

2017-2021 CDC/HRSA INTEGRATED HIV/AIDS PREVENTION AND CARE PLAN

MIAMI-DADE COUNTY, FLORIDA

I. STATEWIDE COORDINATED STATEMENT OF NEEDS/NEEDS ASSESSMENT

While the Florida Department of Health in Miami-Dade County (FDOH-MDC) and the Miami-Dade County Ryan White Part A Program both have participated in the development of and concur with the State of Florida's CDC/HRSA Integrated HIV Prevention and Care Plan (hereafter, Florida Integrated Plan), there are some very important differences that must be highlighted. This narrative reflects the unique characteristics HIV/AIDS incidence and prevalence in the Miami-Dade County Eligible Metropolitan Area (EMA) as they relate to specific vulnerable populations. The data presented here are intended to provide a context for the objectives, strategies, and activities outlined in this jurisdiction's chapter of the Florida Integrated Plan, and are detailed in the accompanying 2017-2021 CDC/HRSA HIV Prevention and Care Plan for Miami-Dade County (hereafter, Miami Integrated Plan). Therefore, the following narrative is intended as a supplement to the Florida Integrated Plan, which addresses all components of the CDC/HRSA Integrated Plan guidance.

Unless otherwise specifically noted, the source of epidemiology data in this narrative comes from the Florida Department of Health, HIV Surveillance Data through December 31, 2015, as reported in 2016, through its electronic HIV/AIDS reporting system (eHARS). Miami-Dade County Ryan White Program Part A/MAI Program data comes from service utilization data for grant Fiscal Year (FY) 2015 (March 1, 2015 through February 29, 2016), as reported in the Ryan White Program Service Delivery Information System (SDIS), the EMA's comprehensive client data management and billing system.

A. EPIDEMIOLOGIC OVERVIEW

The Miami-Dade County EMA is not like the rest of the State of Florida, nor is the HIV/AIDS epidemic in Miami-Dade County like the HIV/AIDS epidemic throughout the rest of the State. Note that while Miami-Dade County occupies only 3.7% of the total land area of Florida, in the southeastern tip of the State, and represents only 13.2% of Florida's population, Miami-Dade County accounts for 23.7% of the total number of persons living with HIV in the State, and leads the United States in the rate of new HIV cases each year. Overall, 26,042 people were living with HIV/AIDS (PLWHA) in Miami-Dade County in 2015, 1% of the entire population. ***Miami-Dade County has the highest number of PLWHA in Florida.***

In addition to Miami-Dade County's high HIV/AIDS incidence levels, Miami-Dade County's racial/ethnic composition differs from the rest of Florida, both in the composition of its residential population and in the composition of the populations of persons living with HIV or AIDS. Table 1, below, illustrates the demographic differences between Florida's overall population and a breakdown of the HIV/AIDS epidemic throughout the state, as compared to the racial/ethnic composition within the Miami-Dade County EMA.

**Table 1:
Differences between the Ethnic/Racial Composition of Miami-Dade County and Florida,
with Particular Reference to Ethnic Differences among PLWH and PLWA**

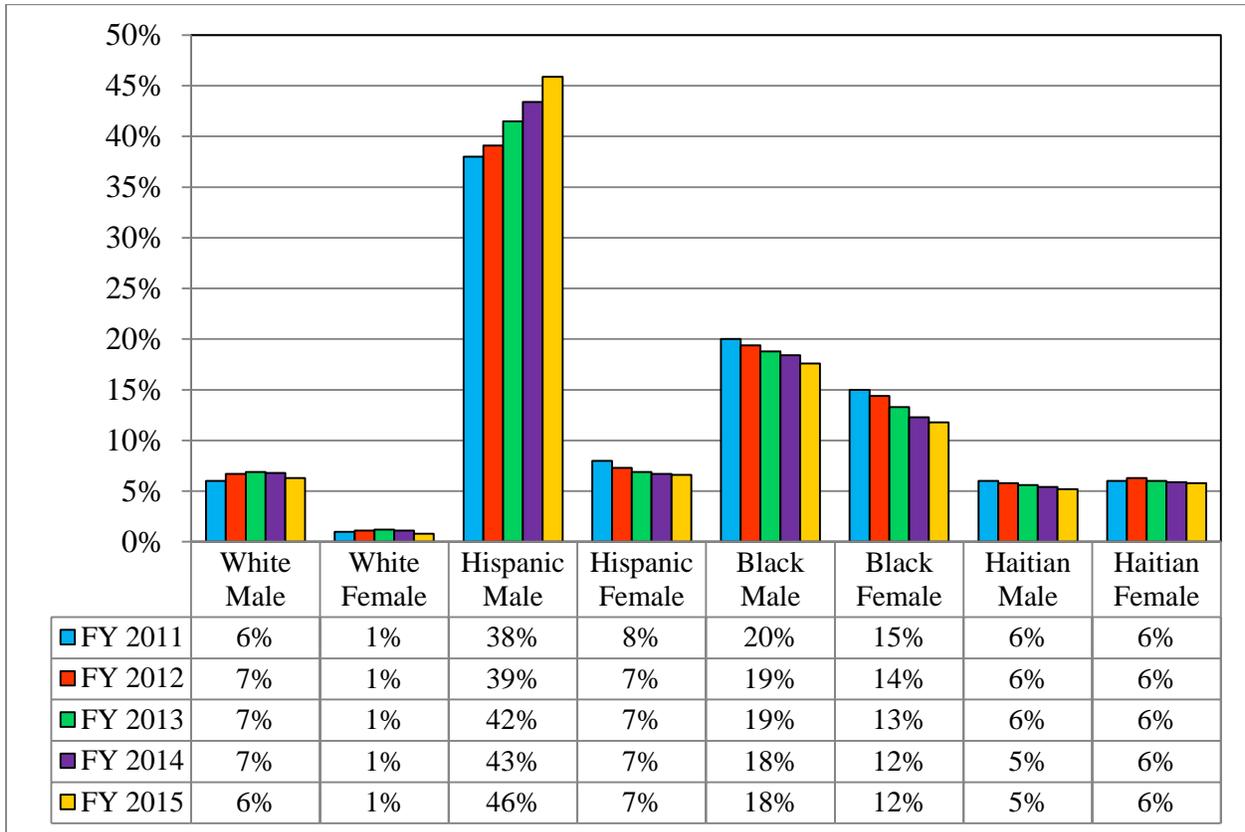
Racial/Ethnic Groups in Florida	Racial/Ethnic % Across Florida and Within Miami-Dade		Racial/Ethnic % Among Persons With HIV		Racial/Ethnic % Among Persons With AIDS	
	State of Florida	Miami-Dade	State of Florida	Miami-Dade	State of Florida	Miami-Dade
White Non-Hispanic	59%	14%	26%	13%	25%	13%
Black/African American	14%	17%	44%	41%	51%	50%
Hispanic	23%	67%	28%	44%	21%	35%
Other	4%	2%	2%	1%	3%	2%

