

## **ECHPP Project** **Workbook #1: SITUATIONAL ANALYSIS & GOAL SETTING**

**(FINAL: March 15, 2011)**

**This workbook is to document:**

- **The results of a current situational analysis for all interventions and public health strategies currently conducted in the jurisdiction**  
**Goals and rationale for selecting each intervention or public health strategy included in the enhanced plan**

*(Please see pp. 9-11 in the published FOA for a complete list of the 14 “required” interventions or strategies. Please see pp. 11-13 of the FOA for an additional list of 10 “recommended to consider” or optional interventions.)*

This Workbook documents the results of Step 1 ‘Situational Analysis’ and Step 2 ‘Goal Setting’. It is organized by intervention/public health strategy and lists the 14 required by the FOA, with additional space to include information for other relevant interventions/public health strategies. Grantees must complete the **entire** Situational Analysis in Step 1 before moving onto Goal Setting in Step 2. The Situational Analysis should consider the current state of their jurisdiction as a whole (not just within each intervention/strategy).

### **Workbook #1: INSTRUCTIONS**

#### **STEP 1: ‘Situational Analysis’ (Box A)**

**In box A , please write a complete and clear description of this intervention or public health strategy. Describe key features on how this intervention or public health strategy currently is being used or delivered in your jurisdiction. See Appendix 1 for points to cover in your description.**

- 1) At a minimum, please address each of the considerations listed in Appendix 1 at the end of the Workbook. This list of considerations is intended to provide some guidance on what to document in your situational analysis. Feel free to address additional considerations, but be certain to address those listed in Appendix 1.
- 2) Whenever possible, please cite sources that support statements about your local situation. (For example, if you cite epidemiologic or other data, did you get it from a specific location in your local Epi Profile or some other source?)

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Upon completing the situational analysis and preparing to consider goals, it is important to identify potential opportunities for maximizing the impact on reducing HIV infections. Also consider how HIV-related health disparities are being addressed by each intervention or public health strategy before moving on to goal setting (Step 2).

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#### **STEP2 ‘Goal Setting’ (Box B)**

**In box B, please do the following:**

- 1) *Description*: State clearly and with detail the primary HIV prevention goals for this intervention strategy
- 2) *Rationale*: Describe the rationale for how each goal will support maximizing the plan's impact on reducing new HIV infections and HIV-related health disparities.
- 3) Describe the extent to which the goal(s) of this intervention or public health strategy is part of an optimal combination of efforts described in the plan.

Goals are defined as broad aims that define the intended results of each intervention or public health strategy included in the Enhanced Plan. Collectively, these goals should optimize the provision of HIV prevention, care and treatment in your jurisdiction.

**In addition to the results of your situational analysis, please consider the following sources of information (as available) when developing these goals:**

- 1) Local epidemiologic data
- 2) Current available resources
- 3) Opportunities for leveraging resources across partners and/or funding streams
- 4) The results of gap analysis
- 5) Priority areas from existing comprehensive plan
- 6) Efficacy data
- 7) Cost information
- 8) Cost-effectiveness data

**Required Intervention #1: "Routine, opt-out screening for HIV in clinical settings"****A: Situational Analysis**

According to the Miami-Dade County Health Department (MDCHD), in 2009 there were 19 sites in Miami-Dade County that offered HIV testing in clinical settings. Twelve of these sites are operated by the Miami-Dade County's Public Health Trust (PHT) as part of the Jackson Health System; and 7 are federally qualified health centers (FQHCs). These sites are categorized as follows: community health centers (4); STD clinics (3); jails (5); emergency departments (3); one drug treatment center; specialty clinics (2); and one mobile unit. Information regarding the number of private health care providers that offer routine HIV testing was not available during the ECHPP process.

In 2009, the MDCHD awarded \$568,750 in contracts for HIV testing in clinical settings. An additional \$234,000 was expended by MDCHD for test kits and supplies (\$215,000 towards rapid testing; \$8,000 to be utilized in *OraSure* testing; and \$11,000 in blood testing). Funding outside of the CDC to support this activity includes funding from the U.S. Department of Health Resources and Services Administration (HRSA) and the National Institute of Drug Abuse (NIDA).

The MDCHD surveillance data showed that in 2009, there were 33,419 HIV tests conducted in clinical settings, which resulted in 32,652 negative results and 767 positive tests. Females represented the largest group of those tested at 17,281, with 245 positive test results. A total of 15,992 males were tested, with 515 positive test results. In addition, blacks and Hispanics represented the two largest ethnic groups being tested, with a total of 16,999 and 13,588, respectively. Blacks undergoing testing

presented with a seroprevalence of 2.79% with a total of 474 positive test results. Hispanics presented a 1.69% seroprevalence, with 230 positive test results. The risk groups that were predominantly tested included heterosexuals, individuals with sexually transmitted disease (STD) diagnosis, and men who have sex with men (MSM). Significant differences were observed in seroprevalence among these high-risk groups.

The risk groups with the highest seroprevalence were individuals who had sex with someone who was HIV-positive (seroprevalence of 14.09%), followed by MSM/intravenous drug users (IDU) at 12.35%, and IDU at 8.33%. Additionally, in 2009 only 20 individuals who identified as transgender were tested in clinical settings, with six testing HIV positive (30%).

The majority of the tests performed in clinical settings were accessed by the 20-29 age group, followed by the 30-39 and 40-49 age groups. Seroprevalence was highest among the 50+ age group with 4.53%, with the 40-49 and 30-39 age groups following at 4.26% and 2.69%, respectively.

#### **High Incidence Areas in Miami-Dade County**

In Miami-Dade County, high HIV/AIDS incidence and prevalence are concentrated in low income communities located in the north east section of the county, primarily, in the following neighborhoods: North Miami, Liberty City, Overtown, and Miami Beach. In 2009, marked differences were observed in HIV/AIDS incidence rate in North Miami by zip code. For instance, in some areas (zip code 33160) the HIV/AIDS incidence rate was 33.6 per 100,000; while in others (zip code 33168), the incidence rate reached as high as 90.4 per 100,000.

In Liberty City, Overtown, and Miami Beach, the incidence rates found were higher than the rates depicted in North Miami in 2009. The three zip codes that fall in the boundaries of Liberty City -33150, 33147, and 33142- portrayed incidence rates of 119.6, 116.1, and 74 HIV/AIDS cases per 100,000, respectively. In Miami Beach (zip code 33139) an incidence rate of 213 per 100,000 was found; while in Overtown, zip codes 33132 and 33136, had the highest incidence rates found in the entire County: 310 per 100,000 and 213 per 100,000, respectively.

South Miami-Dade, which includes Homestead and Redlands, presented a much lower HIV/AIDS incidence rate than the areas described above. The zip codes of Homestead, 33030 and 33033, had incidence rates of 32.7 and 11.9 per 100,000 population, respectively; while in the Redlands, an incidence rate of 28.9 per 100,000 was found. Although incidence rates in Homestead and the Redlands are lower, these numbers might not provide an actual representation of the epidemic in the south. The south is heavily populated by recent Hispanic immigrants that are considered at high risk for HIV and are less likely to be tested or have access to health care services due to their legal status and/or low acculturation rates.

Continued high rates of HIV/AIDS incidence and prevalence in Overtown, Liberty City, Little Haiti, and South Beach provide a basis for focused HIV testing initiatives in these communities. An expanded testing initiative can integrate key linkage services, improve provider education and expand the establishment of testing protocols. Expanded testing can also ensure that high-risk populations have access to education and prevention through multiple marketing activities.

### **HIV Testing Guidelines**

The Miami-Dade County Health Department (MDCHD) HIV testing protocol applies and promotes the 2006 Centers for Disease Control and Prevention (CDC) recommendations that encourage conducting HIV testing as a routine part of overall preventive care. The MDCHD promotes awareness among local healthcare professionals in all settings of Florida laws regarding HIV testing and how the CDC guidelines could be implemented in their practice.

In the state of Florida, county health departments and registered test sites are required to comply with the following HIV testing guidelines:

- provide pre-test counseling and information on the meaning of the test
- inform on the possibility of false positives
- discuss the importance of confirmatory testing
- inform on the social, medical, and economic consequences of positive results
- educate on the need to eliminate high-risk behavior

The provision of written informed consent is required prior to the administration of an HIV test and the delivery of face-to-face post-test counseling. The informed consent process is designed to ensure patients make an informed decision about whether to test for HIV. In addition to the guidelines that must be followed in pre-test counseling, the provision of information on the need for additional testing must also be followed during post-test counseling. Last, prevention counseling must take place at the time of testing. HIV testing guidelines in Florida for screening in private health care setting provides for more flexibility in order to encourage routine testing. In private health care settings, pre-test counseling is not required and although informed consent is required, it does not have to be in writing it can be verbal. After verbal consent, the health care provider must document in the medical record that the test was explained and consent was obtained. Additionally, providers must make a “reasonable effort” to notify the test subject of their test results. However, face-to-face notification is not required. When a person is informed of a positive test, information on preventing transmission, the importance of notifying partners, and the availability of care must be provided. Last, prevention counseling is not required with HIV diagnostic testing in private health care settings.

The laws regarding HIV testing for pregnant women are specific and apply to all

physicians, whether they operate in the public or private sector (Florida Administrative Code 64D.3.042). Among pregnant women HIV testing is routinely conducted unless the women declines testing. Repeat screening of pregnant women in the third trimester is required.

**Existing Strategies and Interventions in Miami-Dade County**

In June 2009, the Miami-Dade County Health Department and the Florida Department of Health launched the “Test Miami” campaign. The development of the Test Miami initiative was a unique effort between the Miami-Dade County Health Department, city, county, state and national officials, concerned citizens, health care providers, CBOs, private and public sector, and faith-based organizations. The goal of the campaign is to promote the CDC recommendation of integrating HIV testing as part of routine clinical care in all healthcare settings. In addition, it aims to encourage individuals to know their HIV status and seek treatment if needed. The campaign also seeks to eliminate perinatal transmission.

Since its inception in June of 2009, the Test Miami initiative has facilitated the collaboration and mobilization of the Miami-Dade community to bring the HIV epidemic to a halt through activities and events throughout the county. The Miami-Dade community is already experiencing an increase in test rates as a result of the Test Miami initiative. For example, compared to 2008, 2009 had an increase of 5.1% in the amount of tests performed. During the same year, an increase of 66.6% in the number of HIV tests provided by community healthcare settings was observed.

The Florida Department of Health (FDOH) has also implemented the Expanded Testing Initiative (ETI) in Miami-Dade County. Launched In September 2007 by the Centers for Disease Control and Prevention (CDC), ETI is an ambitious plan to identify a targeted number of new HIV-infections while focusing on disproportionately impacted populations, particularly African Americans. In 2010, this initiative was expanded to include Hispanics, men who have sex with men and injection drug users. Through procured funding from the CDC, the FDOH is increasing the utilization of rapid HIV testing technologies and promoting routine HIV testing as a standard across health care services. The following healthcare providers in Miami-Dade County are contracted under the ETI funding: The South Florida AIDS Network (emergency departments and jails), Jessie Trice Community Health Center, Community Health of South Florida and Borinquen Health Care Center.

In addition to the interventions mentioned above, the MDCHD is currently funding the implementation of a prevention program called Social Networking Strategy (SNS) through a local CBO called Care Resource, Inc. SNS is a strategy designed to reach and provide HIV CTR (HIV Counseling Testing and Referrals) to persons with undiagnosed HIV infection. The goal of this intervention is to enlist HIV-positive or high-risk HIV-negative persons (recruiters) to encourage people in their networks (i.e., network associates) to

be tested for HIV and then linked for services. SNS strives to reach out to very high-risk individuals who may be infected but unaware of their HIV status. Recruiters are provided with an orientation session that explains the nature of the program and the social networking techniques to approach their associates and discuss HIV testing. Poster, palm cards are used to raise awareness of this program to the target population. In 2010, Care Resource Inc. recruited seven Counselors (recruiters) who referred 61 individuals for testing.

### **Information Gathered From The Community**

Information obtained from community service providers and stakeholders for the purposes of informing the ECHPP delivers a glimpse of current gaps and barriers to the provision of routine HIV testing in clinical settings. During subject-matter expert interviews and community listening sessions community stakeholders regularly mentioned the lack of available information regarding the HIV testing practices of health providers in private healthcare settings. Information regarding how often and how many HIV tests are performed or ordered by private healthcare physicians is not available. Through the surveillance program, MDCHD receives information from private clinical providers on HIV-infected persons.

Additionally, community stakeholders referred to their understanding that several health providers are unaware of the Florida HIV testing regulation that allows for the exclusion of pre-test counseling and written informed consent when administering the test in private clinical settings. They pointed out that the lack of awareness of statutes under the Florida HIV testing regulations might be preventing private health physicians from routinely offering HIV screening in their practices, as they might see pre-test counseling and written consent as an added burden to administering this test.

## **B: Goal Setting**

**GOAL 1:** Implement an enhanced Test Miami initiative to encourage private health providers in Overtown and Liberty City to provide routine HIV screenings as part of primary care

### **Rationale**

Continued high rates of HIV/AIDS incidence and prevalence in Overtown, Liberty City, Little Haiti, and South Beach provide a basis for focused HIV testing initiatives in these communities. For the purposes of ECHPP the focus will be on Overtown and Liberty City. The proposed testing initiative will integrate key linkage services, improve provider education and expand the establishment of testing protocols. The initiative will also ensure that high-risk populations have access to education and prevention through multiple marketing activities. Leveraging current testing programs and resources to expand and maximize access for high-risk populations is a cost-effective means of enhancing testing.

In addition to elevated HIV incidence rates, these communities are highly inhabited by the populations that will be targeted under this plan (ECHPP). The ECHPP target populations are: white, black and Hispanic men who have sex with men (MSM), black intravenous drug users (IDU), and black and Hispanic heterosexuals.

Although low HIV incidence rates are reported for the community of Homestead, anecdotal information provided by community stakeholders' points to the increased need for targeted interventions for marginalized communities located in the south. Focused HIV prevention interventions, including testing, in Homestead address the gap of low availability and/or accessibility to healthcare services, especially for the new resident of that community. In addition, anecdotal information provided by providers suggests that there might be an emergence of unrecognized number of self-reported heterosexual men who are engaging in sexual risky behavior with other men in the south.

## **Required Intervention #2: "HIV testing in non-clinical settings to identify undiagnosed HIV infection"**

### **A: Situational Analysis**

In 2009, the Miami-Dade County Health Department (MDCHD) funded a total of five agencies to provide testing in non-clinical settings. Between 58 and 91 test sites were functioning in the same year in Miami-Dade County. In 2009, the MDCHD awarded \$469,000 in contracts for HIV testing in non-clinical settings. An additional \$3,000 was awarded for training manuals. Funding outside of the CDC to support this activity includes funding from the U.S. Department of Health Resources and Services Administration (HRSA) for Camillus House Inc. (Homeless Assistance Center).

The MDCHD also reported that in 2009 there were a total of 28,993 HIV tests performed in non-clinical settings (28,000 tests conducted in community-based organizations). Out of the total number of tests performed, 28,335 results were negative and 658 results were positive. Males represented the largest group tested, with 15,232 tests completed, resulting in 491 positive test results. Among females, 13,577 tests were performed, resulting in 161 positive test results.

Non-Hispanic blacks and Hispanics represented the two largest racial/ethnic groups being tested, with a total of 13,497 and 12,152 tests performed, respectively. More positive tests were observed among Hispanics (seroprevalence of 2.40%) than non-Hispanic blacks (seroprevalence of 2.15%). In addition, heterosexuals were tested the most (17,659), followed by men who have sex with men (MSM) (4,070), and those with a sexually transmitted disease (STD) diagnosis (3,329). Among the risk groups who were tested, individuals having sex with a person who is HIV-positive had the highest seroprevalence (20.14%); followed by MSM intravenous drug users (IDUs) (10.98%); MSM (7.38%); and those who reported having sex with an MSM (3.73%). A seroprevalence of 9.43% was observed among the transgender population, much higher than the seroprevalence observed among males and females. Finally, a higher seroprevalence was seen among the 40-49 age-category than any other age group

(4.03%).

### **High Incidence Areas in Miami-Dade County**

In Miami-Dade County, high HIV/AIDS incidence and prevalence are concentrated in low income communities located in the north east section of the County. Primarily, in the following neighborhoods: North Miami, Liberty City, Overtown, and Miami Beach. In 2009, marked differences were observed in HIV/AIDS incidence rate in North Miami by zip code. For instance, in some areas (zip code 33160) the HIV/AIDS incidence rate was 33.6 per 100,000; while in others (zip code 33168), the incidence rate reached as high as 90.4 per 100,000.

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South Miami-Dade, which includes Homestead and Redlands, presented a much lower HIV/AIDS incidence rate than the areas described above. The zip codes of Homestead, 33030 and 33033, had incidence rates of 32.7 and 11.9 per 100,000 populations, respectively; while in the Redlands, an incidence rate of 28.9 per 100,000 was found. Although incidence rates in Homestead and the Redlands present to be lower, these numbers might not provide an actual representation of the epidemic in the south. The south is heavily populated by recent Hispanic immigrants that are considered at high risk of HIV and are less likely to be tested or have access to health care services due to their legal status and/or low acculturation rates. Key informant interviews with community-based organizations, such as Union Positiva, state that the recent immigrant population is being reached through targeted, culturally-appropriate interventions. The most appropriate way to reach the immigrant population is through farm worker based efforts that are non-threatening, through migrant association, faith based and lay worker activities. This allows farm workers to become the face of the prevention and screening messages.

The availability of free HIV testing in high HIV/AIDS incidence areas as well as in marginalized and hard-to-reach communities like Homestead, help individuals who have limited access to testing in medical settings know their HIV status. People residing in these areas are increasingly low-income, have limited or no health insurance, have limited access to transportation, or may be experiencing feelings of stigma and isolation. Increasing availability of HIV testing at non-clinical sites fosters the reduction of barriers to accessing care and stigma related to testing. It also presents an opportunity to reach populations at greater risk of infection, specifically in communities already presenting a



high incidence of HIV and AIDS.

### **HIV Testing Guidelines**

In Miami-Dade county HIV testing in non-clinical sites commonly employ Center for Disease Control and Prevention (CDC) standards that pertain to the provision of client-centered HIV prevention counseling; the utilization of rapid test technologies for HIV testing; provision and interpretation of test results; and the reporting of any positive test results by the agency to local health department.

The Miami-Dade County Health Department requires that agencies providing HIV testing in non-clinical settings provide: (1) pre-test counseling informing the client on the meaning of the test, the possibility of false positives, the need for confirmatory testing, the social, medical and economic consequences of positives results and the need to eliminate high-risk behavior; (2) obtain write informed consent; and (3) perform face-to-face post-test and prevention counseling.

### **Existing Strategies and Interventions in Miami-Dade County**

In 2006, the Miami-Dade County Health Department Office of HIV/AIDS Health Education Risk Reduction Program developed and initiated a prevention initiative that seeks to increase number of HIV tests performed in non-clinical settings. The aim of the Take Control initiative is to bring HIV testing to racial/ethnic minorities and individuals who have an increased risk of HIV infection and limited access to medical care. A major strategy utilized by this initiative is the development of partnerships with community-based organizations (CBOs), the private sector, testing sites and other programs within the MDCHD, to carry-out collaboratively the activities. This partnership utilizing MDCHD testing vans and allows the MDCHD Office of HIV/AIDS Prevention Unit to offer rapid HIV testing and referral services outside medical settings to local populations.

