additional Issues

There were additional gaps and issues identified that cut across pillars and systems regarding HIV. For example, mental health, domestic violence, and sex trafficking are not discussed often within conversations about HIV and participants believed these are areas that can use increased attention. Incarcerated populations are also in need of greater attention, as "existing jail linkage-to-care programs appear to be suffering."

Participants suggested uplifting and partnering with PLWH who can serve as peer mentors and advocates. Agencies should "fund more peer positions," as they can be in a particularly effective place to engage with vulnerable populations such as individuals experiencing homelessness and

those lost to care. Working closer with the school board and the school district was also of interest to some participants, in order to promote better sexual health education in schools.

Key Informant Interviews

During the informant one-on-one interviews, several themes were identified as being prevalent in most of the conversations. Note that, as mentioned in the "Methodology" section, key informants are defined as individuals who are senior-level professionals within their fields, some of which sit on the local HIV/AIDS planning body. Individuals come from the following backgrounds: Ryan White Part A, Federally Qualified Health Centers (FQHCs), housing, syringe services programs (SSPs), private sector, homelessness, hospitals, mental health, and corrections.

The following themes are ordered in terms of how often they were discussed, from most often to least often. Note that the interview guide did specifically ask questions on some of these topics, which possibly influences the resulting order of the themes below. While everyone interviewed in this section has a diverse background, many points of agreement exist between the participants. Many participants were also able to provide insight into system-wide problems, discussing potential ideas and solutions from their perspectives.

The word cloud below helps visualize some of the words used most often in this set of interviews. Larger words indicate a higher frequency of the word within the interview notes (Figure 16).

Figure 16: Word Cloud Generated from the Set of Nine Key Informant Interviews

Continuum of HIV Care

The following section describes and identifies points made that relate to the continuum of HIV care. This process includes HIV testing, linkage to care, and retaining individuals in care with the goal of reaching (and maintaining) viral suppression. HIV testing was, by far, the most prevalent

topic within discussions of the HIV continuum of care. Medical providers and medications are additional sub-themes that also fall under this broader umbrella of the continuum of HIV care.

HIV Testing/TTRA

Eight out of the 9 interviewees had substantial comments about HIV testing and identified common problems faced in terms of normalization and implementation of HIV testing. The Syringe Services Program (SSP) representative, from Miami-Dade County's only SSP (IDEA Exchange), specified that "early detection and treatment" are essential for getting people into care and keeping them in care. This is a common goal of HIV prevention and care systems, where the idea is to identify positives through testing as early as possible and link them to care. This also corresponds to the first pillar behind Ending the Epidemic, which is to "diagnose all people with HIV as early as possible."

The SSP representative, like many others interviewed here, applaud the FDOH-MD for their Test & Treat/Rapid Access (TTRA) model. First piloted in 2017, the TTRA model was discussed positively by those who were familiar with it. Still, interviewees identified that there is much room for improvement with this model. The SSP representative clarified that while "the fact that we have the model is great" and FDOH typically links patients to care same-day, the process needs to be a same-day process for all organizations involved. The SSP representative highlighted the importance of "walking patients by the hand" and "getting them through what they need to do." The support and guidance needed for someone who is newly diagnosed is important, especially in the face of a massive healthcare system that is confusing to many and historically distrusted by minority communities. According to the SSP representative, the local SSP has an effective model in place with partners as part of their testing and linkage to care efforts. An employee from the SSP would walk the newly diagnosed individual through the paperwork process at the partner location and connects them to a provider at the local hospital system, all while physically being with them in person with the hopes that the process is completed in the same day.

The need for TTRA to be a same-day process is clear, not just from the perspective of the SSP representative but also for others interviewed. The Ryan White Part A (RW) representative echoes this sentiment and identifies a challenge that they are facing with RW clients. A large barrier they face is that a lot of clients fall out of care. Recent changes in the Florida Administrative Code regarding HIV testing have helped increase testing and linkages to care, but the RW representative says there's still "mountains to move." RW Part A, along with the FDOH-MD, are working together to make TTRA the standard of care. The RW representative also highlights the need to reach out to more clinics and hospitals in their efforts. RW Part A is also hoping to expand TTRA past their current clientele with incoming funding as part of their own Ending the Epidemic plan. The broader implementation of HIV testing across clinical and hospital settings would help normalize testing and make it easier to identify unknown positives.

The private sector (PS) representative was a key player in the implementation of opt-out testing at a local hospital here in Miami-Dade County. When the Florida Administrative Code HIV testing requirements rule was updated in 2017, this hospital soon after developed an opt-out HIV screening program. According to the PS representative, the hospital modified their electronic records and internal policy to implement this change. Essentially, what they have now is an "additional layer of notifications at triage, so when the patient is going through the triage process,

this part is automated. It includes a statement stating their policy on opt-out screening for HIV." All the nurse must do is inform the patient of this policy, click yes (unless the patient opts out), and then the test is ordered. Effectively, every patient that comes in to the emergency room is automatically offered and ordered an HIV test.

> "Everyone is affected somehow, because this really is systems change."
>
> - Private sector representative, on implementing opt-out HIV testing in hospital settings

The PS representative notes that, while this opt-out system has been implemented across hospitals in Florida, significant barriers still exist and have stalled efforts. The PS representative works with hospitals to implement these changes that will allow routine HIV screening and linkage to care. This includes "modifying electronic medical records, updating lab protocols, and other things." The PS representative cites hospitals as "risk-averse," so there was a need to make this process "as automated as possible." Nothing could be implemented that could slow down the workflow, because this really does affect everybody in a hospital setting. When the PS representative goes to meetings at other partner institutions to discuss these efforts, they note how they see "all of the executives" at the meetings as well as representatives from every department. "Everyone is affected somehow, because this really is systems change." The fact that this is systems change underscores the importance of getting everyone involved on-board to make the process as smooth and seamless as possible, especially in a hospital setting where a seamless workflow is crucial and dependent on various individual steps. They initially had trouble getting buy-in from physicians because of this very concern. Physicians were concerned about "who is going to be responsible" and "who is going to link the patient to care."

Reimbursement for the tests is also a major concern from the hospital perspective, as providing a test for virtually every patient that walks in through the door could prove costly. An outside organization funds this opt-out program at Homestead Hospital, but they are unaware how much longer the program is going to be in effect. They specify that "an average hospital will budget $250,000 for a year of HIV testing," and with tests costing "$5 to $9 each," that budget is expended quickly in an opt-out system. The Centers for Medicare and Medicaid Services (CMS) does not provide reimbursement for HIV testing in an emergency room setting, only in a primary care setting. Their program covers funding for this gap, but the expectation is that hospitals will be able to bill and collect from patients that have private insurance. Another workaround that they mentioned could help address the reimbursement issue is if Florida could remove the medical necessity clause for HIV testing in the emergency department.

The potential for the identification of positives in an opt-out emergency room setting is incredibly vast. Past research has shown that, for those living in poverty and without insurance, their main source of healthcare is the emergency room (source). Providing tests for all in this at-risk population would help identify those with unknown statuses as well as help identify additional people in the general population who do not know their status. There are significant barriers that exist for widespread implementation of opt-out testing in a hospital setting but finding ways to

implement this process could prove fruitful in efforts to diagnose all people with HIV as early as possible.

The hospital representative's comments on HIV testing echo these concerns mentioned above. Their hospital does not currently have an opt-out HIV testing in place, but they stated that they are hoping to take future steps towards that opportunity. Their main concern is with the funding and manpower required to implement an opt-out system. Ideally, "they want to test everyone while they're waiting, but it goes back to affordability" as well as the "manpower needed for integration of opt-out testing in hospitals." These concerns are likely shared by hospital administrators and executives across the system, and these barriers should be addressed to provide additional testing for these patients. The hospital representative also notes that it is essential to test for Hepatitis B/C, syphilis, and other STIs when testing for HIV. Individuals with STIs are at a higher risk for also contracting HIV.

Opt-out testing is currently being implemented in the correctional systems as well. The Corrections representative notes that they recently started implementing opt-out testing for HIV and STIs. This test is offered to all individuals as part of a check-in with a nurse at the correctional facility, but it is only for those individuals who have spent at least four days in the facility. The corrections representative also highlights their good relationship with partners and how they implemented TTRA at the facility before they started implementing opt-out testing. From their perspective, they believe testing and knowing your status is "the most effective strategy – you can prevent the spread by knowing your status." Most recently, a Social Worker was brought into their facility that works directly with the incarcerated population in order to link them to care post-incarceration.

FQHCs are also taking steps to implement HIV testing more broadly and include opt-out testing as part of the process. The FQHC representative believes we "need to be more aggressive with TTRA," and that "everyone should be tested and know their status." Like comments made by other interviewees, the main concern here with TTRA is that "it needs to be same-day – you cannot have HIV+ walking out of the clinic without some medications." Currently their network of clinics is seeing relatively low HIV testing rates, especially in some populations that are deemed at-risk. As a solution, they are working on implementing opt-out HIV testing throughout their clinics. The hope is that this will substantially increase the number of patients who receive a test, especially those in the at-risk populations.

The mental health representative interviewed also cited barriers when trying to provide HIV tests for their clients. Their organization received a small amount of funding for HIV tests in clients who use drugs, but unfortunately, they were limited in their reach because of restrictive rules tied to the funding. The definition of who qualifies as a "drug user" was very strict and specific, and this prevented them from reaching most of their intended population. Similar comments were made as it relates to funding rules and policy, which can be found in the "Funding" section below.

Medical Providers

Across the informant interviews, several weaknesses and threats were identified as it relates to medical providers. The homelessness representative comes from an organization that provides comprehensive medical and support services to the homeless community, and they discussed

how they felt their current providers do not have the skillset needed to treat HIV. The lack of HIV certification within providers that serve vulnerable communities seems to be connected to a lack of interest in the certification itself. According to the homelessness representative, "only one out of the 10+ providers here have expressed interest in getting an HIV certification." The organization takes a patient-centered medical home approach in providing care to their patients. It emphasizes the patient's relationships with their nurses and case managers to deliver comprehensive health services. The organization used to partner with an agency that provided HIV testing services once a week, but due to funding issues, those services are no longer provided by the agency.

"If we don't get new doctors interested in HIV, we'll be in trouble."

- Ryan White Part A representative, on the aging HIV provider pool

The above problem was also identified by the RW representative, as they stated there is a limited interest in HIV across medical providers, likely related to the stigma. The stigma attached to HIV reaches even the provider pool, possibly serving as a barrier and contributing to the shortage of HIV certified physicians that exist in Miami-Dade. The RW representative also points to our aging provider pool, and the lack of younger providers doing this kind of work. Simply put, "If we don't get new doctors interested in HIV, we'll be in trouble." The RW representative also finds that providers are generally reluctant to interacting with the RWP.

The FQHC representative stated that they are going to be doing more work in getting their providers more comfortable with HIV. It was mentioned that HIV+ clients do not need to be seen always by an Infectious Disease specialist – primary care doctors can provide quality care as well with the proper knowledge and certification. The representative is confident in the ability of their providers' services and believes they are "doing a good job in the medical community," just that HIV needs to be further normalized in that community. The corrections representative also shares that, typically, medical providers aren't involved in outreach and education. The representative believes that, overall (but especially in the case of an outbreak), providers could have a bigger role in informing their patients on how to prevent HIV and about HIV in general.

Medications

The medications themselves are doing well, according to interviewee responses; the concern is more so with the access to and price of said medications. The corrections representative expressed positive feelings about the fact that modern-day medications have limited the number of pills PLWH need to take. There are "a lot of 3-in-1s" available, and especially in the correctional facility setting, they have been seeing much progress in the availability of these medications for this population.

Both the RW representative and the SSP representative shared extensive reservations with the availability of ADAP locations. The problem, as the SSP representative puts it, is that it "makes it difficult to access ADAP if there's only one location in such a large county." The RW representative describes a recent pilot program where the state ADAP and CVS partnered to allow ADAP clients

to receive their medications at any CVS if the county does not have a Central Pharmacy. Miami-Dade has the one Central Pharmacy, so most RWP clients cannot access this benefit. Only the clients seen at the West Perrine clinic, which is estimated by the RW representative at around 300 clients, can go to CVS for their medications. The representative sees this as a promising pilot program but fears that it might take a long time before we see a broader program implemented for the rest of the RWP population.

The SSP representative identified some innovative strategies for how they reduce barriers to medications for their clients. At the local SSP, they store their clients' expensive medications on-site since many of them are homeless. It is "much safer to store them here rather than it being out on the street." Instead of the patient having the 90-day supply of medications with them, SSP staff prepare weekly pill boxes for the clients to have with them so they are not at risk of being stolen or sold on the streets.

The SSP also does "medication drops" once a week, where staff will physically go to where the client is located and provide them with their medications. This is used as a solution for homeless clients who cannot or do not want to travel to the local SSP to pick up their medications. It is an effective strategy that keeps clients engaged and reduces barriers, but the underlying threat to its existence is sustainability. The SSP currently only runs on private funds, and the additional tasks outside of the syringe exchange "will simply require having state or county funds" in the future. The SSP representative claims that "the private funds can be enough for the needles, but it is not enough to support everything else we do as well."

HIV Education

All the interviewees also pointed to educating the public on HIV as a necessary task to improve our prevention and care systems. The housing representative puts the lack of awareness and information on the disease as one of the top issues in our system. The representative states that "people really take [HIV] for granted, they should know more about the disease, how it's transmitted, etc." Stigma and media are two sub-themes that were discussed heavily within the conversations on HIV education.

Stigma

The stigma around HIV can be a debilitating barrier for those living with HIV and for those in the broader population. As the hospital representative notes, even though "HIV has morphed from a death sentence to a chronic disease," there is still a stigma attached to it. People can now live long and happy lives with HIV, but the stigma still serves as a barrier for many reasons. The hospital representative claims that the stigma "greatly threatens" HIV care because of the stigma attached to visiting what people would perceive as an "HIV clinic." They cite the example of a clinic that the University of Miami used to operate in Florida City that served PLWH. The hospital representative describes how it was closed because people wouldn't go into the clinic, since if

someone walked through those doors, “everyone else knows you go there because you have HIV.” Education is required in the broader public to reduce this stigma attached to HIV.

According to the homelessness representative, stigma has been “a challenge for years” and can come from various sources. The stigma could not only come from HIV, but from one’s own family members: “[Testing positive] could show family members another part of that person’s lifestyle” that they were previously hiding. This could include identifying as LGBTQ+, as an injection drug user (IDU), or reveal some other risk behavior that has a stigma attached to it. This relates to comments made by the SSP representative, where people don’t want to get tested because of an “internalized stigma” attached to even the slight possibility that they might be positive. The SSP representative is also familiar with some cases where he has seen stigma damage PLWH fatally, thinking about young males at the local hospital dying because of their refusal to take medications. “Taking the medication serves as a reminder of their positive status,” and the SSP representative argues that this “internalized homophobia” combines with the stigma around HIV to create this complicated situation.

Stigma also has a significant effect on the incarcerated population living with HIV. The corrections representative states that those living with HIV in correctional facilities face legitimate fears about people knowing their status: “They think that if people know they’re HIV+ they might get beat up, sexually harassed, etc.” There have been patients who did not want to tell the medical providers within the facility because “they were afraid it might get out to the broader incarcerated population.” The incarcerated population living with HIV faces these additional threats to their well-being because of the fear and stigma attached to their status.

While the stigma is clearly a large problem facing our prevention and care systems, many shared comments on necessary actions and potential solutions for reducing the stigma around HIV. The private sector representative commented that the best way to reduce the stigma around HIV is through implementation of opt-out testing. This is because “everyone is going to get a test performed unless they specifically decline.” Routinizing HIV tests as part of standard healthcare will undoubtedly help normalize testing within the broader population. The RW representative also shared that implementing telehealth solutions for PLWH could minimize the effect that stigma has on their pursuit of medical care.

Media

Many of the additional solutions for addressing stigma discussed in this set of interviews were primarily concerned with the use of media to educate the population. Most of the participants interviewed agreed that educating the community and normalizing HIV would help to reduce stigma. While many interviewees did agree that the continued use of standard media outlets is vital to “desensitize” the population on HIV (TV, radio, billboard), there is a need to modernize the message and use other media platforms. The homelessness representative believes “we need to find better strategies,” and one suggestion provided is the use of social media. The RW representative suggests looking to other municipalities’ messages for insight on how to modernize, specifically in Broward County. They discussed how their advertisements look “professionally done, not like your typical government PSA.” The FQHC representative also

suggested looking outside of Miami-Dade for ideas on messages, pointing at the CDC's campaigns on HIV as typically solid messages. Regardless of the campaign or media used, the FQHC representative believes that messaging needs to "have a positive spin on it" and "never a negative message." Using a negative message could run the risk of increasing the stigma around HIV.