- The defining characteristic of Miami-Dade County’s population, compared to the State of Florida, is the low percentage of White Non-Hispanics coupled with a high percentage of Hispanics. White Non-Hispanics represent almost 60% of Florida's population, but only 14% of the population in Miami-Dade County. Hispanics comprise less than a quarter of the population of the State as a whole, but approximately 67% of the population in Miami-Dade County, 44% of the persons diagnosed with HIV (vs. 28% for the State as a whole), and 35% of the persons diagnosed with AIDS (vs. 21% for the State as a whole). The high proportion of Hispanics in the Miami-Dade County EMA, along with the high incidence of HIV/AIDS in this population, is the basis for the designation of Hispanics as a target population for prevention efforts (see NHAS 2020 Goal #3: Disparities in Prevention, Strategy DP 1.2, for Hispanics/Latinos in the Miami Integrated Plan).

- Blacks/African Americans (which includes African Americans, Black Caribbeans, and Black Haitians) comprise 17% of Miami-Dade County’s population, comparable to the 14% shown across the State of Florida; but, based on FDOH-MDC’s data for 2015, comprise 41% of the persons living with HIV in Miami-Dade County and 50% of the persons living with AIDS. This pattern of low percentages of Black/African Americans in the population at large, but much higher percentages of Black/African Americans living with HIV and AIDS in both the State and Miami-Dade County demographics, is the basis for designating Blacks/African Americans as a target population for prevention efforts (see NHAS 2020 Goal #3: Disparities in Prevention, Strategy DP 1.1, for Blacks/African Americans in the Miami Integrated Plan).

- Altogether, 85% of the PLWHA in Miami-Dade County are from ethnic minority groups. The proportion of minorities in care in the local Ryan White Part A/Minority AIDS Initiative (MAI) Program’s system of care is even higher – approximately 93%, a percentage that has remained almost unchanged over the last five years. During the same five year period, the Miami-Dade County EMA has experienced a trend towards having more Hispanic males and fewer Black/African American males and females in care. Figure 1 below presents the racial/ethnic and gender breakdown of PLWHA served in the jurisdiction over the past five years.

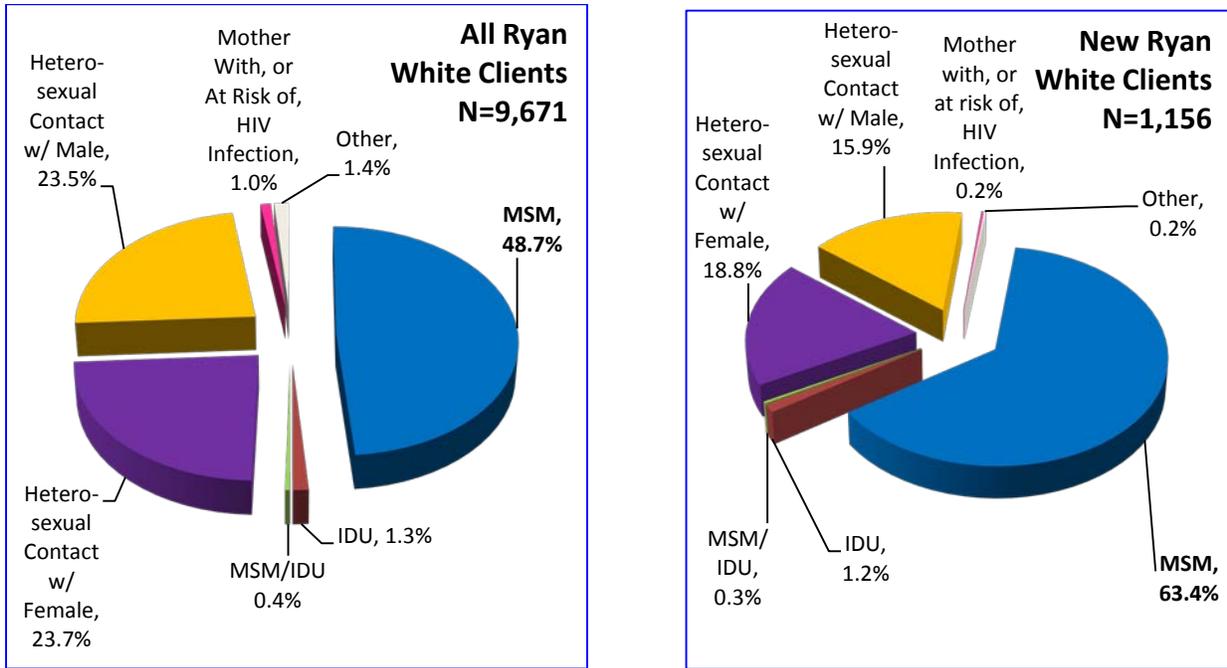
**Figure 1:
Race/Ethnicity of PLWHA in Care in the
Miami-Dade County Ryan White Part A/MAI Program**



