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
PHS	Public Health Standards
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 #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH HIV OR AIDS							
RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
R1. Increase the percentage of RWP clients who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021.	**R1.1** Identify RWP client target populations who are at greatest risk for dropping out of care. **NOTE: All HRSA demographics will be reviewed by the Strategic Planning Committee.**	**R1.1a** Identify RWP client demographic characteristics (ethnicity, gender, age) and risk factor(s) associated with low Retention in Care (RiC) rates and track RiC rates by demographic and risk factor groups across and within subrecipients.	RWP CQM	What are the RiC rates by demographic characteristics? What are the RiC rates by risk factors? What are the RiC rates by co-occurring conditions/acuities? What are the potential problem areas to remediate? What are the "best practices" to replicate? What is the impact of replication of a subrecipient "best practice" for improving RiC rates on actual RiC?	# of RWP clients receiving MCM and OAHS at the beginning of evaluation period. % of RWP clients RiC by subrecipient at 6 and 12 months thereafter. % of RWP clients RiC by demographic characteristics. % of RWP clients RiC by risk factors. % of RWP clients RiC by co-occurring conditions/acuities.		SDIS
		R1.1b Develop assessments of acuities (e.g. substance use, mental illness, incidence of missed appointments or other non-adherence) associated with dropping out of care; track and refine measurements in subsequent years.	RWP CQM				
		R1.1c Identify RWP subrecipients with highest and lowest RiC rates, identify potential problem areas to remediate and "best practices" to replicate.	RWP CQM				

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Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
R1. Increase the percentage of RWP MCM clients who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021.	**R1.4** Provide continuous improvements in MCM and OAHS that meet the needs and identified vulnerabilities of people with HIV in care.	**R1.4a** Monitor quality and appropriateness of MCM and OAHS clinical care through client satisfaction surveys, targeted reviews of SDIS data and clinical record reviews, provide technical assistance to assist subrecipients in self-correction (e.g., on site CQM TA, AETC, etc.). Provide subrecipient-based data to the Recipient and CQMC to make recommendations in service delivery processes.	RWP CQM CQMC	Are there significant relationships between subrecipients' client satisfaction scores for MCM and OAHS service delivery and clinical outcomes (RiC, VLsuppression) for RWP clients served by those subrecipients? Are the RWP OAHS and MCM subrecipients fully engaged in review and response to Service Delivery Guidelines updates? What areas are identified as needing improvement? How many RWP subrecipients received record reviews?	# of OAHS and MCM subrecipients. # of OAHS subrecipients who received an SF-SE AETC Record Review. # of OAHS subrecipients with record review data forwarded to OMB. # of MCM subrecipients identified with service delivery issues resulting in record reviews. # of MCM subrecipients with record review data forwarded to OMB.		SDIS CQM client surveys CQM record reviews
		R1.4c Review and update RWP Service Delivery Guidelines for RWP OAHS and MCM services annually.	RWP CQM OMB				
		R1.4d Conduct record reviews of RWP OAHS and MCM subrecipients to ensure adherence to PHS and RWP Service Delivery Guidelines.	RWP CQM SF-SE AETC OMB				
		R1.4e Provide Peer capacity-building activities that address RiC.	RWP CQM				