"We need to find better strategies."

- Homelessness representative, on our current media promotion techniques

The housing representative suggested focusing messages more on the people themselves rather than the disease. "These folks (PLWH) are regular people, just like you and me." Promoting media messages that highlight the fact that PLWH are regular people with a manageable, chronic disease could help decrease the stigma surrounding HIV and help normalize HIV in the broader population. The messages could also be tailored to specific geographic areas and "hotspots," as the RW representative suggests. They argue that "even though we spend a lot of money on these efforts, the message and delivery are not modern enough." A proposed solution includes incorporating technology to better deliver these messages to specific populations in particular "at-risk" locations, possibly including the use of social media. Another solution they suggested is to promote these kinds of messages around HIV in ports of entry (airports, seaports, etc.), given the high volume of tourists that come to Miami. However, it was noted that there might be significant pushback from the tourism industry if this route were to be taken.

Social Determinants

Social determinants of health have various and significant effects on the health status and overall well-being of individuals.[20] In these interviews, individuals were asked to share their thoughts on social determinants as they relate to HIV. All the participants agreed that social determinants play a role in accessing services as well as the quality of life of PLWH. Various social determinants were discussed, and each is explained below by category.

Housing

The mental health representative describes housing as a "significant barrier" for PLWH trying to access services. The RW representative also mentioned housing in their response and further elaborates on how there "needs to be a more sustainable way to fund housing." There is a housing trust fund meant to be used for affordable housing, but in recent years the Florida Legislature has been diverting funds into other programs and this threatens the stability of affordable housing.

[20] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

"One of the best ways to minimize the risk of propagation of HIV is to have a housing-first approach."

- Housing representative, on how to prevent the transmission of HIV

The housing representative takes a "housing-first approach" in their work, as their main goal is to provide sustainable and quality housing for PLWH. They believe that "one of the best ways to minimize the risk of propagation of HIV is to have a housing-first approach." The representative acknowledges that resources are limited for affordable housing, and it is a "costly proposition." Their agency provides PLWH with a variety of assistance options, including tenant-based, project-based, and short-term. The housing representative claims that over 90% of their clients are satisfied with their program, according to a recent survey their agency distributed. A lot of other programs in other cities utilize short-term housing assistance, but they decided "from the get-go that this is something the community really needs, and they're satisfied with it."

Income

Income and living in poverty were identified as underlying issues that really affect all social determinants. The homelessness representative identifies poverty as an issue for PLWH and connects it to a "lack of employment opportunities" for those living in poverty. They state that "if people are not working, there's nothing for them to do, and that can push them to participate in other risky behaviors." These risky behaviors could then put them directly at risk for contracting HIV, which continues this cycle of poverty, unemployment, and transmission. The mental health representative also sees poverty as a major roadblock for PLWH seeking services. While the "evidence-based treatment exists and is effective," those who are "living in poverty have trouble accessing it."

Income is a major social determinant for the post-incarcerated PLWH population as well. The corrections representative discusses how there is a need to organize a "continuity of care once they get out." This includes establishing "who they will live with, support systems needed, a primary care doctor, etc." Most of these are difficult to establish if the PLWH does not have any financial assistance.

Access to Healthcare

Having access to a healthcare provider or insurance helps secure PLWH in care and keep them engaged. This is echoed by the comments from the SSP representative, who mentions that "the people that have healthcare are in a more stable situation and do not face as many barriers." In our system, there is a "lack of affordable access to health insurance" as stated by the RW representative. They clarify that while ACA enrollment has helped connect clients to care, the cost is extremely high and there is a lack of friendliness from the insurance companies. They also state that there is a "disconnect" between the ACA companies and the RWP.

Many clients served by the housing representative's agency have lost access to healthcare and are currently facing "a lot of uncertainty." Clients who used to have case management through the state's PAC waiver lost it after changes in 2017, and while "some clients reached out personally to their insurance companies for new case management," those who did not have insurance could not do the same. The fact that "everything is done over the phone these days" and the lack of a case manager for these clients has clients confused about their insurance status or who their medical provider is.

Transportation

Transportation was also listed as a significant barrier for PLWH trying to access services. The FQHC, mental health, hospital, and RW representatives all mentioned transportation as barriers in their answers, citing the poor public transportation system in Miami-Dade and how often times PLWH might have to take a half-day off work simply to make a doctor's appointment downtown or take a bus ride to the ADAP pharmacy to pick up their medications.

Immigration Status

The undocumented population faces their own barriers in accessing services, and this is a significant population in Miami-Dade given the "large immigrant population" present here. The corrections, mental health, and SSP representatives mention how their reluctance to seek care due to fear of persecution serves as a deterrent to their care. The SSP representative specifically mentions how "HIV doesn't care about documentation status," which is why "we need to look at everyone in our population."

Partnerships

Partnerships and collaboration between different agencies were identified as essential for our HIV prevention and care systems. All the interviewees specified successful relationships, both current and former, that have helped provide better services for PLWH. For example, the SSP representative described how their partnerships with FDOH-MD and others have been "key to their work." While the beginning of the relationship with FDOH was characterized as somewhat disconnected, they "have a much better relationship" and now work together to "prevent major outbreaks of HIV." They recently published a paper on this work, where they identified and prevented a major outbreak in homeless PWID in 2018.[21] The SSP representative mentioned that the SSP also has good relationships with local hospitals, healthcare systems, and other managing entities.

The housing representative lists some FQHCs and nonprofits as consistent partners that they have for providing services to their clients. Their clients face a lot of tenant-landlord resolution

[21] https://link.springer.com/article/10.1007%2Fs10461-019-02680-9

issues, so they used to have a program where a law firm would provide general counsel for the clients. Due to funding issues, that stopped a couple of years ago and now the clients are referred to local nonprofit agencies that provide free legal aid. The mental health representative also states that their agency has made a lot of local partnerships that has helped them provide more services for the local community, and the private sector representative identifies public-private partnerships like those built with the FDOH as necessary for "strengthening relationships with hospitals and providers."

Effective partnerships have also been necessary to address the needs of the incarcerated population. The corrections representative described the policy they have in place where released inmates can leave with a 7-day supply of medications but working with the DOH has allowed them to make a 30-day supply available to their population. Their agency has a "good relationship" with the FDOH-MD, as well as another service provider. Their recently hired social worker is funded through this agency, and this social worker helps link PLWH to Ryan White services and additional needed services.

There are a lot of barriers that exist to effective partnerships, as discussed in these interviews. The hospital representative believes "there's a lot of people doing good work," but "everything is in silos." The mental health representative echoes this idea of working in silos and claims that this is especially the case for state agencies. While their agency has "great relationships" with the local health department, they see that the state-level department tends to do work in a silo. The RW representative further elaborates on this issue and explains how the "State makes decisions in a vacuum." Systematically, local areas are included at a minimum in decision-making, and there tends to be significant clashes between the local HIV/AIDS sections and the State HIV/AIDS section. This gives way to a lot of "uncertainty" in the overall situation, even though the relationship between the local RWP and the local health department is "the best it's ever been." The RW representative is aiming to work soon with FDOH-MD in identifying HIV clusters and potential outbreaks through a mobile effort.

Engagement

When asked about community engagement, interviewees had a variety of ideas and thoughts on the importance of keeping the community and stakeholders engaged in HIV efforts. Participants generally believed it important to keep the community engaged to help educate and prevent the spread of HIV among vulnerable populations, and the question around engagement in an HIV outbreak situation was critical to understanding participants' views on who needs to be involved in such situations. Participants were presented with a scenario where an HIV outbreak was occurring in the Miami-Dade area, and were asked to identify who would need to be engaged in the response to an outbreak.

The FQHC representative specified some key players that would need to be involved in an outbreak situation: the "healthcare community, public health agencies, and mobile teams that can go out into the community." They described how mobile efforts can help in engaging communities and delivering services to them (e.g. rapid HIV tests). The hospital representative stated that the FDOH-MD would have to be the leaders in this case, as their leadership is "crucial" in getting all

healthcare institutions involved in such efforts. They also mentioned that marketing and education would be important as well to keep the population informed and engaged. The private sector representative agrees that FDOH-MD would lead in such efforts and pointed to past successful identification of outbreaks by the FDOH-MD. They say FDOH-MD has "done some innovative work in predicting different risk factors for people." Providers would also need to be involved in an outbreak effort, and they would be responsible for "being aware, alert, and testing."

> "[FDOH-MD] would be the leaders in this situation."
>
> - Hospital representative, on the importance of FDOH-MD leadership in a potential HIV outbreak

Faith-based organizations were described as key players for engaging the community. The homelessness representative states that "churches are a very powerful avenue," and having church leaders at the table "would go a long way." Churches have long been identified as trusted organizations within communities, especially within minority communities. The hospital representative also mentioned the importance of including faith-based communities in these engagement efforts. Identifying ways to better engage faith-based communities could help in providing better prevention and care services to members of these populations.

Additional strategies for community engagement were shared by interviewees. The corrections representative suggested having educational fairs that are geared more towards fun activities that could attract more people. The FQHC representative mentioned getting more stakeholders involved in Ryan White Part A to keep them engaged. In a clinical or hospital setting where it is difficult to get buy-in from staff, the private sector representative shared that taking back success stories to staff helps keep them engaged in the work. Sharing how their referral or order of a test helped identify someone who was positive "helps them see the big picture and better understand how this helps patients." The RW and SSP representative both discussed the importance of sharing successful strategies and "real experiences" that agencies have. Honest sharing of the "experiences and struggles we have as organizations," as well as more "realistic sharing of knowledge" helps keep stakeholders engaged and the community engaged. This practice of sharing experiences has especially helped IDEA and gotten them a lot of "positive feedback" from clients and other organizations, according to the SSP representative.

Biomedical Strategies

Most of the participants had mixed remarks about PrEP and positive remarks about IDEA Exchange, the SSP located in Miami-Dade County. While PrEP itself is seen as "effective" by some participants, many believe there is still a lot of work to be done in terms of awareness and access to the medication. As the hospital representative notes, "the MSM population seems to understand PrEP, but other at-risk populations don't know as much about it." This is tied to the fact that, while MSM are the highest at-risk for contracting HIV, there are additional populations at-risk that are not as informed about PrEP. The SSP representative agrees with this idea, stating that "PrEP among high-risk populations needs to be expanded." There is a threat to the

sustainability of PrEP as well, in that "it's a very expensive medication so either the price has to go down (which is more sustainable) or we have to get increased funding (which is harder to do)." Despite these long-term threats, the SSP representative sees the rollout of PrEP in Miami-Dade as "robust" and having reached a lot of people in "only a couple of years."

The FQHC representative is a "big promoter of PrEP" and sees it as a key component of Ending the HIV Epidemic. They pointed to the progress California had made at expanding PrEP by being the first state in the nation to offer it, along with PEP, as an over-the-counter medication. To better engage the community and stakeholders on PrEP, they believe advocacy is an important factor as well as including the healthcare community in opportunities to learn more about PrEP.

Regarding IDEA Exchange, the program has been received favorably by interviewees. The corrections representative states the existing SSP is a "good thing, especially for opioid users." The hospital representative mentions the needle exchange program is "doing great work," and the private sector representative says they are doing "innovative work." IDEA Exchange provides syringe exchange services to clients, as well as additional linkage to care for HIV and substance abuse.

Funding

Funding (or the lack thereof) is almost always mentioned as a threat within the key informant interviews. Limited funding resources are cited as a barrier for providing services to PLWH and to the broader population for prevention purposes. The mental health representative links part of the lack of funding to the fact that Florida never expanded Medicaid under the Affordable Care Act (ACA). There are also tight rules tied to funding for other services, and this ignores the reality that "these diseases require a more flexible funding pool." The lack of funding has also limited access to their agency's programs, with "500+ people on waiting lists" because of a lack of funding. The FQHC representative agrees with the above sentiment and states that there is a need for Florida to expand Medicaid under the ACA.

The RW representative also cites the strict rules tied to funding as a threat to the work they do. It is "hard to put together comprehensive care" when they "can only focus on HIV-related care." The RWP can pay for services for a client who is HIV+, but if the person is HIV- then they cannot pay for services. This effectively prevents the RWP from doing a lot of prevention-related work.

Funding to retain a professional workforce is also a necessity for these agencies. The private sector representative sees "a lot of turnover" at the FDOH, and they believe it is tied to the funding issue. The homelessness representative also sees adequate funding as a necessity for "organizations to hire the right professionals." Higher salaries can help in retaining a quality workforce for longer periods of time. Other representatives cite the need for a "comprehensive health approach where resources can be shared." The SSP representative points to San Francisco as having dropped incidence rates to "nearly zero" because of the use of effective programs for decades but acknowledges that they have had more funding from their state available to implement said programs.

Technology

Technology was cited as being a very useful tool for solving problems and bringing many possibilities for the future. In the correctional setting, the recent progression to electronic records from paper records had helped keep track of individuals' past health needs. The electronic record system used in the correctional facilities is connected to the Jackson Health Systems electronic records, so the corrections representative identifies this as a useful development on their end. The FQHC representative has also mentioned that technology has been essential for their work in identifying patients with high viral loads across their network of clinics.

There are complexities associated with data sharing and data coordination, which was listed as a top issue for the private sector representative. They also point to how FDOH-MD embraced technology to develop their syphilis testing model in Homestead Hospital and "applauds" them for this use of technology. RW Part A is currently trying to work on data integration and embracing technology with FDOH-MD, telehealth, and life skills training. The hospital representative suggested a central database which could be easily accessible with information on resources, treatment, and care specifically for HIV.

Additional Themes

The following themes were discussed as well, although at a much smaller rate compared to the themes above. These two smaller themes include the transient population in Miami-Dade and mental health within the PLWH community. The SSP describes our population in Miami-Dade as transient in the sense that there is an intersection of different high-risk populations (MSM, IDU, heterosexual women in high-risk locations), complicated by the influx and outflux of immigrants and tourists. The SSP representative states there is a lot of overlap between these various populations, and the "fluidity" of our population is what makes Miami-Dade different from other municipalities.

The mental health representative describes mental health as a necessary component of addressing HIV in our population. They cite Miami-Dade as having "higher rates of serious mental illness" and, combining that with higher rates of a medical infectious disease like HIV, "creates a perfect storm." There is a need to target mental health and substance abuse issues within the PLWH population and the broader population as well.

Key Stakeholder Interviews

Within the key stakeholder interview group, various themes were identified that parallel themes discussed in the other public input settings. Key stakeholders, by definition, do not sit on any local HIV planning bodies; rather, they are individuals who have backgrounds which intersect with HIV-related work. These backgrounds include medical, social determinants, immigration, research, domestic violence, and support services.

The important themes identified in this series of interviews include the HIV continuum of care, social determinants, HIV education, engagement, prevention strategies, and then additional sub-themes. These interviews help provide additional information that support the public input sessions and contextualizes the broader community. The word cloud below helps visualize the words used most often by individuals interviewed in this section.

Figure 17: Word Cloud Generated from the Set of Six Key Stakeholder Interviews

Continuum of Care

Within the context of care received by PLWH, it was stressed as essential for patients to have access to as many services as possible in one place. The provider representative works at a large university hospital system in Miami, which has a lot of medical providers that see and treat patients with HIV. They stated that they try to “have everything in the clinic so patients can get what they need when they need it.” This allows providers, medical or not, to engage these patients and provide them with services while they are present at the site. This is especially important for those patients who might have a difficult time making it to the clinic in the first place because of other barriers, as their visits are likely not as consistent throughout the year.

For those agencies that do not have the capability to provide comprehensive clinical and support services for PLWH, like the immigration representative, they make sure to refer patients to appropriate services as necessary. The immigration representative provides legal services for undocumented immigrants, and there have been many clients in the past and currently who are living with HIV. The agency itself has been able to provide referrals more effectively thanks to its partnership with FDOH-MD, but that is the extent to which they can help their clients. It is "hard to follow up on the status of these connections," due to their high case volume and limited resources.

