2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan
2018 IMPLEMENTATION PROGRESS
SECOND YEAR PLAN UPDATES
March 2018 – February 2019

Acronyms and Abbreviations Used in This Document

ACA	Affordable Care Act
Acuity	Any of a number of co-occurring conditions or adherence issues contributing to an increased need for MCM attention
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
ART	Antiretroviral Therapy
BSR	Behavioral Science Research Corp., (Admin/CQM Subrecipient)
CQM	Clinical Quality Management Program at BSR
CQMC	Ryan White Program CQM Committee
DIS	Disease Intervention Specialist at FDOH-MDC
FDOH-MDC	Florida Department of Health in Miami-Dade County
FIMR	Fetal Infant Monitoring Review
IDU	Injection Drug Use / Injection Drug User
JIPRT	Joint Integrated Plan Review Team (Members of Partnership's Prevention and Strategic Planning Committees)
MAI	Minority AIDS Initiative, part of the RWP
MCM	RWP Medical Case Management or Medical Case Managers
MSM	Men Who Have Sex With Men
NHAS	National HIV/AIDS Strategy
OHC	Oral Health Care, provided by the RWP
OAHS	Outpatient/Ambulatory Health Services, provided by the RWP
OLTC	Joint RWP/FDOH-MDC Outreach Linkage to Care team
Part A/MAI	Part A and the Minority AIDS Initiative of the RWP
PLWH	People Living With HIV
PLWHA	People Living With HIV/AIDS
PrEP/nPEP	Pre-Exposure Prophylaxis /non-occupational Post-Exposure Prophylaxis
PrEP WG	FDOH-MDC PrEP Work Group
PRIM	Pre-Natal Immunology Clinic, w/in the University of Miami
RiC	Retention in Care
Risk Factor	Self-reported mode of initial HIV/AIDS diagnosis
RWP	Miami-Dade County Ryan White Program - Part A and MAI
SDIS	Service Delivery Information System (RWP client database)
STD	Sexually Transmitted Disease
TTRA	Test and Treat / Rapid Access
VL	Viral Load

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.

NHAS 2020 GOAL #1: REDUCE NEW HIV INFECTIONS (2018 IMPLEMENTATION)							
PREVENTION							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
P1. By 2021, reduce new HIV infection rate by at least 25%, from 50.7 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 50.7 per 100,000 population in 2015, reduced to 40.8 per 100,000 in 2021.**						
	P1.1 Increase access to 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.	**P1.1a** Increase the number of condom distribution sites. (added 2018 Q1)	FDOH-MDC and Partners	How many condoms were distributed to persons living with or at risk for HIV?	**#** of condoms distributed		Condom Distribution Coordinator Monthly reports
		P1.1b Develop an annual condom distribution map to identify new points of service (added Q3 2017)	FDOH-MDC and Partners				
		P1.1c Based on P1.1b data, recruit annually a new location or host an event to provide condom distribution services in the identified underserved area. (added 2018 Q1)	FDOH-MDC and Partners				
		P1.1d Increase the availability and accessibility of condom distribution by 2.0 million a year	FDOH-MDC and Partners				

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P1. By 2021, reduce new HIV infection rate by at least 25%, from 50.7 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.	**P1.2** Implement STD and HIV testing to raise STD and HIV prevention awareness among HIV-vulnerable populations, including but not limited to IDU, Trans-identified persons, gay and bisexual men.	**P1.2a** Conduct HIV testing events in Miami Dade County. **P1.2b** Conduct STD testing events in Miami Dade County. **P1.2c** Partner with healthcare settings (e.g. hospitals, health centers, emergency departments), to increase the provision of routine HIV testing as part of medical care. **P1.2d** Increase the number of registered testing sites to ensure that HIV testing is more readily available and accessible.	FDOH-MDC and Partners	Was there an increase in HIV and STD testing among persons at risk? Was there an increase in the identification of HIV-negative persons at risk of HIV? Was there an increase in the number of persons living with HIV who are aware of their HIV or STD status? Was there an increase in # of registered testing sites?	**#** of HIV tests **%** of tests that are newly diagnosed with HIV # of STD tests % of tests that are newly diagnosed with an STD **%** of tests that are among persons at risk for HIV **%** of tests stratified by priority target population (e.g. Hispanic MSM, IDU, Transgender persons, etc.) "# of new registered testing sites recruited		1628 Testing Forms