INDICATORS OF RISK FOR HIV INFECTION –

The chief exposure category for PLWHA in Miami-Dade County continues to be men who have sex with men (MSM), who comprise 47% of living AIDS cases and 56% of living HIV cases in Miami-Dade County (FDOH-MDC data, 2015), and who comprise the largest single risk category for new cases in the local Ryan White Part A/MAI Program system of care (see **Figure 2** below). In FY 2015-2016, MSMs comprised 63.4% of new Ryan White Program clients in care and 48.7% of the total PLWHA in care. Among male PLWHA in care, 75.6% of the new male PLWHA in care were MSM, and 64.7% of the total male PLWHA in care were MSM. These statistics impacted several decisions in the Miami Integrated Plan, from identifying MSM as a target population for disparity-reduction prevention efforts (see NHAS 2020 Goal #3: Disparities in Prevention, Strategy DP 1.3 in the Miami Integrated Plan), and focusing on the MSM population as a target for HIV testing and provision of PrEP by the FDOH-MDC (see NHAS 2020 Goal #1, Prevention, Strategy P 1.2 and P 1.3 in the Miami Integrated Plan).

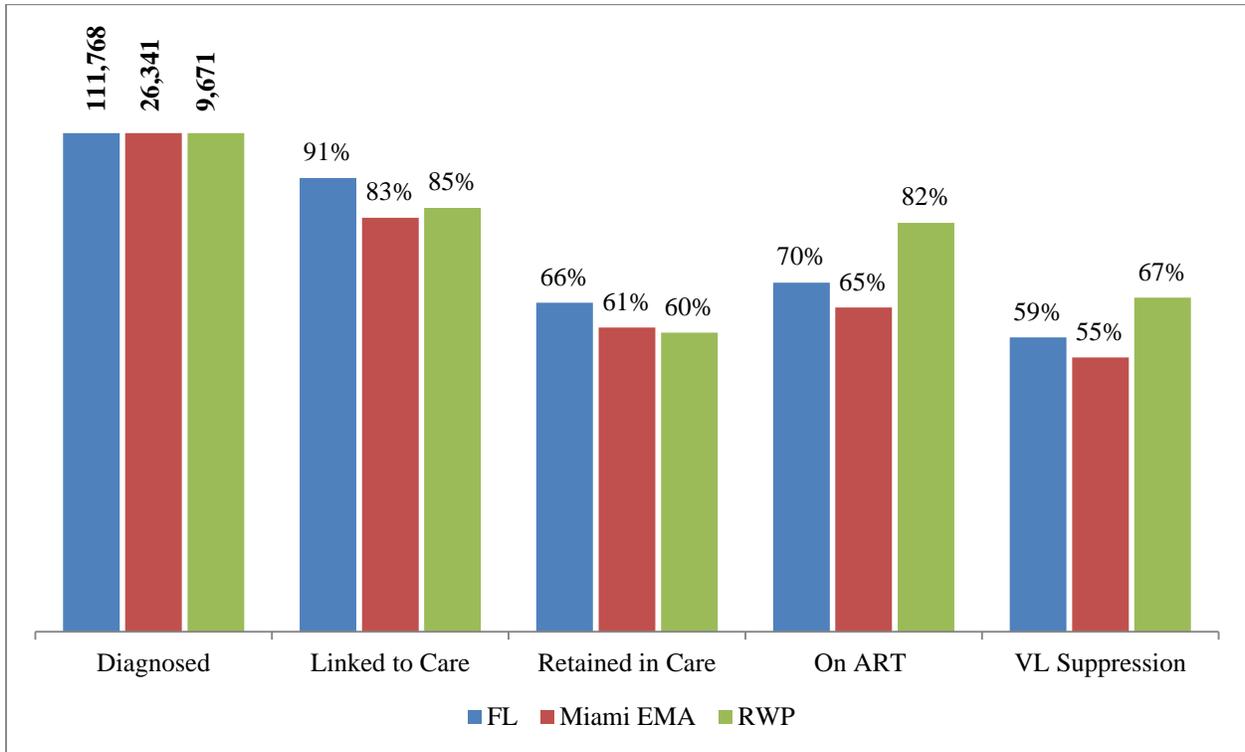
**Figure 2:
Risk Categories for Persons in Care in the
Miami-Dade County Ryan White Part A/MAI Program, FY 2015-2016**



B. HIV CARE CONTINUUM

Miami-Dade County uses the diagnosis-based approach to the HIV Care Continuum, where each step of the continuum is represented as a percentage of the total number of PLWHA who were diagnosed in the jurisdiction. **Figure 3** below depicts the Miami-Dade County EMA’s HIV Care Continuum through calendar year (CY) 2015 (as reported in 2016 for the entire HIV+ population in the jurisdiction) and for the clients in care under the Ryan White Program in FY 2015-16. The data presented in this graph were made available by the FDOH, through its electronic HIV/AIDS reporting system (eHARS), and through the Ryan White Service Delivery Information System, the EMA's comprehensive client data acquisition and tracking system. Despite the fact that Miami-Dade County ranks high in new infections in the US, the EMA in general and the Ryan White Program specifically show high levels of linkage to medical care (83% and 85%, respectively).

**Figure 3:
HIV Care Continuum in Florida (FL; 2015), Miami-Dade County EMA (2015),
and the Miami-Dade County Ryan White Part A/MAI Program (FY 2015)**



There are two areas in the HIV Care Continuum where the Miami-Dade County Ryan White Program has identified weaknesses in provision of care to persons with HIV/AIDS: retention in care and viral load suppression. These areas are specifically addressed in the Miami Integrated Plan.