> "We try to have everything in our clinic, so patients can get what they need when they need it."
>
> - Medical provider representative, on the services available to PLWH at their clinic

There are also particular populations that simply cannot access care services because of a fear of repercussions. The domestic violence representative discusses the population they work with and how "their life could be in danger" when they even go out of the house to access healthcare services. For those (most often women) who are in abusive relationships, they are afraid of how their partner would react for simply seeking services for a possible HIV diagnosis. It becomes "a safety issue" for them to even try and find services. The domestic violence representative also explains how "they don't believe the confidentiality rules" because it is hard for them to trust people. Some of their clients live with HIV, and these clients are unwilling to leave the relationship because "it would be hard to find another partner" who can be understanding of the illness. It makes them feel "hopeless" and not in control of their lives. Victims of domestic violence are especially vulnerable to HIV and, because of that, the domestic violence agency tries to provide as many support services as possible for those victims who can make it out of the house to their agency.

Medications were discussed within these interviews, but to a lesser extent compared to previous sections of this report. The support services representative is from an agency that provides a variety of prevention and care services to the overall population, including PrEP, testing, and education. They describe how we need to continue to stress the importance of adherence, especially given the fact that people see HIV as "not as serious" of a disease these days. Efforts need to be more focused on Black and Latinx groups given the health disparities that exist in life expectancy within the PLWH population. The support services representative cites previous statistics on how, in general, Black and Latinx males live about "half as long as white males." One of the problems they see in their client group is a lack of knowledge on how to correctly take their medications. They are on a "one pill a day regimen," but sometimes "providers didn't explain it well enough to them." The patients sometimes take their medications at different times of the day, not knowing that they are supposed to take it at a specific time of the day every day.

The research representative supports the medications that exist today and highlights adherence as an issue. In their opinion, the "drugs are fantastic" and are effective in getting people's viral loads down to undetectable levels. The main issues are "adherence" and "getting people into care," as historically Miami-Dade has had "poor results in getting people into care."

Two additional sub-themes were discussed at length under the continuum of care: testing and medical providers. The following sections elaborate on each of these sub-themes.

HIV Testing

HIV testing is incorporated into the services offered by these various agencies in different ways. For example, the domestic violence representative partners with a local FQHC that provides weekly HIV testing services for free at the domestic violence agency. Victims that come in have the option of getting tested, but not everyone accepts it: “Some of them take it, some of them reject it.” This is likely connected to the previous comment made by the domestic violence representative regarding domestic violence victims not trusting the confidentiality rules around services, as well as a general fear of anyone else finding out their status.

The research representative specifically highlights same-day TTRA as “essential.” The medical provider representative supports this and adds on that “the TTRA program is getting better.” At their organization, patients that enter the system through TTRA have patient navigators that essentially serve in the same capacity as case managers. These individuals stay with patients for their first year in the program, but the problem is “limited resources” that prevent an expansion of this program. The medical provider also cites some statistics on TTRA success compared to non-TTRA statistics: “If you give someone who just tested HIV+ a referral from a regular testing site or provider, only about 50% of them make their appointment. If it’s someone at a Test & Treat program, 90% of individuals are connected to care.” While these values are approximate, it does suggest that there is a difference between TTRA and non-TTRA referral processes. The medical provider representative also describes a need for “more routinized testing” in clinics and the community, especially in OB/GYN settings.

As mentioned in earlier sections and by the support services representative in this set of interviews, the issue with routinized testing is the cost. The support services representative offers HIV testing at their agency and believes STI testing should be automatically linked to this, but there is a lack of funding for this. In the case of their specific agency, they explain how their HIV testing budget is made up of testing kits provided by a CDC grant as well as staff time. While most agencies offer very limited STI testing together with HIV, their agency provides it to those who request it; last year alone, tens of thousands of dollars were lost by the agency because of a “huge demand” for HIV and STI testing. The lab costs are cited as a large barrier for this routinized testing system, as providers and agencies must pay for labs “multiple times over” for a single client if they are testing them for HIV in addition to other STIs.

Medical Providers

Within this set of interviews, participants generally had negative remarks to point out about the state of medical providers in Miami-Dade County. We “do not have enough culturally competent providers,” which are needed to serve racial and ethnic minority MSM groups as well as trans populations, according to the support services representative. They express that it is “not enough” to simply have someone who speaks a second language on their team to meet the cultural competency requirement, but rather it requires providers to be knowledgeable about the

populations they are serving. The “language is a prerequisite” for populations who speak a different language, but it should not be the “end goal” of cultural competency for providers.

“We do not have enough culturally competent providers.”

- Support services representative, on the need for cultural competency in working with racial and ethnic minority LGBTQ+ groups

The medical provider representative states that “providers are not being very proactive in talking about HIV with their patients.” The representative believes that providers either do not know how to talk about HIV or treat it and are also uncomfortable talking about PrEP. This can have a large impact on at-risk populations if a provider is not talking to their at-risk patients about preventative strategies like PrEP. The social determinants representative also believes providers should be more educated on the LGBTQ+ community and that there is a “need to educate” providers on HIV as it relates to this specific community.

There is typically a “resistance” from the medical community when it comes to HIV, as the domestic violence representative describes it. Whenever they go to their routine checkups and ask to include an HIV test in their bloodwork, they are met with looks of confusion and questioning: “Really? Are you sure? You think it’s necessary?” This points to the fact that providers do not “stress the importance of getting tested,” which likely relates to the lack of knowledge on HIV or lack of interest in HIV.

Additional issues exist within the field of medical providers and HIV. The support services representative cites a source of significant waste within the services provided to clients free of charge. While clients can generally receive free services pertaining to testing, education, etc., there is a back-end reimbursement for these services. Often, some clinics will “re-test” a client even though that client already received a previous test very recently that confirmed their status. The tests are done sometimes for “extra reimbursement,” and sometimes because of “clinical arrogance” such that the clinic does not trust the test done by another clinic or agency. The geographic distribution of medical providers that treat HIV are also an issue, since all are “lined up on the eastern seaboard.” While they do acknowledge that “a lot of PLWH live on the eastern seaboard,” this alienates PLWH who live more out west and especially in the southern regions of Miami-Dade. This could mean “traveling all the way to Miami Beach” to access services not offered in other places within Miami-Dade.

Social Determinants

Social determinants were discussed as “essential” and “important” for PLWH, as well as for the broader population. As the immigration representative states, “all of these [determinants] impact peoples’ knowledge and willingness to access care.” Depending on the social needs of a client or patient, this could determine whether they are able to get the services they need. The medical provider representative describes social determinants as “fundamentally critical” to accessing HIV services and supports his response by stating that people who struggle with social determinants

"use more healthcare resources and get worse health outcomes." Not only do unaddressed social determinants affect the quality of life of a patient, but it also affects the overall resources the system has available to care for the population.

The social determinants representative cites that FDOH-MD does a good job at making sure "efforts are not replicated" within the different programs. FDOH-MD is always "checking where they're at" regarding social determinants and developing strategies to improve on those areas of need, according to them. While FDOH-MD does work to improve these determinants, they cite that "government municipalities" and "other organizations" need to be involved as well to broadly address social determinants.

The following subthemes were identified within the scope of social determinants.

Access to Healthcare

There are different barriers that prevent access to healthcare for PLWH. Many of the clients seen by the domestic violence representative "do not have insurance," or complain that "insurance doesn't cover a lot." The medical provider representative also sees a lot of patients that are uninsured and simply "cannot afford HIV care," which leads to people being treated "fundamentally different" within the healthcare system. They cite Medicaid expansion as a solution that would help for many of these clients. They also cite how their clinic takes a medical home approach and offers patients access to services including "pharmacists, mental health, social services, experts in Hep C, access to legal aid, OB/GYN, etc." The research representative has seen that many of the people who "know their disease and understand their disease stay in care," but the underlying problem for accessing services could have more to do with social determinants.

Immigration Status

Undocumented individuals face barriers that are specific to them and their needs when trying to access services. The immigration and medical prover representatives both explain how "they don't know if they need insurance" for services, or if accessing certain services would increase their risk of "being caught and deported." Additionally, not being able to access services like SSI or other government support makes it more difficult for them to care for themselves. The support services representative also describes how there is a fear of "being expelled from a job, family or church" if they are known to be accessing services for HIV-related issues. Legal Aid was cited a few times as an agency that helps undocumented populations sort through some of these issues, as well as other legal services organizations.

Additional determinants

Housing is also an issue for low-income PLWH. People are generally "unable to find affordable housing," and "housing security" is something that is necessary for any person to have a sense of safety in their lives. Many clients "struggle to make ends meet" because of low income and the costs of living in an "expensive city" like Miami. People who are economically insecure usually

"cannot advocate for themselves" because of their need to address their immediate concerns in their surroundings. Often, they will "put everyone else before themselves," even if that means missing a dose of their medication or not being able to do something for their own good.

HIV Education

The overall lack of information in the community "continues to be a problem." The domestic violence representative sees that there is a "misunderstanding of the illness" and that in part is contributing to disparities seen in HIV systems. The community is seeing HIV as "a disease of the past" and there is a paradox because many people are living healthy lives with HIV, but that takes away attention from the issue. The vulnerable community is at risk because they "might not have access to information on treatment and prevention," according to the immigration representation. One general solution that was proposed includes providing more information at doctor's offices on available services.

Media and stigma were elaborated on by participants under the topic of HIV education.

Media

The proper and effective use of media is important for getting the message out to communities. Social media was cited often as a needed tool for messaging, and there is a need to create "engaging and interactive media." The domestic violence representative also cites how the information must be up to date and relevant to "how serious the problem is." Radio is especially important for Spanish and Creole-speaking populations, and any printed material should be "at an accessible reading level." This is a challenge that the immigration representative faces in the work their agency does – reaching Haitian communities that speak Creole but do not read it as often.

The social determinants representative does see that messaging today has been better than the past. There is "more awareness as opposed to before," thanks to messages on commercials, media, and social media. While progress has been made, there is always room for improved "proper targeting of prevention and care messages." One campaign message promoted by the support services representative's agency is the idea that there is a "diversity" of ways to stay negative, and it is acceptable for people to choose how they wish to prevent the reception of HIV. The main point here would be that it is important to provide people with the knowledge they need to make an informed decision on what prevention strategy they wish to use in order to stay negative.

Stigma

Participants in this set of interviews offered different ways to address stigma. The research representative highlighted the Undetectable = Untransmittable campaign and how using that message could help reduce the stigma around HIV in the population. The social determinants representative sees a broader solution like "talking more and normalizing it more" as important,

especially normalizing HIV testing and taking precautions to prevent HIV as a standard strategy. Accessing vulnerable communities through a "person of trust" that can promote these messages can also help in reducing stigma.

The medial provider representative sees a possible solution as getting providers to treat HIV like "an everyday thing that we do for testing." Letting patients know that it is more like an "everyday disease" and "testing regularly for it" would help normalize HIV in the broader population. Connecting personal stories to faces could also help in reducing the stigma, according to the domestic violence representative. They see a similarity with domestic violence victims in the sense that these victims often will share their stories in settings where they try to empower those listening to make better decisions or take better steps to prevent risk or harm. The domestic violence representative believes that using this system in a support group setting for recently diagnosed individuals could help empower them and give them more hope, reducing the stigma that they associate with their newly acquired status.

Engagement

Participants discussed how engagement is required in any sort of work meant to address HIV. One point that had not been discussed as much previously in other sections but surfaced in this section is the need to be sensitive to the views of different cultures when engaging them about HIV. The domestic violence representative points out how different cultures have different opinions on "intimacy" and on the information that should be out there. This is difficult to navigate because it means finding ways to be inclusive and holistic on the messaging used to engage populations, but also tailoring it in order to not "offend" specific populations with the outreach. They elaborate on this topic: "Some people think if you talk to them about HIV, you are talking to them because you see them as already having HIV or as if they're being promiscuous or something." Essentially, at-risk populations could find the very fact that they are being engaged on HIV as judgmental and assumptive. It is important to have people who are "really trained on reaching these groups," and even more effective when it is someone who belongs to that group and who knows the thoughts within the culture.

Like other interviews and forums, faith-based groups were discussed as key players in community engagement. The medical provider representative had worked with "some church groups in the past," but "not many are interested." There is a need to identify better strategies on how to engage faith-based groups and leaders specifically. One possible solution offered was to conduct focus groups for members of this community where key engagement strategies can be identified.

Participants also explained their thoughts on who should be involved in cases of potential outbreaks. Across the interviews, the FDOH-MD was generally seen as a key player that needs to be involved in such cases, as they are "the first to notice these outbreaks" because of their data collection efforts. The social determinants representative also identified hospitals and community-based providers as important players in efforts to contain potential outbreaks.

"Everyone" must be involved in such efforts, essentially. The domestic violence representative describes this as "something that can damage our entire community, so it's important to have everyone involved." They provide some examples such as high schools, universities, hospitals,

and “even safe communities.” The inclusion of safe communities suggests that something like a “safe” community can easily turn into an unsafe one in the case of an outbreak.

Medical providers have specific roles in these efforts as well. Providers “need to take a larger responsibility on HIV and learn more about this,” according to the medical provider representative. The medical profession must “be involved to a very high extent” in a potential outbreak situation, and it is especially important for them to get people into testing to determine who is negative and who is positive. The social determinants representative says they also have a responsibility to “educate their constituents and getting at-risk people the treatment that they need.”

“[Medical providers] must be involved to a very high extent.”

- Social determinants representative, on the need for providers to be involved in a potential outbreak situation

For effective community engagement and gathering input, the support services representative highlights the importance of having sessions “outside of working hours.” There are “too many committees and meetings” that meet during these hours, and they suggest that often it is the same people and same voices at said meetings. If “new voices” are desired at these input sessions, then “we need to have sessions on Saturday afternoons and bring in lunch.” Other ideas for community engagement also include having fun events to get people out, but then “always remember to focus on the importance of the topic.”

Biomedical Strategies

Multiple prevention strategies were discussed within these interviews, including PrEP, SSPs, and condoms. The immigration representative has seen “a lot more advertising on things like PrEP,” and the research provider mentions condom distribution as “necessary, without saying.” While PrEP is an effective medication, many people in the community still do not know much about it. The benefits of PrEP are “underrealized in South Florida,” with “far too few prescriptions going to those at highest risk.” Most prescriptions go to white MSM, as mentioned by the support services representative, and there is great potential for it in Black and Latinx communities. The medical provider representative sees that “PrEP is improving,” but “far from where it needs to be.”

The initial rollout of PrEP also saw some struggles and resistance from the public health community, according to the support services representative. When this new option for prevention came out initially, it “raised a lot of alarms” and people were “upset” that other options were being discussed besides condoms. While today PrEP is widely accepted in the field, the support services representative believes we need to innovate ways in which we can make the field “more open” to new knowledge on future HIV prevention strategies.

The research representative conducts work with the local SSP and notes that “they are trying to bundle PrEP with syringe services.” Combining these two methods can help injection drug users stay negative, as they are at a “great risk” of contracting HIV as well as Hepatitis C and other

STIs. The social determinants representative also oversees a clinical program that is incorporating PrEP into their family planning services.

Evaluation of existing prevention strategies is also necessary to understand what effect they are having in the community. The support services representative strongly believes that condoms "should be easily accessible," but we need to "stop evaluating condom distribution based on the tens of thousands" that are distributed. There needs to be a better way to determine the need in the community rather than using the number of condoms distributed as a measure of how well we as agencies are preventing HIV.

Additional Themes

Several additional themes are discussed below, including partnerships, funding, and mental health.

Partnerships

Partnerships were generally seen as positive and working within the HIV prevention and care systems. The social determinants representative sees them "working with the right people," and the research representative has current partnerships in place with the FDOH-MD as well as other providers. They are helping FDOH-MD in identifying strategies that work and strategies that do not work as well. The immigration representative also has a partnership with the FDOH-MD that has helped provide immigration legal services for PLWH, and it all started with one volunteer at an event. That "turned into a table at another event," and then from there it turned into a more formalized partnership. Non-traditional partnerships like this help expand the reach of services for potential clients and also serve as potential avenues of information for existing clients of either agency.

Funding

Many participants cite funding as a threat to the stability of current systems. The medical provider representative has seen Ryan White doing a "great job," but resources have not changed substantially in the last 10-20 years. The research representative also cites that many of the projects they conduct are "not big sums of cash," and funding is stretched for these research projects. The one benefit that was mentioned related to funding is that most projects that are being conducted today "align with the CDC's approach with the four pillars," according to the support services representative.

Mental Health

Mental health plays a substantial role for many PLWH. The medical provider sees it affecting adherence, as previously hospitalized people "might not take [their] medication and land back right in the hospital." The research representative sees HIV as bringing these mental health issues

and possibly starting a “cascade of events”: people get lonely (i.e. older age, partner passed), don’t want to “get out of the house,” don’t want to seek treatment, and then don’t take their necessary medications. This could also lead to substance abuse issues, which adds on complications to their overall health status.