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P1. By 2021, reduce new HIV infection rate by at least 25%, from 50.7 per 100,000 population in 2015 to 40.8 per 100,000 populations in 2021, so that Miami-Dade County is no longer among the top three metropolitan areas with the highest incidence of new HIV infections.	**P1.3** Implement combined STD/HIV education to raise STD/HIV prevention awareness among HIV-vulnerable populations, including but not limited to IDU, Trans-identified persons, gay and bisexual men. **NOTE:** The annual County epidemiological profile of HIV cases breaks down by Zip Code. When the 2017 profile is fully available, a presentation will be scheduled.	**P1.3a** Conduct STD/HIV educational events in Miami-Dade County, including but not limited to tabling, mobile units, etc.	FDOH-MDC/ Partners FDOH-MDC/ Partners	How many outreach events were conducted? How many people were seen at outreach events?	# of outreach events # of people seen at outreach events		

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P2. Increase the number of individuals prescribed PrEP by at least 500% from the baseline 663 persons in 2016 to 3,978 persons by 2021.	**P2.1** Increase availability of – and access to – PrEP/nPEP programs.	**P2.1a** Create a process for a PrEP external referral system (added Q3 2017).	FDOH-MDC/ Partners and PrEP WG	How many PrEP/nPEP prescriptions were filled? How many people were screened? How many people were eligible? How many people were new to PrEP/nPEP? How many people were retained in PrEP/nPEP?	# of prescriptions filled # people screened # people eligible for PrEP # people eligible for nPEP # people new to PrEP # people new to nPEP # people retained on PrEP		PrEPLink and HIV contracted provider monthly reports/ PrEP Workgroup
		P2.1b Develop estimates of a PrEP cascade to inform prevention activities (began 01/01/18; dependent on P1.2a).	FDOH-MDC/ Partners and PrEP WG				
		P2.1c Create a local directory of providers prescribing PrEP/nPEP, disseminate same on Part A and FDOH-MDC websites, and update annually thereafter.	FDOH-MDC and RWP				

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P3. Reduce the number of infants born with HIV in Miami-Dade County each year from three (3) to zero (0) by 2021.	**P3.1** Increase number of OB/GYN healthcare providers engaging in HIV prevention activities with pregnant women.	**P3.1b** Conduct in-person educational sessions directed toward medical professionals who participate in the care of pregnant women with HIV, educating them about the requirements of Florida law and ensuring they are aware of community services available for women living with HIV and HIV exposed infants.	FDOH-MDC	Was there an increase in screening and active referral to prenatal HIV care among pregnant women living with diagnosed HIV?	**%** HIV positive post-partum women linked to family planning services / contraception services # of HIV positive pregnant women in HIV care **%** of HIV positive pregnant women in HIV care # of HIV positive pregnant women in prenatal care		Perinatal Coordinator Quarterly Reports
		P3.1c Conduct educational rounds 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 pregnant women living with HIV and their HIV exposed babies.	FDOH-MDC				
		P3.1d Participate in an action-oriented community process to improve service systems and community resources for families.	FDOH-MDC and HBTF				

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P3. Reduce the number of infants born with HIV in Miami-Dade County each year from three (3) to zero (0) by 2021.	**P3.2** 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.	**P3.2a** Conduct community outreach and promote information campaigns towards women of child-bearing age living with HIV.	FDOH-MDC	How many agencies are providing post-partum family planning services to women living with HIV?	# of agencies		
		P3.2b Create linkage services assuring at least 90% of post-partum women living with HIV have access to contraceptive/ family planning and preconception care services after delivery (no baseline).	FDOH-MDC and PRIM				

