2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan

Provided by the Florida Department of Health in Miami-Dade County

and the Miami-Dade County Ryan White Part A/MAI Program

Acronyms and Abbreviations Used In This Document

ADAP	AIDS Drug Assistance Program
BRTA	Business Responds to AIDS, a program of the Florida Department of Health in Miami-Dade County
DIS	Disease Intervention Specialist, within the Florida Department of Health in Miami-Dade County
FDOH-MDC	Florida Department of Health in Miami-Dade County
FIMR	Fetal Infant Monitoring Review
IDU	Injection Drug Use / Injection Drug User
MCM	Medical Case Management, provided by the Ryan White Program
NHAS	National HIV/AIDS Strategy
OHC	Oral Health Care, provided by the Ryan White Program
OMC	Outpatient Medical Care, provided by the Ryan White Program
Part A/MAI	Part A and the Minority AIDS Initiative of the Ryan White Program in Miami-Dade County
PrEP/nPEP	Pre-Exposure Prophylaxis /non-occupational Post-Exposure Prophylaxis
PRIM	Pre-Natal Immunology Clinic, within the University of Miami
QM	The Ryan White Program's Quality Management Contractor
RWP	Miami-Dade County Ryan White Program, both Part A and MAI (Minority AIDS Initiative)
VL	Viral Load

2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan
Provided by the Florida Department of Health in Miami-Dade County
and the Miami-Dade County Ryan White Part A/MAI Program

NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS								
PREVENTION								
Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
P1. By 2021, reduce new HIV infection rate by at least 25%, from 54.4 per 100,000 population in 2015 to 40.8 per 100,000 population in 2021, so that Miami-Dade County is no longer among the top three metropolitan areas with the highest incidence of new HIV infections.	**PROGRESS TOWARD OBJECTIVE: Baseline 54.4 per 100,000 population in 2015, reduced to 40.8 per 100,000 in 2021.**			**53**	**50**	**47**	**44**	**41**
	P1.1 Increase access to and use of condoms by HIV positive persons and HIV-vulnerable populations, including but not limited to injection drug users (IDU), Trans-identified persons, gay and bisexual men .[1]	P1.1a Increase the number of businesses recruited through BRTA to 300 sites (baseline: 115 in 2015).	FDOH-MDC and Partners	152	189	226	263	300
		P1.1b Provide four (4) educational sessions per year on condom use targeted towards HIV-positive and high risk negative persons, for a cumulative total of 20.	FDOH-MDC	4	8	12	16	20
		P1.1c Distribute 2 million condoms per year, for a cumulative total of 12 million condoms (baseline: 2,245,986 in 2015).	FDOH-MDC and Partners	4.0 mill	6.0 mill	8.0 mill	10.0 mill	12.0 mill
	P1.2 Increase availability of – and access to – PrEP/nPEP programs.	P1.2a Conduct 15 PrEP awareness webinars and presentations in the Miami-Dade County community per year, for a cumulative total of 75 presentations.	FDOH-MDC	15	30	45	60	75

[1] Unless otherwise specified in the text of a strategy or activity, all strategies and activities are continuous progressive activities from January 1, 2017 to December 31, 2021. Where appropriate, interim benchmark metrics are shown, either with a specific value (percentages, numbers of activities engaged in, etc.) or a check mark to indicate a process is underway through that year.

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		P1.2b **By December 31, 2017 (First Year)**, create a local directory of providers prescribing PrEP and nPEP, disseminate same on Part A and FDOH-MDC websites, and update annually thereafter.	FDOH-MDC and Part A/MAI	Create	Up-date	Up-date	Up-date	Up-date
		P1.2c **By December 31, 2019 (Third Year)**, facilitate establishment of six (6) new PrEP/nPEP medical providers (baseline: 3 in 2015).	FDOH-MDC and Partners	4	5	6		
		P1.2d Raise proportion of clients identified through the FDOH-MDC PrEP Clinic who are prescribed PrEP to 70% (no baseline).	FDOH-MDC	10%	25%	40%	55%	70%
	P1.3 Implement combined STD/HIV education and testing to raise HIV prevention awareness among HIV-vulnerable populations, including but not limited to injection drug users (IDU), Trans-identified persons, gay and bisexual men.	P1.3a Identify/recruit additional sites to increase the number of HIV testing programs offering integrated STD testing from 12 to 15 sites.	FDOH-MDC and Partners	13		14		15
		P1.3b Conduct 15 testing events per year with integrative screenings of HIV, STD, and viral hepatitis in high prevalence areas of Miami Dade County (baseline: 18 in 2015).	FDOH-MDC	30	45	60	75	90
		P1.3c Organize 50 cycles per year of STD education, targeting high risk negative individuals (baseline: 53 cycles in 2015).	FDOH-MDC	100	150	200	250	300
	P1.4 Achieve a more coordinated local response to the HIV epidemic.	P1.4a **By January 1, 2017 (First Year),** publish the Integrated Plan on Test Miami and Part A websites, promoting awareness of this plan.	FDOH-MDC and Part A/MAI	✓				