Through this initiative the MDCHD has been able to provide HIV testing on local public school grounds. For example, on October 14<sup>th</sup> and 22<sup>nd</sup> 2010, the MDCHD conducted HIV and STD screening in Miami Central and Booker T. Washington High Schools. On October 14<sup>th</sup> 38 students were tested in Miami Central, resulting in 1 HIV-positive test. On the same date at Booker T. Washington High, 81 HIV tests were performed resulting in no positive tests. During the October 22<sup>nd</sup> Take Control event, a total of 42 students were screened for HIV at Miami Central and 88 at Booker T. Washington High, resulting in no positive tests. In addition, Empower U, Care Resource, Union Positiva, and the South Beach AIDS Project are funded through the Expanded Testing Initiative (ETI) to increase testing in non-healthcare settings.

### **Information Gathered From The Community**

Information obtained from community service providers, PLWHA, and stakeholders for

the purposes of informing the ECHPP provides information of current gaps, as well as opportunities in the delivery of HIV testing in non-clinical settings. A major theme that surfaced during the community and group listening sessions was the enormous need for the provision of HIV-testing in the community of Homestead due to the continuous missed opportunity to reach out to recent immigrants and emerging or “hidden” populations like self-identified heterosexual men who are having sex with men. Additionally, the groups mentioned that more targeted outreach towards youth and the homeless should be considered.

In order to address the recommendations stated above, the informants supported the expansion of HIV-testing to non-traditional testing venues such as thrift stores and homeless shelters, and also offering testing after regular business hours.

## B: Goal Setting

**GOAL 1:** Promote HIV testing among white, black, and Hispanic MSM; black IDU; and black and Hispanic heterosexual through the provision of integrative testing at Take Control events taking place in Little Haiti, Liberty City, Homestead, South Beach and Overtown

### Rationale

Availability of free HIV testing in high HIV/AIDS incidence areas as well as in marginalized and hard-to-reach communities like Homestead, help individuals who have limited access to testing in medical settings know their HIV status. People residing in these areas are increasingly low-income; have limited or no health insurance; have limited access to transportation; or may be experiencing feelings of stigma and thus, become isolated.

Information obtained from community service providers, PLWHA, and stakeholders provides information of current gaps as well as opportunities of the delivery of HIV testing in non-clinical settings. A major theme that surfaced during the community and group listening sessions was the enormous need for the provision of HIV-testing in the community of Homestead due to the continuous missed opportunity to reach out to recent immigrants.

Increasing availability of HIV testing at non-clinical sites such as trailer parks, schools, liquor stores, book stores, flea markets, migrant facilities for immigrants and shelters for the homeless, fosters the reduction of barriers to accessing care and addressing stigma related to testing. The availability of testing in non-clinical sites also presents an opportunity to reach populations at greater risk of infection specifically in communities already presenting a high incidence of HIV and AIDS like Overtown, Little Haiti, Liberty City and South Beach. Leveraging current testing programs and resources to expand and maximize access in high-risk, high incidence target areas is a cost-effective means of

enhancing testing.

**Required Intervention #3: “Condom distribution prioritized to target HIV-positive persons and persons at highest risk of acquiring HIV infection”**

**A: Situational Analysis**

In 2009, the Miami-Dade County Health Department (MDCHD) distributed 2,030,000 condoms. A total of 1,878,000 condoms were distributed in 2010. Condoms are distributed in a variety of settings, including health department clinics, community-based organizations, substance abuse treatment centers and businesses. Condoms distributed by the MDCHD are available to both HIV positive and high-risk HIV negative persons. It is difficult to track the condoms distributed specifically to CBOs for HIV-positive persons and high-risk HIV-negative persons because the CBOs who receive condoms do not provide information on whom the condoms were distributed to. The Florida Department of Health condom budget for Miami-Dade county was \$250,000 for the year 2010. Currently there is no other funding outside of the CDC to support this activity.

In 2008, through their *Business Responds to AIDS* (BRTA) program, the MDCHD has secured partnerships with restaurants, cafeterias, dry cleaners, art galleries, supermarkets, grocery stores, dollar stores, and bakeries, as well as other business establishments that serve high-risk populations in Miami-Dade County. The program goal is to reduce HIV/STD-related stigma in the Hispanic/Latino, black and Haitian communities of Miami-Dade County by involving Miami-Dade County merchants and citywide leaders in HIV education and testing. The MDCHD reports that through this partnership 152 venues have agreed to provide HIV/AIDS educational materials and promotional items to their customers. Of these 152 venues, 6 also provide condoms. In addition to businesses, the MDCHD distributes condoms to men who have sex with men (MSM)-related venues, such as clubs, bars, bathhouses, and LGBT-serving agencies (lesbian, gay, bisexual, and transgender community). There are 72 community-based organizations and 10 colleges and universities that are also a part of this program. Condoms are also distributed by the MDCHD through outreach in the community and at Take Control events. MDCHD condoms are also distributed by all the local ADAP pharmacies.

Miami-Dade has several pharmacies providing services to PLHWA and also distributes condoms: Part A has six contracted pharmacies. ADAP provides services through the MDCHD ADAP pharmacy and two DOH contracted pharmacies for ADAP services at Helen Bentley and CHI (Cutler Ridge and Florida City). Approximately 99% of the condoms distributed by these pharmacies are distributed to persons living with HIV/AIDS.

MDCHD receives condoms directly from the Florida Department of Health on a quarterly basis. Community-based organizations (CBOs) and/or businesses who distribute MDCHD

condoms complete a requisition form and make appointments with the MDCHD for pick up usually on a quarterly basis.

Increasing the availability of free condoms in low income communities with high incidence of HIV, is a good measure of prevention with a potential of saving millions of dollars because of the number of infections that would be averted. Implementing a series of strategies that enhance and create a comprehensive condom distribution program will maximize marketing, community-based partnerships, and optimize distribution to specifically targeted areas and demographic populations.

### **Existing Strategies and Interventions in Miami-Dade County**

The Miami-Dade County Health Department STD and HIV/AIDS programs have developed a collaborative initiative called Stop Syphilis in Miami (SIM) Work Group. This workgroup is an action planning committee geared at controlling the syphilis and HIV co-infection outbreak in Miami-Dade County. Syphilis increases the chances of HIV transmission at a rate three to five times of other STDs. According to the Florida Department of Health, in 2009 there were 64 cases of syphilis in Miami-Dade County among the HIV/AIDS population. The SIM Work Group has been sharing key information and surveillance data to effectively target individuals and has helped increase the efficiency of existing initiatives (e.g. the MDCHD condom distribution program). The MDCHD condom distribution program has taken the necessary steps to target venues where surveillance data shows high rates of syphilis exposure.

Additionally, the MDCHD provides targeted HIV/STD prevention workshop for Black and Hispanic adults that educates and encourages condom use. VOICES workshop (Video Opportunities for Innovative Condom Education Safer Sex) provides information on HIV and condoms use, and is delivered in a small group session.

### **Information Gathered From The Community**

According to information gathered through informational interviews and group listening sessions, the MDCHD free condoms are widely accessible and offer an extensive selection. Opportunities for broadening the availability of condoms through condom machines that can be strategically placed in areas and venues frequently visited by tourists, MSM, and transgender populations should be considered.

## **B: Goal Setting**

**GOAL 1:** Enhance current MDCHD condom and educational information distribution strategies and systems in order to increase the availability of free condoms and educational materials to black, Hispanic, and white MSM; black IDU; and black and Hispanic heterosexuals residing in Overtown, South Beach, Liberty City, Little Haiti and

## Homestead

Rationale

The cost of purchasing a condom poses a significant barrier for individuals willing to protect themselves from diseases. Increasing the availability of free condoms in low income communities with high incidence of HIV/AIDS is a good measure of prevention that can save millions of dollars because of the number of infections that will be averted. The CDC reports that condom distribution programs have been shown to be cost-effective and provide cost saving (1). Renaud, et al in *The Free Condom Initiative: Promoting Condom Availability and Use in New York City* reports that increased availability of free condoms led to condom acquisition and use.

Implementing a series of strategies that enhance and create a comprehensive condom distribution program will maximize a combination of marketing and branding, along with an improved regional distribution system, expanded business and community-based partnerships, and a new e-based ordering system that will optimize distribution to specifically targeted areas and demographic populations. The expanded condom distribution program will maximize the utilization of existing resources to reach high-risk populations such as MSMs at bath houses and will streamline the county-wide distribution plan, while enhancing the capacity to create community-driven partnerships with businesses and agencies in the areas of Liberty City, South Beach, Little Haiti, and Homestead.

*Reference: Centers for Disease Controls. Condom Distribution as a Structural Level Intervention. Retrieved from 1. [http://www.cdc.gov/hiv/resources/factsheets/condom\\_distribution.htm](http://www.cdc.gov/hiv/resources/factsheets/condom_distribution.htm).*

**Required Intervention #4: “Provision of Post-Exposure Prophylaxis to populations at greatest risk”****A: Situational Analysis**

In 2005, the U.S. Department of Health and Human Services published guidelines that provide detailed recommendations regarding the use of post-exposure prophylaxis (PEP) following non-occupational exposure to HIV. As referenced in the Northwest AIDS Education and Training Center and the University of Washington website, these guidelines endorse the use of PEP if the exposed individual seeks care within 72 hours of the exposure and the risk of transmission is deemed substantial. Furthermore, the website states that these guidelines define a substantial exposure risk as contact of an area of the body known to be associated with acquisition of HIV (vagina, rectum, eye, mouth, or other mucous membrane, non-intact skin, or percutaneous contact) with a body substance known to transmit HIV (blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood) when the source is known to have HIV infection. Information provided by the CDC for the drafting of the ECHPP plan for Miami-Dade County, suggests that interventions that focus on the provision of PEP after those exposure events between susceptible persons and known HIV-positive persons, present to be the most cost effective.

The Miami-Dade County Health Department currently has no budget to offer any services around the provision and/or linkage to PEP for non-occupational exposure in any of their counseling and testing sites and/or clinics. No official protocol has been established for referring clients to PEP services for non-occupational exposure by the MDCHD due to the unavailability of PEP programs for linkage. MDCHD refers individuals requesting information about PEP to the Post-Exposure Prophylaxis Guidelines published by the Florida/Caribbean AIDS Education Training Center (AETC) which provides the recommended antiretroviral regimen for non-occupational PEP.

This same dilemma was voiced by various providers who were interviewed regarding how they address PEP with their clients. Several referenced the AETC guidelines and mentioned that if the client requesting PEP does not have health insurance, they were unable to refer them to an alternative place.

Miami-Dade County providers would benefit in having an accessible standardized PEP protocol that provides guidelines for identifying and referring to PEP services to those individuals presenting the greatest risk and need.

#### **Information Gathered From The Community**

Although the MDCHD and most providers do not have the resources to provide free PEP services, through subject matter expert interviews with community stake holders, three organizations/programs were identified that are currently providing PEP services intermittently: the AIDS Healthcare Foundation, Jackson Health Systems, and one current clinical trial out-posted at the University of Miami. Through conversations conducted with one program manager of the local AIDS Healthcare Foundation, we received confirmation that this organization has provided PEP to a small number of individuals that were able to demonstrate financial hardship and had presented with a probable risk for infection (mainly young MSM reporting unprotected sex while consuming recreational drugs). Additionally, Miami-Dade's public hospital and largest provider of indigent care, Jackson Health System's, also confirmed providing PEP treatment to a small number of individuals who reported having unprotected and/or condom mishap while engaging in a sexual encounter with an HIV infected individual. Jackson Health Systems providers do not present uniformity in prescribing a specific regimen, but do provide the PEP prescription to the exposed individual who in turn is assessed by the hospital's financial specialist to determine if the prescription will be filled at no cost to the client.

It is important to note, that these PEP provider agencies are serving individuals who reside in high HIV/AIDS incidence and prevalence areas of Miami-Dade County. In Liberty City, Overtown, and Miami Beach, the incidence rates found were higher than the rates depicted in adjacent communities like North Miami in 2009. The three zip codes that fall in the boundaries of Liberty City-33150, 33147, and 33142- presented incidence rates of 119.6, 116.1, and 74 HIV/AIDS cases per 100,000, respectively.

Furthermore, in Miami Beach (zip code 33139) an incidence rate of 213 per 100,000 was found; while in Overtown, zip codes 33132 and 33136, had the highest incidence rates found in the whole county: 310 per 100,000 and 213 per 100,000, respectively.

Although South Miami-Dade, which includes Homestead and Redlands, presented a much lower HIV/AIDS incidence rate than the areas described above (32.7 and 28.9 per 100,000 population, respectively), community-based organizations in Homestead have expressed concern with respect to the limited HIV resources for people who are at risk of infection and are very low- income, which may include immigrants without health insurance who may seek care when the disease has progressed.

Thus, limited PEP resources are available in the community and those who offer these programs are willing to extend their resources to those cases presenting the most need.

## B: Goal Setting

**GOAL 1:** Individuals recently exposed to HIV or at risk of infection receive appropriate information and/or referrals to PEP services and education.

### Rationale

The Miami-Dade County Health Department currently has no budget to offer any services around the provision and/or linkage to PEP for non-occupational exposure in any of their counseling and testing sites and/or clinics. Miami-Dade community relies on the services and information provided by the MDCHD to be able to connect to resources that are otherwise unavailable to the most vulnerable residents. This goal addresses the expressed need for MDCHD providers to develop and utilize a PEP protocol that provides guidelines for identifying and referring to PEP services to those individuals presenting the greatest risk and need

The goal addresses input received from interviews and planning sessions to ensure prevention providers have the information to properly refer clients to PEP who identified themselves as having immediate risk of exposure.

## Required Intervention #5: “Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment”

### A: Situational Analysis

Structural and regulatory barriers for creating an optimal environment for HIV prevention, care and treatment in Miami-Dade County are diverse and at times extensive. This situational analysis will inform on two overarching structural barriers reported by community stakeholders during the ECHPP planning process as being the most relevant and stressing. Under the current MDCHD structure there is no funding to support policy and procedural changes that are barriers to creating an environment for optimal HIV prevention, care and treatment. Currently there is no other funding outside of the CDC to support this activity. For purposes of ECHPP we are not aware of activities

conducted by the MDCHD to support this intervention in 2009.

**Current structures that restrict the leveraging of information and resources in Miami-Dade County**

In Miami-Dade County there is a distinct separation between the entities responsible for administering HIV preventive services, the Miami-Dade County Health Department (MDCHD), and the entities responsible in overseeing HIV care and treatment (Ryan White Part A programs), the Miami-Dade County Office of Grant Management. The MDCHD provides HIV services under four overarching areas: surveillance, testing, drug assistance program, and educational/behavioral interventions.

As reported in their website, the MDCHD delivers planned HIV/AIDS prevention messages through one or more channels to target audiences. These messages build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services. The MDCHD provides both group-level and community-level interventions that utilize several strategies that include: health communication, prevention marketing, community mobilizations and community wide events.

HIV testing is provided by the MDCHD through their STD testing sites and local partners agencies which provide services throughout the Miami-Dade community including county Jails. Also, the epidemiology department conducts active and passive surveillance to collect epidemiologic information on AIDS and HIV cases.

Direct HIV/AIDS service provision is provided by the MDCHD through the AIDS Drug Assistance Program (ADAP) which is currently providing antiretroviral medications to over 3,000 HIV-infected individuals in Miami-Dade.

Similarly, the official website for Miami-Dade County, [MiamiDade.gov](http://MiamiDade.gov), states that the Office of Grant Coordination's Ryan White Program for the Miami-Dade County Government was established in 1991 to address the need for HIV/AIDS-related services among the economically disadvantaged and underserved residents of our community. The program is currently funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), under Part A of the Ryan White HIV/AIDS Treatment Extension Act of 2009.

The Administrative Office of the Ryan White Program is located within the Office of Grants Coordination and is responsible for distributing these grant funds to HIV/AIDS service organizations, community-based clinics, hospitals, and public institutions located throughout the county. Ryan White Program services include outpatient medical care, prescription drugs, oral health care, substance abuse treatment, mental health counseling, medical case management, the prescription drug co-payments, medical insurance deductibles, support to AIDS Insurance Continuation Program (AICP), legal assistance, food assistance, and transportation services. Approximately 10,000 persons



living with HIV or AIDS are served through the county's Ryan White Program on an annual basis.

Under the auspices of the Miami-Dade HIV/AIDS Partnership, the MDCHD provides reports to the community on the status of certain programs like ADAP. As stated in their strategic plan, the Miami-Dade HIV/AIDS Partnership (partnership) is responsible for conducting needs assessment activities and preparing a comprehensive plan for the delivery of HIV/AIDS-related care, treatment, and supportive services in the Miami-Dade County Eligible Metropolitan Area (EMA). The partnership is made up of consumers, service providers, health care planners, and other key stakeholders. Planning for treatment and care under Ryan White Part A is performed collaboratively through the partnership. Prevention planning, especially for Ryan White part B resources, is currently the sole task of the local health department with assistance of the Florida Department of Health.

Numerous articles and guidelines stress the importance of improving linkages and communications across agencies (and funding streams) in order to promote greater use of resources and achieve greater efficiency in the delivery of HIV prevention, care, and treatment services. While there is general agreement in the HIV/AIDS local community that collaboration and coordination of Ryan White Part B (MDCHD) and all the other Ryan White recipients in the delivery of services is beneficial to the agencies involved as well as for the clients, this approach has not been standard practice in Miami-Dade County. Streamlining processes for clients will significantly help those entering the system and access multiple services needed, as well as the ability to interface technology for improved access to client data by multiple users and providers of care.

### **Current policies that impede access to optimal HIV prevention, care and treatment programs/interventions**

#### **HIV-Positive and At-risk Youth**

In 2009, 15 percent of all new HIV cases in Miami-Dade County were among youth (13-24yrs). HIV-positive youth, particularly those disenfranchised from economic and social systems, are often underserved by pediatric and adult HIV and broader care systems. Rosenfeld et al (2000), describe in their article *Youth perceptions of comprehensive adolescent health services through the Boston HAPPENS program*, the significant barriers youth face in accessing care. These barriers include: laws and institutional policies governing adolescents' rights to confidentiality and consent; insufficient income or health insurance; and inability to independently qualify for entitlement programs.

The Advocates for Youth (AFY) website reports that paying for care is a significant problem for most young people. AFY points out that a recent study found that one in seven adolescents was uninsured, and the proportion of uninsured youth was even higher among those with a family income below federal poverty lines as well as among

African American and Latino youth (Brindis et al., 1999). Thus they recommended that providers can help tremendously by assisting youth to obtain treatment through Ryan White services and Medicaid (Advocates for Youth, n.d.).

Similarly, HIV-positive youth in Miami-Dade County face similar barriers and support to overcome these barriers are primarily addressed by the University of Miami (UM) Miller School of Medicine Department of Pediatrics, which is the principle provider of medical services to HIV-positive youth in the county.