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**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
L1. Increase the percentage of newly diagnosed persons linked to HIV medical care within one month (30 days) of diagnosis to 85% by 2021. *[Staff note: FDOH linkage data does not depend on RWP measurement. This statement is consistent with NHAS indicators]*	**L1.1** Improve existing FDOH-Part A diagnosis-to-linkage client management process.	**PROGRESS TOWARD OBJECTIVE: Increase the newly-diagnosed PLWHA linkage rate from 55% linked within 90 days of initial diagnosis in 2015, to 85% linked within 30 days by 2021.**					
		L1.1a Monitor and improve the processes for linking all newly diagnosed persons to HIV medical care within 30 days of initial HIV test result.	FDOH-MDC/ Partners	Is there an increase in the percentage of newly-diagnosed PLWH linked to care within 30 days of diagnosis? [2018 linkage rate: 78%] What percentage of TTRA clients initiated ART within 7 days of TTRA enrollment? What percentage of TTRA clients enrolled in ADAP within 30 days of the first OAHS visit? *TTRA is defined as immediate entry in HIV OAHS primary care & initiation of ART.	***Outputs provided by FDOH-MDC:*** # newly diagnosed PLWH, reported quarterly % increase in newly-diagnosed PLWH linked to care within 30 days of diagnosis # newly diagnosed PLWH linked to medical care with 30 days # TTRA clients enrolled in ADAP within 30 days of the first OAHS visit % TTRA clients enrolled in ADAP within 30 days of the first OAHS visit # and % of TTRA clients who received initial 30 day supplies of ART within 7 days of date of diagnosis % of testing counselors compliant with the annual training requirement(s)		
		L1.1b Measure the success the local Test & Treat/Rapid Access (TTRA)* process for newly diagnosed persons linked to immediate entry in HIV primary care & initiation of ART.	FDOH-MDC				
		L1.1c Hold FDOH-MDC trainings for testing counselors that are targeted to improving linkage to care.	FDOH-MDC				

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L1. Increase the percentage of newly diagnosed persons linked to HIV medical care within one month (30 days) of diagnosis to 85%.	**L1.2** Provide Partner Services to identified HIV+ individuals, allowing for the notification, screening and referral to appropriate services for partners of newly-diagnosed PLWHA.	**L1.2a** Increased participation in HIV partner services among persons with diagnosed HIV (baseline: 68% in 2015)	FDOH-MDC DIS	Was there an increase in notification in HIV testing of partners identified through HIV partner services? What is the impact of Partner Services on engagement, testing and linkage of PLWHA who are partners of persons diagnosed with HIV?	# of all named, notifiable partners identified through HIV partner services % of partners notified for HIV partner services % named, notifiable partners that were tested for HIV		Partner Service Reports
		L1.2b Increased notification and HIV testing of partners identified through HIV partner services. (baseline: 48% in 2015)	FDOH-MDC DIS				

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L1. Increase the percentage of newly diagnosed persons linked to HIV medical care within one month (30 days) of diagnosis. *[Consistent with NHAS indicators]*	**L1.3** Identify and link to medical care at least 25% of the newly-diagnosed HIV+ persons identified through the FDOH-MDC Data To Care (DTC) initiative.	**L1.3a** Provide linkage to HIV medical services using DTC activities.	FDOH-MDC	Was there an increase in linkage of persons to HIV medical care attributable to DTC?	% not in care		

***Objectives, Strategies, and Activities* completed and/or outside the scope of the *Responsible Entities*:**

- **L 1.1b** Create a comprehensive outreach linkage resource directory, mapping outreach service providers by area within Miami-Dade County, and ensuring that at least one outreach provider in each area provides outreach/linkage services outside normal business hours and on weekends.
- **L1.1e** Guarantee flexible after-hours and weekend availability at RWP MCM, OAHS and OHC subrecipients, ensuring that at least one (1) MCM subrecipient, one (1) OAHS subrecipient and one (1) OHC subrecipient 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 RWP linkage once a PLWH has been diagnosed at FDOH-MDC site.
- **L1.2c** Explore creating a video direct observational therapy system for partners (began 01/01/18).