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		P1.4b **By January 1, 2017 (First Year),** implement a short-term intensive "Getting to Zero" Task Force, appointed by the Mayor, to generate high-level community commitment to actions consistent with the Integrated Plan, to eliminate HIV/AIDS in Miami-Dade County.	FDOH-MDC Part A/MAI	✓				
		P1.4c **By January 1, 2017, 2017 (First Year),** implement a joint mechanism for the FDOH-MDC and Part A/MAI to measure, track, review, evaluate and disseminate information on progress toward achieving the Integrated Plan's metrics.	FDOH-MDC Part A/MAI	✓	✓	✓	✓	✓

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Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
P2. Reduce the number of HIV-infected infants born in Miami-Dade County each year from five (5) HIV+ newborns each year to zero (0) HIV+ newborns by 2021.	**PROGRESS TOWARD OBJECTIVE: Continual reduction of live HIV+ births from 5 per year to zero by 2021.**			**4**	**3**	**2**	**1**	**0**
	P2.1 Increase number of OB/GYN healthcare providers engaging in HIV prevention activities with pregnant women.	P2.1a Use Miami-Dade County OB/GYN physician/clinic address data from FDOH-MDC (1) to conduct an annual outbound direct mail and e-mail awareness campaign to inform them of state law 64D-3.042, the local protocol of High Risk Pregnancy Notification and encourage awareness of their responsibility to act on behalf of the HIV infected pregnant women in their care, and (2) to include bounce-back cards to enumerate level of cooperation, number of HIV infected pregnant women in care, and to request more information.	Miami-Dade HIV/AIDS Partnership Staff Support	✓	✓	✓	✓	✓
		P2.1b Conduct four (4) in-person educational sessions per year directed toward medical professionals, who participate in the care of HIV infected pregnant women, educating them about the requirements of Florida law and ensuring they are aware of community services available for HIV infected women and HIV infected or exposed infants.	FDOH-MDC	4	8	12	16	20

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Objectives	**Strategies**	**Activities / Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
		P2.1c Conduct one (1) educational round per year with emergency rooms, urgent care centers, and classified high-risk delivery hospitals, to increase provider awareness of their responsibility to utilize the *High Risk Pregnancy Notification* and *Newborn Exposure Notification* forms and act on behalf of the HIV infected pregnant women and their HIV infected or exposed babies.	FDOH-MDC	1	2	3	4	5
	P2.2 Create an action-oriented community process to improve service systems and community resources for women and infants.	P2.2a Organize four (4) Fetal Infant Monitoring Review (FIMR-HIV) meetings per year to review all information gathered on perinatal transmission cases, identify system issues, and make recommendations for improvement.	FDOH-MDC Healthy Start	4	8	12	16	20
		P2.2b Organize four (4) Community Action Team meetings per year to initiate systems change based on FIMR-HIV recommendations for improvement.	FDOH-MDC Healthy Start	4	8	12	16	20
	P2.3 Conduct targeted public information campaigns toward pregnant women at risk of HIV, to have access to OB/GYN	P2.3a Disseminate a minimum of 1,000 units of educational materials per year, promoting the "Protect Yourself, Protect Your Baby" awareness campaign, encouraging women of childbearing age who are pregnant or considering pregnancy to get tested for HIV (no baseline).	FDOH-MDC	1,000	2,000	3,000	4,000	5,000

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	providers, HIV prevention materials and information on community services for women with HIV/AIDS.	P2.3b Create memorandum of agreement with at least five (5) obstetric healthcare providers per year, who agree to show the "Protect Yourself, Protect Your Baby" DVD in patient waiting rooms (no baseline).	FDOH-MDC	5	10	15	20	25
		P2.3c Create linkage services assuring at least 85% of HIV-infected post-partum women have access to contraceptive/family planning and preconception care services after delivery (no baseline).	FDOH-MDC	65%	70%	75%	80%	85%