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R1. Increase the percentage of RWP MCM clients who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021.	**R1.5** Track and assess the quality of OAHS 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 number of ACA-eligible RWP clients transitioned to ACA from 50% (2015 baseline) to 70%.	RWP CQM	Is care delivered through the ACA doing an effective job of maintaining and improving clinical outcomes for RWP clients in care? Is client satisfaction higher among ACA enrollees vs. RWP? Are VL suppression rates higher among ACA enrollees vs. RWP? Are differences in clinical outcomes shown between ACA-enrolled clients and RWP clients related to: a) differences in the characteristics of people with HIV who can or cannot enroll in ACA, *or* b) differences in the levels of care provided through ACA coverage vs. RWP care?	# of RWP clients determined eligible for ACA enrollment, as of annual enrollment period. # of RWP clients enrolled in ACA plans as of annual enrollment period. % of ACA-eligible people with HIV enrolled in ACA. Client outcome data (VL suppression, RiC) for clients eligible for ACA, vs. clients enrolled in ACA, vs. RWP clients not eligible for ACA.		SDIS
		R1.5b Require all RWP clients enrolled in ACA and receiving RWP MCM to report VL levels at a minimum once every six (6) months, in order to assess and track clinical health outcomes of RWP clients receiving OAHS through an ACA Marketplace insurance plan.	RWP CQM				
		R1.5c Compare rates of missing VL data and VL suppression rates among people with HIV treated through the ACA with missing VL data and VL suppression rates among people with HIV receiving OAHS through the RWP to identify disparities.	RWP CQM				
		R1.5d Increase the percentage of clients transitioned from RWP-funded OAHS to ACA medical care who are retained in ACA-provided medical care for two (2) years after enrollment from 60% enrolled in 2015 and continuously enrolled in 2017 to 75% enrolled in 2019 and continuously enrolled in 2021. (Using VL data as proxy for ACA OAHS)	RWP CQM				

HAS 2020 GOAL #2: INCREASE ACCESS TO CARE AND IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH HIV OR AIDS							
RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
R2. Increase the proportion of "lost to care" RWP MCM clients who are re-linked to care, from 40% in 2017 to 60% by 2021.	**R2.1** RWP MCM subrecipients will partner with FDOH-MDC surveillance to detect clients in danger of being lost to care, update contact information on vulnerable RWP clients, and use both FDOH and RWP outreach specialists to re-link clients in care.	**R2.1a** The joint FDOH/RWP OLTC Team will determine criteria for "truly lost to care" case closures in MCM subrecipients and develop an "early warning system" to identify RWP clients at risk for being lost to care.	FDOH-MDC RWP CQM	Does the "early warning system" improve the RiC rates for people with HIV in MCM care? Are there key client groups (demographic, acuity, co-occurring conditions) that are more likely to show "early warning indicators" for being lost to care? After CQM intervention, are there demonstrable improvements in re-linkage rates among subrecipients with low re-linkage rates? After "best practice" intervention, is there improvement in RiC and re-linkage?	# of people with HIV at each MCM subrecipient at beginning of evaluation period. % of people with HIV with certifiably closed cases at each MCM subrecipient site at 6 and 12 months. % of people with HIV identified by the "early warning system" as RiC risks, at each MCM subrecipient site. % of people with HIV identified by the "early warning system" who are lost to care, at each MCM subrecipient site, at 6 and 12 months.		SDIS
		R2.1b FDOH and RWP will develop data-sharing protocols and feedback mechanisms to provide updated contact information to RWP on clients who are flagged by the "early warning system" as at risk for being lost to care, as well as provide case closure data to FDOH for clients with 6, 9, and 12 months since the most recent VL measurement or on-site RWP OAHS contact.	FDOH-MDC RWP CQM				
		R2.1c Identify RWP MCM subrecipients with lowest and highest re-linkage rates, and determine "best practices" that may be disseminated and adopted within the RWP system.	FDOH-MDC RWP CQM				

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VIRAL LOAD SUPPRESSION							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
V1. Increase the percentage of people with HIV in the EMA who are virally suppressed (<200 copies/mL) from 67% in 2015 to at least 80% by 2021.	**V1.3** Expand role of RWP MCM and OAHS subrecipients in detecting persistent unsuppressed viral loads (VL) and initiate appropriate responses.	**V1.3a** On a monthly basis, detect people with HIV with persistent unsuppressed VL over two consecutive semi-annual measurements and notify RWP MCM and OAHS subrecipients to enable their targeted response. Monitor improvement in VL suppression levels to ensure efficacy of subrecipient response. **Note:** OAHS data will be limited to RWP OAHS subrecipients only.	RWP CQM CQMC	Which MCM and OAHS subrecipients have the highest proportion of clients with new or continued persistent unsuppressed VL? Can alerting RWP subrecipients about clients with persistent unsuppressed VL produce internal responses to address client VL issues? What type of subrecipient service – MCM or OAHS – is more effective in addressing persistent unsuppressed VL when informed?	% of clients served by MCM and OAHS subrecipients who show persistent unsuppressed VL. % of identified clients with persistent unsuppressed VL among MCM and OAHS subrecipients, and whose VL levels show improvement at next semi-annual measurement.		SDIS