- **R1.2a** Identify service improvement opportunities to improve RiC rates, to R1.1.
- **OLD R1.2b** With the CQMC, identify one replicable best MCM program practice for RiC, replicate it as a pilot program and evaluate its impact in another MCM agency.
- **R1.2b4** Monitor and improve clinical proficiency among RWP MCM, outreach workers, and peers, through online and group proficiency development and clinical training.

- **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 OAHS, OHC and MCM subrecipients.
  - **R1.3a** Assess measurement systems for measuring lagtime, wait time and hold time among RWP OAHS, OHC and MCM subrecipients, and track subrecipients thereafter.
  - **R1.3b** Assess RiC rates of subrecipient MCM and OAHS providers based on lagtime wait time. and hold time.
  - **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.
  - **R1.3d** In conjunction with the CQMC, identify at least one (1) program-based lagtime, wait time or hold time best practice or Quality Improvement opportunity resulting in improved RiC.

  Per Recipient, this will no longer be tracked since Client Satisfaction Survey indicates high satisfaction and there is no indication of change in RiC or VL suppression based on lagtime, wait time or hold time. RWP subrecipients are contractually required to meet MCM, AOHS, and OHC appointment setting standards defined by the Recipient.

- **P1.2e** Rebrand the STD clinic name to promote sexual health and wellness (completed).

- **P1.3b** Provide STD/HIV educational sessions, including but not limited to schools, drug treatment centers, etc.
- **P1.3c** Rebrand the STD clinic name to promote sexual health and wellness (completed).

- **P1.4** Achieve a more coordinated local response to the HIV epidemic.
  - **P1.4a** Publish approved updates to the Integrated Plan (IP) on Test Miami and RWP websites, promoting awareness.

- **P2.1d** By December 31, 2019 (Third Year), facilitate establishment of new PrEP/nPEP medical providers.
- **P2.1e** Establish a "PrEP Ambassador" program.

OLD P2.1a Conduct an annual outbound direct mail and email awareness campaign to inform 600+ Miami-Dade OB/GYN physicians and physician assistants of (1) state law 64D-3.042 and (2) the local protocol of High Risk Pregnancy Notification and Newborn Exposure Notification, (3) the Protect Yourself, Protect Your Baby (PYPYB) campaign, and (4) to encourage awareness of their responsibility to act on behalf of the HIV infected pregnant women with HIV in their care. The mail-out will include bounce-back cards to enumerate the level of cooperation and the number of pregnant women with HIV infected pregnant women in care, and to allow providers to request more information.

- **OLD P2.2** Increase the engagement of OB/GYN providers and the community in prevention of perinatally acquired HIV.
  - **OLD P2.2a** Participate in FIMR-HIV meetings to review all information gathered on perinatal transmission cases, identify system issues, and make recommendations for improvement.
  - **OLD P2.2b** Participate in Community Action Team meetings to initiate systems change based on FIMR-HIV recommendations for improvement.
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  - **OLD P3.2a** Disseminate educational materials, promoting the PYPYB awareness campaign, encouraging women of childbearing age who are pregnant or considering pregnancy to get tested for HIV (see also P2.1a).
  - **OLD P3.2b** Partner with at obstetric healthcare providers, who agree to show the PYPYB DVD in patient waiting rooms (no baseline).

- **D1.** Increase the percentage of PLWH who know their serostatus from 86% in 2015 to at least 90% by 2021.
  - **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. **NOTE:** 30% of emergency visits (224,989 / 754,362) are receiving an HIV test and will increase to 41% (316,845 / 754,362) by the end of 2018. The three largest emergency rooms in Miami-Dade County will or are implementing routinized HIV testing.
  - **D1.2** Intensify HIV efforts in high impact areas.

- **V1.1** Provide immediate access to antiretroviral therapy through timely linkage to medical care, expanding the FDOH-MDC Test and Treat model of care.
- **V1.2** Enhance support for FDOH-MDC treatment adherence (FDOH-MDC initiatives).