<table>
<tr><th colspan="9">NHAS 2020 GOAL #1:
REDUCE NEW HIV INFECTIONS</th></tr>
<tr><th colspan="9">DIAGNOSIS</th></tr>
<tr><th>Objectives</th><th>Strategies</th><th>Activities/Measurements</th><th>Responsible Entities</th><th>2017</th><th>2018</th><th>2019</th><th>2020</th><th>2021</th></tr>
<tr><td rowspan="7">D1. Increase the percentage of people living with HIV/AIDS (PLWHA) who know their serostatus from 84.9% in 2014 to at least 90% by 2021.</td><td colspan="3">PROGRESS TOWARD OBJECTIVE: Increase from 85% of PLWHA who know their status in 2016 to 90% in 2021.</td><td>86%</td><td>87%</td><td>88%</td><td>89%</td><td>90%</td></tr>
<tr><td rowspan="4">D1.1 Partner with healthcare settings (e.g. hospitals, health centers, emergency departments), to increase the provision of routine HIV testing as part of medical care.</td><td>D1.1a By December 31, 2017, create a program to enroll, support and evaluate healthcare providers to implement routinized HIV testing in their facilities.</td><td>FDOH-MDC</td><td>Create</td><td></td><td></td><td></td><td></td></tr>
<tr><td>D1.1b Conduct fifteen (15) educational visits per year to healthcare providers to disseminate information regarding the importance of routine HIV screening.</td><td>FDOH-MDC</td><td>15</td><td>30</td><td>45</td><td>60</td><td>75</td></tr>
<tr><td>D1.1c Enroll six (6) new healthcare providers per year in the routinized HIV testing program.</td><td>FDOH-MDC</td><td>6</td><td>12</td><td>18</td><td>24</td><td>30</td></tr>
<tr><td>D1.1d Provide education, training and technical assistance to six (6) healthcare providers per year enrolled in the routinized HIV testing program.</td><td>FDOH-MDC</td><td>6</td><td>12</td><td>18</td><td>24</td><td>30</td></tr>
<tr><td rowspan="2">D1.2 Intensify HIV efforts in high impact areas.</td><td>D1.2a Increase the number of registered testing sites by six (6) per year to ensure that HIV testing is more readily available and accessible (baseline: 118 sites in 2015)</td><td>FDOH-MDC</td><td>124</td><td>130</td><td>136</td><td>142</td><td>148</td></tr>
<tr><td>D1.2b Conduct thirty (30) Take Control events per year in high impact areas (i.e., FDOH-MDC Life Zones II, III, IV and V).</td><td>FDOH-MDC</td><td>30</td><td>60</td><td>90</td><td>120</td><td>150</td></tr>
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NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS								
DIAGNOSIS								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
		D1.2c Document effective strategies in the execution of Take Control activities and host a quarterly debriefing to address barriers to successful implementation.	FDOH-MDC and Partners	4	8	12	16	20
	D1.3 Increase the number of HIV tests conducted, effectively identifying and testing individuals at highest risk including but not limited to injection drug users (IDU), Trans-identified persons, gay and bisexual men.	D1.3a Provide registered testing sites with a quarterly "report card" identifying areas of success and opportunities for improvement in testing.	FDOH-MDC	4	8	12	16	20
		D1.3b Provide technical assistance to registered testing agencies not meeting the standards of the quarterly "report card."	FDOH-MDC	✓	✓	✓	✓	✓
		D1.3c Host an annual 501 Update for HIV Testing Counselor's education on testing technologies and emerging testing trends.	FDOH-MDC	1	2	3	4	5

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS								
LINKAGE TO CARE								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
L 1. Increase the percentage of PLWHA linked to medical care *[at least one (1) outpatient medical care visit, as documented by a billed OMC encounter, or a CD4 or VL test]* within 30 days post-diagnosis from 55% in 2015 to at least 85% by 2021.	**PROGRESS TOWARD OBJECTIVE: Baseline linkage rate of 55% in 2015 increased to 85% by 2021.**		**FDOH-MDC Part A/MAI**	**65%**	**70%**	**75%**	**80%**	**85%**
	L 1.1 Improve existing FDOH-Part A diagnosis-to-linkage client management process.	L 1.1a FDOH-MDC and Ryan White Part A/MAI will jointly identify and address at least one (1) Linkage to Care Quality Improvement Opportunity per year (identify, pilot-test, evaluate, implement), for a total of five (5).	FDOH-MDC Part A/MAI	1	2	3	4	5
		L 1.1b FDOH-MDC and Ryan White Part A/MAI will hold four (4) training events per year with FDOH Disease Intervention Specialists (DIS), Part A outreach workers and FDOH peers to address identified linkage to care gaps and quality improvement initiatives.	FDOH-MDC Part A/MAI	4	8	12	16	20
		L 1.1c Guarantee flexible after-hours and weekend availability at Ryan White Part A/MAI MCM, OMC and Outreach provider agencies, ensuring that at least one (1) MCM provider, one (1) OMC provider and one (1) Outreach provider will offer after-hours service five (5) weeknights per week and will offer four (4) hours of service availability one (1) weekend day, to reduce or eliminate barriers to Part A/MAI program linkage once a PLWHA has been diagnosed at an FDOH-MDC site.	Part A/MAI	✓	✓	✓	✓	✓
	L 1.2 Provide Partner Services to identified HIV+ individuals, allowing for the notification, screening	L 1.2a At least 75% of newly-diagnosed PLWHA eligible for services in Miami-Dade County will be offered Partner Services counseling interviews within thirty (30) days of the positive HIV test (baseline: 68% in 2015).	FDOH-MDC DIS	69%	71%	73%	74%	75%

