2017-2021 Miami-Dade County Integrated HIV/AIDS Prevention and Care Plan
Snapshot of Objectives, Strategies, and Activities
March 14, 2022

This document lists 2017-2021 Integrated Plan Objectives, Strategies, and Activities:

1. **Objectives**
    a. Strategies
        1.1. Activities

PREVENTION

1. 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.

a. 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.

1.1. Increase the number of condom distribution sites.
1.2. Develop an annual condom distribution map to identify new points of service.
1.3. Recruit annually a new location or host an event to provide condom distribution services in the identified underserved area.
1.4. Increase the availability and accessibility of condom distribution by 2.0 million a year.

b. Implement sexually transmitted disease (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.

1.5. Conduct HIV testing events in Miami Dade County.
1.6. Conduct STD testing events in Miami Dade County.
1.7. Partner with healthcare settings (e.g. hospitals, health centers, emergency departments), to increase the provision of routine HIV testing as part of medical care.
1.8. Increase the number of registered testing sites to ensure that HIV testing is more readily available and accessible.

c. 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.

1.9. Conduct STD/HIV educational events in Miami-Dade County, including but not limited to tabling, mobile units, etc.

2. Increase the number of individuals prescribed PrEP by at least 500% from the baseline 663 persons in 2016 to 3,978 persons by 2021.

a. Increase availability of – and access to – Pre-Exposure Prophylaxis /non-occupational Post-Exposure Prophylaxis (PrEP/nPEP) programs.

2.1. Create a process for a PrEP external referral system.
2.2. Develop estimates of a PrEP cascade to inform prevention activities.
2.3. Create a local directory of providers prescribing PrEP/nPEP, disseminate same on Part A and FDOH-MDC websites, and update annually thereafter.

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3. Reduce the number of infants born with HIV in Miami-Dade County each year from three (3) to zero (0) by 2021.

a. Increase number of OB/GYN healthcare providers engaging in HIV prevention activities with pregnant women.

3.1. 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.
3.2. 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.
3.3. Participate in an action-oriented community process to improve service systems and community resources for families.

b. 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.

3.4. Conduct community outreach and promote information campaigns towards women of child-bearing age living with HIV.
3.5. 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).

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4. Increase the percentage of newly diagnosed persons linked to HIV medical care within one month (30 days) of diagnosis to 85% by 2021.

a. Improve existing FDOH-Part A diagnosis-to-linkage client management process.

4.1. Monitor and improve the processes for linking all newly diagnosed persons to HIV medical care within 30 days of initial HIV test result.
4.2. Measure the success the local Test & Treat/Rapid Access (TTRA) process for newly diagnosed persons linked to immediate entry in HIV primary care and initiation of Antiretroviral Therapy (ART).
4.3. Hold FDOH-MDC trainings for testing counselors that are targeted to improving linkage to care.

b. Provide Partner Services to identified HIV+ individuals, allowing for the notification, screening and referral to appropriate services for partners of newly-diagnosed people with HIV.

4.4. Increased participation in HIV partner services among persons with diagnosed HIV (baseline: 68% in 2015).
4.5. Increased notification and HIV testing of partners identified through HIV partner services. (baseline: 48% in 2015).

c. 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.

4.6. Provide linkage to HIV medical services using DTC activities.

5. 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.

a. Track and assess the quality of OAHS care provided to RWP clients who transition to Affordable Care Act (ACA)-provided outpatient medical care.

5.1. 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%.
5.2. 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.
5.3. 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.
5.4. 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.

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6. Increase the proportion of "lost to care" RWP MCM clients who are relinked to care, from 40% in 2017 to 60% by 2021.

a. RWP MCM subrecipients will partner with FDOH-MDC 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 relink clients in care.

6.1. FDOH and RWP will develop data-sharing protocols and feedback mechanisms to provide updated contact information to RWP on clients 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.
6.2. Identify RWP MCM subrecipients with lowest and highest relinkage rates and determine QI interventions and best practices.
6.3. Develop 6-month RiC measurements and protocols for new-in care clients based on the RiC Report Card data prioritized by the CQMC.

VIRAL LOAD SUPPRESSION

7. 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. (In FY2020, the percent of RWP clients with suppressed VL was 82% (89% among MCM clients, 86% among OAHS clients).

a. Expand role of RWP MCM and OAHS subrecipients in detecting persistent unsuppressed viral loads (VL) and initiate appropriate responses.

7.1. On a monthly basis, detect RWP clients with persistent unsuppressed VL over two semi-annual measurements ("virologic failure") 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.)

8. 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.

a. Identify RiC vulnerabilities of *RWP Part A/MAI Black/African American Male-to-Male Sexual Contact (B/AA MMSC) within the RWP network of care* and address them with specific interventions: Increase RiC among B/AA MMSC RWP MCM and OAHS clients from 84% in 2018 to 90% in 2021.