People Living with HIV/AIDS Interviews

Three interviews were conducted with PLWH who do not primarily access Ryan White services. These individuals rely more heavily on private insurance, Medicaid, or other methods to support their HIV needs. HIV education and HIV care were discussed the most, with other themes like engagement and social determinants discussed at a lesser rate. The word cloud below helps visualize the words used most often by individuals interviewed in this section.

Figure 18: Word cloud Generated from the Set of Three PLWH Interviews

Overall Themes from Interviews with PLWH

HIV Education

HIV education was discussed the most in this section, putting it on par with its placement in the order of themes identified in previous qualitative sections. All participants shared that HIV education needs to be more inclusive of other populations besides white MSM, and there are "a lot of misconceptions in the community" due to issues like stigma and lack of awareness. One participant stated that "with education comes destigmatization," which follows findings from other qualitative interviews and analyses in this report.

> "With education comes destigmatization."
>
> - PLWH representative, on how to reduce the stigma around HIV

PLWH interviewees experienced concerns with the lack of education in the broader population, because it contributes to the myths and misconceptions around HIV. One participant stated that "by not being educated, people don't get tested, and they don't know how to talk about it." A lack of education contributes to the idea that HIV is something not to talk about publicly since people are not aware on how to discuss it and prevents efforts like HIV testing from gaining broader utilization and attention. Ironically, some of the points that the broader public has heard about HIV are partially true but much of it also gets lost in transmission of messaging. For example, one participant explains how he hears from people that "HIV is not as big of a deal as it used to be," and that statement in and of itself can deter people from protecting themselves from HIV. It is important to educate and clarify points like these that provide the overall population with as comprehensive of an understanding about HIV as possible.

The participants had multiple ideas on the types of messages that could be effective for educating the public and reducing the stigma tied to HIV. One participant mentions how a prevention message or campaign could focus on the importance of "protecting yourself in all situations." Just as one would protect themselves in any situation, one should protect themselves from HIV as well. Another message tied to this one is to protect oneself not only from HIV, but STIs as well. In order to include injection drug users into the discussion as well, multi-layered messaging can be used in order to "hit multiple points at once," as one participant suggests. Short PSAs on the radio in the morning on HIV and associated services could also help briefly inform the public on this topic, as suggested by the same participant. Regardless of the message, outreach and messaging efforts should "be more inviting" and "promoted to the community at large." While there are certain populations that are at a higher risk, HIV is something that "affects everyone in our community."

Continuum of Care

Participants had generally positive comments about the medications that are available for treating HIV. One participant mentioned how "we are moving forward with new medications," and another participant explained how they are currently in a clinical trial for a new medication. He stressed the importance of adherence to medications, saying he has "lived for 31 years and still strong" because of his dedication to his care. Another mentioned how "treatment is prevention," which is a message that is constantly promoted today in our HIV prevention and care systems.

One participant provided opportunities for increasing adherence in PLWH. He is a consistent user of medication reminder applications, which helps him keep track of his medications and reminds him when he forgets. He explains that "there are a lot of applications out there," and that "we should encourage providers and case managers to use technology in a way that helps remind patients." He also suggested the idea of an incentive or a "positive reinforcement" mechanism that would encourage patients to take their medications.

Testing was also discussed across these interviews. Participants believe that "we need to encourage people to get tested," because in many cases, providers don't offer the test to patients. One participant stated that he knows some female friends "who aren't asked by their providers about testing," and he believes it is linked to the poor level of education that the overall provider population has on HIV. There are additional barriers to testing, such as the fear that comes with the mere thought of testing positive: "Some people are scared and don't want to know their status,

so they don't want to get tested because they don't want to confirm their [possibly] positive status." The fear associated with testing and a positive result is likely connected to the stigma around HIV and misconceptions about living with HIV. By "emphasizing the importance of routine care and checkups," and including HIV as part of this routine care, it can help normalize HIV testing. One participant expressed the need for more accessible testing and care for those who are homeless and/or undocumented.

The TTRA model was specifically addressed by one participant and positively received. He believes that the "TTRA model is good" and "gets people into care right away," getting people onto treatment and "virally suppressed within a month." This aligns with the positive comments that other participants in other interviews had about TTRA and its implementation by FDOH-MD.

Engagement

Engagement was also identified as important for our HIV prevention and care systems. "Meeting people where they're at" and doing outreach in high-risk areas was deemed essential for community engagement. One participant also suggested using mobile units as part of outreach efforts and offering to do intakes out in the community. The important point was that "we can't wait for people to come to the door." Having events, lunches, and town halls are also helpful ways to educate the community on HIV and keeping them informed on the most recent information available.

> "We can't wait for people to come to the door."
>
> - PLWH representative, on the importance of doing community outreach

Community engagement and outreach is also important in a potential outbreak situation. As one participant explains, "everyone should be involved … state level, county level, local mayors, government, etc." Community members should also "go out and talk about this," and medical providers especially have a responsibility to have a plan in place for such a situation, "just like we have a plan for attacks and bomb threats." It would also be important for "all the HIV organizations in Miami-Dade to get together and provide care for people getting infected," as another participant explains. Identifying where the outbreak is coming from would also be of importance in this case.

Participants also identified non-traditional players that should be more involved in community efforts on HIV. Like other findings in this report, these participants identify faith-based organizations as important players to have at the table. Not only faith-based organizations, but any gatekeepers in Latinx and Black neighborhoods should be clearly identified and invited to get involved. Schools and politicians are two other groups that participants suggested should be involved in these efforts as non-traditional players.

PrEP

Participants were very familiar with PrEP and knew many friends or acquaintances who were on the medication. Overall, “people have reacted well and are seeking it” because they know it’s a prevention method, according to one participant. Barriers still exist and prevent other segments of the population from accessing PrEP, mostly those communities that do not identify as LGBTQ+. There is “a lot of education and awareness in the gay community,” but it needs to be promoted in the overall population. One participant specifies that people of color, youth, and straight women are groups that could really benefit from additional messages on PrEP. It is a “relatively easy process” to get PrEP, according to one participant, but they believe the main issue is that people do not know where to start.

Social Determinants

Regarding social determinants, different participants highlighted different social determinants that they believe greatly affect access to HIV services. One participant highlighted documentation status as a large barrier to care, because “they don’t know where to get care” or what resources are available to them. For a second participant, housing was mentioned as a large barrier for PLWH, and especially for MSM and transgender groups. The third participant mentioned transportation as a significant barrier, especially for those who have limited resources. They elaborated on the transportation piece and how the fact that there is only one ADAP Pharmacy with limited available hours forces RW clients to go through a multi-hour process in getting to the pharmacy and back. Even then, clients might face issues within the system itself, so the “bureaucracy delays them even more.” A solution suggested by this participant was to have a shuttle or transportation service available to clients for this need; even though it might be cost-prohibitive, it is one possible solution. The participant also suggested having an agreement with ride-sharing services like Lyft or Uber where the State could pay for round-trip transportation services from a client’s work location to the ADAP pharmacy.

Technology

Technology was mentioned in all the PLWH interviews, pointing to the strengths and opportunities available. One participant describes that technology can be used to better link patients to care and “make the process easier as well.” Another participant explained how he had seen advertisements on dating applications like Tinder and Grindr. Using technology in this way to promote messages on safe sex and HIV could be beneficial. Applications that remind patients to take their medications were also mentioned by two participants, and some of these applications have mechanisms in place that show patients how they have been doing in the past week or month. Seeing a “progress report” like this, whether on adherence or another indicator, could help keep patients on top of their care and motivated.

Government Representatives Interviews

The five government representative interviews were analyzed differently than the other interviews in this report due to a change in the interview tool used. The five government representatives interviewed as part of this project include the following: a county commissioner, a city mayor, a US congressperson, and two local government officials, one from county government and one from city government (non-elected officials).

The results for these interviews are reported by pillar, with a separate section on engagement. General concerns from constituents regarding HIV and HIV services precede these results, as well as comments on addressing social determinants through a policy perspective.

Remaining Set of Interviews

General Comments from Constituents

When the representatives were asked about general comments coming from their communities, access is often cited as an issue that their constituents face. The county official describes how many in the community do not know of the resources that are available and exist, especially in the case of immigrant populations. The city official describes their conversations with community members and, when discussing HIV, they "tend to go more towards access." For example, many community members might know where to get tested, but they largely would not know where to access other related services. Even access to testing is limited for heterosexual people of color (POC), as they hear from residents that testing services are almost always available at LGBT events but not at POC events. A main concern for the city official from a city perspective is "how to expand HIV services to non-LGBT communities."

Discrimination and stigma are also concerns raised by constituents. The city mayor sees discrimination against LGBT groups as a persistent problem in his city, even though they are "a progressive city" that takes multiple steps to support and uphold the LGBT community. The U.S. Congressperson cites the stigma as a recurring issue that prevents certain age, race, and sexual orientation groups from getting tested. Stigma can also "possibly affect relationships with family" as people do not want to get tested out of fear of someone in their family finding out they got a test. The stigma around both HIV and the mere action of getting an HIV test serves as an additional barrier to getting tested. There is also a need to close gaps in insurance coverage and costs for labs and medications, according to the Congressperson. The commissioner suggests that HIV professionals need to "raise the issues and keep them relevant," and making sure people are not afraid to talk and ask about these issues. Stigmatization prevents people from wanting to talk about them in the first place.

The county official describes the need for clear information from the local health department, as they are the objective and reliable source of guidance and information on HIV: "The information that the public needs regarding HIV has to come from FDOH-MD." In particular, he supports increased efforts by local agencies to promote more HIV and sex education in schools. He also describes concerns from community members regarding the mental health needs of the incarcerated population as well as human trafficking victims.

"The information that the public needs regarding HIV has to come from FDOH-MD."

- County official

Engagement

The city mayor explains how they spend "a lot of time and energy" on social media, using platforms like Instagram, Facebook, and Twitter. They recognize that not everyone is on social media, and they still use traditional mediums to engage other populations. For example, with their older populations, they find that "they tend to like magazines better." They also engage these older residents through wellness centers and senior centers, with a heavy emphasis on making food available at any community engagement event. Regardless of the audience, they make every effort to "reach the audience where they're at." The city also has committees which track progress on HIV indicators and plan events for the community such as community health fairs. Similarly, the city official's government has also taken steps to engage the community and PLWH. They engage other city departments with HIV efforts as well as other anchor institutions so they can "work with them and implement changes." They also try to look across sectors and foster partnerships in order to provide better services for the community. The city has a "health equity lens" and has become more data-driven in recent years, according to this official.

All the government representatives in this section highlighted the importance of identifying community leaders in engagement efforts. The Congressperson describes grassroots leaders as being essential to community engagement, as they "reach the heart of at-risk communities." For any agency aiming to engage communities, they suggest that they identify the unofficial but recognized leaders in those communities in order to send messages. A lot of the time, these leaders can be found in CBOs, community health centers, or religious institutions. Religious institutions are "especially important" and "need to be involved"; this is especially difficult though because of the stigma that surrounds HIV. The Congressperson described a need to educate religious leaders so that they can then educate their congregations.

Social Determinants

When asked about which social determinants to focus on from a policy perspective, housing was identified as a top issue for most of the representatives. The county official sees housing and transportation as linked together, since it is equally important to be able to "get from point A to point B." In a neighborhood where housing costs are rising rapidly, the city official managed an initiative that supports their residents in maintaining secure housing. The initiative focused on multiple social determinants, but the critical one for them was housing. The Congressperson also described housing and, more generally, economic stability as a necessity for accessing HIV care. There are also additional issues with transportation, insurance coverage, healthy food options, and employment opportunities. The Congressperson believes focusing on economic stability can address multiple social determinants at once. They also support Medicaid expansion, increased funding for Ryan White, and expansion of the 340b drug pricing program.

The commissioner discussed housing as a necessity for people at risk of HIV and in unstable housing situations; there should be a place where they can receive "subsidized housing" and "a full array of services and treatment." Housing was discussed by the commissioner as a means of prevention as well.

The city official sees local policy as often being overshadowed in conversations by larger policy (i.e. state level). Local policy is an effective way to make change within a community, and he has seen that work first-hand through partnerships with local agencies and organizations. Using local policy to affect change in social determinants can possibly be more effective than seeking change through higher-level policy. The city mayor believes research can help inform policy and help us focus on which social determinants to address more effectively.

Diagnose

The representatives interviewed here are supportive of efforts to increase HIV testing and promote it within their communities. The city mayor emphasized the importance of using multimedia messages to promote testing, including social media, magazines, and email. According to them, the city gathers information from multiple sources and puts it all together in order to "implement that in our own community." They also push messages out on HIV testing based off the information gathered.

> "Routine and universal HIV testing is a gateway to prevention."
>
> - U.S. Congressperson

Even with the proliferation of messages to get tested, people can still be confused as to how to navigate the healthcare system. The city official describes how some people "don't know what to do" after a test if they are positive; there is an overall "uncertainty" and "lack of knowledge" of the system. This likely needs to be addressed since HIV testing is important for identifying unknowns. The congressperson calls routine and universal HIV testing a "gateway to prevention."

Providers were also discussed as playing a necessary role in increasing access to HIV testing. Many doctors are likely not implementing opt-out testing in clinics even though they can, according to the county official. He suggests for a way to better monitor the implementation of opt-out testing and look for additional places where this could take place. The stigma coming from providers is also an issue, claims the city official; many doctors simply do not want to speak about HIV testing.

Treat

Representatives largely focused on the social needs of those who are diagnosed in order to keep them engaged in their care. According to the city official, support services provided by social workers and other related professions are "focused directly on health" too often. A "comprehensive assessment" of the patient's social needs should be conducted so that they can

address the needs of new positives before starting medications. If there are unmet needs that persist, then this could be a "barrier to starting and adhering to medications." The county official described a similar phenomenon in their interview: if "people need to put food on the table first," then these concerns can push things like staying in care and adhering to medications away from one's priorities.

The commissioner sees HIV care as having progressed significantly in recent years. Our delivery of care has "come a long way," they stated, and sees the issue in treatment more so with keeping PLWH engaged in care. The commissioner believes utilizing peer educators can help decrease the stigma around HIV and keep PLWH in a "non-judgmental" setting.

Health literacy is another factor that should be considered when discussing the care of PLWH. The Congressperson calls health literacy "essential" for keeping PLWH in care, so that they can "navigate the system better." There are multiple pieces of our healthcare system that can be confusing, and having a basic level of health literacy can help PLWH deal with issues like "insurance, finding a provider, appointments, troubleshooting problems, etc." Being health-literate helps those with social needs better understand where to find care and how to access that care.

Prevent

Preventing new HIV transmissions is a priority for the city mayor, as their municipality faces high HIV incidence rates when compared to the rest of the county. The city mayor described how the city has provided rental space at a low-cost rate for a PrEP clinic in a government-owned building. They found this necessary as it "makes PrEP more convenient for people to access." The city also partners with a mobile PrEP clinic that goes around promoting access to PrEP. The city mayor also described how the city partners with local police departments to support syringe services, by sharing information with them when needed. Developing appropriate sex education programs and introducing them into schools early on was also part of the conversation on how to increase prevention efforts. The commissioner called age-appropriate sex education in schools "vital" for teaching students about HIV from an early age.

"We should make policies appropriate and data-driven."

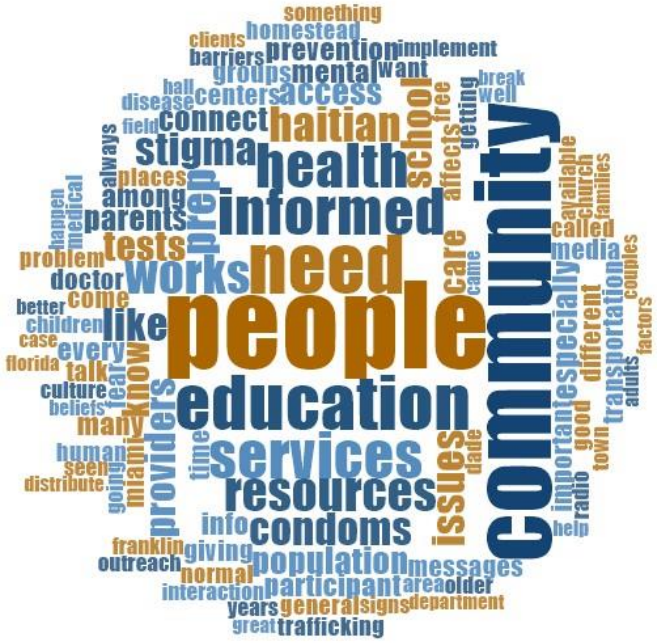
- City official

The city official argues for policy as the basis for prevention efforts. In order to better support prevention efforts, it is necessary to "create systems for policies that allow for sustainable change." By being "appropriate" and "data-driven," policies can have a "great and lasting" impact within our communities. The congressperson mentions the need to identify and include grassroots leaders in any HIV prevention and outreach efforts, as they are also necessary for engaging the community and having a positive impact.