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	and referral to appropriate services for partners of newly-diagnosed PLWHA.	L 1.2b At least 75% of the partners of newly-diagnosed PLWHA interviewed through Partner Services (L1.2a) will be tested for HIV (baseline: 48% in 2015).	FDOH-MDC DIS	55%	60%	65%	70%	75%
		L 1.2c At least 75% of the HIV negative Partners identified through Partner Services will be offered a referral to the FDOH-MDC PrEP clinic (no baseline).	FDOH-MDC DIS	55%	60%	65%	70%	75%
	L 1.3 Identify and link to medical care at least 25% of the HIV-infected persons identified through the FDOH-MDC "Data To Care" (DTC) initiative.	L 1.3a Increase by 5% per year the percentage of DTC clients with a positive diagnosis, but without CD4/VL data, who are contacted to determine eligibility for linkage to care in Miami-Dade County.	FDOH-MDC	60%	65%	70%	75%	80%
		L 1.3b Through FDOH-MDC and Part A/MAI cooperation, link 25% of DTC clients identified as eligible for linkage in Miami-Dade County to care within sixty (60) days of identification.	FDOH-MDC Part A/MAI	5%	10%	15%	20%	25%

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS								
RETENTION IN CARE								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
R1. Increase the percentage of PLWHA in the RWP who had at least two medical visits [or CD4/VL lab tests, or ARV prescriptions filled, or any combination of two (2) or more of these metrics] at least 90 days apart within a 12 month period, from 60% in 2015 to at least 90% by 2021.	**PROGRESS TOWARD OBJECTIVES: Baseline retention rate of 60% in 2015 increased to 90% by 2021.**		**Part A/MAI QM**	**66%**	**72%**	**78%**	**84%**	**90%**
	R1.1 Identify PLWHA who are at greatest risk for dropping out of care.	R1.1a **By December 31, 2017 (First Year),** identify PLWHA demographic background factors associated with dropping out of Ryan White Program OMC care, and track retention annually thereafter.	Part A/MAI QM	Identi-fy	Track	Track	Track	Track
		R1.1b **By December 31, 2017 (First Year)**, develop, test and implement assessment measurements of HIV-related comorbidities and acuity levels associated with dropping out of Ryan White Program OMC care; track and refine measurements in subsequent years.	Part A/MAI QM	Identi-fy	Track	Track	Track	Track
		R1.1c **Beginning January 1, 2018 (Second Year),** identify at least one (1) client characteristic-based Retention In Care Quality Improvement opportunity per year (identify, pilot-test, evaluate, implement improvement).	Part A/MAI QM		1	2	3	4
	R1.2 Enhance the RWP Client-Centered Care quality improvement system that focuses on reduction of barriers to	R1.2a **By December 31, 2017 (First Year),** identify OMC providers with outstanding retention in care rates, independent of client demographics, comorbidities or special need characteristics. Determine best program practices.	Part A/MAI QM	✓				