- "Retained in care" is defined as a PLWHA having at least two medical encounters at least 90 days apart during a 12-month period. The Miami-Dade County EMA in general and the Ryan White Program specifically show a similar retention in care percentage, 61% and 60% respectively, both slightly below the 66% reported at the state level. For clients in the Ryan White Program, the lowest levels of retention in care were reported among specific groups (see **Table 2**, below), including Blacks/African Americans (52%), clients under 25 years of age (52%), clients older than 65 years of age (49%), and individuals who reported injection drug use (IDU) (43%) as their primary HIV exposure category. Similar disparity trends were reported for these groups across the EMA.

Note that the Miami Integrated Plan addresses both the general issue of improvement for rates of retention in care (NHAS 2020 Goal #2: Retention in Care, Objective R1) and reduction of disparities in retention rates for Blacks/African Americans and Hispanics under 25 years of age (NHAS 2020 Goal #3: Disparities in Retention in Care, Objective DR1).

- The Miami-Dade Ryan White Part A/MAI Program reported a higher level of viral load (VL) suppression (67%) than the EMA as a whole (55%) and the State (59%). However, the proportion of PLWHA with suppressed VL is substantially lower than the proportion of PLWHA who are on antiretroviral therapy (see **Figure 3**, above), indicating a problem with adherence in the treatment regimen. In addition, there are important disparities in VL suppression that parallel the disparities shown in the figures for retention in care: for clients in care in the Miami-Dade County Ryan White Part A/MAI Program, Blacks/African Americans (58%) and clients under 25 years of age (47%) reported the lowest viral load suppression percentages of any demographic group (see **Table 2**, below). Similar disparity trends were reported across the EMA in general.

Note that the Miami Integrated Plan addresses both the general issue of improvement in VL suppression in the EMA (see NHAS 2020 Goal #2: Viral Load Suppression, Objective V1) and reduction of disparities in VL levels for Blacks/African Americans and Hispanics under 25 years of age [see NHAS 2020 Goal #3, Disparities in Treatment Outcomes (Suppressed/Undetectable), Objective DV1)].

**Table 2:
Variations in HIV Care Continuum Engagement and Health Outcome
for Clients in the Miami-Dade County Ryan White Part A/MAI Program, 2015**

Characteristic	Linked to Medical Care	Retained in Care	Suppressed/ Undetectable VL
Race/Ethnicity			
White, non-Hispanic	84%	54%	68%
Black/African American	82%	52%	58%
Hispanic	86%	63%	72%
Haitian	89%	67%	68%
Other	90%	63%	80%
Gender			
Male	85%	60%	68%
Female	85%	59%	65%
Transgender	91%	61%	67%
Age			
<25	88%	52%	47%
25-34	87%	57%	63%
35-49	87%	62%	70%
50-64	84%	61%	70%
65+	76%	49%	62%
HIV Exposure			
Heterosexual	85%	60%	66%
IDU	75%	43%	53%
Mother with/at risk of HIV	93%	60%	35%
MSM	86%	61%	71%
MSM/IDU	81%	46%	57%
Other	67%	44%	52%

USE OF HIV CARE CONTINUUM FOR PLANNING AND IMPROVING OUTCOMES

The HIV Care Continuum is utilized in the EMA for **planning, prioritizing, and monitoring available resources** in response to needs of PLWHA and for improving engagement at each stage of the continuum. These activities are reflected in several ways.

- **First**, the HIV Care Continuum has been instrumental in enhancing the cooperation and collaboration among the Florida AIDS Drug Assistance Program (ADAP), the Florida Department of Health in Miami-Dade County (FDOH-MDC), the Ryan White Part A/MAI Program Recipient, and the Miami-Dade HIV/AIDS Partnership (local planning council). For example, the Linkage to Care Quality Improvement Workgroup, organized and hosted by the FDOH-MDC in 2015, has been instrumental in monitoring and making recommendations towards improving the linkage to care rate in the EMA. In fact, the consistent, increased attention and focus has yielded notable success in this area with a linkage to care rate of **83% within 90 days of diagnosis**; 80% for newly diagnosed and 88% for previous positive PLWHAs (Source: FDOH, 2016). Although the linkage rate target goal has been achieved (80%), moving forward the effort will focus on reducing the days of linkage to ultimately achieve 80% or better linkage **within 30 days of diagnosis**.
- **Second**, review of the HIV Care Continuum has been a critical tool in identifying areas or demographics requiring special attention. Despite the achievement in linking newly-diagnosed clients with RWP services (in FY 2015, 1,156 clients entered the Miami-Dade County Ryan White Part A/MAI Program for the first time), a substantial number of clients drop out of the Part A/MAI Program every year (in FY 2015, the number of clients receiving Part A/MAI Program services of any kind rose from 9,655 to 9,671, a net increase of only 26 clients).

Clearly, the most serious challenge facing the EMA is Retention in Care, reported in **Figure 3** above as the largest gap in the EMA's HIV Care Continuum. In this regard, important steps have already been taken to address retention in care in the local Ryan White Program and in the Miami Integrated Plan. As part of the Ryan White Part A/MAI Program's continuous quality improvement (CQI) efforts, Part A Recipient and its contracted quality management service provider have conducted an analysis of dropout rates for the overall program and specific demographic and co-morbidity subgroup, in order to better understand the factors impacting retention in care. In response to the CQI research, the Miami-Dade HIV/AIDS Partnership authorized the establishment of the Retention in Care Workgroup under its Strategic Planning Committee to explore all factors affecting retention in care and make recommendations for future interventions or directives for program improvements.

- **Third**, the HIV Care Continuum encourages data sharing across prevention, care, and treatment entities to improve the accuracy of the local and State's HIV surveillance systems and data management systems. The ability to exchange and compare data – while ensuring client confidentiality, restricted access to client-specific data for authorized persons, and HIPAA compliance – continues to enhance both Ryan White

Part A/MAI Program and FDOH program effectiveness. Expanding on a data-sharing agreement between FDOH and the local Part A/MAI Program that has been in place for several years, the Part A/MAI Program currently provides monthly data files from its client data management system to the FDOH, to ensure that data on Part A/MAI clients in care, clients on antiretroviral therapy (ART), and clients with reported VL data are included in the FDOH HIV/AIDS Surveillance system. Overall, the above mentioned efforts as well as other systematic approaches are critical as greater emphasis is placed on the HIV Care Continuum to guide local efforts to improve the quality of care and client health outcomes.