Town Hall Meetings

In the town hall meetings held, HIV education, stigma, and media were the most prevalent themes within the conversations. Additional themes were identified within each town hall, including social determinants, HIV care, community engagement, etc. These additional themes are discussed in more detail within the context of each town hall in the appropriate sections below. The word cloud below helps visualize some of the words used most often in the town hall meetings. Larger words indicate a higher frequency of the word within the town hall notes (Figure 19).

Figure 19: Word Cloud Generated from the Set of Three Town Hall Meetings



The town hall locations, dates, and languages are listed below in Table 37. The separation of town halls by section allows for area-specific issues and factors to be discussed, as each town hall was conducted in a different area of Miami-Dade County. The Greater Bethel AME Church town hall was excluded from analysis due to a lack of participants.

Table 37. Town Hall Characteristics

Venue	Area	Date	Language
Edison Community Action Center	Little Haiti	11/13/2019	Creole
Unitarian Universalist Cong. of Miami	South Miami	11/18/2019	English & Spanish
South Dade Government Center	Cutler Bay	11/19/2019	Spanish
Betty T. Ferguson Recreational Complex	Miami Gardens	12/05/2019	English
Jessie Trice Community Health System	Brownsville	12/10/2019	English
Greater Bethel AME Church	Overtown	11/12/2019	English

Overall Themes at Town Hall Meetings

HIV Education

Within the context of HIV education, participants from the various town halls identified stigma and media as top issues. There was also an emphasis on the importance of "distributing free condoms," and education on how to use condoms. A participant at the South Dade Government Center (SDGC) town hall meeting explained how "there are not enough spaces like this to talk about these issues among Spanish-speaking communities." The participant works in housing and with Spanish and Haitian communities, and they find that these groups have limited access to this information. The information exists and is available, but there is a disconnect between the populations and connecting them to needed services. Another participant at the SDGC town hall mentioned that "education is key," and one way to share information is through the community centers.

At the Unitarian Universalist Congregation of Miami (UUCM) town hall, a participant shared her experience at a past health fair: "I was working a health fair, and a mom came up to my table with her 13-year-old daughter. I offered the girl condoms and information, but the mom said, "No, she doesn't need that, she is not having sex." Later, the girl came back alone and took the condoms anyway." Participants agreed that this was a common problem in HIV education, where youth is limited in their access to information. Some participants at this meeting suggested that HIV and sex education should be started earlier in schools.

> "Education is key."
>
> - SDGC town hall meeting participant

For the participants at the Jessie Trice town hall, raising awareness on HIV was identified as a top issue. They felt it essential to work together and highlight that "HIV is still an issue" in our community, even though it has recently left the public scope. Several participants drew parallels between tobacco campaigns and HIV-related campaigns. Opportunities suggested for educating people on HIV include at oral care visits and annual wellness checks for seniors. Participants at this town hall also suggested further educating providers on HIV and PrEP due to a lack of knowledge in the provider field on these topics.

Stigma

Stigma was discussed by participants as something that completely prevents people from even talking about HIV. In both the Edison town hall and the SDGC town hall, both groups mentioned that stigma was especially prevalent in the Haitian community. One participant expressed how "anything pertaining to HIV is not talked about in the community and they feel that HIV is a very

touchy subject." Another participant at the Edison town hall explained they believe that people barely discuss HIV in the Haitian community because of "belief issues." When asked to elaborate, it was explained that the community has strongly religious and personal belief systems that keep myths and misconceptions about HIV in place. There is also a "fear of the entire community knowing" about one's HIV+ status, according to one participant.

Stigma is not only specific to the Haitian community but also family structures. A participant at the UUCM town hall explained how "families think it doesn't affect them, so they don't want to know." The stigma prevents families from believing that it could affect them or their children, so they tend to keep exposure to information on HIV limited. According to one participant at the Jessie Trice town hall, the "stigma around sexual health must be addressed within the family setting" in order to effectively address and improve education efforts. This possibly ties in with the themes regarding early education (or the lack thereof) on HIV in schools.

Another participant at the SDGC town hall says they see "the good work the health department does with testing and signs, but people are still afraid of the stigma … they need to know it's like diabetes, if you get it, you can control it." More town halls and related focus groups with possible incentives for people to attend were suggested to help reduce the stigma around HIV and engage communities.

Media

Participants had several ideas on how to better use media to spread information and educate the population. A participant at the UUCM town hall explained how "all sorts of media" needs to be used because not everyone is accessible through a single medium. He also suggested there should be a "variety of types of messages" and to "distribute to the community and test to see what works." It is likely that different messages have different levels of effectiveness and reach depending on the medium used for delivery. Specifically, for Latinx and Haitian communities, it was mentioned that messaging should be very simple and visual to capture their attention.

At the Edison town hall, a participant specified that radio is still the best way to reach the broader Haitian community. They suggested more "radio interaction" with the Haitian community to educate the population. The Getting 2 Zero campaign was mentioned positively at the SDGC town hall, with a participant saying they had seen messages on that before and likes the creative designs on condoms distributed. Another participant remembered seeing an advertisement one time for a medication with someone who looked like a regular, normal person speaking about their experiences – they expressed how that is important in normalizing diseases. The participant expressed that this could help educate the population on how people can live normal lives with HIV, and by showing people from diverse backgrounds, it highlights how HIV can affect anyone in the community.

Edison Town Hall

In addition to the educational points made in the above section, participants at the Edison town hall also described economic barriers for those living with HIV. “Financial reasons” were cited as reasons why people would not be able to access services. When asked about resources in their community and if they knew where to find resources, participants were generally unaware of what was available around them. The facilitator went in detail on some of the resources that were available in their North Miami neighborhood.

From the perspective of an attendee who identified as HIV+, an additional barrier they mentioned was the paperwork and time associated with signing up for Ryan White services. They described the process as long and daunting, even though it is only a one-time process. Participants were also generally unaware of what PrEP is or where to access PrEP.

For engaging the Haitian community, a participant suggested working with faith-based organizations. These are “especially important” in the Haitian community and can help to deliver messages on HIV and educate the community. Participants also suggested doing surveys in the community to get the opinions of the Haitian community, as well as using more targeted efforts like 1-on-1 sessions or focus groups to help break the myths around HIV.

In total, there were four attendees at this town hall, all of which were over the age of 35, Black, Non-Hispanic. Two identified as community members, one as an HIV service provider, and one as a PLWH. Two participants identified as male and two as female.

Unitarian Universalist Congregation of Miami Town Hall

Participants at the UUCM town hall came in with a variety of questions and, as a result, the conversation was at times geared more towards informing the audience about HIV and resources. Participants asked about community health centers, the contents of the EHE plan, involvement in Pride, PrEP, HIV care, and transportation. A participant highlighted the importance of having individuals who can verify existing resources online if possible, due to the prevalence of misleading and outdated information. In terms of innovating care systems, participants identified telehealth as a possible way to provide better care for PLWH and utilizing telehealth for mental health purposes.

Some in the audience were familiar with PrEP, and some were not. One participant said he has friends who use PrEP and have “risky sex,” as well as friends who are HIV- but with an HIV+ partner. In both situations, he explains that it’s worked well for them and it is especially effective to prevent HIV for people who might not have access to condoms for whatever reason. Another participant also shared their concern with the disconnect between parents and their children, as children are having sex at younger ages, but parents refuse to believe that “they are doing any of that.” As a solution, a participant suggested educating parents through events possibly offered at children’s schools.

From the perspective of someone who is living with HIV, the participant felt good about the care they receive. They mention how "the doctors are very good here in Miami," and that generally the care systems are working. Another participant was concerned about recently diagnosed individuals, and the need to address any mental health issues or psychological issues that come up because of their recent diagnosis. Another PLWH in the audience shared her experience with a psychologist from when they received advice about disclosing status, and they were taught how to disclose to close family members and friends. The PLWH members in the audience spent a considerable amount of time on the topic of mental health, highlighting the need to address this in the PLWH community.

Five participants in total attended this town hall meeting. Two identified as Hispanic and three as Non-Hispanic; all identified as white. 60% of them were female and 40% male. Each participant came from a different cluster within Miami-Dade County, and most of them (60%) identified as coming from the faith-based community. Two attendees identified as PLWH.

South Dade Government Center Town Hall

At the SDGC town hall meeting, transportation was discussed as one of the top issues facing the community in the Homestead and Florida City area. The participants who do work in these areas say that when people are referred, many times they can't go to those other locations because of transportation problems. "People from homestead are not going to go to Miami for treatment, we need to connect to the population where they are located," as mentioned by one participant. The Homestead area does have some services available to the community, but transportation and access complicate the issue since the area is primarily more rural and agricultural in nature.

The area also houses a high number of migrant farm workers, some of which are undocumented. This further complicates the transportation issue because undocumented residents will not want to drive or go to an unknown place for services "due to fear of being deported." The best way to reach this specific population, as one participant stated, is to "go to the community centers near agricultural fields to provide services." A handful of participants also felt that FDOH-MD could be helpful by arranging transportation for individuals to access services if needed.

Participants at this town hall generally believed that the South Dade and Homestead area are facing a shortage of resources. The population has increased dramatically within the last 20 years, but "resources have stayed the same or decreased." One participant described a program their agency had a couple of years ago where they engaged the community consistently and had a solid attendance from community members at their events, but funding was cut so the program was ended abruptly.

At this town hall, there was discussion on the needs of older adults living with HIV. Specifically, mental health was cited as an important need for this population. "Everyone's mental health begins to have trouble with age," and that compounds with HIV and the mental health issues that living with HIV could bring. This was cited as important given the fact that the PLWH population is an aging population, thanks to the modern-day medications that allow PLWH to live long and otherwise normal lives.

Knowledge of PrEP was highly limited within the audience, and individuals had questions regarding its effectiveness and cost. One of the participants who has worked with HIV for years mentioned how “if she doesn’t know about [PrEP] and works in the field, imagine the population that doesn’t work with HIV.” Constant messaging was discussed as a way to get more people aware of PrEP and interested in PrEP, and there is a need to target Latinxs with this because “they think [HIV] doesn’t affect them.” They believe Latinxs need to be more aware about PrEP and HIV because “it’s not only college kids and LGBTQ are affected by HIV.”

The five attendees at this town hall identified as Hispanic and female. Three out of five of them (60%) were over the age of 45 and came from Cluster 1, which includes the South Dade/Homestead region. Attendees identified themselves as falling under multiple backgrounds, including community member, HIV service provider, and CBOs.

Betty T. Ferguson “Quasi” Town Hall

The session conducted at the Ferguson center was unlike the other traditional town halls. Rather than having a static audience for two hours like the other sessions, this session was conducted at a World AIDS Day event with another programming schedule already in place. Input for this session was gathered from people walking by a table as they were asked for their thoughts on HIV-related issues. In total, 33 people were addressed and 15 of those provided comments and/or feedback. Due to the fast-paced nature of the event and the fact that participants only stayed engaged for mere seconds, data was collected in the form of a SWOT table. The SWOT table created from the input of these participants is provided below. Demographic data was not available to collect due to the set-up and nature of this session.

SWOT Table – Betty T. Ferguson "Quasi" Town Hall

Strengths	**Weaknesses**
- Today people live much longer with HIV - I think things are going well - The medications are good	- Everything can always be improved - Not enough representation of PLWH in messages and efforts
Opportunities	**Threats**
- More education needed - Target high schools with HIV education - Promote fidelity/one-on-one relationships - Promote abstinence - More HIV testing - Do more outreach events to raise awareness - Include more PLWH in the conversation - Spread messages that promote the quality of life of PLWH, raising their ideas on self-worth - More of a media presence	- Stigma is real - Language used can harm efforts on HIV, i.e. "full-blown AIDS" adds to stigma

Jessie Trice Town Hall

The Jessie Trice town hall meeting had the largest number of participants and representation from eight different clusters. When asked to identify overall top issues regarding HIV, participants identified social, political, and economic issues. One participant stressed the need for a system that is centered on health equity and works for everyone. Social determinants of health were discussed, including transportation, housing, and education; without addressing these, "we cannot effectively fight HIV."

"If we do not solve social needs … then we cannot effectively fight HIV."

- Jessie Trice town hall participant

The conversation at the Jessie Trice town hall meeting often leaned towards the topic of HIV care and keeping patients engaged in care. Participants were familiar with the FDOH-MD's TTRA model and applauded them for its ability to secure medications for patients quickly. Still, there were other parts of the HIV care system that participants highlighted as ineffective. "Routine mental health screening" was suggested as something that should be done in the overall PLWH population, with a specific focus on those who are newly diagnosed. Ryan White-funded agencies were highlighted as places that do a very good job of providing services to PLWH, but there is still a need to further build the network of HIV providers.

Participants generally believed that patients might be reluctant to go seek services, and one participant brought up mobile units as a good solution for community engagement. Not only should mobile units be used to provide HIV-related services, but the participant suggested that it should have "additional services beyond HIV" in order to attract people. The reasoning was that if the mobile unit is perceived not as an "HIV mobile clinic" but as an overall support services mobile unit, it would help decrease the stigma attached to HIV in that scenario.

Other ideas on how to engage PLWH in their care included phone calls and texts between visits and making an appointment 14 days for newly diagnosed individuals instead of 30 days. Utilizing peer groups was also regarded as an effective tool so that PLWH have someone they can relate to. Seasoned staff are also a necessity when working with newly diagnosed PLWH, or at least staff with a mental health background so they can adequately assess the conversations and situations they are having with PLWH. The table below provides some of the demographics from participants at this session.

This town hall had the most participants by far, with a total of 14 in attendance. The majority (78%) identified as Non-Hispanic, and 64% identified as Black. There was a wide range of age groups in this town hall meeting, including three people in the 25-34 age group, four people in the 35-44 age group, and seven people in the 45+ age group. Attendees came from clusters across Miami-Dade and from various organizations, including HIV service providers, research institutes, and CBOs.

Online Community Forums

As discussed in the Methodology section, the four online forums listed below were conducted through Facebook Live and were driven mostly by conversation between the two co-facilitators. Each section below includes the comments made by participants during each session, in their original form. Other statistics provided in the tables below describe how engaged the audience was in each session. Also note that a recording of the live session stays on Facebook after the session ends, and the overall statistics for the recording include both live and post-live values; these numbers are identified accordingly within the tables. While there were not enough substantive comments to identify themes across the forums, some commentators brought up important points that helped guide the conversation between the co-facilitators.

Forum 1

Forum 1 was co-facilitated by Kalenthia Nunnally. Kalenthia is the Chair of Miami-Dade County's Black Treatment Advocates Network (BTAN) and Sistas Organizing to Survive (SOS). She is a community advocate, influencer, and engager. This online forum was directed towards the Black community and topics discussed were tailored accordingly.

Various comments were made throughout the duration of the session, ranging from comments on the topics being discussed to greetings and words of encouragement. Participants commented on civic groups like Black Lives Matter, the inclusion of Black communities in decision-making, stigma, resources/funding, and housing for PLWH.

Seven of the 16 comments above are salutary or supportive, while the other nine helped direct the content of the conversation. Regardless of content, each comment is important because it helps identify those who are engaging with the discussion and the session and provides opportunity for further discussion with the participant. Below are multiple points that were made during this forum.

The conversation during this session was centered mostly around the importance and need for inclusion of racial and ethnic minority communities in the overall conversation and in the work that is done in the community. There was an emphasis on the need for inclusion in order to end the epidemic, as well as a focus on social determinants for addressing the needs of PLWH. There is also an identified need for innovative strategies, and these come best from the people that work directly in the communities and have experiences living as part of their community. It was also discussed how each community has its own needs and issues that they face; two communities could be right next to each other, but each one might need a different approach and strategies for engagement as well as HIV prevention and care efforts.

From an institutional perspective, funding is a large barrier for local CBOs that conduct this kind of work in communities. There is "only so much that CBOs can do when they're not the main dollar holders" or the main decision-makers, and this ultimately limits the activities that they can conduct.