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES (2018 IMPLEMENTATION)							
DISPARITIES IN RETENTION IN CARE							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DR1. By 2021, increase the percentage of RWP MCM clients in three (3) key disparate minority health groups who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021, to match RWP total levels.	**DR1.1** Identify retention in care (RiC) vulnerabilities of **Black/African American male (B/AAM)** clients within the RWP network of care, and address them with specific interventions: **Increase RiC among B/AAM from 53% in 2015 to 90% by 2021.**	**DR1.1a** Determine (1) "best practices" of RWP MCM subrecipients with higher than average RiC rates for B/AAM with HIV; and (2) risk factors and acuities contributing to low RiC rates for B/AAM with HIV.	RWP CQM CQMC	What are the risk-factor/acuity-related RiC rates for B/AAM? What contributes to B/AAM RiC successes among MCM subrecipients? Are these "best practices" that may be replicated? What MAI-funded program initiatives have positive impacts on RiC for B/AAM? What is the impact of replication of a subrecipient "best practice" or MAI initiative on RiC rates for B/AAM?	% RiC for B/AAM by individual MCM subrecipients. % RiC for B/AAM in care with MCM subrecipients by risk factors/ acuities. % RiC for B/AAM clients of MCM subrecipients with identified "best practices" and MAI-funded program initiatives. % RiC for B/AAM clients of subrecipients where "best practices" and/or MAI-funded initiatives have been replicated.		SDIS
		DR1.1b Identify MAI program RiC initiatives of RWP MCM subrecipients directed toward B/AAM, and track RiC rates annually.	RWP CQM CQMC				
		DR1.1c Evaluate "best practices" and MAI program RiC initiatives directed toward B/AAM for replicability, select one or more for replication pilot-testing and evaluation to improve RiC rates for B/AAM people with HIV in RWP-funded MCM subrecipients. **Note:** System-wide replication may be recommended but cannot be mandated.	RWP CQM CQMC				

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DR1. By 2021, increase the percentage of RWP MCM clients in three (3) key disparate minority health groups who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021, to match RWP total levels.	**DR1.2** Identify retention in care (RiC) vulnerabilities of **Black/African American female (B/AAF)** clients within the RWP network of care, and address them with specific interventions: **Increase RiC rates for B/AAF from 52% in 2015 to 90% by 2021.**	**DR1.2a** Determine (1) "best practices" of RWP MCM subrecipients with higher than average RiC rates for B/AAF with HIV; and (2) risk factors and acuities contributing to low RiC rates for B/AAF with HIV.	RWP CQM CQMC	What are the risk-factor/acuity-related RiC rates for B/AAF? What contributes to B/AAF RiC successes among MCM subrecipients? Are these "best practices" that may be replicated? What MAI-funded program initiatives have positive impacts on RiC for B/AAF? What is the impact of replication of a subrecipient "best practice" or MAI initiative on RiC rates for B/AAF?	% RiC for B/AAF by individual MCM subrecipients. % RiC for B/AAF in care with MCM subrecipients by risk factors/ acuities. % RiC for B/AAF clients of MCM subrecipients with identified "best practices" and MAI-funded program initiatives. % RiC for B/AAF clients of subrecipients where "best practices" and/or MAI-funded initiatives have been replicated.		SDIS
		DR1.2b Identify MAI program RiC initiatives of RWP MCM subrecipients directed toward B/AAF, and track RiC rates annually.	RWP CQM CQMC				
		DR1.2c Evaluate "best practices" and MAI program RiC initiatives directed toward B/AAF for replicability, select one or more for replication pilot-testing and evaluation to improve RiC rates for B/AAF with HIV in RWP-funded MCM subrecipients. **Note:** System-wide replication may be recommended but cannot be mandated.	RWP CQM CQMC				