8.1. Determine best practices of RWP Part A and Minority AIDS Initiative (MAI) MCM subrecipients with higher than average RiC rates for B/AA MMSC.
8.2. Determine risk factors and acuities contributing to low RiC rates for B/AA MMSC.
8.3. Identify Part A and MAI RiC initiatives of RWP MCM subrecipients directed toward B/AA MMSC, and track RiC rates annually.

b. Identify RiC vulnerabilities of *RWP Part A/MAI Black/African American (B/AA) Heterosexual Males within the RWP network of care* and address them with specific interventions: Increase RiC among B/AA heterosexual male RWP MCM and OAHS clients from 86% in 2018 to 90% by 2021.

8.4. Determine best practices of RWP Part A and Minority AIDS Initiative (MAI) MCM subrecipients with higher than average RiC rates for B/AAM heterosexual males.
8.5. Determine risk factors and acuities contributing to low RiC rates for B/AAM heterosexual males.
8.6. Identify Part A and MAI RiC initiatives of RWP MCM subrecipients directed toward B/AAM heterosexual males, and track RiC rates annually.

c. Identify 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.

8.7. Determine best practices of RWP Part A and Minority AIDS Initiative (MAI) MCM subrecipients with higher than average RiC rates for B/AAF.
8.8. Determine risk factors and acuities contributing to low RiC rates for B/AAF.
8.9. Identify Part A and MAI RiC initiatives of RWP MCM subrecipients directed toward B/AAF, and track RiC rates annually.

d. Identify RiC vulnerabilities of *Hispanic MMSC (HMMSC) clients within the RWP network of care* and address them with specific interventions: Increase RiC rates among HMMSC from 69% in 2015 to 90% by 2021.

8.10. Determine best practices of RWP Part A and Minority AIDS Initiative (MAI) MCM subrecipients with higher than average RiC rates for HMMSC.
8.11. Determine risk factors and acuities contributing to low RiC rates for HMMSC.
8.12. Identify Part A and MAI RiC initiatives of RWP MCM subrecipients directed toward HMMSC, and track RiC rates annually.

9. 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.

a. Identify VL suppression vulnerabilities of RWP Part A/MAI *Black/African American MMSC (B/AA MMSC) clients within the RWP network of care* and address them with specific interventions: Increase VL suppression levels among B/AAM MMSC from 79% in 2018 to 80% by 2021.

9.1. Determine best practices of RWP Part A and MAI MCM subrecipients with higher than average VL suppression rates for B/AA MMSC clients.
9.2. Determine risk factors and acuities contributing to low VL suppression rates for B/AA MMSC clients.
9.3. Identify Part A and MAI program VL suppression initiatives of RWP MCM subrecipients directed toward for B/AA MMSC clients, and track VL suppression rates annually.

b. Identify VL suppression vulnerabilities of RWP Part A/MAI *Black/African American (B/AA) heterosexual male clients within the RWP network of care* and address them with specific interventions: Maintain B/AAM heterosexual VL suppression levels: 81% in 2018; exceeds 2021 goal of 80%.

9.4. Determine (1) best practices of RWP Part A and MAI MCM subrecipients with higher than average VL suppression rates for B/AA heterosexual male clients.
9.5. Determine risk factors and acuities contributing to low VL suppression rates for B/AA heterosexual male clients.
9.6. Identify Part A and MAI program VL suppression initiatives of RWP MCM subrecipients directed toward for B/AA heterosexual male clients, and track VL suppression rates annually.

c. Identify VL suppression vulnerabilities of RWP Part A/MAI *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 84% in 2018; 79% in 2019 to 80% by 2021.

9.7. Determine (1) best practices of RWP Part A and MAI MCM subrecipients with higher than average VL suppression rates for B/AAF clients.
9.8. Determine risk factors and acuities contributing to low VL suppression rates of B/AAF clients.
9.9. Identify Part A and MAI program VL suppression initiatives of RWP MCM subrecipients directed toward B/AAF clients, and track VL suppression rates annually.

d. Strategy DV1.4 Identify VL suppression vulnerabilities of RWP Part A/MAI *Haitian Male (HM) clients within the RWP network of care* and address them w/ specific interventions: Maintain HM VL suppression levels: 87% in 2018; exceeds 2021 goal of 80%.

   9.10. Determine (1) best practices of RWP Part A and MAI MCM subrecipients with higher than average VL suppression rates for HM clients.
   9.11. Determine risk factors and acuities contributing to low VL suppression rates for HM clients.
   9.12. Identify Part A and MAI program VL suppression initiatives of RWP MCM subrecipients directed toward for HM clients, and track VL suppression rates annually.

e. Identify VL suppression vulnerabilities of RWP Part A/MAI *Haitian Female (HF) clients within the RWP network of care* and address them w/ specific interventions: Maintain HF VL suppression levels: 87% in 2018; exceeds 2021 goal of 80%.

   9.13. Determine (1) best practices of RWP Part A and MAI MCM subrecipients with higher than average VL suppression rates for HF clients.
   9.14. Determine risk factors and acuities contributing to low VL suppression rates for HF clients.
   9.15. Identify Part A and MAI program VL suppression initiatives of RWP MCM subrecipients directed toward for HF clients, and track VL suppression rates annually.