There is also a need to inform, educate, and empower communities. The community needs to be involved in implementation itself as well, not only during the planning process. There were concerns shared that input would only be sought during this planning phase, and then the

community would be left out for the rest of the initiative. It was heavily suggested that they should have influence in the implementation stages of the program as well.

There was a large surge of viewers near the end, during the last five minutes of the session, which could have occurred for multiple reasons. For example, since it was up for an extended amount of time, it gave people a chance to see it on their feed and to sign in. It also could have been due to a specific viewer having shared it onto their page and, as a result, increasing the audience accessible for this forum; this could be a useful strategy for future sessions. By encouraging viewers who are engaging in the conversation to share the session onto their own feeds, it allows a larger reach to be possible since the people that now see this on their feed has increased.

Forum 2

Forum 2 was facilitated by Marco Torrealba. Marco is the Program Director for Prevention305. He is a Journalist originally from Venezuela. For the last couple of years, he has worked throughout South Florida educating communities through outreach programs about HIV prevention and how to get access to PrEP. This forum was tailored to topics that concern the LGBTQ+ community, with substantial conversation on the undocumented population as well.

Only three comments were made by three commentators throughout the duration of this live session. The comments made include the need of community involvement and engagement, as well as visibility to help reduce stigma.

There is no clear explanation for the discrepancy between the number of comments made at each session. The likelihood that people will sign on to a session and provide comments depends largely on the nature of the facilitator's Facebook feed and their knowledge of the people on that feed. It is important to note that this online forum was briefly disconnected at the 36-minute mark due to technical difficulties on Facebook's end – the session was re-started and went live again after a minute passed.

The session was conducted mostly in English, but a little bit of Spanish was utilized as well. This was due to the facilitator's concern that some of his "friends" on Facebook speak only Spanish, and this would be important to clarify for future online sessions. By knowing the language mostly used by the facilitators' network of online friends, the session could be tailored to include both languages (or even just Spanish entirely) if it means having a greater possibility that audience members will stay and engage more with the session. Below are the main points of discussion that drove the conversation during this forum.

Stigma was discussed as a large barrier for PLWH, especially as it relates to disclosing their status. There is a need to make our society more comfortable for PLWH to disclose their status because it helps them accept themselves as well as helps them feel comfortable seeking services. There is also a need to normalize PrEP in the overall population, not just the LGBTQ+ population. The myth around HIV as a "gay disease" or PrEP as a medication "only for gay people" adds on to the stigma around HIV and further efforts are needed to normalize these topics.

Part of the discussion also involved discussing the importance of joining STI testing together with HIV testing. STIs increase the risk of someone contracting HIV as well, and it is important to spread awareness on testing for both conditions. The undocumented population was specified as

a population that is increasingly at risk for HIV and STIs, due to a lack of knowledge of services as well as the fear attached to seeking healthcare services. There is a fear that they could be penalized for seeking services, and there is a clear need for informing this community about the availability of services without fear of penalty.

Partnerships were discussed as being essential for conducting effective and meaningful work within HIV prevention and care systems. Our current system was described as “fragmented” and “working in silos.” While it was acknowledged by the facilitator that each agency has their specific tasks and activities, there are improvements that can be made in our system to make delivery of services more efficient. Better coordination of schedules for large events like Pride, for example, could help minimize expenditures from agencies while still allowing the most efficient delivery of services possible. Improvement and innovation also mean bringing non-traditional players and agencies to the table and working with them to advance goals for HIV prevention. The local department of tourism was mentioned as one example.

Forum 3

Forum 3 was facilitated by Ashley Richardson. Ashley is an education and prevention specialist, a person living with HIV, and has been an advocate for HIV/AIDS for almost a decade. The session was also hosted on Instagram (IG) Live as suggested by Ashley, to reach a broader audience. As such, the live values below include Instagram Live numbers; note that only 10 of the 80 people viewing came from IG, but most of the substantial comments that guided our conversation came from an audience member on the IG feed. The values in Table 8 below describe how engaged the audience was from Ashley’s session.

During this session, participants commented on a variety of issues. Topics included disclosure conversations for those who are newly diagnosed, human trafficking, knowing your status, diversity in South Florida, and risk factors for contracting HIV. Many comments were also supportive of the facilitator, given her long history advocating for HIV-related issues.

It was highly beneficial to conduct live sessions on both FB and IG at the same time because it provided a highly interactive individual in the IG audience the chance to engage and help guide the conversation. Most of the comments with actual content relating to HIV came from this one person, and future sessions should be conducted on multiple media platforms as possible in order to reach a broader audience and gather more input.

On the FB recording of the live session, people can still make comments after the session has ended for everyone to see. One of the facilitator’s followers posted a comment on the video and was “glad this show was done.” They describe in their comment how they went with their daughter to go get tested and both came out negative; they also brought their friends and, while they were scared to initially do it, also came out negative and were “happy” they did it. They expressed comments of love and encouragement for the facilitator as well. This speaks to the impact that online advocacy can have on others, especially when it comes directly from community members who are affected by the condition or disease.

In this session, the facilitator took time to directly speak on their experiences as a PLWH and to educate others watching on how she was diagnosed and the problems she faced through the earlier stages following diagnosis. Ashley spoke in detail about the mental health issues she faced

after diagnosis, and the need there is in the PLWH community to address mental health since it could affect their adherence to medications as well as their hope for the future. Seeking help was also essential for her because it taught her how to deal with disclosure conversations, a challenge that was brought up by an audience member. Disclosing status is especially tricky and sensitive for those who are HIV+ and in a relationship, especially in the Black community where Black men have a "limited education" on HIV. It is important for newly diagnosed individuals to learn how to navigate these relationships and find the right time to tell their partners. Many supportive comments were pouring in during this discussion on Ashley's experiences as a PLWH.

The importance of debunking myths around HIV transmission was also discussed during the session. Many people still hold on to incorrect ideas about how HIV is transmitted, and this adds on to the stigma. The normalization of HIV testing as well as educating the community on prevention methods were also identified as necessary, especially in the Black community. Marketing efforts should also be geared more towards populations of diverse backgrounds and tailor specific messages to specific populations.

Forum 4

Forum 4 was facilitated by Francesco Duberli. Francesco is the Founder and Executive Director of Survivor's Pathway Organization. He is a clinical psychologist with a master's degree in public health and mental health. He is recognized at the national and international level for his work in promoting equality, inclusiveness, and social justice in the United States and Latin America. This session was conducted completely in Spanish, as the facilitator knew his audience well and expected that most of his audience members would be writing in Spanish.

This FB live session was conducted as part of a radio show on Despierta America Cadena Azul, 1550 AM. While the live session went for 50 minutes uninterrupted, the facilitator was on air for about the last 15 minutes of the session. This uniqueness to the live session arguably helped keep audience members engaged, as they had something to look forward to in the session (seeing the facilitator go live on radio). While engagement with the audience was limited during the on-air radio time, it provided audience members something to watch and a chance for people to stay retained in the session. Finding innovative ways to do activities like online sessions can help in engaging audience members and getting their input on these topics.

It was also helpful that the facilitator was very familiar with those that were joining the session and commenting. He would directly call them out by name when joined, which often prompted a written salutary or supportive comment. There were as many (or more) comments made as those in other sessions, with most comments consisting of greetings and emojis. On average, about 11 people would constantly be watching during the session.

The focus of the conversation during the session was between the intersections of domestic violence, human trafficking, and HIV. Francesco works extensively with these topics and, as such, discussed these at length. Some comments made by individuals include "immigrant women are especially vulnerable for HIV" and "we need to keep sounding the alarm on HIV, it is very important." Another commentator works for the Miami-Dade Police Department on cases relating to domestic violence. They mentioned how important it is to keep HIV in the conversation for this population. Commentators also had questions on PrEP and where to access it.

During the radio session, the host asked general questions on HIV and what precisely the community is doing to address the epidemic. The host provided space for the facilitator to discuss many of the similar topics mentioned above, including immigration and the importance of connecting recently arrived immigrants to healthcare and other needed services. The Facebook live session was ended shortly after the radio session.

Impact

Conducting online community forums through mediums like Facebook and Instagram allows for widespread engagement with the online community. Online forums can reach a wide audience given the ease with which participants can join the session. Data is also readily available to collect for online sessions and can be presented in a variety of ways. Table 38 below presents data that shows the impact each session had on their respective online communities. Statistics are shown that are specific to the live session, and then results are displayed for the overall post after the session ended. Due to a technical error, most statistics on live and post-live indicators are not available for forum 4.

Table 38 – Live and Post-live Data for Online Audience Engagement

	Forum 1	Forum 2	Forum 3	Forum 4
Live				
Number of people signed in during session (reach)	121	55	80	n/a
Average number of people watching at any point in time	9	2	3	11
Largest number of people watching at a single point in time	26	6	7	n/a
Total number of commenters	9	3	8	n/a
Total number of comments made	16	3	17	>15
Live + Post-live				
Number of "likes," as of 2/25/2020	26	18	30	n/a
Number of times shared, as of 2/25/2020	5	2	9	n/a
Total number of views, as of 2/25/2020	415	183	374	n/a

SWOT Table

As part of this situational analysis of the public input sessions discussed, a strengths, weaknesses, opportunities, and threats (SWOT) table was developed. This SWOT table includes strengths, weaknesses, opportunities, and threats on HIV prevention and care systems that were analyzed from the key informant interviews, stakeholder interviews, town hall meetings, online forums, and interviews conducted with PLWH.

SWOT - Public Input Sessions

Strengths	**Weaknesses**
- Opt-out HIV/STI testing in correctional systems - Getting 2 Zero Task Force and other testing initiatives - Modern and effective medications with clear guidelines - FDOH-MD has done a good job despite challenges - PrEP has been received positively by those who know about it - Condom distribution, needle exchange doing great work - Ryan White funding available for treatments - HOPWA program effective, clients satisfied with it - FDOH-MD innovative and thinks outside the box - A lot of partnerships and collaborations - TTRA model is effective and has potential - Condoms with creative designs on them, condom dispensers - PrEP is effective - Ryan White program offers a lot of services - Medical care is good quality for those with access to it - Support groups are helpful - Seeing greater inclusivity of young people and trans people at meetings - Opt-out testing implemented at Homestead Hospital - Medication reminder applications are useful - Pharmaceutical companies offer copay assistance for insured patients - Increases in PrEP advertisement - Telemedicine being used at various clinics - Patient-centered medical homes - FDOH-MD does well in identifying clusters and potential outbreaks - Most current projects align with the four EHE pillars	- Correctional systems in Florida are not up-to-date on measures to prevent spread of HIV within facilities - Facilities without RW funding are limited in the activities they can do - Need an improved system for same-day medications - Poor infrastructure in schools for HIV education - Lack of medical providers that are interested in treating HIV - Lack of awareness about PrEP in the general population - Use of current media messages and methodology could be antiquated - Cost barriers associated with opt-out testing and linkage to care in hospitals - Lack of HIV education in at-risk communities - Fragmented system of HIV care - Multiple barriers to care for incarcerated population once released - Lack of knowledge on how HIV is transmitted - Cost of living in Miami is expensive - Weak evaluative standards for local programs and initiatives - Weak data infrastructure within and between agencies - Communication lacking between agencies - Limited affordable housing for PLWH - Unaffordable health insurance - Stigma adds on to ignorance of doctors on HIV - Difficult to get MDCPS at the table - Historically poor results for getting people into care - Only one ADAP pharmacy in all of Miami-Dade - Lack of knowledge on resources in minority communities - First-time process for RW is long and involves a lot of paperwork - Poor transportation systems in Miami-Dade - Case managers have large volume and lack of resources - Limited opportunities for Spanish-speaking communities to talk about HIV issues in a public input setting - Most PrEP goes to white MSM - Geographic distribution of providers - Long wait times for appointments - HIV prevention is limited for heterosexual men and women - Bureaucracy delays the process for patients accessing services - Lack of medical knowledge on HIV from providers - Limited awareness of needle exchange program in population

Opportunities	**Threats**
- Trainings for clinical staff, including providers and nurses - Having an ID/HIV specialist in correctional system instead of having a general provider for PLWH - Social media and online methods for engaging population about PrEP and HIV - Offer educational opportunities like conferences to the workforce - Educational fairs and events that are more enticing and fun for the public - OTC availability in California has made PrEP more accessible to their population - Opt-out testing implementation in more clinical and hospital settings - Using technology to improve data systems and infrastructure - Medicaid expansion under ACA would provide more at-risk people with access to care - Programs that can reduce the lab costs associated with HIV testing - Care coordinators/managers that can help patients find low-cost care - More information on HIV at doctors' offices - Peer educators to educate the workforce and for support groups of newly diagnosed HIV patients - Efforts to include faith-based communities more - Linking additional support services to housing programs - Having comprehensive models with flexible funding pools so resources can be shared - Focusing on testing as a form of prevention - Encouraging State to remove medical necessity clause for HIV testing in ER, to address reimbursement barrier for hospitals - Using ER to reach uninsured and underinsured patients - Cost-sharing mechanisms with the County and State for testing in hospitals - Provide multiple services under one roof - Enhancing HIV testing with STI testing - Using technology to automate orders within EMRs and to re-link people who fell out of care - Telehealth for the purposes of retaining clients in care - Ads from other agencies in other locations look professionally done (i.e. Broward County, CDC) - Focusing media efforts on ports of entry to Miami - Reminding clients of the big picture and what's at stake in their care - Engaging industry groups (FHA, AMA, etc.) - Pilot program currently being done between FL and State ADAP for clients to get medications at CVS, broader implementation for all clients - Expanding TTRA to broader populations and underserved populations - FDOH-MD being the leader in fostering better partnerships between agencies, and knowing the needs of the community more as opposed to sending tasks to the State - Using radio messages specifically for the Haitian community - Engaging Haitian providers - Arranging transportation for individuals who have trouble with transportation and cannot get to services - Film festivals used for mental health, similarly could apply one to HIV - More programmatic accountability for recipients of grants - Conducting input sessions outside of working hours - Partnerships with more non-traditional players, including trusted gatekeepers and agencies in hard-to-reach communities - Using more visual messages to capture attention of people - Compiling information on local resources into one centralized system or media	- PLWH experiencing homelessness are more worried about safety of the night rather than caring for their HIV status - State-level DOH works in a silo - Stigma around HIV for incarcerated population, inmates keeping their status to themselves or not taking medications - Political factors could undermine HIV efforts - Limited funding for community outreach work - Funding cuts limited our ability to provide HIV testing - Changes in funding threaten stability of our systems - Stigma associated with going to an HIV provider or agency - Funding cuts from State (PAC Waiver) resulted in loss of case managers for PLWH - Strict rules tied to funding limit possible activities an agency can do - Very expensive to routinize testing - Disagreements and clashes between HRSA and State, as well as between State HIV/AIDS section and local HIV/AIDS sections - Aging provider pool, lack of new doctors interested in HIV - Expensive ACA premiums and high deductibles - Fluidity of Miami population - PrEP costs are high - If high infection rates continue, RW funding will be strained - Funding threatens sustainability of some innovative activities - Limited resources in the Homestead area - Deeply-rooted personal beliefs, including religious, could stall efforts to educate community - Growing population in Homestead but resources have stayed the same or decreased -The presence of outdated and/or incorrect information online can misinform the public - Drug use in at-risk populations leads to risky behavior which could lead to HIV infection - Less condom use because of PrEP availability, higher rates of STIs - Fragmented school system allows principals to limit or completely block HIV education for an entire group of teenagers - Testing STIs together with HIV is expensive - Aging of the PLWH population brings with it additional needs

- Including testimony from real people in messages, using personal stories - Clinical trials - Greater promotion of PrEP to specific populations - More inviting methods for outreach and education - Partnering with State and ride-sharing companies to provide transportation for PLWH - Including multi-layer messages in media to touch on multiple topics at once (injection drug use, HIV, STIs) - Promoting messages through dating applications	

Best Engagement Practices and Innovative Strategies

During qualitative data analysis, several best practices and innovative strategies were identified by participants as possibly useful for engagement in Miami-Dade County. The list below includes many of these points:

- More town hall meetings on a regular basis
- Radio messages and interactions with the Haitian and Latinx communities
- Reaching out to faith-based communities
    - Not just Black churches but also Latinx churches
- Utilizing small group settings to gather public input and feedback
- Social and support groups for PLWH to empower them
- Hosting events with food and activities for the community to have fun
    - Always with a focus on educating the community
    - Host events and meetings outside of working hours to allow more community members to attend
- Using mobile units to do outreach in high-risk areas
- Identifying gatekeepers to help with accessing hard-to-reach communities in order to increase PrEP uptake
- Involve medical providers to a higher extent
- Develop culturally sensitive messages and methods for outreach work in diverse communities
- Keep stakeholders engaged with findings and updates
- Utilizing case managers and patient navigators to keep PLWH engaged and retained in care
- Better engage the healthcare community on PrEP
- Offering feedback opportunities for clients enrolled in services
- Having a culturally competent and diverse workforce
- Sharing new perspectives and current experiences across agencies and groups

Many of the strategies identified above are central to future efforts by FDOH-MD and community partners to end the HIV epidemic in Miami-Dade. FDOH-MD has been engaging the community through a variety of activities and strategies, including attendance and discussion at local HIV planning bodies, committees, consortiums, and Board of Commissioners' advisory boards. FDOH-MD has also engaged CBOs and service providers in the South Dade area that provide direct services to migrant farm workers. Educational sessions with community members on safe sex practices is also part of these activities, as well as hosting adherence sessions with Ryan White Program clients at the local ADAP pharmacy.