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DR1. By 2021, increase the percentage of RWP MCM clients in three (3) key disparate minority health groups who had at least two (2) instances of either (a) RWP OAHS visits, or (b) CD4/VL lab tests (as proxy for medical care outside the RWP), at least 90 days apart within a 12-month period, from 60% in 2015 to at least 90% by 2021, to match RWP total levels.	**DR1.3** Identify retention in care (RiC) vulnerabilities of **Hispanic MSM (HMSM)** clients within the RWP network of care, and address them with specific interventions: **Increase RiC rates among HMSM from 69%* in 2015 to 90% by 2021.** *****Based on FDOH 2015 Epi data.*	**DR1.3a** Determine (1) "best practices" of RWP MCM subrecipients with higher than average RiC rates for HMSM with HIV; and (2) risk factors and acuities contributing to low RiC rates for HMSM with HIV.	RWP CQM CQMC	What are the risk-factor/acuity-related RiC rates for HMSM? What contributes to HMSM RiC successes among MCM subrecipients? Are these "best practices" that may be replicated? What MAI-funded program initiatives have positive impacts on RiC for HMSM? What is the impact of replication of a subrecipient "best practice" or MAI initiative on RiC rates for HMSM?	% RiC for HMSM by individual MCM subrecipients. % RiC for HMSM in care with MCM subrecipients by risk factors/ acuities. % RiC for HMSM clients of MCM subrecipients with identified "best practices" and MAI-funded program initiatives. % RiC for HMSM clients of subrecipients where "best practices" and/or MAI-funded initiatives have been replicated.		SDIS
		DR1.3b Identify MAI program RiC initiatives of RWP MCM subrecipients directed toward HMSM, and track RiC rates annually.	RWP CQM CQMC				
		DR1.3c Evaluate "best practices" and MAI program RiC initiatives directed toward HMSM for replicability, select one or more for replication pilot-testing and evaluation to improve RiC rates for HMSM with HIV in RWP-funded MCM subrecipients. **Note:** System-wide replication may be recommended but cannot be mandated.	RWP CQM CQMC				

NHAS 2020 GOAL #3: REDUCE HIV-RELATED HEALTH DISPARITIES AND HEALTH INEQUITIES (2018 IMPLEMENTATION) DISPARITIES IN TREATMENT OUTCOMES (SUPPRESSED / UNDETECTABLE VL LEVELS)							
Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DV1. By 2021, increase the percentage of RWP MCM clients in three (3) key disparate minority health groups who have suppressed viral loads, to 80% by 2021, to match overall levels of people with HIV.	**DV1.1** Identify VL suppression vulnerabilities associated with **Black/African American male (B/AAM)** clients within the RWP network of care, and address them with specific interventions: **Increase B/AAM VL suppression levels from 57% suppressed VL in 2015 to 80% by 2021.**	**DV1.1a** Determine (1) "best practices" of RWP MCM subrecipients with higher than average VL suppression rates for B/AAM with HIV; and (2) risk factors and acuities contributing to low VL suppression rates of B/AAM with HIV.	RWP CQM CQMC	What are the risk-factor/acuity-related VL suppression rates for B/AAM? What contributes to B/AAM VL suppression successes among MCM subrecipients? Are these "best practices" that may be replicated? What MAI-funded program initiatives have positive impacts on VL suppression for B/AAM? What is the impact of replication of a subrecipient "best practice" or MAI initiative on VL suppression rates for B/AAM?	% suppressed VL for B/AAM by individual MCM subrecipients. % suppressed VL for B/AAM in care with MCM subrecipients by risk factors/ acuities. % suppressed VL for B/AAM clients of MCM subrecipients with identified "best practices" and MAI-funded program initiatives. % suppressed VL for B/AAM clients of subrecipients where "best practices" and/or MAI-funded initiatives have been replicated.		SDIS
		DV1.1b Identify MAI program VL suppression initiatives of RWP MCM subrecipients directed toward B/AAM, and track VL suppression rates annually.	RWP CQM CQMC				
		DV1.1c Evaluate "best practices" and MAI program VL suppression initiatives directed toward B/AAM for replicability, select one or more for replication pilot-testing and evaluation to improve VL suppression rates for B/AAM with HIV in RWP-funded MCM subrecipients. **Note:** System-wide replication may be recommended but cannot be mandated.	RWP CQM CQMC				