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RETENTION IN CARE								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
	continued care, identification of best practices, and implementation of system-wide service quality improvement.	R1.2b Expand implementation of 2016-17 RWP Texting Intervention Project protocols to PLWHA at five (5) MCM sites per year to apply intervention protocols to improve PLWHA retention in care.	Part A/MAI QM	5	10	15	20	25
		R1.2c Beginning **January 1, 2018 (Second Year),** identify at least one program-based Retention In Care Quality Improvement Opportunity per year (identify, pilot-test, evaluate, implement improvement).	Part A/MAI QM		1	2	3	4
		R1.2d Review and update Client-Centered Care standards for Ryan White Program-funded OMC, OHC and MCM services, and evaluate (track) providers' compliance with these standards annually thereafter.	Part A/MAI QM	Review and Up-date	Track	Track	Track	Track
	R1.3 Enhance the RWP Client-Centered Care quality management protocols for (1) reducing lagtime to first or repeat appointments; (2) reducing wait time in lobby for appointments; and (3) reducing hold time reaching live help by telephone, for Ryan White Program OMC,	R1.3a **By December 31, 2017 (First Year),** identify and review existing provider-based processes for monitoring lagtime, wait time and hold time in 100% of Part A/MAI-funded OMC, OHC and MCM providers; develop and implement system-wide protocols for measurement and reporting.	Part A/MAI QM	Imple-ment				
		R1.3b **Beginning January 1, 2018 (Second Year),** track lagtime, wait time and hold time performance of Ryan White Program OMC, OHC and MCM providers.	Part A/MAI QM		Track	Track	Track	Track
		R1.3c Reduce average lagtime, average wait time and average hold time by 25%, relative to standards updated in R1.2c and tracked in R1.3a and R1.3b.	Part A/MAI QM		-10%	-15%	-20%	-25%

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Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
	OHC and MCM providers.	R1.3d Identify at least one (1) program-based Retention In Care Quality Improvement Opportunity per year (identify, pilot-test, evaluate, implement improvement).	Part A/MAI QM	1	2	3	4	5
	R1.4 Provide continuous improvements in outpatient medical care that meets the needs and identified vulnerabilities of PLWHA in care.	R1.4a Monitor quality and appropriateness of OMC clinical care through client satisfaction surveys, focus groups, targeted reviews of SDIS data and clinical record reviews and improve through various technical assistance methods (on site QM TA, AETC, etc.). Require corrective actions for providers with identified deficiencies.	Part A/MAI QM	✓	✓	✓	✓	✓
		R1.4b Monitor quality and appropriateness of prescription of non-ARV medication, to identify unusual prescription drug patterns reflecting problems in quality of care, through statistical analysis of prescribing frequency and/or desk audits of prescription patterns for particular providers and improve prescribing patterns of these non-ARV medications as needed for appropriateness and cost effectiveness. Require corrective actions for providers with identified deficiencies.	Part A/MAI QM	✓	✓	✓	✓	✓

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RETENTION IN CARE								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
		R1.4c Monitor and improve clinical and administrative proficiency among outreach workers, medical case managers and peers, through systems of proficiency development and enhanced clinical training. Require corrective actions for providers with identified deficiencies.	Part A/MAI QM	✓	✓	✓	✓	✓
	R1.5 Track and assess the quality of care provided to RWP clients who transition to ACA-provided outpatient medical care.	R1.5a Revise and streamline ACA enrollment and re-enrollment processes to increase the proportion of ACA-eligible RWP clients transitioned to ACA from 50% to 70% (2015 baseline: 50%).	Part A/MAI QM	54%	58%	62%	66%	70%
		R1.5b Increase the percentage of eligible clients transitioned from Ryan White Part A/MAI-funded outpatient medical care to ACA medical care who are retained in ACA-provided medical care for two (2) years after enrollment from 45% to 65%.	Part A/MAI QM	45%	50%	55%	60%	65%
		R1.5c Require that all clients receiving Part A/MAI assistance with the ACA report VL levels at a minimum once every six (6) months, in order to assess and track clinical health outcomes of RWP clients receiving OMC through an ACA Marketplace insurance plan. Compare VL levels among PLWHA treated through ACA with VL levels of PLWHA receiving OMC through the RWP to identify disparities.	Part A/MAI QM	Check	Track	Check	Track	Check

NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS								
VIRAL LOAD SUPPRESSION								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
V1. Increase the percentage of people living with HIV in the EMA who are virally suppressed (<200 copies/mL) from 67% in 2015 to at least 80% by 2021.	**PROGRESS TOWARD OBJECTIVES: baseline viral suppression in the EMA overall from 67% in 2015 to 80% by 2021.**		**FDOH MD-C**	**71%**	**73%**	**75%**	**77%**	**80%**
	V1.1 Provide immediate access to antiretroviral therapy through timely linkage to medical care, expanding the FDOH-MDC Test and Treat model of care.	V1.1a Develop capacity for increased Test and Treat sites, setting a goal of one (1) new site identified and in development every 18 months, including: (1) identifying potential new Test and Treat sites; (2) determining what the sites need to become "Test and Treat"-ready; and (3) provide technical assistance to the sites to assure Test and Treat readiness and success (baseline: 1).	FDOH M-DC and Partners		2	3		4
		V1.1b At least 80% of clients identified through the "Test and Treat" model will have received antiretroviral therapy within the seven (7) day time period.	FDOH M-DC and Partners	60%	65%	70%	75%	80%
	V1.2 Enhance support for FDOH-MDC treatment adherence (FDOH-MDC initiatives).	V1.2a **By December 31, 2018 (Second Year**), create an Electronic Direct Observation Therapy system for ARV non-compliant pregnant women.	FDOH-MDC and UM PRIM clinic		✓			
		V1.2b **Beginning in January 1, 2019 (Year Three),** at least 75% of women using the electronic direct observation therapy will be treatment compliant.	FDOH-MDC and UM PRIM clinic			65%	70%	75%