One of the many programs the University of Miami administers with the purpose of reaching HIV-positive youth is Project SMILE. Project SMILE stands for Strategic Multi-site Initiative for the Identification, Linkage, and Engagement in Care. This program is a collaborative effort between the Miami-Dade County Health Department and the University of Miami's Division of Adolescent Medicine to link HIV-positive youth ages 13-24 to medical care and case management. Project SMILE is not only for the newly diagnosed, but also for those who have never been in care. Additionally, agencies wishing to refer their clients who have been lost to care for 6 months or longer can also take advantage of all the services Project SMILE has to offer, including emotional support that can help reduce anxiety about being HIV-positive.

Another of the University of Miami's premier interventions for HIV-positive youth is Connect to Protect (C2P), which aims to create an enabling legal environment that removes barriers to effective, evidenced-based HIV prevention, combats stigma and discrimination and protects the rights of people living with HIV or those vulnerable or at risk for HIV. This is accomplished through the mobilization of governmental, youth-serving, and HIV entities towards HIV prevention. C2P along with community partners has been working together to identify structural changes that can be made in our community's physical and social environment. C2P covers sectors such as correctional institutions, Department of Children and Families, medical community, Miami-Dade County public schools, commercial sexual exploitation of children, local businesses, and Florida statutes. The idea is to have fully functional community coalitions to further this important work in prevention and access to care.

HIV-positive youth residing in Miami-Dade County who qualify for Ryan White Part A often are not in care because they are unable to enroll into the program. Current local Ryan White Part A enrollment protocol requires the applicant to demonstrate economic hardship through the provision of proof of income. Many, if not all, HIV-positive youth residing in Miami-Dade County live with their parent or guardian, who is often unaware of the status of the youth. Requiring HIV-positive minors to present proof of income in order to enroll in possibly the only program that could keep them healthy and alive, poses a significant burden to youth and the system. HIV-positive youth who do not have health insurance and/or Ryan White Part A benefits are faced with visiting the emergency rooms for health related issues that could have been avoided through routine care. Providers interviewed through the ECHPP process acknowledged that

youth, much like the rest of the high-risk population, also encounter a barrier in linkage to care due to the confirmatory testing requirements that create lag-time in access/linkage to care and presents potential lost to care scenarios.

In addition to HIV-positive youth, a large number of youth who are currently in foster care reside in Miami-Dade County. Studies indicate that compared to public high school students, youths in foster care know less about AIDS, perceive less personal threat of AIDS, feel less confident about preventing AIDS, and engage in high-risk sexual behaviors. Furthermore, adolescents in foster care are characterized with multiple psychosocial and behavioral problems that may increase their risk of HIV infection. These include histories of physical or sexual abuse, neglect, family instability and disruption, multiple placements, mental health and delinquent behaviors. Currently, the Miami-Dade County Department of Children and Families does not have in place specific strategies that address HIV prevention, or policies that promote the implementation of HIV prevention services for youth entering foster care. In order to address the increased risk of foster youth entering the system, it is important that the Miami-Dade County Department of Children and Families consider effective and recommended policies that facilitate:

- HIV testing and counseling among the youth in foster care
- the provision of information on HIV/STD prevention to youth
- the provision of training and education to foster care parents on the topic of HIV/AIDS, the law, and how to convey this information to adolescents
- and linkages to care for those identified as HIV-positive, are considered to be

Similarly, both foster youth and youth in general attending Miami-Dade Public Schools are currently accessing general health education or targeted HIV/AIDS information in lieu of comprehensive sexual education. This information is currently provided to students during physical education classes. Numerous research points to the importance of comprehensive sex education in public schools for reducing sexually transmitted diseases (STDs). In Florida, public schools are not required by law to provide comprehensive sex education, but if a district chooses to offer such courses, they must include information about abstinence until marriage.

### *Intravenous Drug Users*

In 2009, the MDCHD reported that individuals testing in clinical settings under the exposure category of MSM/intravenous drug users (IDU) and IDU were among the populations presenting the with highest seroprevalence rates (12.35% and 8.33%, respectively). Similarly in non-clinical settings, MSM/intravenous drug users (IDUs) presented with a seroprevalence rate of 10.98%. IDUs are at high risk of becoming infected with HIV and other blood borne pathogens through sharing injection-drug equipment with HIV-infected persons or by engaging in unprotected sex. Unfortunately, optimal preventions strategies that help decrease transmission rates among this population are non-existent in Miami-Dade County.

The benefits of implementing needle exchange programs as a method of reducing HIV incidence among the IDU population have been reported in numerous articles and may serve as a platform for addressing current state policy barriers. The *Miami-Dade County National HIV Behavioral Surveillance System IDU* report states that Miami-Dade County is subject to state laws prohibiting needle exchange programs (NEPs). Section 893.147, Florida Statutes, states that “it is unlawful for any person to use, or to possess with intent to use, drug paraphernalia.” Section 893.145, Florida Statutes, includes in the definition of drug paraphernalia “all equipment, products, and materials of any kind which are used, intended for use, or designed for use” in “preparing,” “injecting,” “or otherwise introducing into the human body” an illegal substance.

The above mentioned report states that “while it is illegal to operate an NEP in Florida, NHBS staff is aware of several small-scale NEPs operating in Miami-Dade County in recent years. To avoid detection and arrest, the people operating these programs have deliberately decided against joining forces or combining their operations and reject the notion of storefront operations. The NEPs distribute condom, HIV and hepatitis C prevention materials. Previous direct observation of the operations of NEPs by the field ethnographer during the NHBS-IDU1 cycle indicate a heterogeneous clientele, including IDUs who inject steroids, Botox, and other illegally obtained substances for body building and cosmetic purposes. While the NEPs were operating prior to and during the NHBS-IDU1 cycle, only 3% of the Miami-Dade County NHBS-IDU1 sample reported receipt of free, sterile syringes or injection equipment in the past 12 months.”

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## B: Goal Setting

**GOAL 1:** Develop and promote community partnerships that maximize and leverage resources for improving access to HIV prevention, treatment and care services.

### Rationale

Review of local funding information for local HIV/AIDS services and transcripts from interviews and listening sessions revealed an opportunity to enhance communication between work executed by the Miami-Dade Health Department and the work being done by other Ryan White service providers in order to reduce potential duplication of

services and funding. In order to capitalize on the limited resources available to provide the highest level of quality prevention, treatment and care for those most affected by HIV/AIDS in Miami-Dade County, funding entities, service providers/programs, and local health/government authorities need to coordinate and plan together for optimal program outcome. This goal envisions a Miami-Dade HIV/AIDS community that employs a more organized approach to garner the greatest impact. Additionally, streamlining the intake process for clients will significantly help those entering the system to access multiple services needed. Streamlining will also give the clinic employee the ability to interface technology for improved access to client information by multiple users and providers of care. This is the cost-effective means of improving access to care through an integrated approach that builds on existing systems and structures for optimal service delivery.

**GOAL 2:** Accurately inform processes that address the elimination of barriers to accessing HIV prevention, treatment, and care services for HIV positive and at-risk individuals

#### Rationale

As described throughout numerous interviews and strategic planning meetings, current policies restrict HIV-positive youth, at-risk youth, and intravenous drug users from accessing optimal services, benefits, and/or programs, and are thereby fueling the current epidemic in the County. Thus, it is important that the county and state departments (i.e. DCF) begin to address the policy and regulatory barriers that continue to marginalize these high-risk groups (such as youth and IDUs) in accessing care, treatment, and prevention services. Additionally, the Dade Public School System (DCPS) has the opportunity to expand prevention and sexual education with the restructuring of current policies that will improve identification and early intervention/prevention of HIV and related STDs.

**GOAL 3:** Enhance internal contracting policies and regulations to ensure provision of optimal care for individuals living with HIV.

#### Rationale

Current MDCHD contracts and Memorandums of Agreement (MOAs) do not provide specific and clear guidance on what is expected from providers who are contracted to provide linkage services to clients. This results in clients not receiving adequate services nor does it establish a comprehensive approach to linkage to care.

**Required Intervention #6: “Implement linkage to HIV care, treatment, and prevention services for those testing HIV-positive and not currently in care”**

**A: Situational Analysis**

Florida HIV testing guidelines for their HIV testing sites require staff to inquire about the client's immediate plans after leaving the test site and provide the newly diagnosed with:

- an explanation of the purpose and advantage of receiving early intervention services, and how treatment and support may prolong and improve the quality of their life
- an assessment of client's willingness to seek support and complete a referral
- a discussion on the need for the client to disclose to their health care providers their HIV status
- a risk reduction plan, including the risk of additional infection exposure and transmission to others
- a discussion on client's past and present sex and/or needle sharing partners who may have been exposed to HIV
- additional linkages
- educational literature and condoms

MDCHD operates under the Ryan White Program Service Delivery Guidelines for linkage and referral services. Ryan White Program outreach services target HIV-positive clients in need of assistance accessing HIV care and treatment who are: HIV positive, formerly in care, currently not receiving medical care, HIV-positive persons at risk of being lost to care, newly diagnosed with HIV/AIDS not receiving medical care and HIV-positive persons that have never accessed care.

Linkage agreements form the basis for collaborative relationships between providers. Outreach providers maintain formal referral and linkage agreements under Ryan White with one or more key points of entry: STD clinics, HIV counseling and testing, hospitals, substance abuse and mental health treatment, adult and juvenile detention centers, jail and correctional facilities, and homeless shelters.

The Ryan White medical case manager develops comprehensive and individualized needs assessment plans of care for the client to access timely, appropriate services, medication and treatment. Follow-up for medication adherence and follow-up related to the coordination of care are also established procedures. Additionally, follow-up to verify clients are receiving care and to ensure linkage to other services as needed are completed.

In addition, the guidelines also delineate the importance of informing all pregnant women who test positive for HIV of the benefits of antiretroviral therapy during pregnancy, where she can go to obtain the medications, and that breastfeeding can transmit HIV infection to her baby.

It has been documented that "when community-wide health care and economic challenges are linked to PLWHA, they become complexity factors and treatment

challenges” (Miami-Dade HIV/AIDS Partnership, 2009). In the Comprehensive Plan for HIV/AIDS 2009-2011, the Miami-Dade HIV/AIDS Partnership, states that in Miami-Dade County, complexity factors that may delay or inhibit linkage to HIV/AIDS care are substance abuse, mental illness, homelessness, lack of insurance, and late presenters.

In 2007, there were 1,864 PLWHA identified by the Ryan White Part A program as substance abusers, and 3,317 with chronic mental illness. It has also been reported that there were significant overlaps between homelessness, mental illness, and substance abuse among PLWHA who are part of the Ryan White Part A program. Homeless PLWHA present challenges to health workers, which include increased consultation time, intensive medical case management, increased needs for follow-up and/or outreach, likelihood of being lost to care, and increased needs for support services. In Miami-Dade there are two “special need” populations that may face cultural barriers to engagement and retention in treatment are Hispanic and Haitian MSM. Focus groups conducted by Behavioral Science Research and a Special Projects of National Significance project, revealed that feelings of stigma about HIV/AIDS, fear of deportation and/or incarceration, and the non-western system of beliefs about health behavior, are common in both populations, and inhibit the treatment of HIV/AIDS (Miami-Dade HIV/AIDS Partnership, 2009).

According to the Comprehensive Plan for HIV/AIDS 2009-2011, non-Hispanic blacks are significantly more likely to drop out of care than any other ethnic group. In 2007, 17% of non-Hispanic blacks who were in care and treatment the previous year were lost to follow-up. Non-Hispanic blacks comprised 33% of new Part A Program clients who entered care in 2007, but are also 55% of PLWHA who required outreach efforts to be retained in and/or reconnected to care in the same year.

Women of childbearing age are also at high risk of dropping out of care (21% of women between 15 and 44 who had received HIV services in 2006 had fallen out of care in 2007). The University of Miami Family Care Program reported that 25% of the pregnant HIV clients had psychiatric symptoms including depression, anxiety disorders, post-traumatic stress syndrome, conduct disorders, psychosis, and attention deficit disorder. Fear of family rejection once HIV status is revealed, as well as the stigma of HIV, are contributing factors that affect adherence to medical regimens. County STD Clinic referral services may include OB/GYN, family planning, HIV clinic, tuberculosis clinic, substance abuse treatment, medical case management, STD and hepatitis screening, and domestic violence counseling.

Public health officials in Miami-Dade County define an “unmet need” for care among PLWHA as the absence of viral load testing, CD4 count, and/or anti-retroviral therapy (ART). According to the 2009 Miami EMA Demographic Analysis of People In and Out of Care Report 23,477 individuals were living with HIV/AIDS in Miami-Dade County. Of that number 8,490 (36%) had unmet needs.

The MDCHD does not provide care and treatment services other than ADAP. Consequently, they do not track HIV-positive persons that are not currently in care. No funding from the MDCHD is currently in place to support prevention with HIV positives, and there is no other funding identified outside of the CDC to support this activity.

**Existing Strategies and Interventions in Miami-Dade County**

The SMILE Program (Strategic Multi-site Initiative for the identification, Linkage, and Engagement in Care), is the collaboration between the MDCHD and the University of Miami, Division of Adolescent Medicine. The ultimate goal of this program is to ensure that all youth (13-24 years old) diagnosed with HIV are linked with HIV medical care and case management.

The Minority AIDS Initiative (MAI) identifies minorities who are HIV infected and who have not accessed available medical care. Through the Antiretroviral Treatment Access Study (ARTAS) model, clients are assisted in obtaining the necessary medical care. The ARTAS model aims to empower the client to become his or her own medical advocate. A newly diagnosed or out-of-care client is encouraged to identify goals that are important to them with the ultimate goal of obtaining medical care and treatment. It consists of a maximum of five face-to-face visits where the care coordinator helps to identify the client's own abilities to achieve delineated goals. Under the MAI, clients who have a positive HIV diagnosis can enroll in interventions such as Partnership for Health, L.I.F.E., Comprehensive Risk Counseling and Services (CRCS), and Healthy Relationships. In addition, one of the primary goals of MAI is to link minority clients to the AIDS Drug Assistance Program (ADAP).

The South Florida AIDS Network (SFAN) offers a Jail Linkage Program, and the Florida Department of Corrections, provides a Pre-Release Planning Program. Both programs identify, inform, refer and link HIV-positive individuals to care. Jackson Memorial Health System is Miami-Dade's only Public Hospital which provides infectious disease treatment facilities in the county. SFAN is co-located on the Jackson Health System main campus.

Linkage and retention is a program designed to target HIV-infected individuals that are either lost to follow up or in danger of falling out of care. This program works with the county Ryan White case managers and other key points of entry, such as STD clinics, counseling and testing agencies, and blood banks. The main purpose is to identify and bring back individuals in need of HIV primary care. It targets non-Hispanic black heterosexual females and males, Hispanic MSM, non-Hispanic MSM and IDU living with HIV/AIDS, Hispanic heterosexuals living with HIV/AIDS, and non-Hispanic white MSM and IDU living with HIV/AIDS.

The Miami Dental Access Program (MDAP) aims to increase access to oral health care services among HIV-infected patients and to decrease identified barriers. The program



emphasizes prevention, early intervention, and linkage to comprehensive oral health care for low-income persons living with HIV. Workers of the MDAP visit HIV primary care clinics that do not have on-site dental care in Miami-Dade County and offer dental services to patients who are seen on that day for HIV primary care initial screenings.

### **Information Gathered From The Community**

As unanimously described by providers, health care practitioners, and consumers during listening sessions, focus groups, and strategic planning meetings, linkage to care immediately after initial diagnoses instead of linking clients to care after they receive a confirmatory test result could prove effective in reducing the number of HIV-positive individuals that are lost to care annually.

Additionally, ensuring that linkage specialists follow the client for a minimum of two months from the time of initial encounter can be an essential element that ensures clients return for their second and subsequent appointments.

On December 3, 2010, ECHPP staff conducted a group listening session with Rembrandt Flores a community-based organization located in Homestead, Florida. Several concerns were voiced regarding the provision of HIV services in this area of South Florida. For instance, an HIV-positive non-Hispanic Black female stated that although she had access to primary care, her doctor had limited knowledge on HIV, and when a referral was needed, contact information was not provided. Other residents of Homestead experienced barriers to care, such as cancellation of appointments few minutes prior to their visit; lack of competency in Spanish; lack of mental services; and limited availability to case managers.

The focus group session at the South Beach AIDS Project revealed that the high “turnover rate” of case managers as well as the fixed schedule of 9-5, lead to HIV patients being lost to care. In addition, the lack of “bundling of services” or a “one-stop shop” for HIV services is needed in the community, according to the participants.

The following organizations provide linkage to care for HIV-positive clients and individuals newly diagnosed with HIV in Miami-Dade County: Alert Health, Borinquen Health Center, University of Miami Prenatal Program, Dade County Public Schools (DCPS), Union Positiva, University of Miami Comprehensive Study, Empower U, AIDS Health Care Foundation, Miami Beach Community Health Center, AIDS Education and Training Center, and the HIV Testing and Policy Prenatal area. It was noted by one key informant representing a community-based agency that improved linkage and referral is needed for hepatitis C.

## **B: Goal Setting**

**GOAL 1:** Newly diagnosed white, black, Hispanic MSM; black IDU; and black and Hispanic heterosexual residing in Overtown, Liberty City, Homestead, South Beach and Little Haiti are linked to care immediately after initial diagnosis through Take Control events.

Rationale

It is crucial to target these high incidence communities as the majority of its residents may be burdened not only with HIV infection, but with an array of factors such as substance abuse, feelings of stigma, cultural barriers (e.g. rejection by family members), mental illness, fear of deportation, among others. These factors could be impediments to care among high-risk populations soon after they have learned of their positive HIV diagnosis.

By partnering with the private sector, CBOs, and other programs within the MDCHD to maximize current resources/programs, the Take Control initiative could implement new cost-effective models for diagnosing HIV infections outside medical settings, and offer HIV counseling, and linkage. The provision of these services to high-risk populations, who otherwise would not have access, could prove to be an important strategy to link them to care and improve the follow-up process. As unanimously described by providers, health care practitioners, and consumers during listening sessions, focus groups, and strategic planning meetings, linking to care immediately after initial diagnoses instead of linking clients to care after they receive a confirmatory test result, could prove effective in reducing the number of HIV-positive individuals that are lost to care annually. Additionally, ensuring that linkage specialists follow the client for a minimum of two months from the initial encounter will be an essential element to ensure that clients return for their second and subsequent appointments. Creating an alliance between Ryan White Part A and Part B, would also be an effective way to reach high-risk populations at Take Control events.

Because of the factors described in the situational analysis exacerbate lost to care for the identified high-risk population, prevention and linkage efforts that are comprehensive, take place at time of diagnosis, and employ the ARTAS model for client empowerment are critical components for re-engagement, linkage, and maintenance/adherence to care.

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**Required Intervention #7: “Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons”**

**A: Situational Analysis**

The Florida Department of Health-Bureau of HIV/AIDS reports that as of June 3, 2010 there were 24,151 people living with HIV/AIDS (PLWHA) in Miami. Of that number, 47% were non-Hispanic black and 38% were Hispanic. Males represented the largest group

of PLWHA at 70%. The following age groups, sequentially, denoted the major age groups of PLWHA: 40-49 (36.1%), 50-59 (25.5%), and 30-39 (18.6%).