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Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DV1. By 2021, increase the percentage of RWP MCM clients in three (3) key disparate minority health groups who have suppressed viral loads, to 80% by 2021, to match overall levels of people with HIV.	**DV1.2** Identify VL suppression vulnerabilities associated with **Black/African American female (B/AAF)** clients within the RWP network of care, and address them with specific interventions: **Increase B/AAF VL suppression levels from 60% suppressed VL in 2015 to 80% by 2021.**	**DV1.2a** Determine (1) "best practices" of RWP MCM subrecipients with higher than average VL suppression rates for B/AAF with HIV; and (2) risk factors and acuities contributing to low VL suppression rates of B/AAF with HIV.	RWP CQM CQMC	What are the risk-factor/acuity-related VL suppression rates for B/AAF? What contributes to B/AAF VL suppression successes among MCM subrecipients? Are these "best practices" that may be replicated? What MAI-funded program initiatives have positive impacts on VL suppression for B/AAF? What is the impact of replication of a subrecipient "best practice" or MAI initiative on VL suppression rates for B/AAF?	% suppressed VL for B/AAF by individual MCM subrecipients. % suppressed VL for B/AAF in care with MCM subrecipients by risk factors/acuities. % suppressed VL for B/AAF clients of MCM subrecipients with identified "best practices" and MAI-funded program initiatives. % suppressed VL for B/AAF clients of subrecipients where "best practices" and/or MAI-funded initiatives have been replicated.		SDIS
		DV1.2b Identify MAI program VL suppression initiatives of RWP MCM subrecipients directed toward B/AAF, and track VL suppression rates annually.	RWP CQM CQMC				
		DV1.2c Evaluate "best practices" and MAI program VL suppression initiatives directed toward B/AAF for replicability, select one or more for replication pilot-testing and evaluation to improve VL suppression rates for B/AAF with HIV in RWP-funded MCM subrecipients. **Note:** System-wide replication may be recommended but cannot be mandated.	RWP CQM CQMC				

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Objectives	**Strategies**	**Activities**	**Responsible Entities**	**Evaluation Questions**	**Outputs**	**YTD Data**	**Data Source**
DV1. By 2021, increase the percentage of RWP MCM clients in three (3) key disparate minority health groups who have suppressed viral loads, to 80% by 2021, to match overall levels of people with HIV.	**DV1.3** Identify VL suppression vulnerabilities associated with **Haitian** clients within the RWP network of care, and address them with specific interventions: **Increase Haitian VL suppression levels from 68% suppressed VL in 2015 to 80% by 2021.**	**DV1.3a** Determine (1) "best practices" of RWP MCM subrecipients with higher than average VL suppression rates for Haitians with HIV; and (2) risk factors and acuities contributing to low VL suppression rates of Haitians with HIV.	RWP CQM CQMC	What are the risk-factor/acuity-related VL suppression rates for Haitians? What contributes to Haitian VL suppression successes among MCM subrecipients? Are these "best practices" that may be replicated? What MAI-funded program initiatives have positive impacts on VL suppression for Haitian clients? What is the impact of replication of a subrecipient "best practice" or MAI initiative on VL suppression rates for Haitian clients?	% suppressed VL for Haitians by individual MCM subrecipients. % suppressed VL for Haitians in care with MCM subrecipients by risk factors/acuities. % suppressed VL for Haitian clients of MCM subrecipients with identified "best practices" and MAI-funded program initiatives. % suppressed VL for Haitian clients of subrecipients where "best practices" and/or MAI-funded initiatives have been replicated.		SDIS
		DV1.3b Identify MAI program VL suppression initiatives of RWP MCM subrecipients directed toward Haitians, and track VL suppression rates annually.	RWP CQM CQMC				
		DV1.3c Evaluate "best practices" and MAI program VL suppression initiatives directed toward Haitians for replicability, select one or more for replication pilot-testing and evaluation to improve VL suppression rates for Haitian with HIV in RWP-funded MCM subrecipients. **Note:** System-wide replication may be recommended but cannot be mandated.	RWP CQM CQMC				

***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).

Abbreviations

- Per 2020 HRSA RWP grant guidance, “people with HIV,” replaces “PLWH” (People Living With HIV) and “PLWHA” (People Living With HIV/AIDS).