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VIRAL LOAD SUPPRESSION								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
		V1.2c **By December 31, 2017 (Year One),** establish a referral service between ADAP and FDOH Peer Educators and Linkage staff to target ADAP clients not achieving viral suppression, and maintain throughout following years.	FDOH-MDC ADAP FDOH Peer Educators	Estab-lish	Main -tain	Main-tain	Main-tain	Main -tain
		V1.2d **By December 2018 (Year Two**), at least 55% of HIV+ persons enrolled in peer navigation programs will receive treatment adherence education, rising to 70% by 2021. (No baseline)	FDOH-MDC FDOH Peer Educators		55%	60%	65%	70%
		V1.2e **By December, 2018 (Year Two),** 45% of the PLWHA who fail to pick up medications through ADAP will be contacted and efforts made to diagnose barriers and move them to compliance, rising by 5% per year thereafter.	FDOH-MDC ADAP		45%	50%	55%	60%
	V1.3 Expand role of Part A/MAI MCM and OMC providers in detecting lapses in adherence or persistent viremia, and initiate appropriate responses.	V1.3a Hold quarterly meetings between ADAP and Part A/MAI MCM supervisors during MCM supervisor trainings to find ways to increase awareness of early detection of lapses in adherence and persistent high viremia.	Part A/MAI ADAP	4	8	12	16	20
		V1.3b Expand implementation of 2016-17 RWP Texting Intervention Project protocols to PLWHA at five (5) MCM sites per year to apply intervention protocols to improve PLWHA viral load suppression.	Part A/MAI	5	10	15	20	25

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VIRAL LOAD SUPPRESSION								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
		V1.3c On a monthly basis, detect PLWHA with persistently high viremia and notify OMC and MCM providers to enable targeted response. Monitor improvement in VL levels to ensure efficacy of provider response.	Part A/MAI	✓	✓	✓	✓	✓
		V1.3d **Beginning January 1, 2018 (Second Year),** identify at least one (1) Viral Load (non)Suppression Quality Improvement opportunity per year (identify, pilot-test, evaluate, implement improvement).	Part A/MAI		1	2	3	4

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN PREVENTION								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
DP1. By 2021, reduce number of persons in key disparate minority health groups who are newly-diagnosed with HIV/AIDS by 15%, relative to 2015 levels.	**PROGRESS TOWARD OBJECTIVES:** **a. Blacks/African Americans: from 464 in 2015 to 394 in 2021.** **b. Hispanics: from 659 in 2015 to 560 in 2021.** **c. Gay and bisexual men: from 678 in 2015 to 576 in 2021.**		**FDOH-MDC**	**a. 450** **b. 639** **c. 657**	**a. 436** **b. 619** **c. 637**	**a. 422** **b. 600** **c. 617**	**a. 410** **b. 582** **c. 598**	**a. 394** **b. 560** **c. 576**
	DP1.1-1.3 Enhance HIV prevention, testing, communication and community mobilization efforts in Miami-Dade County towards the following groups:							
	DP1.1 Blacks/African Americans	DP1.1a FDOH-MDC in collaboration with local community based organizations, will annually organize sixty (60) community mobilization events engaging Blacks/African Americans in HIV prevention, harm risk reduction, and addressing stigma (baseline: 73 events in 2015).	FDOH-MDC and Partners	60	120	180	240	300
		DP1.1b FDOH –MDC will mobilize leaders and the Black/African American community by hosting quarterly meetings to invigorate HIV prevention efforts, support the reduction of risky behavior, and address stigma.	FDOH-MDC and Partners	4	8	12	16	20
		DP1.1c FDOH-MDC and non-clinical HIV counseling and testing sites will educate the Black/African American community about the importance of getting an HIV test, increasing the number of HIV tests by at least 10% (Baseline: 34,860 tests in 2015)	FDOH-MDC and Partners	35,557	36,268	36,993	37,732	38,486