The information that follows has been extracted in its entirety from the Miami-Dade HIV/AIDS Partnership Comprehensive Plan for HIV/AIDS 2009-2011 (*Miami-Dade HIV/AIDS Partnership Comprehensive Plan for HIV/AIDS 2009-2011.*)

For those individuals living with HIV/AIDS in Miami-Dade County, core medical services are delivered through both the general healthcare delivery system and a specialized network of clinics and service providers focused on the most vulnerable populations in the county. Core medical services (as defined by HRSA) for those living with HIV/AIDS include: outpatient medical care, prescription drugs, medical case management, mental health therapy, outpatient substance abuse treatment, and insurance services.

The county has a number of clinics designed to serve as a healthcare safety net for the low income and uninsured, including PLWHA. These facilities consist of 12 clinics operated by Miami-Dade County's Public Health Trust (PHT) as part of the Jackson Health System and seven Federally Qualified Health Centers (FQHCs). The clinics supported by the PHT receive General Revenue (GR) funds from the PHT as well as from third party payers. Both PHT and the FQHCs usually receive funds from other sources, including Department of Health and Human Services (DHHS) programs such as Maternal and Child Health, Ryan White (all Parts), substance abuse, in addition to Medicaid and other commercial insurance sources.

Primary care services are provided to PLWHA at two major hospitals: the University of Miami, which provides primary and specialty care physicians for the Jackson Memorial Hospital Special Immunology Clinic and outpatient clinics; and Mercy Hospital, which also provides primary and specialty care for PLWHA. The University of Miami, connected with Jackson Memorial Hospital, one of the nations' largest and best-known public hospitals, is the single largest provider of HIV care in the county. In addition to HIV specific primary care, adolescent care, and specialty care the University of Miami's Obstetrics and Gynecology program treats virtually all HIV-positive infants and children, as well as most pregnant women.

In 2007, the Ryan White Part A Program, administered by Miami-Dade County, provided medical and support services to almost 10,000 HIV-positive people. The program supports 14 medical care providers at approximately 40 locations. Providers range from the University of Miami Medical School, a large public teaching hospital, to small community clinics, and include several FQHCs. All major providers of HIV-related medical care participate in the federally funded Ryan White Part A program. In addition, a number of private physicians participate through contractual agreements with Ryan White-funded providers. Part A provided service to 42% of those living with HIV disease in Miami- Dade County.

In addition to the Part A Program, the HIV/AIDS community receives services funded by Parts B, C, D and F. Part B supports the State AIDS Drug Assistance Program (ADAP), Part C supports Early Intervention services at five clinics, Part D supports maternal and child health care at the University of Miami Miller School of Medicine Obstetrics and Gynecology clinic, and Part F supports oral health care services. Ryan White funds only outpatient services; inpatient services are supported by Medicaid, Medicare, State GR, county indigent care funds, and other payer sources.

In addition to medical care, medical case management is offered by a number of agencies that include hospitals, community-based organizations, and FQHCs. Medical case management is intended to help clients obtain, coordinate, and adhere to medical care and other treatments. Primary sources of medical case management funding are Ryan White Part A and Medicaid Project AIDS Care (PAC) Waiver. Ryan White Parts A, B, C and D, and State GR funds medical case management at 15 agencies. The PAC Waiver program funds 13 case management agencies. In 2007, about 10,000 clients received medical case management from these sources. The MDCHD (with the exception of the Minority AIDS Initiative) currently do not work with health care providers to promote retention or re-engagement into care outside of ADAP.

#### Unmet needs of PLWHA in Miami-Dade County

In fiscal year (FY) 2008, 5,739 persons, or 25% of reported PLWHA, were estimated to be out of care. Unmet need was higher for PLWH (31%) than for PLWA (19%). In addition, there are several dynamics in the county that contributes to the high cost and complexity of providing care and present unique challenges to service providers. These include: community factors and PLWHA complexity factors.

#### Community Factors

Miami-Dade County faces a number of problems with the ability to provide adequate resources, which include the high cost of medical care, lack of adequate affordable housing, significant internal and external migration, widespread poverty, lack of insurance, and higher than state averages of other diseases (e.g., sexually transmitted infection (STIs), diabetes, and heart disease), and lower income levels for residents.

#### Cost of Care

The cost of medical care in the EMA is among the highest in the nation; 25% of people under the age of 65 are uninsured, and the per capita cost of Medicare in Miami-Dade County is 25% higher than in Florida as a whole. AIDS-related Medicaid costs in the EMA were almost \$100 million in 2007. At the same time, the Medicaid reimbursement rates are unreasonably low, relative to the actual cost of care, which is a major disincentive for physicians practicing in Miami-Dade County.

### Housing

Miami-Dade County's affordable housing supply imbalance, along with other economic pressures, makes the cost of living one of the highest in the nation. According to the 2008 Miami-Dade County Workforce Housing Needs Assessment (May 2008), the increases in home prices, taxes, and homeowner's insurance in the EMA have made housing unaffordable for approximately 85% of Miami-Dade County's households.

### Immigration and Migration

Miami-Dade County has one of the highest immigration rates in the nation. As of the 2000 Census, updated in 2004, 53% of the population in Miami is foreign born. Hence, Miami is the largest city with the highest percent of immigrants of any U.S. city (Miami-Dade County HIV/AIDS Partnership, 2009-2011). Net domestic migration has been negative with an average of 30,400 residents migrating out of the county annually since the 2000 Census. At the same time, net immigration has been over 40,000 residents annually since 2000. In effect, every year Miami loses 1.3% of its population to outbound domestic migration, and gains 1.7% of its population from other countries. A majority of the one million legal immigrants in the EMA are not eligible for most public assistance programs, leaving the Part A Program as the only source of care for a significant portion of the county's HIV- positive population. In Florida, only people with an AIDS-defining diagnosis plus a documented disability are eligible for Medicaid. This policy excludes a significant number of legal immigrants living with AIDS who are not disabled and thousands of HIV- positive clients. Many immigrants are not connected to care and lack basic knowledge of the American health care system. A majority of Part A Program clients in the EMA are foreign-born and among Haitians and Hispanic MSMs almost 90% are foreign-born. Large numbers of immigrants increase the need to provide services in three languages; 36% of Part A clients are Spanish-speaking and 11% speak Creole.

### Undocumented Population

The undocumented population in the EMA is estimated at 225,000 persons and an estimated 10% of PLWHA not in care are undocumented and ineligible for most public assistance programs. This places additional pressure on Ryan White programs and creates challenges for getting people tested and into treatment. In addition, undocumented immigrants are often reluctant to seek care largely because they fear deportation. When they do seek care, they are likely to be late presenters who are sicker and thus more costly to treat. While the EMA's large Hispanic population helps many Spanish speakers overcome language access barriers, other immigrant populations, including Haitians and non-Spanish-speaking indigenous Central Americans, experience both language and cultural barriers.

### PLWHA Complexity Factors

When community-wide health care and economic challenges are linked to PLWHA, they become complexity factors and treatment challenges. The largest number of PLWHA receiving care through Ryan White that present with complexity factors are those individuals who have an AIDS diagnosis, do not have health insurance and/or are late presenters to care. These complex factors increase the cost of care, and – more importantly – serve to limit access or to have an impact on service delivery. The total cost of care for the 9,826 clients served by the Part A Program in FY 07-08 was \$19,902,672, yielding a per capita cost of care of \$2,026 for each PLWHA client. For most PLWHA, complexity factors contribute to a greater than average cost of treatment and the majority of Part A clients are complicated by more than one complexity factor, increasing the cost and the challenges of delivering services.

#### Substance Abuse Among PLWHA

In 2007, 1,864 clients in care in the Part A Program had identifiable substance abuse problems, requiring allocation of funds to residential and outpatient substance abuse treatment. The addition of substance abuse to an HIV/AIDS treatment profile significantly increases the cost of care and reflects a high likelihood of recidivism (and therefore a high re-infection potential).

#### Mental Illness among PLWHA

Chronic mental illness affected 3,217 PLWHA receiving care in the Part A Program. Mental illness contributes to an inadequate knowledge and understanding of risk factors and difficulty navigating the health care system. Physician visits with dually-diagnosed clients frequently require increased consultation time, increased coordination of care, increased provision of treatment education, and more follow-up to ensure adherence to both psychiatric and HIV-related treatment.

#### Homelessness

There are significant overlaps between homelessness, mental illness, and substance abuse among Part A Program clients, and homeless clients are three times as likely to drop out of care during the first year of treatment as are other Part A Program clients. Homeless clients present many challenges to the practitioner, including increased consultation time, intensive medical case management, increased needs for follow-up and/or outreach, high likelihood of being lost to care, and increased needs for other support services, such as transportation assistance and food bank.

#### The Uninsured

Although national studies estimate that 21% of PLWHA lack any type of health insurance, the rate of uninsured and/or under-insured clients served by the Part A

Program is 63 %. Of Haitian Part A Program clients, 72% are uninsured, and over half of all other racial/ethnic groups lack insurance. This places significant strain on the Part A Program as payer of last resort. The Part A Program assisted 442 under-insured clients with pharmacy co-payments and deductibles at a cost of \$490,846 in FY 2007, an 18% increase over FY 2006. Finally, since the State ADAP does not cover the under-insured, Part A absorbs additional prescription drug costs averaging \$1,035 per client per year.

#### AIDS at Diagnosis / Late Presenters

Nearly half of all AIDS diagnoses in 2007 occurred in the EMA's public hospital, indicating that a large proportion of the PLWHA population enter the system as late presenters. Of PLWHA enrolled in the Part A Program in 2007, 40% had AIDS at the time of intake, and 62% of current Part A clients have an AIDS diagnosis. Outreach efforts now focus on strengthening connections with key points of entry and working in cooperation with DOH-funded programs such as emergency room rapid testing and partner notification programs.

Miami-Dade County considers PLWHA to have an unmet need for care (or be out of care) when there is no evidence that they received any of the following three components of HIV primary medical care during a defined twelve-month time frame: viral load testing, CD4 count, and/or anti-retroviral therapy. In 2009, the FDOH reported there were a total of 23, 477 PLWHA in Miami-Dade and 36% had unmet needs. Males had a higher percentage of unmet need, at 70%, compare to females, at 30%, while African Americans/blacks and Hispanics having the highest unmet need with 50 and 39 percent, respectively. The PLWH group presented with the highest number (4,634) of individuals who did not receive primary care medical services within a 12 month period. A total of 8,490 PLWH/PLWA did not receive primary care medical services within a 12 month period. Quality managers, contracted by the county's Office of Grants Coordination Ryan White Program, reported that in 2009 approximately 700 PLWHA were lost to care in Miami-Dade County.

#### **Existing Strategies and Interventions in Miami-Dade County**

*Minority AIDS Initiative (MAI) ARTAS* – The Florida Department of Health currently funds seven agencies to provide services under the Minority AIDS Initiative (MAI). The MAI intervention can be divided into three phases. In Phase I, the emphasis is on client engagement by assessing client strengths and developing plans based on the strengths identified by the client. Phase II is built on effecting the elements of the plan. Phase III recognizes that disengagement from the MAI program is imminent and assists the client in obtaining care and social services. MAI uses strengths-based case management to target HIV-positive clients of minority populations. The purpose of the program is to link recently or previously (no care for at least six months) diagnosed HIV-positive clients to available medical care. Once identified, the client meets with a care coordinator. The ultimate goal is to link the client to the proper medical care services to receive

treatment. Other expected outcomes for the client are to identify treatment-supporting goals, such as becoming their own medical advocate, obtaining stable housing (if applicable), and achieving a more stable lifestyle. MAI clients receive case management, assistance with applying for qualifying benefits (ADAP, Medicaid, Medicare), and transportation (bus passes, cab vouchers, or care coordinator drives them to their appointments).

Currently, the community-based organization Care Resource holds a contract with the FDOH for \$140,000 to implement MAI in Miami-Dade County. Assessment and planning activities occur throughout the client's involvement with the project. Phase I and perhaps Phase II focuses on identifying and then reducing external and internal barriers to medical care engagement and retention. Phases II and III focuses on the achievement of client-defined goals, such as finding stable housing and substance abuse treatment or mental health services. A further focus of Phase III is on disengagement from the MAI care coordination and transition to an alliance with appropriate case management agencies. Upon release from the MAI program, a three-month follow-up is conducted to see if the client remains in care.

Unlike most federally-funded programs, qualification for MAI-ARTAS is not income based. The only criterion is that the HIV-positive individual should not be currently receiving medical treatment or care. Providers are community-based organizations experienced in conducting culturally sensitive and non-judgmental outreach in their local areas. Most agencies have bilingual staff speaking both Creole and Spanish. Services are geared toward HIV-positive persons within minority communities. Providers use incentives like bus passes, food vouchers, and gift bags to enroll clients into the program and ensure continued participation.

The MDCHD should work with care and treatment providers who identify PLWHA and are not in care and connect these individuals at the time of contact with Linkage Specialists. Although there currently is no other identified funding outside of the CDC to support this activity, the Miami-Dade HIV/AIDS Partnership 2010 Needs Assessment reported that \$8,413,203 was allocated to Case Management Services which includes retention and re-engagement in care services.

### **Information Gathered From The Community**

One of the major issues that were revealed during group discussion sessions with residents of Homestead, Florida, that hindered retention in care was limited access to buses that would transport patients to designated clinics. One participant in particular had been out of care for 10 months. For populations such as migrant workers, legal status and language barriers with case managers were concerns voiced during focus groups, which, in turn, inhibit retention in care.

During the focus group session conducted at the South Beach AIDS Project, participants



voiced their concerns regarding the need to address the transgender population. Participants stated that health care providers are not trained to communicate effectively with this population, which may lead this high-risk group being lost to care. Furthermore, this communication barrier could inhibit adherence to a medical regime. Information gathered through community and individual listening sessions revealed that many community-based organizations in Miami-Dade County report an increase in the number of individuals retained in care. For instance, the University of Miami Comprehensive Study was successful in directing people to clinics after discharge (increased from 10% to 50%); and CBOs contracted with the Miami-Dade County Ryan White Part A, re-engaged approximately 60% of 700 individuals that had dropped out of care. In addition, Ryan White Part A is currently planning to implement a program that would track individuals with a determined number of missed appointments (at risk of dropping out of care), and alert providers or community outreach worker for immediate follow-up. The AIDS Care Foundation currently calls clients if they miss an appointment, and provides bus passes for clients with limited or no transportation.

Agencies contracted with the MDCHD Ryan White Part A have a pro-active approach to re-engage their clients. After consent has been given by clients, case managers will visit their homes to ensure they keep their medical appointments. It was stated during focus group sessions, the importance to have more case managers with a pro-active approach to re-engage clients to care, as it has proven to be very successful.

*Reference*

- Fisher, J.D., Smith, L.R., & Lenz, E.M. (2010). Secondary Prevention of HIV in the United States: Past, current, and future perspectives. *Journal of Acquired Immune Deficiency Syndromes*, 55, S106-S115.

## B: Goal Setting

**GOAL 1:** Identify and re-engage to care HIV-positive individuals lost to care living in Overtown, Liberty City, Homestead, South Beach, and Little Haiti through Take Control events.

### Rationale

Reasons for individuals dropping out of care are numerous and complex. MDCHD has experienced, through their targeted outreach during Take Control events, that a number of PLWHA willingly report their seropositive status as well as if they are currently or not receiving care. Unfortunately, a large number of these encounters reveal that several PLWHA are not in care. Therefore, the MDCHD will work on ensuring that Take Control event providers who identify PLWHA who are not in care during outreach activities connect these individuals at time of contact with Linkage Specialists who will be out posted at Take Control events. This allows for efficient utilization of established, Ryan White Part A outreach workers who will serve as Linkage Specialist connecting the recently diagnosed at Take Control events to care and relevant social services. The coordinated approach builds on the existing capacity of multiple programs.

**Required Intervention #8: “Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons”****A: Situational Analysis**

The goal of the NIH guidelines is to provide guidance to HIV care practitioners on the optimal use of ARV agents for the treatment of HIV infection in adults and adolescents in the United States. According to the *NIH Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, although ART adds to the annual cost of treatment, several modeling studies support the cost effectiveness of HIV therapy initiated soon after diagnosis. In addition, the use of antiretroviral therapy during pregnancy in HIV-infected women has resulted in a dramatic decrease in the transmission rate to infants. The rate is less than 2% in the United States, and the number of infants with AIDS in the United States continues to decline, as stated in the NIH Guidelines for the use of Antiretroviral agents in Pediatric HIV Infection. <sup>1</sup>

Studies have reported that the annual cost of care is 2½ times higher for patients with CD4 counts <50 cells/mm<sup>3</sup> compared with patients with CD4 counts >350 cells/mm<sup>3</sup>. A large proportion of the health care expenditure in patients with advanced infection is from non-ARV drugs and hospitalization. However, no cost comparisons have been reported between those starting ART with a CD4 count between 350 and 500 cells/mm<sup>3</sup> versus >500 cells/mm<sup>3</sup>. To this end, it is important for patients and the health care system to maximize means to provide ART treatment to HIV-positive persons. Because the Miami-Dade County Health Department (MDCHD) does not provide primary care to HIV-positive persons (nor do they have funding to do so outside of ADAP), they do not determine how to treat HIV/AIDS or have written policies and procedures/guidelines on the use of antiretroviral treatment. However the MDCHD utilizes the NIH guidelines when advising or educating HIV healthcare practitioners on antiretroviral treatment. The MDCHD captures Miami-Dade PLWHA treatment information in the FDOH database for individuals enrolled in ADAP.

The health department collects data on treatment and enters it into the ADAP database. The information is not readily available in a reporting format, only on a per-individual file basis. The data collected shows that all patients are receiving antiretroviral treatments per the guidelines and most are responding well, as the indicators keep improving with patients having undetectable viral loads and higher CD4 levels (>500). ADAP Florida is administered by the Department of Health’s Bureau of HIV/AIDS and all program protocols and guidelines are statewide. There are no Miami-Dade specific policies on the use of antiretroviral medications.

**Existing Strategies and Interventions in Miami-Dade County**

ADAP provides HIV-related medications to uninsured and under-insured people living with HIV/AIDS or about one-quarter of the people with HIV/AIDS estimated to be receiving care in the U.S. ADAP is part of the Ryan White HIV/AIDS program, which is funded by both federal and state resources. Receiving medications daily is critical to

effective AIDS treatment.

The current ADAP crisis is not unique to Florida. Ten states have instituted waiting lists to receive medications from the program. Of the over 7,261 people on waiting lists, Florida's is the largest with 3,616. Wait lists are just one measure of how a state ADAP is doing. States are also reducing their eligibility, and in the process, actually dis-enrolling patients from the program, and reducing their formularies.

The AIDS Drug Assistance Program in Florida has a \$14.5 million funding gap that could last until the new funding year begins April 1. In Florida, ADAP has been providing drugs to 10,600 patients, with 3,000 of them in Miami-Dade. Short of money last year, the state on June 1, 2010, started placing new patients on a waiting list that now has an additional 2,879 people, including 685 in Miami-Dade.

The shortfall in funding is attributed to the poor economy and a list of applicants that has grown by 25 percent since 2008 to reach 13,000 people statewide. In 2009, the Legislature reduced ADAP support to \$10.5 million, a \$1 million dollar cut. No additional funding was appropriated in 2010.