Systematic approaches have been developed and implemented **to address gaps** (less than 100%) in the following stages of the HIV Care Continuum: Linkage to Care, Retention in Care, ARV Use, and VL Suppression.

Part of the **gap in Linkage to Care** is believed to be a product of under-reporting of connections to medical care (i.e., medical visits) to FDOH of newly diagnosed persons. Although FDOH testing and counseling staff members have a direct connection to Part A/MAI outreach workers, as a result of the Early Identification of Individuals with HIV or AIDS (EIIHA) Initiative, to ensure that newly diagnosed clients have a direct connection to Part A/MAI-funded outpatient medical care, visits to a medical provider are not always being captured in FDOH's data system. The connection from HIV testing/counseling to the Part A/MAI outreach worker is facilitated through a formal referral process. In FY 2015, through the aforementioned data sharing agreement, the FDOH's HIV/AIDS Surveillance Team in Miami-Dade County began reporting higher linkage to care numbers after they were granted access to the data system for the purpose of confirming medical visits received by newly diagnosed clients who received the service from the local Part A/MAI Program.

In response to the **Retention in Care gap**, in July 2015, the Miami-Dade HIV/AIDS Partnership voted to establish the aforementioned seven-member Retention in Care Workgroup. The group was commissioned to examine issues related to retention in Ryan White Part A/MAI Program care, the development or modification of protocols for adjusting care to improve retention, and the evaluation of the retention success of specific demographic subgroups. Specific attention is given to examining the effect of minority status as a complicating factor for retention in care. The efforts of this workgroup are complemented by the analysis of RWP data for the past three years. The objective of workgroup is to identify patterns, both positive and negative, that can help improve retention in care by identifying and addressing lost-to-care risk/protective factors as clients enroll in and drop out of the RWP. To identify lost-to-care risk factors, detailed service utilization analyses are supported with chart reviews.

Two systematic approaches to the **gap in ARV use** have been implemented as well. First, through the aforementioned data sharing agreement, the Florida ADAP and the Part A/MAI Recipient match clients against one another's data systems to confirm which clients are enrolled in the local ADAP [whose services are limited to ARV and opportunistic infection (OI) medications] to identify the actual number of clients on ARV

therapy. Second, review and discussion of the current Department of Health and Human Services (DHHS) treatment guidelines for HIV are conducted regularly by the Partnership's Medical Care Subcommittee (MCSC). Based on this regular review, the MCSC then revises and disseminates the local Primary Medical Care Standards in accordance with the HHS treatment guidelines to subrecipients of outpatient medical care to ensure clients begin ARV therapy according to the guidelines.

The gap in the final stage, **Viral Load Suppression**, is expected to improve with the aforementioned improvements in linkage, retention, and ARV use.

C. FINANCIAL AND HUMAN RESOURCES INVENTORY

See corresponding sections in the Florida Integrated Plan.

D. ASSESSING NEEDS, GAPS, AND BARRIERS

In addition to the gaps in care shown in the HIV Care Continuum analysis, several additional key gaps in care or treatment issues were identified by the FDOH-MDC, the Miami-Dade County Ryan White Part A/MAI Program, and community stakeholders who were part of the development of the respective Florida and Miami Integrated Plans. Some of these are directly reflected in the Miami Integrated Plan; others are reflected in the prevention, diagnosis and linkage efforts of the FDOH-MDC and the quality of care, retention in care and VL suppression efforts of the Miami-Dade County Ryan White Part A/MAI Program. These include:

- **Needs of women who are living with HIV:** As part of the NHAS 2020 Goal #1 (Reducing New HIV Infections) efforts under the Miami Integrated Plan, the FDOH-MDC is seeking to reduce the number of HIV-infected infants born in Miami-Dade County from five (5) per year to zero (Objective P 2), through a combination of community services, public relations campaigns and interface with non-HIV OB/GYN medical providers, and to create an electronic direct observation system for pregnant women living with HIV who are in danger of dropping out of ARV care (NHAS 2020 Goal #2, Viral Load Suppression, Objective V1). Concurrently, the Miami-Dade County's MAI Program specifically is engaging in focus groups and survey research directed toward identifying the dynamics of initial HIV infection and patterns of abusive/exploitive relationships with infected men, to raise retention in care rates for Black/African American, Hispanic, and Black Haitian women who are living with HIV or AIDS, and to identify strategies that may reduce disparities.
- **Addressing housing problems for PLWHA:** as reported by over 75 PLWHA respondents in Miami-Dade County Ryan White Program needs assessment and client satisfaction surveys in 2015 and 2016, and responses to open-ended questions about unmet need in needs assessment focus groups held in 2014, 2015, and 2016 – and in light of the demonstrated negative impact of housing insecurity on adherence to ARV treatment regimens (and subsequent impairment of VL suppression) – the Miami-Dade County Ryan White Part A/MAI Program is conducting a qualitative and quantitative study of the dimensions of housing insecurity among Ryan White Program clients.

Because the impact of housing insecurity spans numerous HIV Care Continuum issues – linkage to medical care, retention in care, ARV use – this activity is not reflected in a single outcome-based strategy or activity, but is intended to form the basis for future services planning.

- **Continuous improvement in service quality, access to care and sensitivity to PLWHA needs in delivery of services.** Throughout the Integrated Plan, the MDC-RWP has identified areas of service quality improvement, improving the RWP's existing Client-Centered Care program to generate increased retention in care, treatment adherence and VL suppression. Many of these initiatives are reflected in NHAS 2020 Goal #2, Retention, (see Objective R1, Strategies R 1.1 – R1.4).