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN PREVENTION								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
	DP1.2 Hispanics/Latinos	DP1.2a FDOH-MDC will mobilize leaders and the Hispanic/Latino community by hosting quarterly meetings to invigorate HIV prevention efforts, support the reduction of risky behavior, and address stigma.	FDOH-MDC and Partners	4	8	12	16	20
		DP1.2b FDOH-MDC will partner with community based organizations and host at least one (1) annual ***Iniciativa Hispana*** activity engaging the Hispanic community in HIV prevention.	FDOH-MDC and Partners	1	2	3	4	5
		DP1.2c FDOH-MDC will have implemented fifty (50) cycles of educational sessions, including harm risk reduction methods targeting positive and high risk negative Hispanic persons.	FDOH-MDC	10	20	30	40	50
		DP1.2d FDOH-MDC and non-clinical HIV counseling and testing sites will educate the Hispanic/Latino community about the importance of getting an HIV test, increasing the number of tests by at least 10% (baseline: 40,741 tests in 2015).	FDOH-MDC and Partners	41,555	42,386	43,233	44,097	44,978
	DP1.3 Gay and bisexual men	DP1.3a FDOH-MDC will have coordinated fifteen (15) outreach/testing events targeting high risk gay and bisexual men.	FDOH-MDC and Partners	3	6	9	12	15

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN PREVENTION								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
		DP1.3b FDOH –MDC will mobilize leaders and the gay and bisexual community by hosting quarterly meetings to invigorate HIV prevention efforts, support the reduction of risky behavior, and address stigma.	FDOH-MDC and Partners	4	8	12	16	20
		DP1.3c FDOH-MDC and non-clinical HIV counseling and testing sites will mobilize and educate the gay and bisexual community about the importance of getting an HIV test, increasing the number of tests by at least 10%, compared to 2015 baseline of 16,711 tests.	FDOH-MDC and Partners	17,045	17,385	17,732	18,086	18,447

NHAS 2020 GOAL #3:
REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES

DISPARITIES IN RETENTION IN CARE

Objectives	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
DR1. By 2021, increase the percentage of clients in three (3) key disparate minority health groups who are retained in RWP outpatient medical care [at least two (2) medical visits, or CD4/VL lab tests, or ARV prescriptions filled, or any combination of two (2) or more of these metrics, at least 90 days apart within a 12 month period] to 90%, to match overall PLWHA levels.	**PROGRESS TOWARD OBJECTIVES:** **a. Black/African American males: from 53% retained in care each year to 90%.** **b. Black/African American females: from 52% retained in care each year to 90%.** **c. Hispanics under 25 years of age: from 49% retained in care each year to 90%.**		**RWP Part A QM**	**a. 65% b. 65% c. 63%**	**a. 71% b. 71% c. 70%**	**a. 77% b. 77% c. 77%**	**a. 83% b. 83% c. 84%**	**a. 90% b. 90% c. 90%**
	DR1.1-1.3 Identify risk factors associated with retention in care for the specialty groups listed below, and address them with specific interventions:							
	DR1.1 Black/African American males	DR1.1a **By December 31, 2017 (First Year),** determine (1) best practices of Part A/MAI agencies with higher than average PLWHA retention rates for Black/African American males; and (2) risk factors contributing to low Black/African American male PLWHA retention rates.	RWP Part A	✓				
		DR1.1b **By December 31, 2018 (Second Year),** design, pilot-test and evaluate interventions to improve retention of Black/African American male PLWHA in Part A/MAI-funded services.	RWP Part A QM		✓			
		DR1.1c **By December 31, 2019 (Third Year),** implement interventions directed to Black/African American male PLWHA throughout the RWP Part A/MAI networks of care, thereby reducing lost-to-care rates for Black/African American males. Evaluate annually thereafter.	RWP Part A QM			✓	✓	✓

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN RETENTION IN CARE								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
	DR1.2 Black/African American females	DR1.2a **By December 31, 2017 (First Year),** determine (1) best practices of Part A/MAI agencies with higher than average PLWHA retention rates for Black/African American females; and (2) risk factors contributing to low Black/African American female PLWHA retention rates.	RWP Part A QM	✓				
		DR1.2b **By December 31, 2018 (Second Year),** design, pilot-test and evaluate interventions to improve retention of Black/African American female PLWHA in Part A/MAI–funded services.	RWP Part A QM		✓			
		DR1.2c **By December 31, 2019 (Third Year),** implement interventions directed to Black/African American female PLWHA throughout the RWP Part A/MAI networks of care, thereby reducing lost-to-care rates for Black/African American female PLWHA. Evaluate annually thereafter.	RWP Part A QM			✓	✓	✓
	DR1.3 Hispanics under 25 years of age	DR1.3a **By December 31, 2017 (First Year),** determine (1) best practices of Part A/MAI agencies with higher than average PLWHA retention rates for Hispanics under 25 years of age; and (2) risk factors contributing to low young Hispanic PLWHA retention rates.	RWP Part A	✓				