The EHE survey was also a significant strategy used to engage the community and gather input from community members. FDOH-MD staff distributed surveys and had conversations on EHE at local libraries, museums, health fairs, and public transportation. FDOH-MD staff also partnered with local agencies to engage students aged 15-20 on EHE efforts, as well as college-level students. Residents at local residential treatment centers were also engaged by FDOH-MD and thousands of people were reached through local radio shows.

Strategies to End the HIV Epidemic in Miami-Dade County

Based on the above findings and results, the following strategies and activities align with the four EHE pillars and are best suited to end the epidemic in Miami-Dade. Execution of these strategies will rely on the leadership of FDOH-MD and collaboration with key partners in the area.

Pillar One: Diagnose

Key Strategies/Activities:

1. 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.

2. 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.

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

Key Strategies/Activities:

1. 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.).

2. 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.

3. Social needs of PLWH 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.

4. Marketing strategies that destigmatize HIV care and encourage PLWH 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

Key strategies/activities:

1. 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.

2. 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.

3. 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

Key strategies/activities:

1. 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.

2. 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.

3. 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.

*Please be advised that this is a living document and may be subject to change at any time.

Appendix

Appendix A

EHE Key Informant Interview Tool

Introduction: *Hello, today we're going to be talking about HIV/AIDS as it relates to our Miami-Dade community. As we discussed previously, this is for the purposes of the Ending the HIV Epidemic project being done by the Health Council of South Florida in conjunction with the Florida Department of Health – Miami-Dade County. Ending the HIV Epidemic: A Plan for America is an initiative by the US Dept of Health and Human Services that targets high-impact areas across the country, with the goal of reducing new HIV cases in the next five years by 75% and by 90% in the next ten years. Your feedback is vital for the creation of a jurisdictional EHE plan for Miami-Dade County. These key informant interviews are part of a situational analysis that will be included into a final report for the DOH. I'll be taking some notes during our interview in order to highlight important points that come up. Please feel free to stop me at any time and ask any questions you may have throughout the duration of this interview.*

General Questions

What do you think are the top three issues we currently face as a community regarding HIV/AIDS?

What do you believe is the role of social determinants of health on HIV?

- Which determinants, if left unaddressed, pose a barrier to HIV prevention and care efforts?

HIV Prevention

In this section we're going to focus on HIV prevention systems and strategies. Think about answers to these questions that focus on how we prevent HIV transmission and infection.

What are your thoughts on current HIV prevention strategies in Miami-Dade County?

- What can be done to improve these strategies?
- Are there any factors that threaten the stability of the systems we have here in Miami-Dade?

What do you believe are some of the strengths of the HIV prevention systems here in Miami-Dade?

What are some of the things our system does poorly when it comes to HIV prevention?

How do you envision your organization within Miami-Dade's landscape of HIV prevention?

- Can you identify and elaborate on some key relationships your organization has made within this landscape?
- Do you think there's something "missing" in this landscape? (i.e. some key providers or services that are lacking in Miami-Dade)

Are there any prevention strategies that you believe the HIV systems in Miami-Dade should embrace more?

- What about any other outside opportunities or solutions that Miami-Dade could benefit from?

Are there any additional needs or gaps in our HIV prevention services that need to be addressed?

HIV Care

Now we're going to focus on HIV care systems and strategies. For this section, think about how we care for people living with HIV.

What are your thoughts on current HIV care treatments and strategies in Miami-Dade County?

- What can be done to improve these factors?
- Are there any factors that threaten the stability of the systems we have here in Miami-Dade?

What do you believe are some of the strengths of the HIV care strategies here in Miami-Dade?

What are some of the things our system does poorly when it comes to HIV care?

Are there particular solutions that your organization has implemented in order to address the needs of your HIV+ clients?

What are some of the biggest barriers that your clients face in accessing care?

- For the clients that do have access to care, how do we keep them engaged in care?
- How would you solve this issue from a system-level perspective?

How can we best address the needs of HIV+ patients that spend thousands of dollars on treatment, even with insurance coverage?

What improvements or changes (if any) would you recommend to the Test & Treat model?

Are there any additional needs or gaps in our HIV care services that need to be addressed?

PrEP

In general, how do you think the Miami-Dade community has responded to PrEP? Positively, negatively, etc.?

What are some barriers that prevent at-risk populations in Miami-Dade from getting on PrEP?

What would you identify as best practices for engaging the population about PrEP?

Community Involvement & Engagement

Given that Miami has the highest HIV incidence rate in the US, there is a small risk of an HIV outbreak happening here at any time. What should be the community's involvement in an HIV outbreak? If there was an outbreak tomorrow, who should be involved and to what extent?

- What do you think medical providers are responsible for in such a situation?

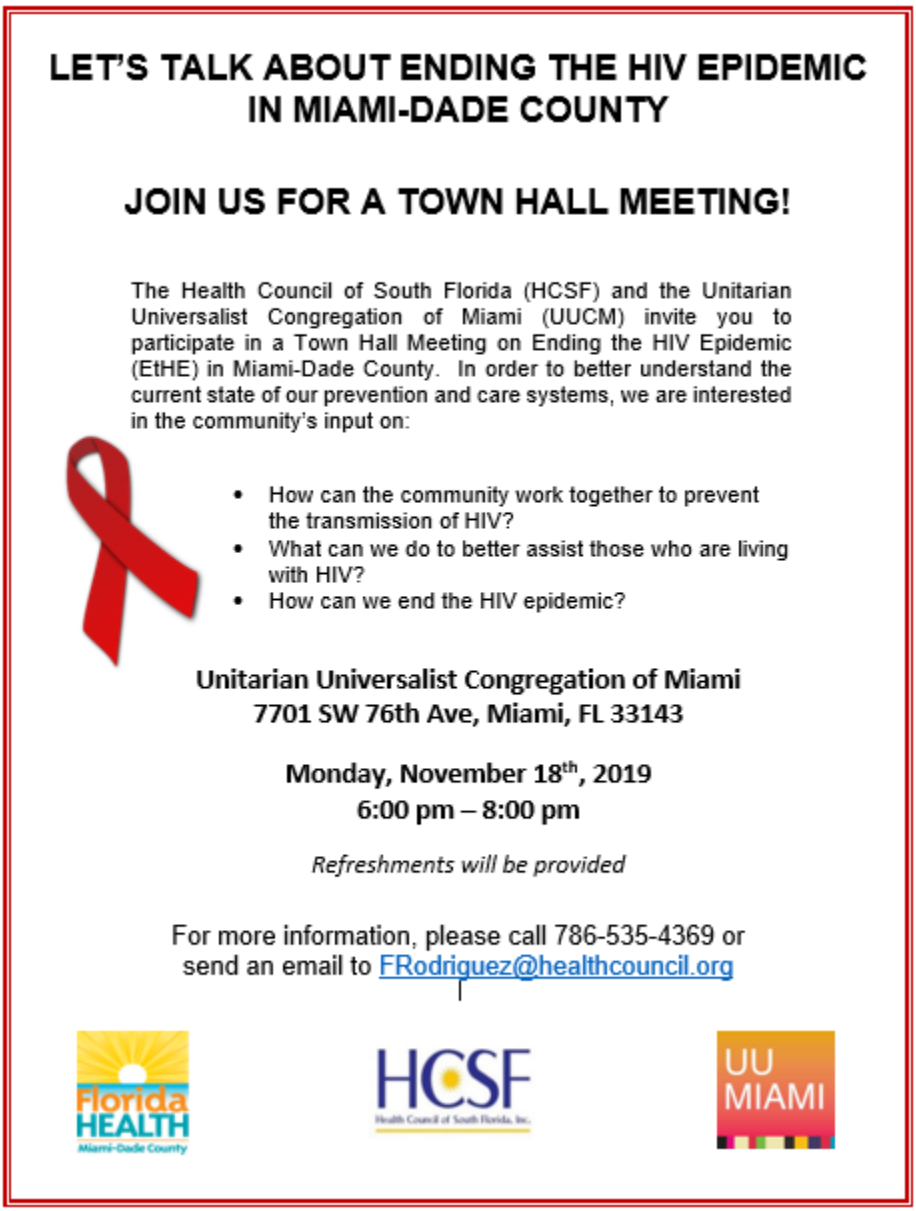
How can we best train a workforce to be culturally competent on HIV/AIDS?

What are the best strategies for us to continue engaging key stakeholders and the community on HIV efforts?

Do you have any additional ideas on how to reduce the stigma around HIV/AIDS in our Miami-Dade community?

Appendix B

Town Hall Flyer



LET'S TALK ABOUT ENDING THE HIV EPIDEMIC IN MIAMI-DADE COUNTY

JOIN US FOR A TOWN HALL MEETING!

The Health Council of South Florida (HCSF) and the Unitarian Universalist Congregation of Miami (UUCM) invite you to participate in a Town Hall Meeting on Ending the HIV Epidemic (EtHE) in Miami-Dade County. In order to better understand the current state of our prevention and care systems, we are interested in the community's input on:

- How can the community work together to prevent the transmission of HIV?
- What can we do to better assist those who are living with HIV?
- How can we end the HIV epidemic?

Unitarian Universalist Congregation of Miami
7701 SW 76th Ave, Miami, FL 33143

Monday, November 18th, 2019
6:00 pm – 8:00 pm

Refreshments will be provided

For more information, please call 786-535-4369 or send an email to FRodriguez@healthcouncil.org

Florida HEALTH Miami-Dade County

HCSF Health Council of South Florida, Inc.

UU MIAMI

Appendix C

Example of sign-in sheet for town halls

Ending the HIV Epidemic: A Plan for Miami-Dade County

Town Hall Meeting November 19, 2019 10am-12pm: South Dade Govt Center

Zip Code	Gender	Age Group	Race	Ethnicity	What community do you represent?
	A) Female B) Male C) Transgender D) Other	A) <13 B)13-18 C)19-24 D)25-34 E)35-44 F) 45+	Black (B) White (W) Asian (A) Multi-Racial (MR) Other (O)	Hispanic (H) Non-Hisp. (NH)	A) Community Member B) HIV Service Provider C) Community Based Organization D) Person Living with HIV/AIDS or affected by HIV/AIDS E) Member of Local Planning Body F) Faith-Based G) Research Institute H) Other: Please specify

Appendix D

EHE Online Forum Tool

Introduction: *Hello, today we're going to be talking about HIV/AIDS as it relates to our Miami-Dade community. This conversation is for the purposes of the Ending the HIV Epidemic project being done by the Health Council of South Florida in conjunction with the Florida Department of Health – Miami-Dade County. Our goal is to hear from the online community in Miami-Dade about HIV issues and topics, so that we can then include the community's ideas in our report for the Department of Health. We will be asking you all some basic questions today on HIV prevention and care, as well as PrEP and community engagement. We are also interested in any questions you may have during this session on HIV-related matters. We want to facilitate a discussion on these matters in an engaging and productive way.*

To begin: What do you think are the top three issues we currently face as a community regarding HIV/AIDS?

HIV Prevention

In this section we're going to focus on HIV prevention systems and efforts. Think about answers to these questions that focus on how we prevent HIV transmission and infection.

What are your thoughts on the current HIV prevention systems in Miami-Dade?

What are the strengths of our HIV prevention systems?

- What strategies and best practices do you think have been successful?
- What do we do well in comparison to other places?
- (For providers) Can you identify and elaborate on some key relationships your organization has made within the HIV prevention landscape?

What are the weaknesses of our HIV prevention systems?

- Are there any strategies or practices in our community that have not been successful?
- What does our system not do so well in comparison to other places?

- Do you think there's something "missing" in this landscape? (i.e. some key providers or services that are lacking in Miami-Dade)

Do you think there's anything that poses a threat to our HIV prevention efforts?

- Legislation, funding, the economy, physical environment, changing demographics, etc.

Are there any innovative strategies or opportunities that you believe our HIV prevention systems could benefit from?

HIV Care

Now we're going to focus on HIV care systems and efforts. For this section, think about how we care for people living with HIV.

What are your thoughts on the current HIV care systems in Miami-Dade?

What are the strengths of our HIV care systems?

- What strategies and best practices do you think have been successful?
- What do we do well in comparison to other places?
- (For providers) Are there particular solutions that your organization has implemented in order to address the needs of your HIV+ clients?

What are the weaknesses of our HIV care systems?

- Are there any strategies or practices in our community that have not been successful?
- What does our system not do so well in comparison to other places?

(For providers) What are some of the biggest barriers that your clients face in accessing care?

- What factors would you say contribute to HIV+ people falling out of care?
- How would you solve these issues from your perspective?

Do you think there's anything that poses a threat to our HIV care efforts?

- Legislation, funding, the economy, physical environment, changing demographics, etc.

Are there any innovative strategies or opportunities that you believe our HIV care systems could benefit from?

PrEP & Community Engagement

In general, how do you think the Miami-Dade community has responded to PrEP? Positively, negatively, etc.?

What are some barriers that prevent at-risk populations in Miami-Dade from getting on PrEP?

What should be the community's involvement in an HIV outbreak? If there was an outbreak tomorrow, who should be involved and to what extent?

Do you have any additional ideas on how to reduce the stigma around HIV/AIDS in our Miami-Dade community?

Appendix E

EHE PLWH Listening Session Tool

Introduction: *Hello, today we're going to be talking about HIV/AIDS as it relates to our Miami-Dade community. As we discussed previously, this is for the purposes of the Ending the HIV Epidemic project being done by the Health Council of South Florida in conjunction with the Florida Department of Health – Miami-Dade County. Ending the HIV Epidemic is an initiative by the US Dept of Health and Human Services that targets high-impact areas across the country, with the goal of significantly reducing HIV transmission rates in the coming years. Your perspective is vital for the creation of a jurisdictional EHE plan for Miami-Dade County. I'll be taking some notes during our interview in order to highlight important points that come up. Please feel free to stop me at any time and ask any questions you may have throughout the duration of this interview.*

As a disclaimer, it is possible that I might ask a question on a topic that you might not have a lot of previous experience or background with. That is completely fine and understandable, we are simply trying to cover all our bases and get as full of a perspective as possible.

General Questions

What do you think are the top three issues we currently face as a community regarding HIV/AIDS?

Based on your knowledge about what is being done in Miami-Dade County to combat HIV/AIDS, what do you believe is being done well? What should we increase in these efforts?

HIV Prevention

In this section we're going to focus on HIV prevention systems and strategies. Think about answers to these questions that focus on how we prevent HIV transmission and infection.

What are your thoughts on current HIV prevention strategies in Miami-Dade County?

- What are some of the strengths and weaknesses of these strategies?
- What can be done to improve these strategies?

What is the best way to stop the spread of HIV in our community or among vulnerable populations?

Do you believe there are any needs or gaps in our HIV prevention services that need to be addressed?

HIV Care

Now we're going to focus on HIV care systems and strategies. For this section, think about how we care for people living with HIV.

What are your thoughts on current HIV care treatments and strategies in Miami-Dade County?

- What are some of the strengths and weaknesses of these treatments and strategies?
- What can be done to improve these factors?

What are the best ways to keep people living with HIV engaged in their care?

How can we better connect people living with HIV to care?

Do you believe there are any needs or gaps in our HIV care services that need to be addressed?

PrEP

We're now focusing on PrEP. As you may know, PrEP is a medication meant to prevent HIV infection. It is intended for populations and individuals who have a high risk of contracting HIV. When taken daily, it is extremely effective at reducing the risk of contracting HIV.