E. DATA: ACCESS, SOURCES, AND SYSTEMS

As previously stated, FDOH uses eHARS to track and report HIV/AIDS Surveillance data. The Miami-Dade County Ryan White Part A/MAI Program uses Automated Case Management Systems' proprietary software known as Casewatch Millennium® (or known locally as the Service Delivery Information System). A fully functioning Business Agreement/Data Sharing Agreement is in effect between FDOH, FDOH-MDC, and the Ryan White Part A/MAI Program, to coordinate services, eliminate duplication, and track and report client outcomes along the HIV Care Continuum.

II. INTEGRATED HIV PREVENTION AND CARE PLAN

A. INTEGRATED HIV PREVENTION AND CARE PLAN

See the accompanying “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.”

B. COLLABORATIONS, PARTNERSHIPS, AND STAKEHOLDER INVOLVEMENT

See related section in Florida Integrated Plan.

C. PLWH AND COMMUNITY ENGAGEMENT

Miami-Dade County's chapter of the Florida Integrated Plan was constructed with extensive attention to the needs of the PLWHA community and the ability of the FDOH-MDC and Miami-Dade County Ryan White Part A/MAI Programs (MDC-RWP) to work together in an integrated fashion. Beginning with a series of six cross-organizational planning meetings by FDOH-MDC and MDC-RWP managers and planners, major issues linking prevention, diagnosis, linkage, retention and treatment outcome were outlined; eight (8) meetings were held with PLWHA and outside community stakeholders (e.g., community town hall meetings, meetings with the FDOH MSM Collaborative), service providers (at scheduled Partnership and Quality Management committee meetings and provider forums), and Partnership Committee and Subcommittee meetings. A checklist of over 40 potential areas of future activity was reviewed by the cross-

organizational team, and concentrated in the objectives, strategies and activities found in the Integrated Plan. Drafts of this plan were reviewed by the Miami-Dade HIV/AIDS Partnership's Care and Treatment Committee, Medical Care Subcommittee and Retention in Care Workgroup, and detailed reviews of the Plan were conducted with the Prevention Committee (principally an FDOH-MDC entity, concentrating on objectives and strategies related to prevention and diagnosis) and the Strategic Planning Committee (principally a Partnership entity, concentrating on objectives and strategies linked to linkage, retention and treatment outcomes) prior to its ratification by the Partnership and submission to the State for inclusion in the Statewide Integrated Plan.

III. MONITORING AND IMPROVEMENT

IMPLEMENTATION, MONITORING AND COMMUNITY INPUT

As a means of managing the implementation and evaluation of the Miami Integrated Plan, the Partnership's Prevention Committee, Strategic Planning Committee, and Retention in Care Workgroup will oversee specific objectives, strategies and activities in monthly meetings. These meetings will be publicly noticed (i.e., following Florida Sunshine Law, will be open to all interested parties including stakeholders, involved community members, and PLWHA) to ensure maximum transparency with the implementation of the Miami Integrated Plan. Once per quarter, the Partnership's Prevention Committee, Strategic Planning Committee, PLWHA, and other stakeholders will meet together in a collective process to evaluate progress of Integrated Plan implementation, as well as to ensure that the Miami Integrated Plan is truly integrated and does not devolve into separate planning and implementation "silos." During the October-December 2016 quarter, a summary "dashboard indicator" system will be drafted and will become the basis for tracking, reporting, disseminating, and evaluating the implementation of the Miami Integrated Plan.

Data on the selected performance measures will be collected by the MDC-RWP and the FDOH-MDC, will be shared at these quarterly meetings, and will be disseminated on a semiannual basis. As the activities under the Miami Integrated Plan develop and evolve, additional strategies and activities may be added to the plan by the Strategic Planning Committee, Prevention Committee, and the Partnership, which will have final approval of any changes. This collaboration allows for consensus on the goals and SMART objectives. Local progress will also be reported through the Florida Integrated Plan process.

Meaningful measures and indicators will be used to monitor both operational performance and progress on initiatives in the Integrated Plan. Data is used to make program decisions, direct efforts to assure the program achieves the intended results, and help identify additional operational and process improvement opportunities. This approach will align, support and advance the goals of National HIV/AIDS Strategy, the Florida Department of Health in Miami-Dade County, and the Miami-Dade County Ryan White Part A/MAI Program, to ensure improvement in the access and quality of HIV services and overall improvements in client health outcomes.

IV. ADDITIONAL NARRATIVE DISCUSSION OF INTEGRATED PLAN OBJECTIVE AND STRATEGIES

The following section outlines the objectives, strategies and activities of the “2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan” (i.e., the Miami Integrated Plan), focusing on unique aspects of the HIV/AIDS epidemic in Miami-Dade County and the community’s response.

The Miami Integrated Plan draws heavily on the unique characteristics of the population living with HIV/AIDS in Miami-Dade County, and those HIV+ persons in the population that are connected to medical care and support services. For example:

- Prevention programs under NHAS 2020 Goal #1 (e.g., condom distribution, PrEP) are directed toward HIV-vulnerable populations identified in the FDOH-MDC and MDC-RWP data, with particular emphasis on injection drug users, Trans-identified persons and gay/bisexual men.
- Prevention activities focused on reducing disparities (NHAS 2020 Goal #3: Objective DP 1) are directed toward Blacks/African Americans (because of their disparate representation among the PLWHA throughout the state and in Miami-Dade County in particular), toward Hispanics (because of the high representation in the Miami-Dade County population, relative to the rest of the State, and because of the growing number of Hispanic men in the MDC-RWP treatment population as shown in **Figure 1**) and toward men who have sex with men.

The narrative descriptions below refer to the specific objectives and strategies of the corresponding Miami Integrated Plan, and are intended to provide context for the plan strategies and activities in the Miami Integrated Plan itself. Please refer to the Miami Integrated Plan for specific activities and measurements associated with the strategies outlined below.