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN RETENTION IN CARE								
Objectives	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
		DR1.3b **By December 31, 2018 (Second Year),** design, pilot-test and evaluate interventions to improve retention of young Hispanic PLWHA in Part A/MAI-funded services.	RWP Part A QM		✓			
		DR1.3c **By December 31, 2019 (Third Year),** implement interventions directed to young Hispanic PLWHA throughout the RWP Part A/MAI networks of care, thereby reducing lost-to-care rates for young Hispanic PLWHA. Evaluate annually thereafter.	RWP Part A QM			✓	✓	✓

NHAS GOAL #3:
REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES

DISPARITIES IN TREATMENT OUTCOMES (SUPPRESSED / UNDETECTABLE VL LEVELS)

Objective	Strategies	Activities/Measurements	Responsible Entities	2017	2018	2019	2020	2021
DV1. By 2021, increase the percentage of clients in RWP care among three (3) key disparate minority health groups with suppressed viral loads to 80%, to match overall PLWHA levels.	**PROGRESS TOWARD OBJECTIVES:** **a. Black/African American Males: from 57% suppressed VL in 2015 to 80%.** **b. Black/African American Females: from 60% suppressed VL in 2015 to 80%.** **c. Haitians: from 68% suppressed VL in 2015 to 80%.**		**RWP Part A QM**	**a. 60% b. 64% c. 72%**	**a. 65% b. 68% c. 74%**	**a. 70% b. 72% c. 76%**	**a. 75% b. 76% c. 78%**	**a. 80% b. 80% c. 80%**
	DV1.1 Identify risk factors associated with Black/African American male clients within the Ryan White Part A/MAI networks of care having high VL, and address them with specific interventions.	DV1.1a **By December 31, 2017 (First Year)**, determine best practices of Part A/MAI agencies with high proportions of Black/African American male PLWHA with undetectable VL.	RWP Part A QM	✓				
		DV1.1b **By December 31, 2018 (Second Year),** design and pilot-test interventions to improve Black/African American male PLWHA undetectable VL levels.	RWP Part A QM		✓			
		DV1.1c **By December 31, 2019 (Third Year),** implement Black/African American male VL suppression interventions throughout the RWP Part A/MAI networks of care, thereby increasing undetectable VL rates for Black/African American males.	RWP Part A QM			✓	✓	✓
	DV1.2 Identify risk factors associated with Black/African American female PLWHA clients within the Ryan White	DV1.2a **By December 31, 2017 (First Year),** determine best practices of Part A/MAI agencies with high proportions of Black/African American female PLWHA with undetectable VL.	RWP Part A QM	✓				

NHAS GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES								
DISPARITIES IN TREATMENT OUTCOMES (SUPPRESSED / UNDETECTABLE VL LEVELS)								
Objective	**Strategies**	**Activities/Measurements**	**Responsible Entities**	**2017**	**2018**	**2019**	**2020**	**2021**
	Part A/MAI networks of care having high VL, and address them with specific interventions.	DV1.2b **By December 31, 2018 (Second Year),** design and pilot-test interventions to improve Black/African American female PLWHA undetectable VL levels.	RWP Part A QM		✓			
		DV1.2c **By December 31, 2019 (Third Year**), implement VL suppression interventions for Black/African American females throughout the RWP Part A/MAI networks of care, thereby increasing undetectable VL levels for Black/African American female PLWHA.	RWP Part A QM			✓	✓	✓
	DV1.3 Identify risk factors associated with Haitian clients within the Ryan White Part A/MAI networks of care having persistently high VL, and address them with specific interventions.	DV1.3a **By December 31, 2017 (First Year),** determine best practices of Part A/MAI agencies with high proportions of Haitian PLWHA with undetectable VL.	RWP Part A QM	✓				
		DV.3b **By December 31, 2018 (Second Year),** design and pilot-test interventions to improve Haitian PLWHA undetectable VL levels.	RWP Part A QM		✓			
		DV1.3c **By December 31, 2019 (Third Year**), implement Haitian VL suppression interventions throughout the RWP Part A/MAI networks of care, thereby increasing undetectable VL levels for Haitians.	RWP Part A QM			✓	✓	✓