Other organizations such as the AIDS Health Care Foundation (AHC) have been working closely with ADAP leadership to find short-term resolutions in order to ensure patients continue to receive their treatments. Wellvista, a nonprofit organization that works with nearly every major pharmaceutical manufacturer is attempting to help provide drugs to patients who can't afford them.

According to the Miami-Dade County HIV/AIDS Partnership, another measure being considered locally is the temporary restrictions on certain non-essential medications like vitamins and aspirin. During the ECHPP strategic planning process and with discussions with funders of service, it was apparent that clients must navigate a multitude of public programs, many of which may not be the most appropriate setting in their particular situation.

Efforts should be sustained by private and public health care stakeholders to continue to support the efforts undertaken by the Bureau of HIV/AIDS to find alternatives to fund the shortfalls for 2011, expand ADAP coverage to eliminate the wait list, and fully fund ADAP to meet the increasing demand.

Supplemental Programs: Pharmaceutical clinical studies and patient drug assistance programs have been around since the early 1960s. These new and innovative therapies have improved the quality and longevity of life for countless people around the world, including many with HIV/AIDS. Access to these charitable programs is vital to the uninsured and underinsured population that does not have access to treatments or cannot afford them. Wellvista and other individual pharmaceutical patient assistance programs (Pfizer Answers, Lily Cares, Together Rx) are currently being accessed and

linkages are being made in both clinical and community-based health care settings. The University of Miami is also conducting clinical trials in HIV/AIDS.

Miami-Dade County is highly populated by minority populations which are disproportionately affected by HIV/AIDS. According to the U.S. Census Bureau, in 2009 62.5 percent of the population in Miami-Dade is of Hispanic or Latino origin and 19.5 percent are black. Currently, more than 30 percent of Miami-Dade County residents are uninsured. That represents more than 600,000 residents who lack coverage for health care. Racial and ethnic minorities are disproportionately uninsured and are unevenly located throughout the county; yet found in high levels of concentration in the Miami-Dade ECHPP target areas of Overtown, Liberty City, Little Haiti and Homestead/South Miami-Dade.

### **Information Gathered From The Community**

In meetings conducted with the MDCHD and health care providers through the ECHPP planning process, it became apparent that it would be of great value to the health and medical community to have inventories that would supplement access to treatment coverage for HIV-positive patients. It was also suggested that having a centralized resource to refer, access, and apply to pharmaceutical and public patient assistance programs in order to leverage existing resources and efforts to supplement access to antiretroviral treatment for people living with HIV/AIDS would be beneficial.

#### *Reference*

1. Centers for Disease Control and Prevention. Reduction in perinatal transmission of HIV infection - United States, 1985-2005. *MMWR*. 2006;55(21):592-597.

## **B: Goal Setting**

**GOAL 1:** Develop new processes that assess, utilize, and inform of existing resources that improve access to antiretroviral treatment and information.

### **Rationale**

Supplementing existing systems that provide antiretroviral treatments will ensure optimal access and utilization of local resources by increasing the capacity of providers to improve communication with clients and increase the availability of treatment options for people living with HIV/AIDS that have no access or are at risk of losing antiretroviral treatments. Expanding access to ARTs will reduce the risk of new HIV infections and enable people living with HIV/AIDS that have no current access to ARTs (many of which are minorities, residing in the high-incidence target areas, and encounter disparities in access to care and treatment) to potentially qualify for treatment.

Increasing the availability of treatment and ART coverage options through access of centralized pharmaceutical assistance programs and leveraging existing clinical trials will

also improve patient health outcomes, adherence and retention and/or re-engagement into care for HIV-positive persons.

**Required Intervention #9: “Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons”**

**A: Situational Analysis**

According to the *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, at any CD4 count, adherence to therapy is essential to achieve viral suppression and prevent emergence of resistant mutations. Several behavioral and social factors associated with poor adherence, such as untreated major psychiatric disorders, active substance abuse, social circumstances, patient concerns about side effects, and poor adherence to clinic visits, have been identified. Clinicians should identify areas where additional intervention is needed to improve adherence both before and after initiation of therapy.

The Miami-Dade County Health Department ADAP Program reports the adherence rate in Miami-Dade County is at 85%, exceeding the state goal of 80%. Research shows that several factors account for the higher rate of adherence. These factors include a significant increase in ADAP client compliance because of fear of losing coverage and being placed on the ADAP Wait List of 685 people in Miami-Dade, and also because of adherence programs that have been implemented at the state and local levels. The MDCHD ADAP Programs follows state wide guidelines, policies, and procedures relating to adherence to antiretroviral medications.

The Miami-Dade HIV/AIDS Partnership 2010 Needs Assessment reported that adherence services were provided in Miami-Dade County under Part C at \$127,482 serving 1,623 clients and Part D at \$11,889 serving 1,187 clients. The number of agencies providing adherence services is unknown at this time.

**Information Gathered From The Community**

It became evident through the strategic planning process that enhancements made to the current system and the development of new protocols to ensure optimal access for those persons facing disparities in access to care and treatment will positively impact and promote adherence to antiretroviral medications. Thereby increasing the number of individuals that have consistent access to antiretroviral treatments. Multi-faceted strategies that create client incentives around adherence, as well as potentially enhancing medication dispensing systems and improving pharmacy operating hours are key to increasing consistent access to antiretroviral treatments. Consistent access to antiretroviral treatments will promote adherence, improve retention and re-engagement into care, reduce transmission, and promote optimal health outcomes for people living with HIV/AIDS.

During listening sessions with case managers from community-based organizations

servicing HIV/AIDS clients in Miami-Dade County, we learned that adherence interventions and counseling take place during semi-annual and annual client assessments. Ryan White Part A case managers also complete adherence counseling during client assessments.

Additionally, the sessions with case managers, provider interviews, and consumer meetings revealed an array of issues and barriers to on-going adherence, including:

- Transportation difficulties for those living in Southern Miami-Dade County to access pharmacies in central Miami-Dade (access and distance barriers in Southern Miami-Dade County)
- Transportation costs for those living in Liberty City, Overtown and Miami Beach
- Continuous coverage barriers for undocumented persons
- Stigma and reluctance to accessing local pharmacies for HIV medications for fear of public knowledge of HIV status
- Mental health and/or substance abuse
- Hardships with work or family responsibilities and accessing pharmacy during business hours
- Difficulty in identifying, accessing, and applying for pharmaceutical patient assistance programs
- Patients (more prevalent in youth) become non-adherent because they feel well or are a-symptomatic
- Adherence problems because of the state's rules (7 days late to pick up and clients become non-compliant and get removed from ADAP and put back on the waiting list)
- Cultural acceptance barriers surrounding HIV/AIDS
- Lack of insurance or coverage (uninsured/underinsured)
- Cost of co-pays and out-of-pocket expenses for pharmaceuticals
- Difficulty with medication management

### **Existing Strategies and Interventions**

Miami-Dade has several pharmacies providing services to PLHWA: Part A has six contracted pharmacies. ADAP provides services through the MDCHD ADAP pharmacy and two DOH contracted pharmacies for ADAP services at Helen Bentley and CHI (Cutler Ridge and Florida City); ADAP serves close to 3,000 clients in Miami-Dade County. Language is not a barrier in ADAP pharmacies because they employ bilingual pharmacists, techs, and ADAP staff.

Locally, ADAP staffs compare the number of active open clients versus the number of clients picking up medication every month to determine the level of treatment adherence of its clients. In December 2010, the local ADAP administrator reported that adherence amongst ADAP enrollees was up from approximately 85% to 93 %. This measure, defined by DOH as Pick-Up Rate, is used as a tool to monitor adherence.

According to the MDCHD, however, disparities in medical adherence in South Dade are due to limited access and long distances to pharmacies. Miami-Dade ADAP supports a series of adherence interventions and programs. For the 3,000 Miami-Dade ADAP clients, there are monthly reminders in the pharmacy at time of dispensing on core eligibility and program requirements, timely re-enrollment, and reminder/warning notices for timely pick-up.

All clients receive a message on adherence (93% of clients are picking up medications on time). A more intense review takes place with clients that are late for pick-up and a *Patient Statement of Understanding Medication Regimen* adherence tool is utilized.

ADAP Reminder/Warning System:

- Reminder: Re-enrollment due within 90 days (time to re-enroll and a checklist with items needed to complete re-enrollment).
- Final Reminder: Re-enrollment due within 60 days (time to re-enroll and a checklist with items needed to complete re-enrollment).
- Final Warning: Re-enrollment due within 30 days (time to re-enroll and a checklist with items needed to complete re-enrollment). At this stage, clients must meet with ADAP staff to review list and confirm last medications, unless the re-enrollment is completed by the following month.
- Reminder Cards: business-like cards with due dates for re-enrollment, new labs, date of medication pick up, as well as the ADAP staff contact information.

In addition, ADAP also maintains an *Adherence Response Team* comprised of a Pharmacy Manager, Program Manager, ADAP Adherence Manager, and a Medical Case Manager. They are responsible for contacting, reviewing, and following-up with clients who have failed to adhere and comply with medical treatments, or who have missed appointments with health care providers.

*Lost to Care/Lost to Follow up* is a program with contract providers and medical case management agencies in the community that targets and follows up with individual clients who have failed to pick up their medications or are about to be dis-enrolled from the program.

ADAP staff and medical case managers also support the *Return to Stock/RTS* system from the MDCHD ADAP Pharmacy that identifies clients who have ordered refills, but failed to pick-up meds after 7 – 10 days.

The Rewarding Adherence to Medications Program (RAMP) provided a 90-day supply of medications to clients in compliance between October 2009 and April 2010. However, the program was suspended due to funding shortfalls in ADAP. By the time RAMP was suspended, more than 750 clients had been enrolled in the program out of approximately 1,500 potentially eligible clients. The current Florida ADAP crisis prevents implementing the recommendation of re-instituting the RAMP program in Miami-Dade

County.

No additional funds were allocated to the RAMP program, as ADAP implemented the program using the medication allocation. ADAP was the only program implementing the RAMP program. No additional funding was allocated specifically to promote treatment adherence under ADAP.

During focus groups and interviews with community-based organizations and other health care providers, it was stated the need to extend ADAP pharmacy hours beyond regular business hours at least once a week. This approach would allow clients, who otherwise wouldn't be able to access the pharmacy during regular business hours, to obtain their much needed medications.

## B: Goal Setting

**GOAL 1** Implement enhanced procedures and activities that promote adherence to antiretroviral medications at the Miami-Dade County Health Department ADAP pharmacy.

### Rationale

It became evident through the strategic planning process that enhancements made to the current system, and the development of new protocols to ensure optimal utilization of existing resources for improving access for those persons facing disparities to care and treatment, will positively impact and promote adherence to antiretroviral medications. These efforts will increase the number of individuals that have consistent access to antiretroviral treatments. Multi-faceted strategies that create client incentives around adherence, as well as potentially enhancing medication dispensing systems and improving pharmacy operating hours are integral parts that increase consistent access to antiretroviral treatments. Consistent access to antiretroviral treatments will promote adherence, improve retention and re-engagement into care, reduce transmission, and promote optimal health outcomes for people living with HIV/AIDS.

## Required Intervention #10: "Implement STD screening according to current guidelines for HIV-positive persons"

### A: Situational Analysis

In all Florida counties, all sexually active patients seeking STD clinical services or otherwise at risk for STDs are counseled regarding means to reduce their risk of acquiring STDs at each clinical visit. Through the STD Program, partner elicitation and referral services for clients infected with an STD to include HIV are provided. A comprehensive disease prevention approach is utilized by the health provider in order to meet the needs of infected individuals. The goal of this approach is to identify risk behaviors and provide risk reduction counseling.



As reported on their website, the Miami-Dade County Health Department Sexually Transmitted Disease (STD) Prevention and Control Program works to reduce the incidence of sexually transmitted diseases. The four major program components of the STD Prevention and Control Program for Miami-Dade county are as follows: surveillance, field services including partner counseling and referral services, clinical services, community relations and information for teens. Funding for this program derives from general revenue. For 2010-2011, \$1,130,234 has been budgeted for this program. The Florida Department of Health provides a series of guidelines (in addition to annual monitoring to assure screening and treatment are taking place in accordance with the 2006 STD Treatment Guidelines) to be followed by health care providers if an individual tests positive for HIV (Please refer to intervention 1 and 2). Included in these guidelines is the need to evaluate the types of linkages to which the client would be most receptive and to make the necessary linkages to care. Counselors should assist clients in making appointments or make the appointments for the client with her or his permission. Referrals may include OB/GYN, family planning, HIV clinic, tuberculosis clinic, substance abuse treatment, medical case management, STD and hepatitis screening, and domestic violence counseling.

In the last decade, several articles have been published on the importance of screening for STDs among HIV-positive individuals (Hoover, K.W., et al., 2010, p. 771). Hoover, K.W., et al., state that HIV-infected persons have an increased risk of acquiring STDs due to the continuation of high-risk sexual behaviors. In their study, Backmann, L.H., et al. (2005), concluded that HIV-infected men performing insertive anal sex were 5 times less likely to utilize condoms when the partner was HIV positive; and those with higher CD4 counts were "more likely to engage in unprotected receptive anal sex."

According to the Florida Department of Health, Bureau of STD Prevention and Control, people with a previous positive HIV diagnosis are routinely interviewed and determined to be a high priority if they meet one or more of the following criteria: subsequent pregnancy; subsequent sex exposure to a person newly identified as infected with an STD; subsequent self-disclosure of sexual exposure; and/or are court ordered to submit HIV/STD testing. The Florida Department of Health, Bureau of STD Prevention and Control, states that if a person has had three or more STD infections in one year, he or she should be referred to an STD Epidemiologist for partner notification and counseling services regardless of the provider.

Many jail HIV testing programs funded by the Florida Department of Health, Bureaus of HIV/AIDS and STD conduct concurrent STD testing and all STD clinics offer HIV testing. In 2009, there were over 87,800 HIV tests conducted in STD clinics throughout Florida. In addition, staff members at STD clinics refer individuals who have been screened for HIV/STD to HIV/STD prevention interventions if they are considered to be at high risk for HIV and/or STD transmission.

The Florida Department of Health, Bureau of HIV/AIDS, reports that in 2009, there were

69 cases of gonorrhea in Miami-Dade County among HIV-infected persons; 64 were diagnosed with infectious syphilis; and 51 individuals among this population had also acquired Chlamydia. Mapping performed by the Miami-Dade County Health Department in 2009 reveals that the high HIV concentration areas in Miami-Dade, such as South Beach, Liberty City, Overtown, and Little Haiti, correlate with observed high incidence of gonorrhea, infectious syphilis, and Chlamydia. .

### **Information Gathered From The Community**

Interviews conducted during the ECHPP process revealed that the majority of agencies and community-based organizations that were interviewed provide STD screening, STI tests, counseling and treatment, and HIV tests. They include Alert Health, Borinquen Health Center, University of Miami Prenatal Program, University of Miami Comprehensive HIV/AIDS Study, and the Miami Beach Community Health Center. Borinquen Health Center provides hepatitis screening and vaccination, both services funded by the health department.

The majority of participants during the strategic planning meetings agreed that STD screening is the “standard” among Ryan White grantees, and that STD screening and related services are funded by the Ryan White Program. In addition, participants agreed that interventions to increase STD screening should be guided towards high-risk women, especially women of childbearing age, and groups such as MSMs that are at high risk, but don’t know their HIV status.

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## **B: Goal Setting**

**GOAL 1:** HIV-positive white, black, and Hispanic men who have sex with men are routinely informed and screened for rectal gonorrhea and Chlamydia and pharyngeal gonorrhea by health care providers serving South Beach, Overtown, Liberty City, Homestead, and Little Haiti

### **Rationale**

As mentioned, several studies have reported that HIV-infected individuals have an increased risk of acquiring STDs due to the continuation of high-risk sexual behaviors. Due to the high prevalence of STDs among HIV-positive MSM in Miami-Dade County, it is crucial for health care providers to adhere to STD guidelines guided towards this population (Please refer to the epidemiologic data in the situational analysis). Studies have also shown, that although health care providers follow syphilis screening

guidelines that yield high screening rates, gonorrhea and Chlamydia screening rates are low (Hoover, et al., 2010, p. 774), which suggest barriers in complying with gonorrhea and Chlamydia screening guidelines.

A specific barrier that surfaced during strategic planning meetings is the lack of resources (and research) that supports the provision of screening by Ryan White Part A for rectal gonorrhea and Chlamydia, as well as pharyngeal gonorrhea, which would allow health care providers to adhere to STD screening guidelines. Also supported by clinical and community-based providers that were interviewed was the need for educational information on the importance of syphilis, gonorrhea, and Chlamydia screening among HIV-positive MSM for physicians, staff and clients.

**Required Intervention #11: “Implement prevention of perinatal transmission for HIV-positive persons”**

**A: Situational Analysis**

Since mandatory offering of HIV testing to pregnant women became a law in Florida in 1996, the proportion of perinatally infected children who received Zidovudine (ZDV) has increased substantially. In addition to ZDV, protease inhibitors have also been administered to exposed infants and mothers of HIV-infected children, which has contributed to the decrease in the number of perinatally HIV-infected children and perinatally acquired HIV/AIDS cases since 1994 in Florida (Florida Department of Health, 2009). Initiatives in Florida, such as provider education and social marketing, have helped educate not only local providers but also the public on the importance of testing pregnant women for HIV, and the need to provide treatment during pregnancy and at delivery to reduce the chances of vertical transmission. As a result, Florida has experienced a 94% decline in HIV perinatally infected births since 1993.

According to the Miami-Dade County Health Department, from 2005 to 2009 the number of HIV-positive pregnant women had remained relatively constant; 119 HIV-infected pregnant women gave birth in 2009. There was one HIV-infected baby born in 2009 and two in 2010 in Miami-Dade County. The MDCHD reports that when a pregnant woman has a positive HIV diagnosis, she is automatically referred to the University of Miami Jackson Hospital Immunology Clinic for OB/GYN care. Private practice physicians have the right to treat HIV-positive women, but must follow the Florida Administrative Code 64D-3.042. However, in the majority of cases HIV-positive pregnant women and their exposed newborn are referred to University of Miami/Jackson Immunology Department for treatment and care. A perinatal HIV nurse will have face-to-face contact with mothers of newly diagnosed infants. Perinatal HIV nurses will also have contact with mothers that are not following through on their scheduled obstetric visits.

HIV-positive women who have recently given birth and newly diagnosed HIV-positive women who are pregnant would benefit from perinatal nursing assistance to guarantee

the attainment of her delineated goals that ensures access to care and treatment during pregnancy and at delivery to reduce the chances of transmission.

The Targeted Outreach for Pregnant Women Act (TOPWA) program was established by the Florida Legislature in 1998, with the main purpose of finding at-risk or HIV-infected pregnant women who are not receiving adequate prenatal care and link them with the appropriate services. The Florida Department of Health contracts with community-based organizations in high-risk neighborhoods in nine Florida counties, including Miami-Dade. Clients from the TOPWA program are located through outreach efforts and are linked to community agencies such as substance abuse centers, domestic violence shelters, homeless shelters, and food banks. Women who are screened for the TOPWA program are provided with information on HIV prevention, and offered free on-site HIV and pregnancy testing. Once risk assessment is completed, women are linked to appropriate services and followed up to birth of the infant.