A.1. NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS

A.1.1 PREVENTION

OBJECTIVE P 1: 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.

Strategy P 1.1 Increase access to and use of condoms by HIV positive persons and HIV-vulnerable populations, including but not limited to injection drug users, Trans-identified persons, gay and bisexual men. *The Florida Department of Health-Miami Dade County (FDOH-MDC) provides over two million condoms a year through a variety of channels, through the Business Responds to AIDS (BRTA) project, partnering with businesses in neighborhoods with high-risk local populations as condom distribution centers. By 2021, the*

BRTA program will have been expanded to 300 commercial sites in Miami-Dade County and will have distributed a cumulative total of 12 million condoms in the five year time frame.

Strategy P 1.2 Increase availability of – and access to -- PrEP/nPEP programs. *In conjunction with the Ryan White Part A/MAI (RWP) Grantee, the FDOH-MDC will generate and distribute a local directory of providers prescribing PrEP and nPEP. By 2021, FDOH-MDC will effectively double the number of medical providers providing PrEP and nPEP.*

Strategy P 1.3 Implement combined STD/HIV education and testing to raise HIV prevention awareness among HIV-vulnerable populations, including but not limited to injection drug users, Trans-identified persons, gay and bisexual men. *FDOH-MDC implements and promotes integrated STD/HIV testing and educational services with its testing providers. This effort increases access, improves the timeliness of service delivery, and increases the effectiveness of efforts to prevent infectious diseases and disorders that share common risk factors, behaviors, and social determinants.*

Strategy P 1.4 Achieve a more coordinated local response to the HIV epidemic. *Coordination of community resources beyond the FDOH-MDC and the MDC-RWP is an essential component of the Integrated Plan. One element of this enhanced coordination is the implementation of a HIV/AIDS “Getting to Zero” Task Force, appointed by the Mayor of Miami-Dade County to collectively create a community plan that will invoke county-wide systems change and help eliminate HIV. This task force will operate hand-in-hand with the FDOH-MDC, and the Miami-Dade HIV/AIDS Partnership, and will use the Miami Integrated Plan as the skeleton and guide for the mayoral initiative.*

OBJECTIVE P 2: 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.

Strategy P 2.1 Increase number of OB/GYN healthcare providers engaging in HIV prevention activities with pregnant women. *In FY 2015-16, the MDC-RWP initiated an outbound direct mail campaign to local OB-GYN providers, informing them of the need for testing pregnant women for HIV and referring them to supportive care if they tested positive. This activity will be expanded in the five years of the Plan.*

Strategy P 2.2 Create an action-oriented community process to improve service systems and community resources for women and infants. *FDOH-MDC is partnering to create a case review team and a community action team that will address perinatal transmission cases and initiate change based on the case review recommendations.*

Strategy P 2.3 Conduct targeted public information campaigns toward pregnant women at risk of HIV, to have access to OB/GYN providers, HIV prevention materials and information on community services for women with HIV/AIDS. *FDOH-MDC will expand its “Protect Yourself, Protect Your Baby” campaign to encourage health care providers and pregnant women to follow the CDC’s HIV testing recommendations. A key element in this*

strategy is aggressively partnering with a growing network of private obstetric medical providers throughout the Miami-Dade County EMA.

A.1.2 DIAGNOSIS

OBJECTIVE D 1: 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.

Strategy D 1.1 Partner with healthcare settings (e.g., hospitals, health centers, emergency departments), to increase the provision of routine HIV testing as part of medical care. *Routinized HIV testing is a vital part of HIV diagnosis, leading to linkage to care for persons who are unaware of their HIV status and reducing new infections. In 2015, Florida mandated primary care providers, as well as hospitals and emergency departments, to offer HIV testing to all persons between the ages of 13 and 64 years, removing written consent but allowing opt-out testing. FDOH-MDC has been exploring partnerships with local hospitals and non-traditional health care providers to encourage HIV prevention, incorporate routinized HIV testing, and educate on implementing third party billing for testing.*

Strategy D 1.2 Intensify HIV testing efforts in high impact areas. *The Take Control program utilizes non-clinical venues in high-prevalence areas providing HIV/STD screenings and outreach information to the appropriate high-risk populations.*

Strategy D 1.3 Increase the number of HIV tests conducted, effectively identifying and testing individuals at highest risk, including but not limited to injection drug users, Trans-identified persons, gay and bisexual men. *Registered counseling and testing sites are required to maintain a desired level of testing excellence. FDOH-MDC provides technical assistance and capacity building to increase and effectively identify target populations.*

A.2 NHAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV OR AIDS

A.2.1 LINKAGE

OBJECTIVE L 1: Increase the percentage of PLWHA linked to medical care [at least one 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.

Strategy L 1.1 Improve existing FDOH-Part A diagnosis-to-linkage client management process. *Since 2012, the FDOH-MDC and MDC-RWP have worked together to create a seamless diagnosis-to-care process, continually identifying areas to strengthen cooperation, referral and data capture. The strong partnership between the FDOH-MDC and MDC-RWP is part of an ongoing monitoring and improvement process to enhance the linkage to care systems and outcomes. Activities include (but are not limited to): a shared State and County approved consent/referral form, collaborative monitoring and trainings activities, and a dynamic data sharing agreement supporting joint reporting efforts.*

Strategy L 1.2 Provide Partner Services to identified HIV+ individuals, allowing for the notification, screening and referral to appropriate services for partners of newly-diagnosed PLWHA. *Partner services are offered to individuals who are infected with HIV/STDs, to their partners, and to other persons who are at increased risk for infection in an effort to prevent transmission of these diseases. The focus is to identify and locate the sexual contacts of infected persons and other persons at risk for behavioral or other factors, and then refer them for medical examination and, as appropriate, for treatment.*

Strategy 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. *The "Data to Care" program uses laboratory reports received by FDOH-MDC's HIV surveillance program and analyzes them to identify individuals who were either never linked to care after diagnosis or did not continue to receive care. The program then offers individuals on this list assistance with getting into HIV care.*

A.2.2 RETENTION IN CARE

OBJECTIVE R 1. 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 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.