How familiar are you with PrEP? Have you noticed its presence in any way in our Miami-Dade community?

What do you think are some effective strategies we could use to further promote access to and the availability of something like PrEP?

Community Involvement & Engagement

Given that Miami has the highest HIV incidence rate in the US, there is a small risk of an HIV outbreak happening here at any time. What should be the community's involvement in an HIV outbreak? If there was an outbreak tomorrow, who should be involved and to what extent?

- What do you think medical providers are responsible for in such a situation?

Who or what are some of the non-traditional players in our community who should be involved? What can their roles be in this effort?

What are some of the things we can do to train our community to be culturally competent on HIV/AIDS?

What are the best strategies for us to continue engaging key stakeholders and the community on HIV efforts?

Do you have any additional ideas on how to reduce the stigma around HIV/AIDS in our Miami-Dade community?

Appendix F

Ending the HIV Epidemic Provider Survey 2019

In collaboration with the Florida Department of Health, the Health Council of South Florida is conducting a needs assessment to evaluate HIV/AIDS services in Miami-Dade County, as part of the broader Ending the HIV Epidemic initiative. This survey is intended for **providers** (physicians, case managers, nurses, social workers, outreach specialists, etc.) that provide medical and/or support services for people living with HIV/AIDS in **Miami-Dade County.** Your feedback will help us assess which HIV/AIDS services are helpful, which services need improvement, and which services are missing from our region. Individual participants will not be identified in the needs assessment document. Thank you for participating, we value your feedback.

Background Information

Name of Agency/Organization _____

Address of Agency/Organization _____

City and State_____

Zip Code_____

What is your role or position in the organization?

☐ Administrative

☐ Clinical

☐ Case management

☐ Community outreach/ service delivery

☐ Other *(please specify)*

What is your job title?

How many years have you worked professionally in the HIV field?

Services

What types of services does your organization provide?

What services are utilized the most by clients accessing your organization?

What services are utilized the least by clients accessing your organization?

What do you see as the most significant barriers facing your ***organization*** in the provision of services?

What are some of the challenges in ***your role/position specifically*** around providing services to consumers?

Barriers to Receiving Services

What population group(s) does your organization serve?

Please describe the challenges that different population groups face in accessing your organization's services.

From your perspective, what reasons cause your consumers to miss medical or case management appointments? What reasons cause them to stop taking medications?

Based on what you've seen at your organization, what are your consumer's greatest unmet needs?

Possible Changes to Services

What services or programs would you like to see **expanded or strengthened** in your organization? In Miami-Dade County?

What services or programs would you like to see **introduced** in your organization? In Miami-Dade County?

Are there other changes you would like to see in your organization's services?

What kinds of training, technical assistance or other tools would improve your ability to serve your consumers? (Either as an individual or as an organization)

Additional input/comments

1) Is there other information that you would like to add, or issues that you think should be taken into consideration as we conduct this HIV/AIDS community needs assessment in Miami-Dade County?

Appendix G

EHE Key Stakeholder Tool

Introduction: *Hello, today we're going to be talking about HIV/AIDS as it relates to our Miami-Dade community. As we discussed previously, this is for the purposes of the Ending the HIV Epidemic project being done by the Health Council of South Florida in conjunction with the Florida Department of Health – Miami-Dade County. Ending the HIV Epidemic: A Plan for America is an initiative by the US Dept of Health and Human Services that targets high-impact areas across the country, with the goal of reducing new HIV cases in the next five years by 75% and by 90% in the next ten years. Your perspective is vital for the creation of a jurisdictional EHE plan for Miami-Dade County. These key stakeholder interviews are part of a situational analysis that will be included into a final report for the DOH. I'll be taking some notes during our interview in order to highlight important points that come up. Please feel free to stop me at any time and ask any questions you may have throughout the duration of this interview.*

As a disclaimer, it is possible that I might ask a question on a topic that you might not have a lot of previous experience or background with. That is completely fine and understandable, we are simply trying to cover all our bases and get as full of a perspective as possible.

General Questions

What do you think are the top three issues we currently face as a community regarding HIV/AIDS?

How do you believe social determinants affect people's access to HIV services? (Some examples of social determinants include things like housing, education, healthy food access, employment, and income.)

Based on your knowledge about what is being done in Miami-Dade County to combat HIV/AIDS, what do you believe is being done well? What should we increase in these efforts?

HIV Prevention

In this section we're going to focus on HIV prevention systems and strategies. Think about answers to these questions that focus on how we prevent HIV transmission and infection.

What are your thoughts on current HIV prevention strategies in Miami-Dade County?

- What are some of the strengths and weaknesses of these strategies?

- What can be done to improve these strategies?

What do you believe your organization's role is or could be within Miami-Dade's landscape of HIV prevention?

How can we work collectively, as partners, to stop the spread of HIV in our community or among vulnerable populations?

Based on the clients that you serve, are there any additional needs or gaps in our HIV prevention services that need to be addressed?

HIV Care

Now we're going to focus on HIV care systems and strategies. For this section, think about how we care for people living with HIV.

What are your thoughts on current HIV care treatments and strategies in Miami-Dade County?

- What are some of the strengths and weaknesses of these treatments and strategies?
- What can be done to improve these factors?

Has your organization had to implement particular strategies in the past to address the needs of any HIV+ clients?

What are some of the biggest barriers that your clients face in accessing HIV care?

- For the clients that do have access to care, how do we keep them engaged in care?

Based on the clients that you serve, are there any additional needs or gaps in our HIV care services that need to be addressed?

PrEP

We're now focusing on PrEP. As you may know, PrEP is a medication meant to prevent HIV infection. It is intended for populations and individuals who have a high risk of contracting HIV. When taken daily, it is extremely effective at reducing the risk of contracting HIV.

How familiar are you with PrEP? Have you noticed its presence in any way in our Miami-Dade community?

What do you think are some effective strategies we could use to further promote access to and the availability of something like PrEP?

Community Involvement & Engagement

Given that Miami has the highest HIV incidence rate in the US, there is a small risk of an HIV outbreak happening here at any time. What should be the community's involvement in an HIV outbreak? If there was an outbreak tomorrow, who should be involved and to what extent?

- What do you think medical providers are responsible for in such a situation?

Who or what are some of the non-traditional players in our community who should be involved? What can their roles be in this effort?

What are some of the things we can do to train our workforce/community to be culturally competent on HIV/AIDS?

What are the best strategies for us to continue engaging key stakeholders and the community on HIV efforts?

Do you have any additional ideas on how to reduce the stigma around HIV/AIDS in our Miami-Dade community?

Appendix H

EHE Government Rep Interview Tool

Introduction: *Hello, today we're going to be talking about HIV as it relates to our Miami-Dade community. This is for the purposes of the Ending the HIV Epidemic project being done by the Health Council of South Florida in partnership with the Florida Department of Health – Miami-Dade County. Ending the HIV Epidemic: A Plan for America is a national initiative with the goal of reducing new HIV cases significantly in the coming years. Your perspective is vital for the creation of a jurisdictional Ending the Epidemic plan for Miami-Dade County. These interviews are part of a situational analysis that will be included into a final report for the Miami-Dade County Dept of Health. I'll be taking some notes during our interview in order to highlight important points that come up. Please feel free to stop me at any time and ask any questions you may have throughout the duration of this interview.*

1. From conversations with your constituents and with the community at large, what are some of the concerns they raise regarding HIV and accessing HIV services?

2. It has been consistently shown that social determinants of health can play a significant role in the lives of those living with HIV and in the overall population. People who have safe and secure housing, quality education, access to healthy foods, good employment, steady income, etc. tend to live happier and healthier lives. From a policy perspective, which of these social determinants would be most effective for us to focus on in our efforts?

The four central strategies that serve as a foundation for this project are the following: diagnose, treat, protect, and respond. These next questions will ask for your thoughts on how to best achieve these strategies on a community level from your perspective.

3. "Diagnose" aims to diagnose all people living with HIV as early as possible. An important part of this strategy involves the widespread use of HIV testing. How can we gather widespread support for the idea of getting tested regularly, and then implementing policy changes that makes it easier to get tested?

4. "Treat" is about treating people with HIV rapidly and effectively in order to reach very low levels of virus in their system (which we call "undetectable"). The medications we have today are very good at achieving this, but the issue we face is that we see a lot of people falling out of care. What policies should we have in place within our healthcare system so that we can prevent at-risk people from falling out of the system?

5. “Prevent” aims to prevent the transmission of HIV by using proven interventions. PrEP is a pill that high-risk individuals can take once a day to prevent getting HIV, and syringe services programs (SSPs) are places where injection drug users can exchange used needles for clean ones. Both have been proven to work in reducing new cases of HIV, but there is a stigma attached to the use of PrEP and SSPs. How can we decrease the stigma around the utilization of these methods and promote their access in the community?

6. Throughout your service you have successfully worked with the community to understand their needs and worked to enact policies to elicit change, what are some of the best tools or ways we can engage the community in the Ending the HIV Epidemic response?

7. How can the District/City/Municipality engage in Ending the HIV Epidemic efforts?

8. We understand that some Cities/Municipalities have plans to address health issues in their communities and neighborhoods, is HIV one of those issues on your agenda?

Appendix I

2017 HOUSING GAP ANALYSIS
PROJECTION OF HIV/AIDS HOUSING NEED IN MIAMI-DADE METROPOLITAN DIVISION

There is no clear formula for projecting the amount of housing assistance necessary to accommodate people living with HIV/ AIDS. However, the methodology below attempts to measure the depth and intensity of need using existing data for an informed estimate, based on a similar methodology employed by the Chicago EMSA. The following projection of need is based on epidemiological data from the Miami-Dade Health Department and data collected by the Ryan White Program.

Estimated Number of Individuals Living with HIV/ AIDS in Need of Housing Assistance within the Miami-Dade Metropolitan Division

1.	HIV-Positive Individuals Receiving Ryan White Services Living at or Below Poverty Level and in Need of Housing Assistance	**4,422**
2.	Remaining Individuals Living with HIV/ AIDS in Need of Housing Assistance	**+ *6,576***
3.	Total Number of Individuals Living with HIV/ AIDS in Need of Housing Assistance.	**= 10,998**
4.	Existing Housing Resources— Units and Subsidies Dedicated to Individuals Living with HIV/ AIDS	**– 882**
TOTAL:	Estimated Gap Between Existing Housing Resources and Total Number of Individuals Living with HIV/ AIDS in Need of Housing Assistance	**= 10,116**

Methodology

1. **HIV-Positive Individuals Receiving Ryan White Services in Need of Housing Assistance**

   This number was reached by:

   - Determining the number of individuals with incomes equal to or less than the federal poverty guidelines who received Ryan White Title I services. ***In the 12-month data collection period of March 1, 2016 through February 28, 2017, 4,422 persons receiving Ryan White services reported incomes equal to or less than the federal poverty guidelines (based on family size).***

   - All of these households (4,422) require some form of housing assistance (rental assistance or subsidized affordable housing) based on housing burden in Miami-Dade.

     A single person living at 100% of the 2017 Federal Poverty Guideline has income of $11,880 ($990 monthly)*, 2017 HUD Fair Market Rent (FMR) for an efficiency is $871 while a one-bedroom unit is $1,066. A single household at poverty would be required to spend approximately 88% of its household income just for an efficiency and 107.7% of their*

*income for a one-bedroom. Even in a roommate situation, a single person at poverty would need to spend **68.2%** of their income to afford to live in a two-bedroom unit at FMR ($1,351). Individuals on SSI currently receive $735 a month (or $8,8820 a year) and clearly cannot afford an efficiency or a one-bedroom unit. A shared two-bedroom would cost them approximately **91.9%** of their monthly income.*

*A household of three at the Poverty Level has income of $*20,160 ($1,680 monthly), *requiring such household to spend approximately **80.4%** of its income on housing for a two-bedroom unit.*

2. **Remaining Individuals Living with HIV/AIDS in Need of Housing Assistance**

This number was reached by:

- Determining the number of individuals living with HIV/ AIDS in the Miami-Dade Metropolitan Division. ***According to the most current available information from the Florida Department of Health for Miami-Dade County), there were 13,259 adult cases of persons living with AIDS and 13,082 adult cases of persons living with HIV (not AIDS) as of June 2016 with total combined living cases of 26,341.***

- Subtracting the number of Ryan White clients with income equal to or less than 100% of the federal poverty level from this total to arrive at a number of those living with HIV/AIDS whose need for housing assistance had not yet been accounted for: ***26,341 minus 4,422 equal 21,919.***

- Using the above number, *conservatively* estimating that thirty percent (30%) of persons living with HIV/AIDS were in need of housing assistance. **21,919** ***x 30% = 6,576.***

3. **Total Number of Individuals Living with HIV/AIDS in Need of Housing Assistance**

This number was reached by:

- Adding together the number of individuals receiving Ryan White services in need of housing assistance and the remaining individuals living with HIV/ AIDS in need of housing assistance.

4. **Existing Units and Subsidies Dedicated to Individuals Living with HIV/AIDS**

This number was reached by determining, and combining, the number of long-term housing units dedicated to people living with HIV/ AIDS with the number of rent subsidies dedicated to people living with HIV/ AIDS.

HOPWA Program	
Long-Term Tenant-Based Rental Subsidies	850 units
Project-Based Units with HOPWA support and/or subject to Rent Regulatory Agreement	32 units

TOTAL: Estimated Gap Between Existing Housing Resources and Total Number of Individuals Living with HIV/AIDS in Need of Housing Assistance.

This number was reached by subtracting the number of existing housing resources (number of units and subsidies) and estimated number of Ryan White clients receiving other forms of housing assistance from the estimated number of individuals living with HIV/ AIDS in need of housing assistance.

NUMBER OF MIAMI-DADE COUNTY RYAN WHITE PROGRAM CLIENTS (HIV & AIDS) AT OR BELOW POVERTY BASED ON NUMBER OF PERSONS IN FAMILY UNIT REPORTING PERIOD 3/1/16-2/29/17			
Persons in Family Unit	**100% of Poverty**	**Clients Living at 100% Poverty Level**	
1	$11,880	3,722	84.2%
2	$16,020	362	8.3%
3	$20,160	160	3.6%
4	$24,300	104	2.4%
5	$28,440	51	1.2%
6	$32,580	13	0.3%
7	$36,730	3	0.1%
8+**	$40,890+	2	0.0%
GRAND TOTAL		4,422*	

*Please note: This number represents clients in Ryan White Program care in Miami-Dade County living AT or BELOW 100% of the Federal Poverty Level. The Ryan White Program allows services (with certain exceptions) to be provided to persons up to 400% of the Federal Poverty Level. The total number of clients in Ryan White Program care in Miami Dade County during the fiscal period was 10,156 persons. In 2017, 43.5% were living at or below 100% of Federal Poverty Guidelines.
** For families/households with more than 8 persons, add $4,160 for each additional person.

Comparison of 2016 Data to 2017 Data

Ryan White:
Increase of 159 in poverty (4,263 to 4,422).

Percentage of Living Cases in Need (30%)
Increase of 52 (6,524 to 6,576)

Number of Living Cases of HIV or AIDS
Increase of 330 (26,011 to 26,341)

LTRA
Down by 150 (1,000 households budgeted to 850)

Gap
Up by 361 (9,755 to 10,116)

Appendix J

Online Forum Flyer

LET'S TALK ABOUT ENDING THE HIV EPIDEMIC IN MIAMI-DADE COUNTY

The Health Council of South Florida (HCSF) invites you to participate in a live online community discussion on Ending the HIV Epidemic (EtHE) in Miami-Dade County. In order to better understand the current state of our prevention and care systems, we are interested in the community's input on:

- How can the community work together to prevent the transmission of HIV?
- What can we do to better assist those who are living with HIV?
- How can we end the HIV epidemic?

JOIN ANY OF OUR LIVE FACEBOOK SESSIONS:

Tuesday, November 5th, 2019
8:00 am – 9:00 am
www.facebook.com/fduberli

Wednesday, November 6th, 2019
11:30 am – 12:30 pm
www.facebook.com/knunnally1

Thursday, November 7th, 2019
11:30 am – 12:30 pm
www.facebook.com/facematv

Friday, November 8th, 2019
12:00 pm – 1:00 pm
www.facebook.com/ahmazin.ashley

For more information, please call 786-535-4369 or send an email to FRodriguez@healthcouncil.org

Florida HEALTH Miami-Dade County

HCSF Health Council of South Florida, Inc.