In addition to the TOPWA program, “Mama Bear Coalitions” exist in several parts of the state, including Miami. This coalition consists of county health department (CHD) nurses, surveillance staff, Healthy Start Staff, STD, Ryan White case managers, and TOPWA. The main purpose of the coalition is to coordinate the care of HIV-infected pregnant and post-partum women. The group assesses a woman’s needs and strengths to ensure she is able to adhere to her medical regimen. Women are assisted with transportation, medication pick-up, and any other needs to ensure the new mother will have the best possible birth outcome.

### **Information Gathered From The Community**

Miami-Dade County Health Department Surveillance report of all exposed perinatal cases by zip code of residence at birth (November 20, 2006 through 2010) reveals that there is significant overlap of exposed pediatric cases in the ECHPP target area zip codes, with the highest HIV-positive cases and exposed pediatric cases in zip code 33147. The high incidence areas of exposed pediatric cases are in zip codes 33147 (26-44), 33139 (26-44), and 33127 (15-24). Zip code 33127 is also an ECHPP target area. Of these cases, special attention to pregnant Haitian women is important due to the high rates of exposed pediatric cases in the ECHPP target area of Little Haiti as further described below. Serious consideration should be given to understanding the current situation with pregnant teens and minority women to better equip providers serving these special populations.

During the ECHPP process, several interviews were conducted with several different agencies in Miami-Dade. All of the agencies interviewed provide distinct services for pregnant HIV-infected women. For example, Borinquen Health Center has a targeted TOPWA outreach and care coordination program for pregnant women. The University of Miami Prenatal Program, serves approximately 1,500 patients a year (300 adolescents, and 70 children; and 33% learn of their HIV-positive diagnosis, when they

learn they are pregnant).

In addition to the centers mentioned above, the HIV Prenatal Clinic at the University of Miami has a comprehensive program whose main objective is to prevent HIV transmission to babies. The clinic provides care for 150 to 170 pregnant HIV-positive women every year. The clinic employs care coordinators, peer educators, clinical nutritionists, and a mental health team. In 1994, the successful clinical trial of the antiretroviral drug Zidovudine (ZDV) gained medical acceptance for the treatment of HIV-positive pregnant women. The administration of AZT during pregnancy, at delivery, and treating infants during the first 6 weeks of life reduced the percentage of babies born with HIV from 25% to 2% in the study.

Two themes were discussed during the strategic planning meetings among community-based organization representatives and health care providers during the ECHPP process. First, the need to get teenagers into care sooner, as a substantial number of pregnancies are observed among this group; and second, the lack of knowledge in terms of what is occurring or being provided by health providers outside of the Ryan White Partnership.

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- MDCHD Surveillance Report - All Exposed Perinatal cases by ZIP Code of residence at birth since November 20<sup>th</sup>, 2006, through 2010

## B: Goal Setting

**GOAL 1:** HIV-positive pregnant women living in Overtown, Liberty City, Little Haiti, South Beach, and Homestead receive culturally sensitive support, referrals, linkages, and information on pre and post-partum care.

Rationale

Health professionals at the University of Miami Comprehensive Prenatal Care Clinic have stated during the ECHPP process that Haitian women seek prenatal care late compared to other populations, and teenagers seek prenatal care at later stages of their pregnancies. In both instances, HIV testing is delayed. Early diagnosis of HIV infection, preferably prior to pregnancy, and appropriate medical intervention provides the best chance of a healthy baby. These focus areas have high rates of HIV infection among women of childbearing age.

HIV-positive women who have recently given birth, and newly diagnosed HIV-positive women who are pregnant would need to be followed by a perinatal nurse in order to guarantee the attainment of the delineated goal. The enhanced intervention will ensure women and their newborns are connected to appropriate and timely care.

**Required Intervention #12: “Implement ongoing partner services for HIV-positive persons”**

### A: Situational Analysis

According to the CDC *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydia Infection*, studies have shown that partner services are cost-effective and cost saving, and the many benefits extend to the people living with HIV or other STDs, their partners and the larger community as well.

On October 30, 2008, CDC released its *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydia Infection* to guide the delivery of partner services. The recommendations highlight the importance of program collaboration and service integration. Co-infection with HIV and one or more other STDs are common. Persons diagnosed with HIV should be tested for other STDs and vice versa. Similarly, many persons at risk for these infections are also at risk for other infectious diseases, such as tuberculosis (TB) and viral hepatitis, as well as a variety of other health conditions. Partner services offer STD, HIV, and other public health programs an excellent opportunity for collaborating to deliver comprehensive services to clients, improve program efficiency, and maximize public health impact.

The following principles serve as the foundation for providing partner services under the new CDC recommendations as well as for Florida state:

- **Client centered**. All steps of the partner services process should be tailored to the behaviors, circumstances, and specific needs of each client.
- **Confidential**. Confidentiality should be maintained and is essential to the success of partner services. Confidentiality also applies to data collected as part of the partner services process. When notifying partners of exposure, the identity of the index patient must never be revealed, and no information about partners should be conveyed back to the index patient.  
Disclosed private information should be held in strict confidence, both because of its private nature and as a sign of respect for the person who is volunteering to share the information to help others. Real or perceived breaches can endanger persons being served, who might face stereotyping; social isolation; loss of social or financial support; barriers to accessing housing, employment, and various social and medical services; and physical or emotional abuse. Breaches also can undermine community trust in and access to important public health programs and services.
- **Voluntary and non-coercive**. Participating in partner services should be voluntary for both infected persons and their partners; they should not be coerced into participation.
- **Free**. Partner services should be free of charge for infected persons and their partners.
- **Evidence based**. Partner services should be as evidence based as possible
- Culturally, linguistically, and developmentally appropriate. Partner services should be provided in a nonjudgmental way and be appropriate for the cultural, linguistic, and developmental characteristics of each client.

- Accessible and available to all. Partner services should be accessible and available to all infected persons regardless of where they are tested or receive a diagnosis and whether they are tested confidentially or anonymously. Because of the chronic nature of HIV infection, partner services for HIV should not be a one-time event. They should be offered as soon as HIV-infected persons learn their serostatus and should be available throughout their counseling and treatment. HIV-infected persons should have the ability to access partner services whenever needed.
- Comprehensive and integrative. Partner services should be part of an array of services that are integrated to the greatest extent possible for persons with HIV or other STDs and their partners.

Each year in Florida, the STD Program Disease Intervention Specialists (DIS) offer partner services to more HIV-infected persons than any other state in the nation. Formerly referred to as Partner Counseling and Referral Services (PCRS), partner services has long been a cornerstone strategy to fulfill the department's public health obligation to notify, counsel, and test as many persons as possible with a known or suspected exposure. The Florida Department of Health, Bureau of STD Prevention and Control continues to increase the proportion of newly identified HIV-positive persons who are assigned for partner services, and the proportion of persons who are offered and accept partner services. In 2009, the Bureau offered partner services to 4,052 out of 4,552 (89%) newly identified HIV-positive persons, from public and private providers.

The Department of Health maintains exclusive responsibility for conducting partner services for HIV-infected persons and their sex and needle-sharing partners, from all HIV reporting sources. This collaboration is grounded in Florida Statute, which authorizes the Department of Health to be solely responsible for delivering partner services for HIV and other STDs.

#### **Existing Strategies and Interventions in Miami-Dade County**

Partner service activities are overseen by the Bureau of STD Prevention and Control, and assigned to the local STD Prevention Programs to be carried out. The local STD Prevention Programs collaborate with local HIV programs and community partners to ensure the expedient and competent delivery of HIV partner services and to avoid any duplication of HIV partner services activities. The Bureau of STD Prevention and Control receives HIV-positive results from all provider sources directly and forwards those on to the respective STD program jurisdiction. Once received by area STD programs, results are record searched and if there is no previous history in the state's STD data system (PRISM) or the HIV/AIDS Reporting System (e-HARS), a field record is created and assigned to a DIS for follow-up and to offer partner services. Additionally, for HIV-positive results received where the client is pregnant or diagnosed with a concurrent or subsequent STD, they are assigned to a DIS for priority partner services follow up. It was noted through informant interviews with community-based HIV/AIDS providers

and case manager listening sessions that partners are reached through a variety of interventions such as:

- Linkage coordinators that build relationships with the couple as well as the client
- Clients and family members/partners that belong to a community clinic – the clinic already has contact with the family and they should be in care.
- Case managers encourage partners to test every six months

Additionally, key expert interviews with community-based HIV/AIDS providers and case manager listening sessions revealed that many times it is difficult to get partner information from clients for a host of reasons such as fear of domestic violence, casual encounter/unknown partner, and cultural stigma.

Additionally, partner services are many times difficult to execute, specifically within communities that continue to have cultural stigmas surrounding HIV/AIDS. Local targeted alliance development efforts have demonstrated that in order to reach these disenfranchised populations, one must establish a credible, trustworthy presence within the community and leverage community leaders' support to effectively reduce stigma and promote acceptance, and understanding.

Many times, the valued leaders of communities of color are not only elected officials, but are faith-based leaders, media personalities, and heads of civic groups and associations. Engagement and education must come from these credible sources and in their own words in order to be understood and accepted.

The high-incidence and prevalence of the disease in Miami-Dade's black and Hispanic MSM population is strongly concentrated in Miami Beach. One way to target the MSM, and the transgender population and their partners, is for the Miami-Dade County Health Department to contract with community-based organizations to offer HIV and STD screening in non-traditional areas (e.g. mobile testing units). Establishing non-traditional points of entry and access to health services in locations and settings within the community that are culturally and linguistically acceptable is very important. Currently, the South Beach AIDS Project (SOBAP) has a Florida DOH grant for \$85,000 to conduct *Their Partners* Program targeting black and Hispanic MSMs. It was also mentioned during strategic planning meetings that SOBAP could use mobile testing units to capture partners.

## B: Goal Setting

**GOAL 1:** Empower and mobilize faith based leaders among the Haitian population to serve as HIV stigma reduction advocates in their communities.

### Rationale

Because of Miami-Dade County's diverse population, partner services are many times



difficult to execute, specifically within communities that continue to have cultural stigmas surrounding HIV/AIDS. Research and targeted alliance development efforts have demonstrated that in order to reach these disenfranchised populations, one must establish a credible, trustworthy presence within the community and leverage community leaders' support to effectively reduce stigma and promote acceptance, and understanding in order to have messages resonate and be accepted.

In many communities of color, the valued leaders are not only elected officials, but are faith-based leaders, media personalities, and heads of community-based/civic groups and associations. Engagement and education must come from these credible sources and in their own words in order to be understood and accepted. As an example, many Haitian families will not access services at public institutions, but they will actively participate and access services during faith-led activities or church-run outreach events. During strategic planning meetings, health care providers stated that one way to reach the Haitian population at-risk of HIV infection is to conduct church events to obtain feedback from participants, rather than to provide them with "instructions". Improving tolerance and understanding of HIV/AIDS will reduce incidence and disparities associated with access to care and treatment. This strategy builds on community-based capacity already established through the MDCHD Faith-based Initiative as a cost-effective means of engaging and educating hard-to-reach populations.

The goal to promote tolerance among disenfranchised populations in high-incidence areas will improve their understanding of the importance of screening and testing, prevention, entering care early, medication adherence, and accessing health and social services when needed. In addition, these efforts will potentially result in a greater acceptance of the partner services program.

**GOAL 2:** Increase access to HIV services for partners of white, black and Hispanic MSM living in Overtown, Liberty City, Little Haiti, Homestead, and South Beach.

### Rationale

The high-incidence and prevalence of the disease in Miami-Dade's black and Hispanic MSM population is strongly concentrated on Miami Beach. One way to target the MSM, and the transgender population and their partners, is for the Miami-Dade County Health Department to contract with community-based organizations, and offer HIV and STD screening in non-traditional areas (e.g. mobile testing units). Establishing non-traditional points of entry and access to health services in locations and settings within the community and in settings that are culturally and linguistically acceptable. For example, many transgender persons will not enter the health care system through clinic-based settings, but will access services through non-traditional community groups and organizations such as thrift stores or hair salons.

Improving access to high-incidence populations within their communities and in non-

traditional settings will reduce the populations' disparities in HIV incidence and lack of access. Increasing access to the identified high-risk populations will impact on-going testing, the availability of risk assessments, access and adherence to treatment, and access to other needed interventions through linkage and referral.

**Required Intervention #13: "Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV"**

**A: Situational Analysis**

According to the CDC MMWR (July 18, 2003) *Incorporating HIV Prevention into the Medical Care of Persons Living with HIV*, medical care providers can substantially affect HIV transmission by screening their HIV-infected patients for risk behaviors; communicating prevention messages; discussing sexual and drug-use behavior; positively reinforcing changes to safer behavior; referring patients for services such as substance abuse treatment; facilitating partner notification, counseling, and testing; and identifying and treating other sexually transmitted diseases (STDs).

The findings of a study published in the *Journal of Acquired Immune Deficiency Syndrome* underscores the need to integrate ongoing effective HIV risk reduction counseling better within medical and other care programs serving persons living with HIV infection. For many years, HIV services were conceptualized primarily as prevention for the uninfected and as health care for those with the disease. This conceptualization is inadequate. Just as health, social, and other care service needs must be met to help at-risk uninfected persons successfully reduce their vulnerability to HIV, it is also essential to recognize that risk reduction behavior change assistance is needed by those HIV-infected persons who engage in risky behavior. Primary care clinicians need to recognize the importance of sexuality in the lives of their patients and the reality that many of them do engage in specific behaviors that carry risk to their own health as well as to the health of some of their partners. It may be important for providers to initiate discussions around such issues to address the relative risks of certain activities, helping the patient to consider his or her own health the responsibility for potential transmission of HIV to partners.

It may also be important to reinforce safer sex practices among people who report using protection to maintain the behavior over time. Although brief post test counseling is ordinarily given at the time individuals learn of their positive serostatus, this alone is not sufficient to assist many people in making and consistently sustaining, risk reduction steps for many years. Although some patients are successful on their own refraining from risky practices with minimal encouragement, others are likely to require much more intensive and ongoing behavior change assistance. Continued HIV risk behaviors among those with HIV has a negative impact on public health and carries significant personal risks as well. By integrating prevention with medical and social care services, it will be possible for persons with HIV infection to live longer healthier lives and avoid behaviors that could result in virus transmission to others and their own exposure to additional sexually transmitted infections and treatment-resistant strains of HIV.

According to the Florida Department of Health, risk assessment allows the counselor and the patient to identify, acknowledge, and understand the patient's HIV risks in their own social contexts. The Department has delineated several HIV risk assessment guidelines to be followed by HIV counselors. Before the beginning of the session, the counselor should introduce and explain the purpose of the session, which includes the importance of maintaining all information provided by the client confidentially. The following list directly assesses the client's HIV risk: client's reason and history for testing; perception of risk; influence of substance abuse or use on the client's HIV risk; client's history with respect to STD, hepatitis, and TB; and transfusion or transplant history. In addition, the counselor should also assess whether the client has been sexually assaulted in the past and/or has experienced domestic violence; the client's occupational risk, whether in a medical setting or through sex work; condom use and partner's risk. Once this information has been assessed by the counselor, it should be documented in the client's record.

If the client has been identified by the counselor as being at risk, he or she should receive HIV pre-test counseling and should be strongly encouraged to accept testing. If an at-risk client refuses testing, information should be provided about local anonymous and confidential test sites for future reference. Risk reduction is a standard component of pre- and post-test counseling for all clients.

As mentioned throughout this document, a strong correlation exists between STD and HIV in Miami-Dade County. In all Florida counties, sexually active patients seeking STD clinical services or otherwise at risk for STDs are counseled at each clinical visit with the intention to reduce their risk of acquiring STDs. Through the STD Program, partner services for clients infected with an STD to include HIV are provided. A comprehensive disease prevention approach is utilized by the health provider in order to meet the needs of infected individuals. The goal of this approach is to identify risk behaviors and provide risk reduction counseling.

### **Existing Strategies and Interventions in Miami-Dade County**

Healthy Relationships, Partnerships for Health, and L.I.F.E. are evidence-based interventions for HIV-infected persons. Healthy Relationships is a five-session, small group intervention for men and women living with HIV/AIDS, and focuses on developing skills building self-efficacy, and positive expectations about new behaviors through modeling behaviors and practicing new skills. During these sessions, people can interact, examine their risks, develop skills to reduce their risks, and obtain feedback from others.

Partnership for Health is a one-on-one, provider-administered safer sex intervention (3-5 minutes) for HIV-positive persons in care. The intervention builds on the importance of the patient-provider relationship to promote patient's healthy behavior. Learning

Immune Function Enhancement (LIFE) program is a structured risk reduction prevention-counseling program that attracts, retains, and motivates HIV-infected individuals by emphasizing health enhancement.

Concerns were voiced during strategic planning meetings and focus groups with different agencies in Miami-Dade in the context of risk-reduction. A recurrent theme that surfaced was that the focus should not be on the HIV-infected client only, but on the providers and whether they are making risk-reduction part of their clinical routine.

### **Best Practices**

Researchers have noted the importance of taking the necessary steps to increase the effect sizes of existing interventions guided towards MSM. They propose in-depth qualitative interviews with men who did not change at-risk behaviors during an HIV prevention intervention and men who did change. This will allow for a better understanding of positive change “strengths-based processes,” and obstacles that may have inhibit changes in men whose HIV risk has remained the same. Authors believe that by addressing psychological factors that affect MSM will not only improve the mental health of those at higher risk of HIV infection, but also improve the effect sizes of existing HIV prevention interventions (Safren, S.A. et al., 2010).

Studies conducted in the U.S. and abroad have shown that sexual behaviors and needle sharing were motivated by the following: reproduction, desire, peer pressure, pleasure, physical or psychological dependence, self-esteem, love, access to material goods, obligation, coercion and force, habit, gender roles, customs, and culture (Coates, T.J. et al., 2008). Furthermore, the authors suggest that reductions in HIV transmission result from a “complex combination of strategies and several risk-reduction options with strong leadership and community engagement that is sustained over a long time,” thus a comprehensive prevention strategy is needed. A comprehensive prevention approach would entail the inclusion of multilevel behavioral strategies, which might be more likely to influence behavior than those strategies working at one level (e.g., abstinence, or condom use). Thus, the authors have defined behavioral strategies as those that try to delay the onset of first intercourse; decrease the number of sexual partners; increase the number of sexual acts that are protected; provide HIV counseling and testing; encourage adherence to medications preventing HIV transmission; decrease sharing of needles and syringes; and decrease substance use.

The importance of developing risk-reduction interventions that are not “short-lived” is also pointed out by Coates et al. The authors cite project EXPLORE, which involved two different types of risk-reduction interventions to two different groups at risk of acquiring HIV. The control group was given brief risk-reduction counseling twice a year; while counseling to another group attempted to increase knowledge, perceived risk of acquiring HIV, and to motivate participants by teaching them the necessary skills to change. At the end of 12 months, a 39% risk-reduction was observed in the intensive

intervention group; however, at the third year, when the study ended, the difference in risk-reduction between the two groups was not significant.