Strategy R 1.1 Identify PLWHA who are at greatest risk for dropping out of care. *Through the efforts of the MDC-RWP Quality Management Program, the MDC-RWP will engage in a systematic statistical analysis of the factors affecting retention in care among the 9,600+ PLWHA in care through the RWP. This analysis will be combined with a quality improvement initiative to identify client-based warning signs. The systematic analysis will focus on identifying risk as well as protective factors associated with retention in care. The results will inform initiatives and interventions to increase access and retention in care.*

Strategy R 1.2 Enhance the RWP Client-Centered Care quality improvement system that focuses on reduction of barriers to continued care, identification of best practices, and implementation of system-wide service quality improvement. *The MDC-RWP Quality Management Program will generate a five-year systematic analysis of its Client Centered Care program, looking at program-based quality improvement opportunities, and creating at least one intervention implementation per year throughout the five years of the Miami Integrated Plan.*

Strategy R 1.3 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 outpatient medical care (OMC), oral health care (OHC) and medical case management (MCM) providers. *The MDC-RWP Quality Management Program will monitor non-clinical program-based wait-time indicators to identify opportunities, and creating at least one time-saving initiative per year throughout the five years of the Miami Integrated Plan.*

Strategy R 1.4 Provide continuous improvements in outpatient medical care that meets the needs and identified vulnerabilities of PLWHA in care. *Through the efforts of the MDC-RWP Quality Management Program, the MDC-RWP will monitor the quality and appropriateness of OMC clinical care to identify patterns of high quality of care delivery as well as areas of improvement. Specific efforts will be made to integrate lessons learned from providers delivering high quality of care with providers in need of technical assistance to enhance quality of care delivery.*

Strategy R 1.5 Track and assess the quality of care provided to MDC-RWP clients who transition to ACA-provided outpatient medical care. *The MDC-RWP Quality Management Program will conduct an annual assessment of clients who transition to an ACA Marketplace health insurance plan (both ADAP and non-ADAP ACA transitioned) and clients who remained in the Ryan White Program (non-ACA transitioned). The purpose of this analysis is to assess and identify differences in service utilization and health outcomes that may be associated with retention in care and overall quality of care of clients in the MDC-RWP.*

A.2.3 VIRAL SUPPRESSION

OBJECTIVE V 1. Increase the percentage of people living with HIV who are virally suppressed (<200 copies/mL) from 67% in 2015 to at least 80% by 2021.

Strategy V 1.1 Provide immediate access to antiretroviral therapy through timely linkage to medical care, expanding the FDOH-MDC Test and Treat model of care. *The Test and Treat Model provides early treatment initiation, which is linked to improved health outcomes. FDOH-MDC is working with local hospitals and healthcare providers to expand this model of care, and will effectively double the number of Test and Treat sites by the close of the planning period.*

Strategy V 1.2 Enhance support for FDOH-MDC treatment adherence initiatives. *Optimizing treatment adherence reduces viral transmission. FDOH-MDC understands that utilizing peer educators and interventions is an opportunity to suppress HIV and raise the continuum of care bars.*

Strategy V 1.3 Expand role of MDC-RWP Medical Case Management (MCM) and Outpatient Medical Care (OMC) providers in detecting lapses in adherence or persistent viremia, and initiate appropriate responses. *The MDC-RWP Quality Management Program will conduct quarterly assessments to identify detectable viral loads patterns in the RWP and at the provider level. The “Quality Assurance Report Card” will serve as the primary tracking mechanism for monitoring and reporting viral load as a quality of care measure for the entire MDC-RWP and each provider.*

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

A.3.1 DISPARITIES IN PREVENTION

OBJECTIVE D P1. 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.

Strategy DP 1.1-1.3 Enhance HIV prevention, testing, communication and community mobilization efforts in Miami-Dade County towards the following groups, reducing the numbers of newly-diagnosed:

- DP 1.1 Blacks/African Americans: from 464 diagnosed in 2015 to 394 in 2021. Note that in Miami-Dade, as throughout the State of Florida, the incidence of HIV/AIDS is disproportionately high in this population (see Epidemiological Profile, above).
- DP1.2 Hispanics: from 659 diagnosed in 2015 to 560 in 2021. Note that in Miami-Dade County, the proportion of Hispanics in the general population is substantially higher than the Hispanic proportion throughout the state (Table 1), as is the proportion of Hispanics among persons with HIV or AIDS. Note also that the proportion of Hispanic males in Ryan White Program-funded medical care has been growing steadily (Figure 1).
- DP1.3 Gay and bisexual men: from 678 diagnosed in 2015 to 576 in 2021.

A.3.2 DISPARITIES IN RETENTION

OBJECTIVE DR 1. 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 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%.

Strategy DR1.1-1.3 Identify risk factors associated with retention in the Ryan White Part A/MAI network of care for the special populations listed below, and address them with specific interventions:

- DR1.1 Black/African American males, from 53% retained in care in 2015 to 90%.
- DR1.2 Black/African American females, from 52% retained in care in 2015 to 90%.
- DR1.3 Hispanics under 25 years of age, from 49% retained in care in 2015 to 90%.

A.3.3 DISPARITIES IN TREATMENT OUTCOMES

OBJECTIVE 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.

Strategy DV1.1 -1.3 Identify risk factors associated with having high VL (low proportions of suppressed or undetectable VL) within the Ryan White Part A/MAI network of care for the special populations listed below, and address them with specific interventions:

DV 1.1 Black/African American Males: from 57% suppressed VL in 2015 to 80%.

DV 1.2 African American Females: from 60% suppressed VL in 2015 to 80%.

DV 1.3 Haitians: from 68% suppressed VL in 2015 to 80%.