Among the many interventions proposed in their article, Coates et al. include network-based interventions, that involves gaining access to social networks through key individuals; identifying members of the injection, sexual, or social networks; training network leaders as peer educators, asking leaders to distribute HIV risk reduction messages in their networks; and lastly, assessing the effects. Network-based interventions are based on the premise that HIV transmission is a social event and many factors other than “perceived threat, knowledge, self-efficacy, behavioral intentions, and perceived social norms affect the transmission of HIV.

In their HIV Intervention for Provider (HIP) study, Rose et al. (2010), discuss how providers could play a critical role in supporting HIV risk reduction. The results from their study revealed that even a brief provider-level intervention could lead to risk reduction among individuals at high risk for HIV transmission. In the HIP study, physicians and patients alike were enrolled based on delineated guidelines set prior to commencement of the study. Physicians participated on several sessions (e.g. skills building to provide behavioral and contextual risk assessment) where they received training on how to “deliver the message” to the patients. Patients who had agreed to participate in the study were randomly assigned to the intervention or control group.

The primary goal of the study was to assess whether patients of providers randomized to the intervention group reported greater change in sexual transmission risk behavior (e.g. unprotected anal or vaginal intercourse with an HIV-negative or unknown-status partner), than patients of providers randomized to the control group. The results from the study revealed that a brief intervention to train HIV providers to identify risk and provide a prevention message leads to increased prevention discussions and a reduction in patients’ HIV transmission risk behavior. What made this study effective is that providers focused on prevention messages they felt most comfortable conveying. For instance, if providers felt uncomfortable discussing drug use with a patient, but felt more competent addressing sexual risk behaviors or treatment adherence, then they could focus on that particular intervention.

### **Information Gathered From The Community**

Provider listening sessions and expert interviews conducted through ECHPP revealed strategies that are being implemented to promote risk behavior risk screenings that include “Doc Talk” programs (similar to Partnership for Health) in a community provider setting, as peer educator sessions and electronic record notes reminding practitioners to complete risk assessments and screenings.

Local Ryan White Part A providers provide routine risk screening at their sites that include identifying risk behaviors and provide risk reduction counseling. Frequently,

these same providers are unaware of available resources that could be utilized to connect individuals with known risk factors to appropriate interventions. Through the identification of available resources and creation of a document that compiles this information, providers can leverage current resources to the fullest in identifying and/or reducing new HIV infections.

In one of the focus groups conducted in Sembrando Flores, participants were overall satisfied with the HIV services they currently receive. It was stated that physicians who provide risk assessments to the MSM population, convey the importance of risk behavior reduction, and the need for preventive approaches. One participant stated how the pharmacist explains, in Spanish, the need for medicine adherence and the avoidance of risk behavior.

The focus group session conducted at Empower U, revealed that its staff ensures that patients see their doctors regularly with follow-up calls and face-to-face contact.

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## **B: Goal Setting**

**GOAL 1:** HIV-positive ECHPP priority populations (white, black, Hispanic MSM; black and Hispanic heterosexuals; black IDU) are routinely screened and connected to appropriate interventions.

### Rationale

Due to the high HIV incidence rates among the ECHPP targeted populations, it is important that risk reduction interventions such as Doc Talk or physician reminders are accessible to these groups. The HIV Intervention for Provider (HIP) study discusses how providers could play a critical role in supporting HIV risk reduction. The results from the study revealed that even a brief provider-level intervention could lead to risk reduction among individuals at high risk for HIV transmission.

Local Ryan White Part A providers provide routine risk screening at their sites that include identifying risk behaviors and provide risk reduction counseling. Frequently, these same providers are unaware of available resources that could be utilized to connect individuals with known risk factors to appropriate interventions. The identification of available resources and creation of a document that compiles this information is a cost effective means for providers to leverage current resources to identify and/or reduce new HIV infections within the ECHPP targeted populations.

**Required Intervention #14: “Implement linkage to other medical and social services for HIV-positive persons”**

**A: Situational Analysis**

Linkage-to-care services are an essential component of comprehensive HIV/AIDS care and treatment. Linkage services that begin at time of diagnosis and/or pre-test screenings, are integrated, done over a series of time, empower the client to become their own medical advocate, and modeled after strengths-based case management significantly improve linkage to care compared to passive referral services.

Florida Department of Health general revenue funds are used to support HIV counseling, testing, and linkage efforts in the state’s correctional facilities. The Department of Corrections pre-release planning (jail linkage) program is funded through HRSA’s Ryan White Part B funds to link HIV-positive inmates to care as they are released from a correctional facility.

Linkage agreements form the basis for collaborative relationships between providers. Outreach providers maintain formal referral and linkage agreements under Ryan White with one or more key points of entry: STD clinics, HIV counseling and testing, hospitals, substance abuse and mental health treatment, adult and juvenile detention centers, jail and correctional facilities, and homeless shelters.

The Ryan White medical case manager develops comprehensive and individualized needs assessment plans of care for the client to access timely, appropriate services, medication and treatment. Follow-up for medication adherence and follow-up related to the coordination of care are also established procedures. Additionally, follow-up to verify clients are receiving care and to ensure linkage to other services as needed are completed. The efficacy of the plan to ensure consistency and quality of care across the medical case management service system.

Through a Minority AIDS Initiative (MAI) grant from HRSA, DOH funds seven Minority AIDS Initiative contracts. The initiative serves to link newly diagnosed minorities and HIV-positive persons who have dropped out of care to medical and support services. The Antiretroviral Treatment Access Study (ARTAS) model is used to empower clients to become their own medical advocate.

In 2010, the FDOH provided approximately \$349,038 in contracts to Miami-Dade CBOs for linkage, retention and referral services. The Miami-Dade County Health Department (MDCHD) has a contract with the South Florida AIDS Network (SFAN) funded by State of Florida general revenue dollars to include case management services. Screening for mental health and linkage to other medical and social services is provided by SFAN Case Management in accordance with the Florida Department of Health, Bureau of HIV/AIDS, Case Management Operating Guidelines. SFAN Case Managers receive ongoing training on these guidelines by the Florida Department of Health.

In addition to MDCHD, funding outside of the CDC is available for other medical and social services through Ryan White Part A, Part C, Part F, the Substance Abuse and Mental Health Services Administration (SAMSA), and Housing Opportunities for Persons with AIDS (HOPWA).

In terms of publicly funded mental health treatment facilities, there are approximately 20 throughout Miami-Dade County. There are approximately 25 publicly funded substance abuse treatment facilities in the county. Six publicly funded housing agencies are located in Miami-Dade County including HOPWA and over 60 agencies in the county were publicly funded to provide social services.

In 2009 three agencies were funded to deliver HIV Prevention programs/interventions for PLWHA. The agencies were the Jackson Memorial Hospital, Care Resources and Empower U. These agencies implemented the Healthy Relationships and Partnerships for Health programs.

SFAN is funded by the MDCHD to refer PLWHAs to other medical and social services.

#### **Existing Strategies and Interventions in Miami-Dade County**

The Florida Department of Health, through general revenue (GR), funds the Florida AIDS Hotline to make HIV/AIDS information, linkages, and supportive counseling accessible to the public via telephone.

Drug treatment centers are funded to implement evidence-based HIV prevention interventions that address both high-risk sexual and drug use behaviors; many of these interventions are designed both for injection and non-injection drug users.

*Antiretroviral Treatment Access Study (ARTAS)* – The ARTAS Linkage Case Management (ALCM) intervention was developed by the Center for Interventions, Treatment, and Addictions Research (CITAR) at Wright State University’s Boonshoft School of Medicine, Department of Community Health in Dayton, Ohio. Under CDC funding, the ARTAS-I project used a randomized control trial to implement and evaluate the effectiveness of this brief, strengths-based case management intervention to link individuals recently diagnosed with HIV to medical care for more than a single visit. ARTAS-II replicated the intervention in real world settings, using ten urban and rural demonstration sites. The study project concluded that strengths-based case management in ARTAS-I significantly



improved linkage to care compared to a passive referral, and found significant correlates to linkage.

*Minority AIDS Initiative (MAI) ARTAS-* providers coordinate with mental health agencies to receive linkages for individuals who were recently diagnosed with HIV and MAI providers refer HIV-positive clients with mental health issues for treatment in return. Similarly, Miami-Dade Ryan White Part A provides 15 support services including prescription drugs, ADAP coordination, pharmacy program, food/meals, oral medical care, medical case management, mental health and substance abuse. Part A works closely with organizations such as AIDS Action and the Children's Alliance, and is also a member of the Miami-Dade County HIV/AIDS Partnership and Care Committee.

Community-based health centers and providers of HIV/AIDS care under Ryan White Part A also provide linkage to care services in wide variety of ways. Comprehensive community-based provider examples from key informant interviews include:

- Borinquen Health Center – Provides clinic-based oral health, primary care, substance abuse, transportation, HIV testing and counseling, and prevention counseling. Additionally they have outreach teams in the community (baths, trailer parks, bridges) providing testing services along with nutrition guidance, vision, and linkage to care.
- Miami Beach Community Health Center – Once tested, counseling for risk behavior if negative. If positive, assign a medical case manager and doctor at that same time. Labs are done the same day if symptomatic and nutritionist, dental and psycho-/social and behavioral mental health services are also available.
- AIDS Health Care Foundation – Full resource referral that includes housing and transportation.

#### School-based Youth Interventions

*Health Connect* – Miami-Dade County Schools, with support from the Children's Trust implement the *Health Connect* Program that currently serves half of the middle and high schools in the county. Dedicated health teams that include a nurse, social worker and aides provide linkage services and each team is aligned with a medical home and a mental health home.

*Project SMILE* – SMILE stands for Strategic Multi-site Initiative for the Identification, Linkage, and Engagement in Care. This program is a collaborative effort between the Miami-Dade County Health Department and the University of Miami's, Division of Adolescent Medicine to link HIV-positive youth ages 13-24 to medical care and case management. Project SMILE is not only for the newly diagnosed, but also for those who have never been in care. Additionally, agencies wishing to refer their clients who have been lost to care for 6 months or longer can also take advantage of all the services Project SMILE has to offer, including emotional support that can help reduce anxiety

about being HIV-positive.

*HEALTHY TEENS EXPO* (HTE) – The goal of the Expo is to provide opportunities for students to receive health information and services that will help them live longer, healthier lives. Under this program, target schools are located in at-risk Hispanic, Haitian and African-American communities in an effort to reach out to Miami's most vulnerable youth population. The HTE, with the school principal's approval, takes place on school grounds during school days and provides an opportunity for students to attend during school hours or after class dismissal. Disseminated information and services rendered at these events help students gain insight on youth health-related issues.

The most recent *HEALTHY TEENS EXPO* took place on November 12, 2010, at Booker T. Washington Senior High School. The event consisted of a rally which served as an educational kickoff for the student body, meant to instill enthusiasm and inform students about the health fair and testing activities throughout the day. Two young guest speakers presented to a crowded auditorium where Hispanic, African-American, and Haitian-American students gathered to hear their testimonials. More than 200 students attended the rally, which really ignited interest among participants to visit the fair and access HIV/STI testing. A great number of students took the opportunity to access testing:

- 88 HIV/AIDS tests
- 60 Chlamydia screenings
- 60 Gonorrhea screenings
- 60 Syphilis screenings

The *University of Miami Prenatal Program* also provides pregnant women/youth with linkage to community-based organizations upon discharge from the prenatal system.

### **Information Gathered From The Community**

Being that most clients have multiple needs in addition to HIV/AIDS care, it is critical to improve the opportunities for collaboration to ensure clients are linked to all needed services.

Community/provider listening sessions and meetings revealed the need for specialty services to be located in community settings where these services are currently not available or only available once-a-week. Ryan White Part A does provide oral health, but none of the health providers, other than Medicaid which provides minimal oral health services, are located in the Southern Miami-Dade area. Other specific examples of needed services included transportation assistance, legal, pharmacy, food and nutrition services.

Transportation is an issue that overwhelmingly surfaced with all groups of providers and consumers. Transportation issues varied from cost, to distance and location of service providers. Providers also made it clear that current transportation assistance programs are not enough to cover need, are intervention-based versus need based, and clients continue to be significantly impacted because of this barrier.

Specifically, in Southern Miami-Dade which is geographically distant from most services and has a diverse high-risk population, clients that are underserved or underinsured find themselves seeking care in hospital emergency rooms at times of crisis. Even then, the number of specialty physicians and services within an emergency room setting are limited for the HIV/AIDS population.

Because Southern Miami-Dade, including Homestead, has such a diverse population, consumers of all ethnic backgrounds expressed that services and providers should be more culturally sensitive and linguistically able, especially in providing specialized care and treatment.

Housing assistance and availability was a priority issue with case managers, providers, and consumers. The lack of current housing availability and wait lists under HOPWA and other housing programs create a significant barrier in maintaining communication with clients, adherence to care and treatment, and overall ability to provide linkage to care services.

It was also clear that community-based agencies that are integral parts of their community and a valued/trusted service provider can have success in providing linkage and referral. Empower U in Liberty City provides oversight for 250 of the approximately 1,000 clients enrolled in HOPWA in Miami.

Supplementing access to existing resources will significantly improve linkage to medical and social services by streamlining access to referral/linkage resources and a centralized community wide resource inventory that improves access to support services and allows clients to access and maintain care, thereby expanding care to underserved areas and populations. Miami-Dade County maintains service directories and service linkage resources that can be accessed by providers electronically, via telephone, or printed materials. Referral guides are also available for HIV/AIDS specific services.

## B: Goal Setting

**GOAL 1:** Assess, collect, and inform on available specialty care, transportation, and social services for HIV-positive persons living in Miami-Dade County to increase access to health and human services.

Rationale

Supplementing access to existing resources will significantly improve linkage services to other medical and social services by streamlining access to referral/linkage resources, accessing a centralized, community-wide resource inventory, improving access to support services that allow clients to access and maintain care, and expanding care to underserved areas and populations. Implementing strategies such as the co-location of services will leverage existing resources while expanding the array of available care through a collaborative approach that improves access to care. In turn, having improved access to resource linkages and specialty services will improve the health outcomes of people living with HIV/AIDS, improve adherence and retention in care, and reduce the impact for those lost to care in a cost-effective means. The goal will also positively impact the high-incidence geographic areas and populations that have been traditionally hard-to-reach, underserved, and are disproportionately affected by HIV related health disparities and access to overall health care and treatment.

Transportation is an issue that overwhelmingly surfaced with all groups of providers and consumers. Transportation issues varied from cost, to distance and location of service providers. Providers and stakeholders will benefit from cohesively identifying strategies that reduce transportation barriers.

**Recommended Intervention #24: “Community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among their family, friends, and neighbors”**

#### **A: Situational Analysis**

HIV prevention programs that incorporate elements of community education and involvement can contribute to long term attitudinal and knowledge change. MDCHD has been involved in putting forth local interventions that address the promotion and implementation of existing community mobilization efforts that target men, black women, and faith-based organizations to increase HIV awareness, HIV prevention, and reduce AIDS-related stigma and discrimination. Below is a list of these interventions:

Man Up seeks to mobilize men, regardless of sexual orientation, to eliminate their risk of acquiring HIV/AIDS. It promotes recommendations for individuals such as using condoms, seeking treatment, getting an annual physical, avoiding drugs and alcohol, and getting tested for STDs/HIV. Community recommendations include engaging in public awareness campaigns, ensuring that young men are appropriately taught in school health classes, and holding a stakeholders meeting for HIV/AIDS/STD education, prevention, and testing needs for men. For providers, men should be informed about the benefits of condom usage, creating a forum for men to discuss gender differences in sexual decision making to increase open dialogue, and HIV testing as a routine part of healthcare, consistent with CDC guidelines. (Source: *MAN UP: The Crisis of HIV/AIDS*)

*Among Florida's Men – A Report by the Bureau of HIV/AIDS, Florida Department of Health; released in 2009).*

Through 2009, the Miami-Dade County Health Department, Office of HIV/AIDS reports that 1 in 70 males (1 in 35 black males and 1 in 97 Hispanic males) are living with HIV/AIDS in Miami-Dade. Throughout 2010, Man Up has been presented at health fairs, faith-based organizations, and at local conferences. One example is the Man Up Youth Summit in Dec. 2010 that was held for 540 male students from the Miami-Dade County Public Schools (MDCPS). This was a collaborative effort between the MDCPS – Office of HIV/AIDS Education, the Urban League of Greater Miami, and the Office of HIV/AIDS for the Miami-Dade County Health Department.

Sistas Organizing to Survive (SOS) is a grassroots mobilization of black women in the fight against HIV/AIDS. The SOS movement aims to educate black women about the impact of HIV/AIDS and to develop an action plan that prevents the further spread of HIV/AIDS and other diseases. Through SOS, black women are educated about HIV/AIDS and other STDs; black women are empowered to take charge and control of their sexual health, black women are connected to HIV/AIDS resources, offered tools to enable them to educate others where they live, work, play, and worship; and black women are encouraged to take a pledge to get tested for HIV and to educate others where they live, work, play, and worship.

Through 2009, the Miami-Dade County Health Department, Office of HIV/AIDS reports that 1 in 48 black women are living with HIV/AIDS in Miami-Dade. In June 2010, the Florida Department of Health presented a statewide teleconference on SOS and encouraged Florida communities to promote SOS. As a result, an SOS “call to action” was conducted in October 2010 at Mt. Calvary Missionary Baptist Church in Liberty City where 54 black women were educated on HIV/AIDS, how to conduct outreach, and took a pledge to educate others to get tested for HIV where they live, work, play, and worship. After the outreach training, the women participated in community outreach where they’ve educated others about HIV, including where to get tested and distributed condoms provided by the Miami-Dade County Health Department – Office of HIV/AIDS.

In 2008, the Eleventh Episcopal District of the African Methodist Episcopal (AME) Church and the Bureau of HIV/AIDS for the Florida Department of Health entered into a partnership agreement to establish one AME church in every county in Florida as an HIV community test site or testing location. Miami-Dade has identified Greater Bethel AME Church in Overtown as a community HIV testing site. Also, through Churches United for HIV/AIDS Prevention, the Miami-Dade County Health Department, Office of HIV/AIDS partners with Churches United in planning and participating in community events during National Week of Prayer for the Healing of AIDS. In 2010, community events included a prayer breakfast and press conference, HIV testing, community forums, and community outreach in Liberty City and Overtown. In addition, throughout 2010, the faith-based initiative was promoted during health fairs and was expanded beyond the Office of

HIV/AIDS to include the STD Prevention and Control Program for the Miami-Dade County Health Department.

**Information Provided By the Community**

Community members support existing FDOH community mobilization initiatives and would like to see these efforts expanded among the ECHPP targeted populations and communities. In particular, efforts to strengthen mobilization around MSM should be prioritized.

**B: Goal Setting**

**GOAL 1:** To increase awareness of the magnitude of HIV/AIDS in Liberty City, Overtown, South Beach, Little Haiti and Homestead through Man Up, Sistas Organizing to Survive (SOS), the faith-based initiative and efforts to mobilize MSM.

**Rationale**

Increasing community-based interventions that are specifically designed for targeted high-risk populations and that are culturally and demographically appropriate will motivate individuals, improve education, and reduce stigma around HIV. Furthermore, establishing interventions that are truly grass-roots, involving non-traditional community organizations as the trusted source of information and service will lead to greater tolerance, understanding, and access to HIV prevention and treatment. Increasing awareness through non-traditional, community-based interventions that target high-risk populations will significantly impact the scope of prevention and treatment interventions addressed in the ECHPP plan, and more importantly, create a comprehensive community-based mobilization effort that will aid in reducing new HIV infections through education and empowerment, while improving disparities related to HIV by focusing the comprehensive efforts towards high-risk populations

**PROCESS INFORMATION**

**Step 1: In the box below, please describe the process that occurred to collect the information used in Step 1 that is documented in this workbook. Please address the list of considerations below.**

- With whom did you meet? Who participated in conducting the situational analysis?
- What were the main sources of data you used?
- What data and/or information would you like to have used, but were unavailable?

In order to produce a plan that truly represented the needs and wants of the Miami-Dade County community, the ECHPP plan was informed by the information gathered through informational interviews, consumer focused group listening sessions, provider focused community discussions, and strategic planning meetings. In addition, to information gathered from the community, numerous articles and program descriptions

were reviewed as well as epidemiologic data. Similarly, the creation and application of a series of tools and materials were utilized to optimize the manner in which the most relevant data needed for drafting the ECHPP plan document was collected.

Information presented in the fourteen situational analyses was acquired from the following sources: the Florida Department of Health (FDOH), Bureau of HIV/AIDS; Miami- Dade County Health Department (MDCHD); community stakeholders, consumers, and providers; and research, opinion, and news articles.

To begin presenting a general picture of the HIV/AIDS epidemic in Miami-Dade County, epidemiologic data provided by FDOH and MDCHD was gathered and synthesized. Information reviewed included 2009 data on HIV and AIDS incidence, prevalence and deaths in Miami-Dade County classified by race/ethnicity, gender, age, and exposure category. Zip code level HIV/AIDS incidence and prevalence data was utilized to locate the areas which presented the highest concentration of HIV and/or AIDS cases. This information provided an important visual, highlighting a close association between those neighborhoods with the highest HIV/AIDS incidence and prevalence with those reporting the lowest household income.

Reported HIV and AIDS cases among special populations for 2008 and 2009 were reviewed to develop an understanding of which populations are heavily impacted by the disease in Miami-Dade County. Data from 2000-2009 categorized by race/ethnicity, age and gender was evaluated to determine trends of the disease. National HIV Behavioral Surveillance data provided by the FDOH was assessed to learn about the utilization of prevention services by special populations as well as HIV seroprevalence and unrecognized infection numbers among intravenous drug users (IDU), at-risk heterosexuals, and men who have sex with men (MSM).

The second set of information collected for the situational analyses was provided by community stakeholders, providers and consumers through a series of subject matter expert phone interviews, group listening sessions, and provider listening sessions.

A total of 25 one-on-one phone interviews were conducted with community stakeholders. These stakeholders included HIV/AIDS funding managers; HIV medical providers; directors of community-based organizations servicing HIV/AIDS clients; directors of organizations that provide HIV counseling and testing; organizations providing substance abuse treatment and counseling services to HIV-positive individuals; administrators of organizations servicing youth, the incarcerated, the homeless, intravenous drug users, MSM and transgender populations; individuals living with HIV/AIDS; and ethnic minorities. The interviews conducted with these individuals provided a wealth of information that allowed for the identification of gaps and barriers as well as opportunities and innovative ideas in the provision of services to HIV/AIDS affected clients.

The needs of PLWHA in Miami-Dade County were ascertained through three group

listening sessions. Three groups of approximately 12-15 individuals candidly discussed the barriers they encountered in accessing care and services. In order to gather the perspective of a broad group of individuals, the group listening sessions were conducted in three different locations; Overtown, South Beach, and Homestead. These communities were selected for the primary reason that it allowed for a varied population reach. In Overtown, group facilitators met with PLWHA who were black, substance abusers, and/or homeless. Due to its significant distance from central Miami-Dade County, the community of Homestead presents a pronounced marginalization with PLWHA in this community having little to no access to services. For this reason, Homestead was selected as one of five ECHPP target community/areas as well as a location to conduct one group session. The group in Homestead was comprised of a broad range of individuals traditionally underserved, including the elderly, mothers, and undocumented immigrants. The final group was conducted in South Beach, where the facilitators met with a group largely made up of MSM and/or individuals who identified as transgender.

In order to discover the most pressing needs of PLWHA in Miami Dade County, the facilitators conducted four community listening sessions with the individuals who are continually interacting with this population: case managers and service providers. A great number of ECHPP goals and strategies were developed by the information obtained from these listening sessions in addition from the informational gathered through the three strategic planning sessions that were conducted with community stakeholders.

Since the local health department is administered by the state government and focuses its HIV/AIDS work on prevention and surveillance, it was difficult to acquire care and treatment data which is primarily managed by the local county government. Readily available and accessible cost data for each of the proposed strategies under each of the 14 interventions, as well as a local repository of current programs, financial sources, as well as articles presenting data from interventions conducted in South Florida would have benefited the development of the plan.

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***Step 2: In the box below, please describe the process that occurred to complete the evidence-based goal setting in Step 2 that is documented in this workbook. Please address the list of considerations below.***

- In making decisions about which goals to set, what were the most useful sources of data? What other resources were the most useful?
- What additional resources would have been helpful to support goal setting (e.g., data sets, planning tools, staff, other)?
- How did you make decisions about the combined effects of required activities to optimize HIV prevention efforts?
- How did you reach final decisions about which activities to change and include in the enhanced plan (e.g., consensus of key staff, voting, other)?



The ECHPP goals, strategies, and objectives presented in the Miami-Dade ECHPP were drafted and subsequently selected after a thorough review of the epidemiologic data and through a series of meetings and discussions with community stakeholders and the Miami-Dade County Health Department (MDCHD). After an initial phase of data collection, the HCSF staff conducted an early strategic planning meeting as well as a review session with the MDCHD to present the data collected from the epidemiologic profile, informational interviews, group and community listening sessions conducted to date. With the information gathered from these two meetings HCSF staff drafted a series of proposed goals, strategies and objectives which were reviewed, revised, and vetted among the key stakeholders during the last two strategic planning sessions. The product derived from the strategic planning meetings was subsequently presented to the MDCHD during two sessions where goals, strategies and objectives for each of the 14 interventions were reviewed and voted upon for inclusion in the plan. Selection criteria for the final goals, strategies and objectives in the plan were heavily weighted by the capacity and available resources of the MDCHD to undertake the activities aligned with each strategy. Additionally, special consideration was given to those strategies that promoted long-term comprehensive system improvement through the promotion of collaborative work that maximized and leveraged current resources. This last consideration assumed that collaborative efforts will yield the optimal HIV prevention results for the selected ECHPP intervention areas.

Drafting and selecting the goals could not have been possible without the vast and unwavering support of the community stakeholders, who made themselves available consistently and at short notice. They were the primary resource utilized in drafting this plan, while articles and epidemiologic data supported all of the information they provided.

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## WORKBOOK #1: APPENDIX 1

**NOTE:** The lists in this Appendix are intended to help you think about and write your situational analyses for the interventions. You may need to take into account other important considerations in your jurisdictions or MSA targeted by the ECHPP project.

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### **Required Intervention #1: “Routine, opt-out screening for HIV in clinical settings”**

- What was the HD’s 2009 budget for testing in clinical settings?
- How many facilities were funded or supported in 2009?
- What types of clinical facilities did the HD support?
- What was the seroprevalence for HIV tests conducted in clinical settings supported by the HD?
- What funding outside of the CDC is used to support this activity?

### **Required Intervention #2: “HIV testing in non-clinical settings to identify undiagnosed HIV infection”**

- What was the HD’s 2009 budget for the jurisdiction for testing in non-clinical settings?
- How many agencies were funded in 2009?
- What was the seroprevalence for HIV tests conducted by agencies supported by the HD?
  - Organize data by gender, age, race, ethnicity, and transmission category

## Appendix 1: ECHPP Workbook 1

- What funding outside of the CDC is used to support this activity?
- How many HIV testing sites were in the jurisdiction in 2009? (consider all funding sources)

### **Required Intervention #3: “Condom distribution prioritized to target HIV-positive persons”**

- What was the HD’s 2009 budget for the jurisdiction for condom distribution for HIV-positive persons?
- How many agencies were funded in 2009?
- What locations did agencies use for condom distribution?
- Approximately how many condoms were distributed?
- Approximately how many HIV-positive persons were reached?
- What funding outside of the CDC is used to support this activity?
- How many condom distribution programs targeting HIV-positive persons were implemented in the jurisdiction in 2009?

### **Required Intervention #3: “Condom distribution prioritized to target persons at highest risk of acquiring HIV”**

- What was the HD’s 2009 budget for the jurisdiction for condom distribution for high-risk HIV-negative persons?
- How many agencies were funded in 2009?
- What locations did agencies use for condom distribution?
- Approximately how many condoms were distributed?
- Approximately how many high-risk HIV-negative persons were reached?
- What funding outside of the CDC is used to support this activity?
- How many condom distribution programs targeting high-risk HIV-negative persons were implemented in the jurisdiction in 2009?

### **Required Intervention #4: “Provision of Post-Exposure Prophylaxis to populations at greatest risk”**

- Did the HD fund facilities in the jurisdiction to provide nPEP in 2009?
- What was the HD’s 2009 budget for this activity?
- How many persons received nPEP at HD supported facilities in the jurisdiction in 2009?
- What funding outside of the CDC is used to support this activity?

### **Required Intervention #5: “Efforts to change existing structures, policies, and regulations that are barriers to creating an environment for optimal HIV prevention, care, and treatment”**

- What activities did the HD conduct to support this activity?
- What was the HD’s 2009 budget for this activity?
- What structures, policies, and regulations did the HD address in 2009?
- What accomplishments occurred during 2009?
- What funding outside of the CDC can be used to support this activity?

### **Required Intervention #6: “Implement linkage to HIV care, treatment, and prevention services for those testing HIV-positive and not currently in care”**

- Does the HD have written policy and procedures on linkage to HIV care, treatment, and prevention for those testing positive and not currently in care?
  - Did grantees in the jurisdiction receive training on the policy and procedures?
- What data do the HD use to track HIV-positive persons not currently in care, treatment, and prevention services?
- How many PLWHA reside in the jurisdiction?
- What is the estimated number of PLWHA in need of treatment?

## Appendix 1: ECHPP Workbook 1

- How many publicly funded HIV/Infectious Disease treatment facilities are in the jurisdiction?
- What funding outside of the CDC is available for care and HIV prevention for PLWHA?
- What was the HD's 2009 budget for the jurisdiction for prevention for persons living with HIV?
- Which agencies recruited the greatest number of at-risk persons?
- Which agencies retained the greatest number of at-risk persons in their interventions?

### **Required Intervention #7: "Implement interventions or strategies promoting retention in or re-engagement in care for HIV-positive persons"**

- In what ways, if any, do you work with healthcare providers to promote retention or re-engagement in care?
- Do you provide funding to agencies or organizations to promote retention or re-engagement in care?
  - How many agencies were funded in the jurisdiction in 2009??
  - What types of agencies were funded?
  - What was the HD's 2009 budget for the jurisdiction for this activity?
- What funding outside of the CDC is available for interventions or strategies to promote retention in care?
- How many agencies in the jurisdiction implemented interventions or strategies to promote retention in or re-engagement in care?

### **Required Intervention #8: "Implement policies and procedures that will lead to the provision of antiretroviral treatment in accordance with current treatment guidelines for HIV-positive persons"**

- Does the HD collect data on the treatment regimens persons living with HIV are prescribed and the treatment they receive?
- Does the HD have written policy and procedures or its own guidance on the use of antiretroviral treatment in accordance with current guidelines?
- What funding outside of the CDC is available to support this activity?
- How many agencies/organizations in the jurisdiction addressed this activity in 2009?

### **Required Intervention #9: "Implement interventions or strategies promoting adherence to antiretroviral medications for HIV-positive persons"**

- Does the HD have written policy and procedures on adherence to antiretroviral medications?
- Did you fund any agencies or organizations in the jurisdiction to conduct interventions or strategies to promote adherence in 2009?
  - What was the HD's 2009 budget for the jurisdiction for this activity?
  - What kinds of agencies were funded?
  - How many agencies were funded?
  - What interventions or strategies were used?
  - How many PLWHA were served?
- What funding outside of the CDC is available to promote treatment adherence?
- How many agencies in the jurisdiction delivered interventions or strategies to promote treatment adherence in 2009?
- How many PLWHA received interventions for medical adherence beyond standard clinical care?

### **Required Intervention #10: "Implement STD screening according to current guidelines for HIV-positive persons"**

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- Does the HD have written policy and procedures on linkages of HIV-positive persons to STD screening and treatment?
- Does the HD have its own guidelines on STD screening and treatment?
- In what ways does the HD monitor its STD clinics to assure screening and treatment take place in accordance with the 2006 STD Treatment Guidelines?
- How many of your funded agencies in the jurisdiction referred HIV-positive persons to STD screening during 2009?
  - How many of these persons kept their first appointments?
- What funding outside of the CDC is available to promote linkage of PLWHA to STD screening?
- How many agencies in the jurisdiction referred PLWHA to STD screening in 2009?
  - How many PLWHA kept their first appointments?

### **Required Intervention #11: “Implement prevention of perinatal transmission for HIV-positive persons”**

- Does the HD have written policies and procedures for perinatal prevention and treatment?
- What specific activities were funded by the HD for perinatal prevention in the jurisdiction in 2009?
- What was the HD’s 2009 budget for the jurisdiction for this activity?
- How many agencies in the jurisdiction carried out perinatal prevention activities in 2009?
- How many pregnant women in the jurisdiction were tested for HIV during 2009?
  - How many were newly diagnosed with HIV?
- How many HIV exposed infants were born in 2009?
- How many infants were born with HIV in 2009?
- What funding outside of the CDC is available to promote perinatal prevention?

### **Required Intervention #12: “Implement ongoing partner services for HIV-positive persons”**

- Does the HD have its own policy and procedures for partner services that comply with the 2008 recommendations?
  - Do grantees receive training on the policy and procedures?
- How many FTEs were devoted to PS in the jurisdiction in 2009?
- What was the HD’s 2009 budget for the jurisdiction for PS?
- How many newly identified, confirmed HIV-positive tests were reported in the jurisdiction 2009?
- How many partners were contacted by HD staff?
- How many partners received HIV tests?
  - How many tests were newly identified, confirmed positive tests?

### **Required Intervention #13: “Behavioral risk screening followed by risk reduction interventions for HIV-positive persons (including those for HIV-discordant couples) at risk of transmitting HIV”**

- Does the HD have written policy and procedures on behavioral risk screening for HIV-positive persons?
- Do grantees receive training on the policy and procedures?
- How many agencies in the jurisdiction did you fund in 2009 to implement interventions for HIV-positive persons

## Appendix 1: ECHPP Workbook 1

- What was the HD's 2009 budget for the jurisdiction for this activity?
  - How many agencies were funded?
  - Did the agencies conduct behavioral risk screenings before HIV-positive persons enrolled in risk reduction interventions?
  - What interventions or strategies were implemented?
  - How many PLWHA in the jurisdiction were served?
- What funding outside of the CDC is available for risk reduction interventions for HIV-positive persons?
- How many agencies implemented risk reduction interventions for HIV-positive persons in the jurisdiction in 2009?

### **Required Intervention #14: "Implement linkage to other medical and social services for HIV-positive persons"**

- Does the HD have written policy and procedures on screening for mental and social services and linkage to other medical and social services for PLWHA?
  - Did grantees receive training on the policy and procedures?
- What funding outside of the CDC is available for other medical and social services for PLWHA?
- How many publicly funded mental health treatment facilities are in the jurisdiction?
- How many publicly funded substance abuse treatment facilities are in the jurisdiction?
- How many publicly funded organizations are there in the jurisdiction that provide housing assistance?
- How many publicly funded organizations in the jurisdiction provide social services (e.g., domestic violence agencies)?
- How many agencies were funded in 2009 to deliver HIV prevention programs/interventions for PLWHA?
  - What programs/interventions were implemented (e.g., CRCS, Healthy Relationships, Partnership for Health)?
- How many HD funded agencies in the jurisdiction referred PLWHA to other medical and social services?
  - How many PLWHA kept their first appointments?

### **General Questions (use for any of the FOA's 10 Recommended Activities)**

- What was the HD's 2009 funding for the activity in the jurisdiction?
- How many agencies were funded?
- What did the agencies accomplish?
- What other funding is available in the jurisdiction for the activity?

## **WORKBOOK 1: APPENDIX 2**

### **Clarification for Use of ECHPP Workbooks**

Below are some clarifications about using the ECHPP workbooks. If a question remains after reviewing these, please let your ECHPP project officer know so you can get a clear response.

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**Q1.** *It is difficult to separate some of the situational analysis, goals, objectives, and strategies across intervention type. For example, linkage to care, partner services, and re-engagement are one cohesive system of care, which means that there will be a lot of repetition splitting the information out by each intervention.*

## Appendix 2: ECHPP Workbook 1

Although repetition in some sections of the workbooks is acceptable, the workbooks are designed to be flexible enough to avoid repetition when desired. For the situational analysis in workbook 1, overlapping relevant content across interventions can be minimized by providing a thorough description for the first occurrence. For subsequent interventions for which the same information is relevant, grantees should reference the previous description with a note clarifying the piece that is relevant to the intervention area being described (e.g., “the system described under ‘(#6) linkage to care’ is also relevant here with the following pertaining specifically to the provision of partner services...”).

Similarly, the justifications associated with goals should reference content that is previously described in detail. In both cases, enough detail should be included in the abridged section to be explicitly clear of the situation or goal justification.

Strategies should be stated in full each time even if they overlap across interventions. Objectives should be distinct to each intervention even if similar and therefore should not repeat or reference others. Cross-referencing in the justification for the goals should provide enough information to identify relevant overlap.

**Q2.** *Workbook 1 describes goals as "Broad aims that define the intended results of each intervention or public health strategy included in the Enhanced Plan....." however, the examples provided do not seem to reflect this definition. Goal 1 says "increase the provision of routine opt-out screening..." This seems to be more of a strategy. The goal seems to "increase status awareness county-wide" or "Decrease unrecognized infection."*

Goals can be framed in a variety of ways. The important piece is that within a given plan, the strategies should support achieving a given goal. The goal justification associated with Step 2 in Workbook 1 should provide the context for the rationale associated with selecting the specific strategies.

**Q3.** *The examples of Objectives provided in Workbook 2 appear to be primarily outcome- or service-oriented. Given this is only 1 year of funding, should we include more process-oriented objectives such as "hire 2 navigator staff by 6/30/10" if we will not be able to realistically reach outcome/service objectives within the ECHPP one year funding time frame?*

Yes. Your plan should include relevant, specific and measurable objectives that will show progress in achieving your overall goals and that can be realistically accomplished within the one-year funding period.

**Q4.** *Workbook 1 includes a rationale in the goal-setting box. Should a rationale be included for each individual strategy in Workbook 2?*

It is not necessary to include a rationale for the selection of each strategy. The description of how the interventions in the Enhanced Plan will work together to achieve 2015 targets (i.e., in the National Strategic Goals Tool) will describe the context for how the given strategies are the most appropriate to select. This information in combination with the rationales provided for each intervention goal is all that is required.